Section	Contents
0	Introduction
1	General Description and Purpose of the Children's Health Insurance Plans and the Requirements
2	General Background and Description of Approach to Children's Health Insurance Coverage and Coordination
3	Delivery Standards
4	Eligibility Standards and Methodology
5	Outreach and Coordination
6	Coverage Requirements for Children's Health Insurance
7	Quality and Appropriateness of Care
8	Cost Sharing and Payment
9	Strategic Objectives and Performance Goals and Plan Administration
10	Annual Reports and Evaluations
11	Program Integrity (section2101 (a))
12	Applicant and Enrollee Protections (Section 2101 (a))

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts
Introduction

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: Massachusetts
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

_____
(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Daniel Tsai Position/Title: Assistant Secretary for MassHealth
Name: Matthew Klitus Position/Title: Chief Financial and Strategy Officer
Name: Robin Callahan Position/Title: Deputy Medicaid Director and CHIP Director

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts
Introduction

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP

SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)

5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment**- This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)

11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification
Mail Stop - S2-01-16

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 ☒ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans

with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Effective date: October 1, 1997
Implementation date: August 24, 1998

SPA #1 (Benchmark Change)
Submission date: October 12, 2001
Approval date: March 22, 2002
Effective date: January 1, 2002
Implementation date: January 1, 2002

SPA #2 (Compliance)
Submission date: June 28, 2002
Approval date: September 19, 2002
Effective date: August 24, 2001
Implementation date: August 24, 2001

SPA #3 (Cost Sharing)
Submission date: April 8, 2003
Approval date: June 23, 2003
Effective date: March 1, 2003
Implementation date: March 1, 2003

SPA # 4 (Healthy Start)
Submission date: April 24, 2003
Approval date: September 15, 2003
Effective date: November 1, 2002
Implementation date: November 1, 2002

SPA #5 (Family Assistance Expansion)
Submission date: May 2, 2006
Approval date July 20, 2006
Effective date: July 1, 2006
Implementation date: July 1, 2006

SPA #6 (CHIPRA Legally Residing Immigrants)
Submission date: March 12, 2010
Approval date: February 9, 2012
Effective date: August 29, 2009
Implementation date: August 29, 2009

SPA #6 (CHIPRA Dental Requirement)
Submission date: March 12, 2010
Approval date: February 9, 2012
Effective date: August 29, 2009
Implementation date: October 1, 2009

SPA #6 (RWJ Grant and State Share)
Submission date: March 12, 2010
Approval date: February 9, 2012
Effective date: August 29, 2009
Implementation date: March 12, 2010

SPA #7 (Health Services Initiative)
Submission date: June 28, 2010
Approval date: August 29, 2011
Effective date: July 1, 2009
Implementation date: July 1, 2009

SPA #8 (Express Lane Renewal)
Submission date: January 27, 2012
Approval date: November 9, 2012
Effective date: January 23, 2012
Implementation date: January 23, 2012

SPA#9 (Health Services Initiative)
Submission date: June 26, 2012
Approval date: October 16, 2012
Effective date: October 1, 2011
Implementation dates:
October 1, 2011 for the following provisions: Child At-Risk Hotline; Teen Pregnancy Prevention Program; Youth Violence Prevention Program; Youth Parents Support Program; and Safe and Successful Youth Program.
January 1, 2014 for the following provisions: Children's Medical Security Plan; Failure to Thrive Program; Pediatric Sexual Assault Nurse Examiner (SANE) Program; and Pediatric Palliative Care.

SPA #10 (in MMDL as TN-13-026) (CS24, CHIP Application)
Submission date: December 30, 2013 through the MMDL
Approval date: May 5, 2014
Effective date: October 1, 2013
Implementation date: October 1, 2013

SPA #11 (in MMDL as TN-14-003) (CS3, CHIP Medicaid Expansion) Pending
Submission Date: January 16, 2014 through the MMDL
Approval date: December 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #12 (in MMDL as TN-14-005) (CS14, CHIP 2101(f))
Submission date: February 11, 2014 through the MMDL
Approval date: April 15, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #13 (in MMDL as TN-14-013) (CS15, 17-21, CHIP MAGI Eligibility and Income)
Submission date: March 28, 2014 through the MMDL
Approval date; September 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #14 (in MMDL as TN-14-006) (CS7,9,13, CHIP non-financial eligibility)
Submission date: March 28, 2014 through the MMDL
Approval date: September 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #15 (Unborn child option benefits) (TN-14-014)
Submission date: June 27, 2014
Approval date: March 11, 2015
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #16 (Health Services Initiative) (TN-014-015)
Submission date: June 27, 2014
Approval date: December 8, 2014
Effective date: July 1, 2013
Implementation date: July 1 2013 for the following H.S.I provision: "Services for Homeless Youth"

SPA #17 (Applied Behavior Analysis) (TN-016-004)
Submission date: March 31, 2016
Approval date: May 18, 2016
Effective date: July 1, 2015
Implementation date: July 1, 2015

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Verification of Tribal Consultation is attached.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 2. General Background and Description of State Approach to Child Health

Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

Table 2a displays the distribution of children by insurance status based on the Current Population Survey (CPS) data made available by the U.S. Bureau of the Census. The CPS is an annual national survey providing data on health insurance coverage, income, employment status, demographic characteristics and other family and individual characteristics. The CPS is considered the most reliable source of estimates of the uninsured population at the state level. To enhance the statistical reliability of demographic estimates contained in this data, the Commonwealth completed an analysis using a merged database comprising survey samples from the March, 1993 supplement and the March, 1994 supplement. In this analysis, the 1993-1994 data is considered a proxy for estimating the current distribution of Massachusetts children based on income, age and health insurance status.

Although more recent data from the March, 1995 supplement is available, it is not comparable to the 1993 and 1994 data for purposes of this analysis because survey questions were changed. The March, 1996 supplement contains a Massachusetts sample too small in aggregate to provide statistically reliable estimates.

Data has been manipulated by the Massachusetts Institute of Social and Economic Research at the University of Massachusetts in Amherst.

Table 2b displays the distribution of insured children by type of health care coverage.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 2. General Background and Description of State Approach to Child Health

Table 2a.

Health Insurance Status of Children in Massachusetts by Age and Income Level (1)

Uninsured Children					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18 (2)	Total
0% - 100% FPL	12,738	10,215	9,581	2,072	34,607
101% - 133% FPL	7,985	1,840	5,710	828	16,362
134% - 150% FPL	3,149	266	2,600	353	6,369
151% - 200% FPL	2,338	6,623	9,506	1,410	19,876
201% - 400% FPL	15,016	10,868	15,380	3,544	44,808
401% + FPL	14,055	2,941	4,432	2,607	24,035
Total	**55,281**	**32,753**	**47,210**	**10,814**	**146,058**
Insured Children					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18	Total
0% - 100% FPL	92,244	69,043	38,390	4,005	203,682
101% - 133% FPL	32,829	27,732	23,640	1,948	86,150
134% - 150% FPL	14,899	9,679	10,841	1,072	36,490
151% - 200% FPL	39,240	29,630	21,585	2,832	93,287
201% - 400% FPL	194,427	161,942	135,331	17,751	509,451
401% + FPL	178,375	151,055	122,694	32,066	484,189
Total	**552,013**	**449,080**	**352,482**	**59,674**	**1,413,249**

(1) Based on 1995, 1996, and 1997 Merged Current Population Survey (CPS) data.
(2) Estimated based on CPS and Census data.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 2. General Background and Description of State Approach to Child Health

Table 2b

Coverage of Insured Children in Massachusetts by Age and Income (1)

Insured Children					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18 (2)	Total
0% - 100% FPL	92,244	69,043	38,390	4,005	203,682
101% - 133% FPL	32,829	27,732	23,640	1,948	86,150
134% - 150% FPL	14,899	9,679	10,841	1,072	36,490
151% - 200% FPL	39,240	29,630	21,585	2,832	93,287
201% - 400% FPL	194,427	161,942	135,331	17,751	509,451
401% + FPL	178,375	151,055	122,694	32,066	484,189
Total	**552,013**	**449,080**	**352,482**	**59,674**	**1,413,249**
Children Covered by Employer Related Group Health Insurance					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18	Total
0% - 100% FPL	7,408	13,282	9,544	873	31,107
101% - 133% FPL	16,258	11,201	8,891	745	37,095
134% - 150% FPL	8,847	6,181	8,612	652	24,291
151% - 200% FPL	19,349	14,747	13,678	1,863	49,638
201% - 400% FPL	157,962	129,847	111,084	14,844	413,737
401% + FPL	162,714	139,641	107,194	29,539	439,088
Total	**372,539**	**314,899**	**259,003**	**48,516**	**994,957**
Children Covered by Other Health Insurance (3)					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18	Total
0% - 100% FPL	84,835	55,761	28,846	3,132	172,575
101% - 133% FPL	16,571	16,531	14,749	1,203	49,054
134% - 150% FPL	6,052	3,497	2,230	420	12,199
151% - 200% FPL	19,891	14,883	7,907	969	43,649
201% - 400% FPL	36,465	32,095	24,247	2,907	95,714
401% + FPL	15,661	11,414	15,500	2,526	45,101
Total	**179,475**	**134,180**	**93,479**	**11,158**	**418,292**

(1) Based on 1995, 1996, and 1997 Merged Current Population Survey data.
(2) Estimated based on CPS and Census data.
(3) Includes Medicaid, Medicare, CHAMPUS, and Other Insurance.

Updated children's uninsurance data for the State Plan Amendment submitted on April 28, 2006:

The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in Massachusetts for the two most recent reporting periods.

Program	FFY 2004	FFY 2005	Percent change FFY 2004-2005
SCHIP Medicaid Expansion Program	119,377	115,858	(3.0%)
Separate Child Health Program	47,131	42,715	(9.3%)

Three-year averages in the number and/or rate of uninsured children Massachusetts based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2004.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	70	15.5	4.6	1.0
1998-2000	68	15.5	4.2	0.9
2000-2002	40	9.9	2.6	0.7
2002-2004	53	11.7	3.4	0.7
Percent change 1996-1998 vs. 2002-2004	-24.3	NA	-26.1	NA

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Massachusetts has many efforts currently underway to identify and enroll eligible children in either MassHealth. These efforts are described below.

MassHealth

MassHealth has made significant strides in outreach, application processing and enrollment of eligible children with the development of the EOHHS Virtual Gateway. The goal of the Virtual Gateway (VG) is to provide a single point of intake, eligibility screening, and referral services for applicants. This allows potential applicants of health and human services in the Commonwealth, either directly through the web or with assistance from a health and human services agency or a patient-accounts staff person, to obtain information and to gain access to available HHS programs. In addition, providers are also able to track electronically submitted applications.

Application volume through the VG for MassHealth and Uncompensated Care Pool (UCP) determinations increased steadily since implementation. By the end of FY 2005, the VG deployment had reached provider sites constituting 80% of UCP volume. There are currently 120 MassHealth providers using the VG, made up of 72 hospitals and 48 community health centers.

The Virtual Gateway has been pivotal in improving access to MassHealth since its implementation in October 2004. Access improvements have resulted in an 8.4% increase in family enrollment and a 6.7% increase in children's enrollment in MassHealth in the period October 2004 to November 2005.

In the last quarter of FFY05, MassHealth awarded $500,000 in mini-grants to 22 community-based organizations across the state to increase MassHealth enrollment. These grants will help provide critical access to people who are already eligible for MassHealth but not enrolled. MassHealth is working closely with these grantees to give them the knowledge and tools to enroll new MassHealth members. One component of this effort is training those grantees who are not already doing so to submit electronic applications for MassHealth. Each of the grantees has tailored programs specific to the people and regions they serve. To buttress training provided by MassHealth, grantees will use novel approaches for outreach, including health fairs, public notices, multi-lingual

collaborations with YMCAs, YWCAs, hospitals, community service organizations, soup kitchens, homeless shelters, clinics, schools, and businesses, as well print, radio, and television marketing campaigns.

Massachusetts continues as a Robert Wood Johnson Foundation Covering Kids' site, collaborating with Health Care for All. MassHealth also continues to work with the medical community including the Massachusetts Hospital Association, the Massachusetts Medical Society, and the American Academy of Pediatrics to promote the MassHealth program. Providers are encouraged to participate in training sessions on MassHealth and are supplied with enrollment kits titled "What to do when an Uninsured Child Shows up at your Door".

Additionally, to support member education efforts, MassHealth continues to provide funding for the Health Access Networks (HANs). HANs were developed in partnership with the University of Massachusetts Medical School's Area Health Education Center (AHEC) as a forum to share information, strategies, and experiences on effective member education practices. HANs have been established in each of the six regional areas and continued to meet monthly during SFY05. MassHealth Operations continues to fund this effort as MassHealth Technical Forums. The meetings currently promote information dissemination, sharing of best practices, and building of community/public sector linkages to increase targeted outreach and member education information about MassHealth.

MassHealth has also elected the Express Lane Renewal option to provide a simplified renewal process for eligible Medicaid Expansion CHIP children (133% to at or below 150% of the federal poverty level for children aged 1 to 5 years old; 114% to at or below 150% of the federal poverty level for children aged 6 to 17 years old; and 0% to at or below 150% of the federal poverty level for children aged 18 years old). This option is also provided for unborn-CHIP children from 0% to at or below 150% of the federal poverty level. Gross income is used for all income calculations. The Express Lane renewal process allows Medicaid Expansion CHIP and CHIP children who are also receiving Supplemental Nutrition Assistance Program (SNAP) benefits to have their eligibility renewed through an automatic process that will not require a paper renewal form. This process promotes retention of children in health benefits

Children's Medical Security Plan (CMSP)

CMSP is a state-funded program that provides coverage for certain preventive and ambulatory medical services for children of any income who are not eligible for MassHealth. EOHHS has created a single point of access for the two programs. There is a streamlined, single application for both MassHealth and CMSP. An application is reviewed first for MassHealth eligibility. If the child is determined ineligible for MassHealth, an eligibility determination is automatically made for CMSP.

Other EOHHS Programs

There are several other programs operated by EOHHS agencies that also evaluate families for potential eligibility for MassHealth and CMSP. These programs include:

- Early Intervention Programs: Early Intervention Programs (EIPs), certified by the Department of Public Health, offer developmental services to both insured and uninsured children. EIPs are reimbursed by the Department of Public Health for services delivered to uninsured children. EIP staff provides information about CMSP and MassHealth to families with uninsured children.

- School-Based Health Centers: Thirty-one school-based health centers in the Commonwealth are funded by the Department of Public Health to offer comprehensive primary care services to children and adolescents who are students at the schools served by the centers. The sites are able to bill MassHealth, CMSP and other insurers for services delivered, and also provide services to uninsured children. Additionally, these sites are required to provide information about CMSP and MassHealth to children who indicate they are uninsured.

- Community-Based Primary Care**:** Forty-nine community-based primary care sites are funded by the Department of Public Health to offer supportive services to ease access to medical primary care. These services, which include social services, nutrition and health education, outreach, case management and transportation, are available to both insured and uninsured children. Medical services provided to uninsured children are billed to the Commonwealth's uncompensated care pool. Additionally, these 49 primary care sites are required to provide information about CMSP and MassHealth to children who are uninsured.

- The Supplemental Nutrition Program for Women, Infants and Children (WIC): WIC sites are operated under the auspices of the Department of Public Health. The program provides nutritious food to supplement the regular diet of pregnant women, infants and children under age five who meet federal and state income and adjunct eligibility requirements. Women and children under five years old qualify if the combined family income is at or below 185% FPL. WIC staff encourages uninsured pregnant women and parents and guardians of uninsured children to apply for MassHealth. Staff also refers uninsured clients with higher levels of income to CMSP.

- Disproportionate Share Hospitals**:** These hospitals are MassHealth providers that serve a disproportionate share of low income and uninsured people. The hospitals are entitled to apply to the Commonwealth's free care pool for payment for health care services delivered to uninsured patients. In addition, staff at these hospitals is able to assist uninsured patients in applying for CMSP and MassHealth benefits.

- Case Management Program for Children with Special Health Care Needs: The Department of Public Health employs regionally-based case managers who offer case management services to children with special health care needs and their families. These case managers often assist families with MassHealth or CMSP applications, if the child is uninsured. Case managers also provide other social services that may increase access to medical primary care services, including identification of providers with experience in treating children with special health care needs and assisting the family with accessing transportation or other necessary services.

- Early Intervention Partnerships and Healthy Families Home Visiting Programs**:** Under these home visiting programs operated by the Department of Public Health, community-based providers perform home visiting services for high-risk pregnant women, and first-time teen mothers. Home visitors perform many activities, including assisting the pregnant women or mothers in accessing health insurance through either CMSP or MassHealth, as well as facilitating the child's access to primary medical care services.

- The Municipal Medicaid Program: MassHealth contracts with municipalities to provide direct health care services to special education students and to assist with administration of the Medicaid program in general. One of the activities that is included in the administration is identification of potential MassHealth eligibles, and referral of those eligibles to MassHealth. In addition, under the Municipal Medicaid program, school health personnel are working to increase coordination with the MassHealth managed care system.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

MassHealth continues to form public/private partnerships with Massachusetts employers through its premium assistance programs.

MassHealth encourages employer-sponsored coverage for low-income employees and their families through a combination of the SCHIP program and its 1115 Waiver. MassHealth provides premium assistance payments on behalf of eligible children with family income at or below 300% FPL (before disregards). In addition, under the 1115 Waiver, MassHealth provides premium assistance to eligible adults who work for a qualified small employer and makes an incentive payment to the small employer.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*

(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

EOHHS will assess children's eligibility for both Title XIX and Title XXI programs. EOHHS is the Commonwealth's Title XIX agency and has been charged with expanding its health programs to cover Title XXI populations. Eligibility for MassHealth Title XIX and MassHealth Title XXI will be determined simultaneously. The Medical Benefit Request (MBR) is used to assess eligibility for all MassHealth programs (Title XIX and Title XXI), as well as the Children's Medical Security Plan. Sufficient information is collected on the MBR to assess if the applicant is eligible for any MassHealth coverage type (e.g. MassHealth Standard, CommonHealth or Family Assistance). The MBR information is data entered into MassHealth's eligibility system (MA21) to invoke an eligibility

determination. MA21 is designed to assign the most comprehensive coverage type to the eligible applicant. See Section 4.4.1 for a more detailed description of the eligibility process.

If a child with family income between 150% and 300% of the FPL (before disregards) appears to have access to health insurance through an employer, MassHealth will conduct a health insurance investigation to determine if the insurance meets MassHealth standards and is cost effective. If there is access to qualified health insurance coverage, the children will be eligible for premium assistance towards the cost of their employer sponsored insurance. Children between 200 and 300% of the FPL may be subject to a waiting period of up to six months for coverage if they are found to have dropped employer-sponsored insurance within the previous six months (see section 4.4.4.2).

The MBRs of children who are ineligible for MassHealth are automatically processed for CMSP and Safety Net Care.

MassHealth notices include information regarding the WIC program if a family member is pregnant or under age five.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 3. Methods of Delivery and Utilization Controls

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 4.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to CMS' Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other

hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. Delivery Standards Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

☐ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

MassHealth uses Title XXI funds to deliver child health assistance through the following MassHealth coverage types: MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance (including the Family Assistance Expansion for Children - FAEC), and MassHealth Prenatal . Coverage types are described below.

MassHealth Standard

Delivery system options: managed care organization (MCO) or primary care clinician (PCC) plus behavioral health program (BHP). Standard members who have other comprehensive third-party health insurance and those who have not yet enrolled in a managed care plan may obtain services from any MassHealth provider on a fee-for-service basis.

MassHealth CommonHealth

Delivery system options: Generally CommonHealth members obtain services on a fee-for-service basis. Uninsured CommonHealth members may, at their option, participate in the MassHealth managed care network.

MassHealth Standard and CommonHealth Premium Assistance Program (MSCPA)

MassHealth Standard and CommonHealth members may receive premium assistance toward the employee's full share of the cost of employer-sponsored health insurance through the MSCPA program. Additionally, MassHealth will cover any MassHealth covered services not covered by the member's private health insurance or on a fee-for-service basis.

MassHealth Family Assistance (including FAEC)

(A) Premium Assistance

Delivery system options: Premium Assistance payments are made to parents to subsidize the employee share of employer-sponsored insurance (ESI). All medical services are provided through the ESI. Dental services are provided directly by MassHealth on a fee-for-service basis. .

(B) Purchase of Medical Benefits

Delivery system options: Generally, managed care (MCO or PCC plus BHP) Family Assistance members who have not yet enrolled in a managed care plan may obtain services from any MassHealth provider on a fee–for-service basis and behavioral health services through the Behavioral Health Plan. MassHealth Family Assistance members who are eligible to receive covered services through

other state agencies under agreement with MassHealth may obtain services on a fee-for-service basis as well.

MassHealth Prenatal

Delivery system options: fee-for-service.

Methods of delivering insurance product and services

MassHealth members receive services through the following.

Primary Care Clinician (PCC) Plan Provider Network and the PCC Plan's Behavioral Health Program (BHP)

The PCC plan is a primary care case management program administered by MassHealth. In the PCC Plan, members enroll with a primary care clinician (PCC), who provides most primary and preventive care. There are currently approximately 1,100 PCC practices in the PCC Plan network, including individual physicians, group practices, community health center, independent nurse practitioners, and hospital outpatient departments. MassHealth monitors the performance of providers in the network, including developing and implementing quality improvement.

The BHP is a managed behavioral health care program that offers a comprehensive provider network including a broad spectrum of mental health and substance abuse providers who provide a full continuum of mental health and substance abuse services to eligible members. Covered mental health benefits are described in section 6. Members enrolled in the PCC Network are automatically enrolled in the BHP: there are no pre-enrollment assessments required. In addition, eligible members are only disenrolled if they become ineligible for managed care or enroll in an MCO, as MassHealth MCOs are separately responsible for behavioral health services for their members.

MassHealth contracts with a vendor to administer and manage its BHP.

BHP Linkage with the PCC Plan

The BHP vendor is required to facilitate communication and coordination of care with primary care clinicians and to establish annual BHP – PCC linkage improvement goals.

Managed Care Organization (MCO) Provider Network

MassHealth currently contracts with MCOs that provide comprehensive health coverage, including medical, pharmacy, and behavioral health services, to MassHealth Standard members and Family Assistance members, as well as to uninsured CommonHealth members who opt to participate in the MCO network. The network of MassHealth MCOs reflects industry trends towards mixed models, a combination of staff, network, and IPA. MCOs are available to MassHealth members throughout the state, although not all contracting MCOs are statewide. MassHealth members enrolled in MCOs choose a primary care provider (PCP) from among an MCO's list of participating providers. These MCO participating providers must assure equal access to MassHealth member (i.e., PCPs may not be closed to MassHealth members if they are open to commercial MCO members).

Fee-for-service

Members may receive certain services on a fee-for-service basis. Rates for these services are established either through contracts with MassHealth or regulations promulgated by the Massachusetts Executive Office of Health and Human Services. Any provider who meets program participation requirements set forth in the MassHealth regulations and provider agreements may participate in the MassHealth program.

School Based Health Centers (SBHC)

School health clinics (hereinafter referred to as School-Based Health Centers, or SBHCs) have linkage to primary care providers in the PCC Plan. Some MCOs also have contractual agreements with School Based Health Centers (SBHC) to pay the SBHC for care delivered to members enrolled in the MCO.

SBHCs are operated as satellite sites of existing MassHealth providers. If the provider that operates the SBHC is a PCC, then the qualified SBHC site can act as an arm of that PCC, and treat those students who are enrolled with the operating provider as their PCC. SBHCs use the provider number of the existing MassHealth provider of which they are a satellite. If the provider is an MCO, the MCO pays the SBHC from the MCO capitation paid by MassHealth. Where SBHCs do not have their own provider agreements, they cannot claim payment from MassHealth directly.

School Based Medicaid

School Based Medicaid providers have linkage to PCPs in both the PCC and MCO Plans. Special education-related services are paid for by either the municipality or the child's insurer, including MassHealth.

Family Planning

PCC members are guaranteed confidentiality and unrestricted access to Family Planning services by being able to obtain these services from any participating provider without consulting their PCC or obtaining prior approval from MassHealth. MassHealth members enrolled in an MCO may access Family Planning services provided by the MCO. However, such MCO enrollees may also receive Family Planning services from any Family Planning provider without consulting their PCP or MCO and are not required to obtain prior approval from MassHealth. For Family Planning services provided by MassHealth providers not participating in the MCO network, MassHealth reimburses the provider on a fee-for-service basis.

Payment mechanisms

PCC Payment Mechanisms

Fee-for-service

MassHealth currently reimburses both PCCs and non-PCCs on a fee-for-service basis.

Enhancement

MassHealth pays PCCs an enhancement for most office and home visits when they see one of its members. An enhanced fee is not paid for referrals. MassHealth also pays PCCs an enhancement for providing EPSDT services according to the periodicity schedule. These additional payments compensate PCCs for the case management functions they perform.

Prospective Interim Payment (PIP)

A prospective interim payment (PIP) is also available to PCCs. The PIP is an optional monthly cash advance for PCCs. The payment is made at the beginning of each month and is equal to twenty-five percent (25%) of MassHealth's average monthly payment to the PCC for services to the PCC's plan members in the previous quarter. Reconciliations occur using subsequent claims submissions.

BHP Payment Mechanisms

Capitation and Risk Sharing Arrangements

MassHealth pays a different per member per day capitation rate for each rating category. A rating category groups members by eligibility status and reflects assumptions about projected service utilization and cost. MassHealth and the BHP vendor share the risk of over or underspending according to actuarially sound risk corridors.

MCO Payment Mechanisms

Capitation Payments

MassHealth pays the MCOs a monthly capitation rate on a per-member per-month basis, based on a member's rating category. Capitation rates are developed commensurate with the risk facing an MCO. Rating categories, therefore, are distinguished either by differences in expected utilization of services among groups of MassHealth members and differences in the covered services for which the MCOs are capitated. Capitation rates are established in accordance with regulations at 42 CFR 438.6 regarding actuarial soundness. The MCOs are at full risk for nearly all members, with the exception of certain small risk pools for high-needs children. In addition, MassHealth offers the MCOs the option to purchase stop-loss insurance coverage for persons with disabilities.

MassHealth reconciles estimated capitation payments with actual enrollment volume.

In addition, pursuant to Section 2105(a)(1)(D)(ii), Massachusetts will use administrative funds to offer "Health Services Initiatives" under the plan. Programs offered as part of these Health Services Initiatives with the overarching goal of improving the health of children (defined at 42 CFR 457.10 as "individual(s) under the age of 19 including the period from conception to birth"). Please note that, to the extent that any program does provide services to individuals age 19 or over, reimbursement will only be claimed for services or activities targeted towards children under age 19. The Health Services Initiatives will be activities funded by state appropriations to the Executive Office of Health and Human Services or the Executive Office of Education, and administered by related state departments or agencies, as described below. Specific Health Services Initiatives include the following programs:

- **Healthy Families**

  Healthy Families is a statewide neonatal and postnatal home parenting education and home visiting programs for at-risk newborns. This program is administered by the Massachusetts Children's Trust Fund (MCTF), a quasi-public agency that receives its state appropriation via the Department of Early Education and Care. MCTF provides funding through contracts with community-based human services organizations that furnishes the home visiting services to at-risk families. MCTF selects providers pursuant to Requests for Responses (RFR). The program is designed to prevent child abuse and neglect; achieve optimal health, growth and development in infancy and early childhood; and prevent repeat teen pregnancies. Specific services include home visits in which staff model and support positive parent-child interactions; teach about child development; help the family to

provide a safe and enriching environment for children; provide crisis intervention as needed; and connect the family with other services as needed.

- **School Based Health Programs**

School based health programs are sponsored by the Massachusetts Department of Public Health (DPH). School based health programs that are included as part of the Health Services Initiative are:

  - *"**Essential School Health Services,**"* which strengthens the infrastructure of school health services in the area of school nursing. The program provides funding to eligible school districts through RFRs with the goal of creating and expanding the Essential School Services structure and standards throughout the Commonwealth. This program provides school-age children access to a school health service program that includes nursing assessment/health education; medication management; and screenings with respect to postural, height/weight, hearing, oral health, and vision.

  - ***"Safe Spaces,"*** which provides suicide prevention and violence prevention programs for Gay, Lesbian, Bisexual and Transgender (GLBT) Youth. Through Safe Spaces, DPH funds youth development programs across Massachusetts; the programs are selected pursuant to an RFR issued by DPH. The programs are not necessarily based in schools and may provide services during after-school hours or weekends. The programs engage young people in shared decision-making, expanding life skills, leadership development, and affirming support around multidimensional GLBT identity development which includes successfully navigating race, ethnicity, gender expression, national origin, language, sexual orientation, socio-economic background, age, religion and ability.

- **Nutrition Programs for Children:**

  - ***"School Breakfast Programs,"*** which provide nutritious breakfasts to children on school days and during summer vacation. The program is funded with state appropriations that are supplemental to federal funding. All children may participate, but low income children are eligible for free or reduced price meals depending on family income. The Department of Elementary and Secondary Education (DESE) provides funding to school districts based on schools meeting the criteria of:
    - meeting the requirements of "Severe Need Schools" which are defined as schools where 40 percent or more of the lunches served to students at the

school in the second preceding year were served free or at a reduced prices; and

- having on file a combined total of fifty or more free and reduced price meal applications as of October of the preceding school year.

Expenditures claimed as part of this Health Services Initiative exclude expenditures used as "maintenance of effort" for other federal grants.

- o ***"State-Funded WIC"***, provides the following services through peer counseling and professional medical staff: breastfeeding support, dietary assessments, nutrition education and counseling, immunization screening and referrals to other health and social services. To administer this program, DPH uses an RFR process to select qualified community based organizations, such as community health centers and community action programs, which provide the services.

- **Smoking Prevention and Cessation Programs**

Through Smoking Prevention and Cessation Programs, DPH funds a wide range of activities to promote tobacco control and prevention. The activities serve a wide variety of populations, including children, adolescents, families, and adults. Only the expenditures associated with programs directed toward individuals below the age of 19 will be claimed under CHIP Health Services Initiative. DPH funding supports:

- o Production and dissemination of educational materials for youth and parents;
- o Funding to non-profit organizations (via an RFR process) to promote activities - such as interactive web sites and short-movie contests - to discourage youth from tobacco use.

- **Family Planning Programs**

Through Family Planning Programs, DPH provides the following services at family planning sites throughout the state.

- o Comprehensive family planning services, including complete gynecological and breast exams, cervical cancer screening, diagnosis and treatment of sexually transmitted diseases, contraceptive supplies including emergency contraception, pregnancy testing, follow-up and referral for identified medical problems, and other pre-conceptional care.
- o Individual health education and counseling on reproductive anatomy and physiology, all contraceptive methods, AIDS/HIV, sexually transmitted diseases, all options for positive pregnancy tests, infertility, and other related health concerns.

- Outreach and education to local communities and populations. These activities vary with each program but may include classes in schools and community organizations on reproductive health, sexuality, and HIV prevention; training and resources for teachers, health care providers and parents; peer education programs; participation in community coalitions; and collaboration with other organizations serving high risk populations.

- **DDS/DESE Project to Prevent Out of Home Residential Placements**

  This project provides services to youth with disabilities to enable the youth to live at home rather than in residential facilities. The project is sponsored by the Massachusetts Department of Developmental Services (DDS) and the Massachusetts Department of Elementary and Secondary Education (DESE). DDS receives funds from DESE to provide community based supports to students who a.) meet DDS eligibility criteria for services and b.) also receive special education services. The goal is to provide community based services to enable the youth to continue living with their families and prevent placement in a residential facility.

  Services are provided through this project are based on the individual needs of youth and are planned in conjunction with the families. Most services are provided in the child's home. Each child's needs and services are determined through an individualized plan reviewed with the DDS authorized case manager. The program empowers the youths' parents to arrange for the services needed for their children by providing the parents with funds to purchase necessary services. The range of services are diverse and may include behavioral intervention analysis and training, speech therapy, physical therapy, occupational therapy, adaptive equipment, specialized nutrition, and activities of daily living training.

- **The Children's Medical Security Plan to provide primary and preventive health services for uninsured children from birth through age 18.**

  The Children's Medical Security Plan (CMSP) provides coverage for primary and preventive health services for uninsured children from birth through age 18 who are not eligible for MassHealth. The CMSP is managed by the Executive Office of Health and Human Services (EOHHS). Eligibility for CMSP is determined by MassHealth, and re-determinations are conducted annually. CMSP covers medically necessary medical, behavioral-health, dental, and pharmacy services, but not inpatient services.

- **Child At-Risk Hotline for after hours reporting of suspected child abuse and neglect.**

  The Department of Children and Families engages a private social services agency to provide telephone coverage for reports of child abuse and neglect during nights and weekends. The staff triage reports and communicate information to the state agency.

- **Teen Pregnancy Prevention Program**

  The Department of Public Health engages community based agencies to provide science-based teen pregnancy prevention strategies to high-risk adolescents.

- **Failure to Thrive Program**

  The Department of Public Health oversees the Failure to Thrive Program which focuses on providing evaluation and treatment for infants or children who are exhibiting childhood malnutrition and growth failure known as Failure to Thrive. The overall goal of the program is to improve the growth and developmental outcome of the children. The Department of Public Health contracts with hospitals and community health centers to provide services by multidisciplinary teams.

- **Youth Violence Prevention Program**

  The Department of Public Health oversees the Youth Violence Prevention Program. Community based organizations provide comprehensive youth violence prevention programs to youth in at-risk communities.

- **Pediatric Sexual Assault Nurse Examiner (SANE) Program**

  The SANE program is administered by the Department of Public Health and provides direct patient care to adolescents and children who disclose sexual assault and who go to SANE designated Emergency Departments or Children's Advocacy Centers across Massachusetts. The nurses of the SANE program provide direct patient care to individuals who disclose sexual assault. This includes necessary medical exams, testing, and preventive treatment for HIV, STDs, and pregnancy. These services are the first step in psychological, physical, and emotional healing for the child.

- **Pediatric Palliative Care**

  The Department of Public Health funds the Pediatric Palliative Care Program which helps children with life-limiting illnesses and their families gain a sense of control in their lives. A network of licensed hospices helps children and their caregivers manage the pain and other symptoms brought on by illness.

- **Young Parents Support program**

  The Department of Children and Families funds this program whose goal is to strengthen parenting skills of low-income young mothers for the ultimate benefit of their children.

- **Safe and Successful Youth Program**

  The Executive Office of Health and Human Services oversees this program whose goal is to support a full continuum of services to support young men most likely to be victims or perpetrators of violence.

- **Services for Homeless Youth**

  Through Services for Homeless Youth, the Department of Early Education and Care (EEC) contracts with licensed organizations to provide a stable, nurturing environment that meets the individual, developmental, behavioral and emotional needs of homeless youth. Each family is assessed for their unique issues and needs and the provider develops a "Family Service Plan" to address the needs. Each child is assessed for developmental concerns and where developmental delays are identified, appropriate referrals are made. Parents are provided access to parenting programs, a variety of community resources (e.g., WIC), nutritional guidance, information on building positive parent-child interactions, and skills to help identify the best quality child care for their children. Based on the "Family Service Plan", when therapeutic supports are needed (medical, psychological, etc.), providers assist parents in accessing needed services.

  Expenditures claimed as part of this Health Services Initiative exclude costs for providing services to MassHealth covered members.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the State plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved State plan. (Section 2102)(a)(4) (42CFR 457.490(b))

Primary Care Clinician (PCC) Plan Provider Network

A PCC Plan Provider must sign MassHealth PCC Provider Contract and meet the requirements specified in the Contract. The requirements include, but are not limited to: informing members about service availability, referral processes, grievance procedures, after-hour call-in systems, and procedures for appointments, emergencies and urgent care; providing 24-hour/7-day/week telephone coverage system with physician back-up; making necessary referrals, and monitoring all Medicaid-covered services which require a referral; and ensuring that care is provided in accordance with acceptable medical practices and professional standards.

The PCC is responsible for authorizing most specialty services. Members can access any MassHealth provider for specialty services; however, some services require that members first obtain authorization from their PCC.

The PCC must provide primary care as appropriate, and maintain an adequate appointment system that ensures prompt access to medical care.

PCC Network Management

The PCC Plan Network Management Services (NMS) is a clinically focused management system that monitors, measures, and analyzes health care delivery by PCCs. The major goal of Network Management Services is to improve health care delivery systems that promote improved member health outcomes.

The NMS program assists PCCs and MassHealth by: measuring, monitoring and promoting improvements in health care delivery and outcomes; conducting visits to PCC practices; producing data reports; and assisting PCCs in understanding their utilization statistics. The NMS program also conducts periodic regional information meetings with PCCs, and performs provider-relations, information, and referral activities through the PCC Plan Hotline.

NMS site visits focus primarily on PCCs with large practices. Regional Network managers make site visits to these PCCs to review the Profile Reports, discuss how the measures reflect on the PCC practice, and help formulate improvement plans to address opportunities for improvement.

The PCC Plan Hotline is toll free and staffed by PCC Plan Hotline Provider Service

Representatives. Providers may call the PCC Plan Hotline for information regarding the PCC Plan or MassHealth.

Managed Care Organization (MCO) Provider Network

MCO qualifications and responsibilities

MassHealth's MCO contract details the MCOs' qualifications and responsibilities. MassHealth's decision to contract with an MCO is largely based on that organization's ability to meet MassHealth-defined contract requirements concerning:

- Access, member services and utilization;
- Quality;
- Behavioral health; and,
- Financial stability.

These requirements define what the MCOs must provide to MassHealth members enrolled in their plan, and are the cornerstone of all contract management activities. MassHealth's contract requirements for MCOs are designed to:

- Be consistent with generally accepted standards;
- Address the specific needs of the MassHealth population;
- Address all significant aspects of the performance of MCOs;
- Be set at best practice level and be improvement-oriented; and
- Be specific and measurable so that data from measures can be used by MassHealth and the MCO to identify opportunities for improving performance.

Coordination of Services

MassHealth members enrolled in MCOs may receive the same covered services as MassHealth members in the PCC Plan. However, there are differences in how services are obtained.

For each member enrolled in an MCO, MassHealth pays the MCO a monthly capitation to provide most, but not all, MassHealth services. MCOs are responsible for providing behavioral health services to MassHealth members enrolled in MCOs. MassHealth members enrolled in an MCO may obtain non-capitated MassHealth services from any MassHealth provider. Contracted MCOs are responsible for coordination of such non-capitated services. This coordination includes informing members of the availability of non-capitated services and the processes for accessing those services.

School-Based Health Centers (SBHC)

MassHealth's MCO contracts contain language requiring MCOs to coordinate with SBHCs to improve the quality of, and access to, health care services at SBHCs. The MCOs have undertaken, and will continue, several activities to meet this goal.

The following are examples of these activities: Representatives from DPH's SBHC program attend MCO meetings. At the meetings, participants address MCO-SBHC linkage issues. MCOs work with SBHCs located in their service area(s), to improve their individual relationships. Each MCO has identified a single contact person for the SBHC to call. Finally, the MCOs and SBHCs are currently investigating other ways to communicate with each other regarding children being seen by both providers.

MCO Contract Management

MassHealth maintains a quality-focused, collaborative management approach with its contracted MCOs, an approach that emphasizes continuous quality improvement in several components of service delivery, including clinical care, customer service and administration.

Each MCO's contract management requirements include, but are not limited to, 1) compliance with the contract and with all applicable state and federal laws and regulations, 2) designating a representative to act as a liaison with MassHealth, and 3) participation in and successful completion of performance evaluation activities related to the continuous quality improvement model of contract management utilized by MassHealth. MassHealth oversees compliance by the MCOs using a continuous quality improvement model.

MCO contracts substantially comply with the requirements of the Balanced Budget Act at 42 C.F.R. Part 438.

Behavioral Health Program Provider Responsibilities

The vendor must develop policies and procedures for the provider network. These policies are subject to review and approval by MassHealth and at a minimum must address:

- Timeliness for rendering services;
- Service authorization requests;
- Frequency of reviews;
- Continued stay/continued care clinical criteria; and,
- Required reporting formats.

Through its contracted provider network, the vendor is responsible for providing all medically necessary care, 24 hours a day with the most clinically appropriate provider and at the most clinically appropriate level of care.

The vendor must ensure that members have access to all covered services utilizing the following standards:

- inpatient services – within 15 miles or 30 minutes travel time, whichever requires less travel time;
- all other covered services – within 20 miles or no more than 30 minutes travel time, whichever requires less travel time.

In addition, MassHealth requires that members' access to service is consistent with the degree of urgency as set forth below:

- Emergency services must be provided immediately;
- Urgent care must be provided within 48 hours; and
- Non-urgent care must be provided within ten (10) working days.

MassHealth also required the vendor to develop a protocol to ensure linkage between primary care providers and BH providers. The vendor and MassHealth's PCC Plan collaborated to issue a communication protocol to facilitate coordination and integration in the physical and behavioral health treatment of members.

BHP Vendor's Administration of Diversionary Services

The BHP vendor is required to maintain a network of diversionary services that meet the access standards and to arrange, coordinate, and oversee the provision of medically necessary diversionary services. Diversionary services are provided as alternatives to inpatient mental health services in more community-based, less structured environments. Diversionary services include crisis stabilization, observation and holding beds, partial hospitalization, and psychiatric

day treatment. The provision of these services are arranged for by the vendor's clinical staff who receive requests for hospitalization and then make a clinical decision to locate and authorize alternative or "diversionary" services for members, as appropriate.
MassHealth monitors the BHP vendor's compliance for the administration of diversionary services through the following mechanisms:

- The BHP vendor is required to submit utilization and expenditure reports to MassHealth for all diversionary services provided during the reporting period; these reports must be submitted monthly, quarterly, semiannually, and annually. MassHealth analyzes and monitors these reports to determine if the utilization of diversionary services is clinically appropriate;

- MassHealth requires the BHP vendor to submit provider profiles on a semiannual basis;

- On a regular basis, MassHealth reviews patterns of care, monitors case manager activities, and randomly audits vendor records to monitor and ensure the appropriate use of diversionary services;

- On a regular basis, MassHealth requires the vendor to conduct provider site visits to review randomly selected medical records and participate in case conferences;

- MassHealth's BHP staff regularly join vendor staff supervision meetings and clinical management department meetings to monitor compliance with the administration of diversionary services; and

- MassHealth and DMH review and approve the vendor's medical necessity criteria, level of care determination criteria, and provider policies and procedures, along with the vendor's compliance with the administration of these items.

If MassHealth determines that the vendor is not in compliance with the administration of diversionary services, MassHealth will require the BHP vendor to implement a corrective action plan that has been reviewed and approved by MassHealth. MassHealth will then closely monitor the vendor's compliance with the approved corrective action plan.

<u>BHP Network Management</u>

MassHealth requires the vendor to conduct network management functions. Network management includes:

development, maintenance, and management of the BHP provider network; and,
BHP provider contracting, and provider education.

Specifically, the Network Management service administered by the vendor and monitored by MassHealth includes the following:

- A system for provider profiling and benchmarking;
- A system for the vendor and provider to identify and establish improvement goals and Periodic measurements to track the provider's progress or lack of progress towards improvement goals;
- Monitor the annual turnover of outpatient providers (e.g., therapists, psychiatrists) and use this information to establish improvement goals for the providers for future periods;
- Corrective action plans for the year, methods to be employed to monitor corrective action plans, implementation, and progress;
- A plan, subject to MassHealth approval, for taking appropriate management action with providers who performance is determined to be unacceptable by the vendor's network management department; and
- A plan, subject to MassHealth approval, to terminate or take other appropriate management action with providers who may be insolvent or otherwise financially unsound.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 4. Eligibility Standards and Methodology (Section 2102)(b)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

Pages CS7 and CS9 of TN-014-013 MMDL Supersed 4.1.1., 4.1.2 and income standards at 4.1.3

4.1.1. ☐ Geographic area served by the Plan:

MassHealth is available statewide.

4.1.2. ☒ Age:

In general, children under age 19 are eligible for Title XXI MassHealth. Eligibility for a coverage type is determined by a combination of age, family income, disability or pregnancy status, and the availability of health insurance. For specific eligibility guidelines, see Attachment 4.1 (d).

Language on income counting is superseded by TN-014-006 MMDL (CS15)

4.1.3. ☒ Income:

Title XXI MassHealth has a family income limit of 300% FPL (before disregards, see chart below) and who are not eligible for Medicaid under title XIX. For specific eligibility guidelines see Attachment 4.1 (d).

In the determination of eligibility for MassHealth, the gross income of all family group members is counted and compared to an income standard

based on the family group size.

A family includes natural, step, or adoptive parents who reside with their child(ren) under age 19, and any of their children, or whose child(ren) are absent from home to attend school; or siblings under age 19, and any of their children, who reside together when no parent(s) are present. A family includes both parents when they are mutually responsible for one or more children who reside with them.

Family may also include a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family.

MassHealth Standard through the CHIP unborn child option is available to uninsured pregnant women with family incomes from zero percent of the FPL up to and including 200 percent of the FPL who are not otherwise eligible for MassHealth Standard.

Countability of Income

Eligibility is based on the family group's gross countable earned and unearned income and countable rental income, as defined in (A) and (B), (C) below. Income that is not counted in the eligibility determination is defined in (D), below.

(A) Earned Income

Gross earned income is the total amount of compensation received from work or services performed before any income deduction.

Earned income for the self-employed is the total amount of business income listed or allowable on a U.S. tax return, minus allowable business deductions.

For persons who are seasonally employed, annual gross income is divided by 12 to obtain a monthly gross income with the following exception. If the person experiences a disabling illness or accident during or after the seasonal employment period which prevents the person's continued or future employment, only current available income shall be

considered in the eligibility determination.

(B) Gross Unearned Income

This is income that does not directly result from the individual's own labor. The total amount of unearned income before any deductions is countable. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, and interest and dividend income.

(C) Rental Income

Rental income is the total amount of gross income, received from a tenant or boarder, less any allowable deductions listed on an applicant's or member's U.S. tax return.

(D) Non-Countable Income

The following types of income are non-countable in the determination of eligibility:

- Income received by a TAFDC, EAEDC, or SSI recipient;
- Sheltered workshop earnings;
- The portion of Federal veterans benefits identified as aid and attendance benefits, unreimbursed medical expenses, housebound benefits, or enhanced benefits;
- Income-in-kind;
- Temporary income from U.S. Census Bureau related to Census 2000 activities, or federal unemployment benefits related to the termination of that temporary income.
- Roomer and boarder income; and
- Any other income excluded as provided by federal laws other than the Social Security Act (see 42 C.F.R. Part 416, Appendix to Subpart K).

Verification of Income

Verification of gross monthly income is mandatory. In lieu of any of the specific sources and verifications listed below, any other evidence of the applicant's or member's earned or unearned income is acceptable.

Earned Income

The following are required to verify earned income:

- Two recent pay stubs;
- A signed statement from the employer; or
- Most recent U.S. tax return.

Unearned Income

The following are required to verify unearned income:

- Copy of a recent check or stub showing gross income from the source; or
- Statement from the income source, where matching is not available.

Rental Income

The following are required to verify rental income

- Most recent U.S. tax return

Transfer of Income

All family group members are required to avail themselves of all potential income. If MassHealth determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received. If MassHealth is unable to determine the amount of available income, the family group will remain ineligible until such information is made available.

Calculation of Financial Eligibility

The financial eligibility for various MassHealth coverage types is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage. The monthly income standards are determined according to annual FPL standards published by the Federal Register using the following formula:

- Divide the annual federal poverty income standard as it appears in the Federal Register by 12;
- Multiply the un-rounded monthly income standard by the applicable FPL standard (e.g. 133%); and
- Round up to the next whole dollar to arrive at the monthly income standards.

MassHealth will adjust these standards in April of each calendar year.

Cost of Living Adjustment (COLA) Protections

Members whose income increases each January as the result of a cost of living adjustment shall remain eligible until the subsequent FPL adjustment.

Income Disregards

Gross Income as % of FPL	Income Disregards (as a % of FPL)
Below 200%	0
200	0
250	50
300	100

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

Section 4.1.5 Superseded by TN-014-006 MMDL

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):

As a condition of eligibility an applicant or member must:

- Live in the Commonwealth, with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address; or
- Live in the Commonwealth at the time of application having entered the Commonwealth with a job commitment, whether or not currently employed, (also applicable to migrant or seasonal workers.)

Examples of applicants or members who generally do not meet the residency requirement for MassHealth are:

- Students under age 19 whose parents reside out of state; and
- Individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts.

4.1.6. ☒ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Children under age 19 may establish eligibility for MassHealth CommonHealth under Title XXI provided they:

- Are uninsured;
- Are ineligible for MassHealth Standard;
- Have family group gross income that is less than or equal to 300% of the federal poverty level; and,
- Are permanently and totally disabled as defined below

Note: disabled children, regardless of income, are covered under CommonHealth through the Commonwealth's 1115 waiver.

Permanent and Total Disability
Children meeting the following requirements shall be considered permanently and totally disabled.

(A) For 18 Year Old Children
(1) The child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:
(a) can be expected to result in death; or

(b) has lasted or can be expected to last for a continuous period of not less than 12 months.

(2) For purposes of this definition, an 18 year old shall be determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(B) For Children Under 18
The child has any medically determinable physical or mental impairment of comparable severity to that which is required of an 18 year old, or is unable to engage in age-appropriate activities. For purposes of this definition, an individual under the age of 18 shall be determined to be disabled only if the child's physical or mental impairments are of such severity that the child is unable to engage in age-appropriate activities.

Verification of Disability
Disability shall be verified by one of the following:

- certification of legal blindness from MCB; or
- a determination of disability by the Social Security Administration; or
- a determination of disability by MassHealth's Disability Determination Unit (DDU).

4.1.7. ☒ Access to or coverage under other health coverage:

Other Health Coverage
A child shall be considered insured and, as a result, ineligible for Title XXI MassHealth if he or she is:

- a member of a family that is eligible for health benefits through a state

health benefits plan based on a family member's employment with a public agency in the state;
- eligible for MassHealth Standard and has family group gross income that is less than the standards described in **Attachment 4-1 (d)**; or
- covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

Access to Health Insurance

A child has access to health insurance, for the purpose of determining eligibility for Title XXI MassHealth, where the prospective member, the parent, spouse or legal guardian has access to group health insurance that includes the member, through an employer, the employer contributes at least 50% of the premium cost, and the insurance meets a basic benefit level as defined by MassHealth.

MassHealth will require a Title XXI MassHealth child who has access to health insurance to enroll in the employer sponsored insurance plan if:

- the child is ineligible for MassHealth Standard or CommonHealth;
- the family group gross income is between 150% and 300% FPL (before disregards); and
- MassHealth has determined it is cost effective to purchase the insurance.

MassHealth will provide premium assistance toward the child's private health insurance premium payment through MassHealth Family Assistance.

4.1.8. ☒ Duration of eligibility:

A pregnant woman who has been determined eligible for MassHealth Standard, including under the unborn child option, shall continue to be eligible for the duration of her pregnancy and the two calendar months following the month in which her pregnancy ends, regardless of any subsequent changes in family group income. No other children will receive a durational guarantee of eligibility. They will be subject to a periodic review of eligibility.

4.1.9. ☒ Other standards (identify and describe):

All MassHealth members must meet the requirements described in this section.

Social Security Number language superseded by TN-014-006 MMDL

Social Security Number (SSN) Requirements
As a condition of eligibility for any MassHealth coverage type, applicants and members must furnish a SSN. Applicants who do not have a SSN will be notified of their obligation to apply for one.

MassHealth shall verify each applicant's SSN by a computer match with the Social Security Administration.

Right to Know Uses of Social Security Numbers
All household members will be given written notice in a booklet accompanying their MassHealth Benefit Request of the following:

- the reason the SSNs are requested;
- the computer-matching with SSNs in other personal data files within MassHealth, other government agencies, and elsewhere; and
- that failure to provide the SSN of any person receiving or applying for benefits may result in denial or termination of his or her benefits.

Assignment of Rights to Medical Support and Third Party Payments
Every legally able applicant or member must assign to MassHealth his or her own rights to medical support and third party payments for medical services provided under MassHealth as well as the rights of those for whom he or she can legally assign medical support and third party payments.

The applicant or member must provide MassHealth with information to help pursue any medical support and source of third party payment,

including support available from the absent parent, who is legally obligated to pay for care and services for the applicant/member and/or for person(s) on whose behalf benefits are requested unless he or she can show good cause not to provide this information.

Refusing to comply with the requirements of this section will exclude the applicant or member from receipt of MassHealth benefits unless the applicant or member is a pregnant woman who is eligible for Mass Health Standard or the mother of an unborn child eligible for MassHealth Healthy Start.

Good Cause for Non-cooperation

Good cause for non-cooperation is present if at least one of the following circumstances exists regarding the child of the applicant or member:

- the child was conceived as a result of incest or forcible rape;
- legal proceedings for adoption are pending before a court;
- a public agency or licensed facility is assisting in resolving the issue of adoption and discussions have not lasted longer than three months; or
- cooperation would result in serious harm or emotional impairment to the child or relative with whom the child resides or to the applicant or member.

Assignment for Third Party Recoveries

As a condition of eligibility, an applicant or member must inform MassHealth when a household member is involved in an accident, or suffers from an illness or injury which has or may result in a lawsuit or insurance claim. The applicant or member must:

- file a claim for compensation;
- assign to MassHealth the right to recover an amount equal to the MassHealth benefits provided from either the member or the third party; and
- provide information about the third party claim and cooperate with MassHealth's Post Payment Recovery Unit unless MassHealth determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the applicant or member.

Citizenship language superseded by TN-014-006 MMDL

Citizenship and Immigration Requirements

In determining eligibility for Title XXI MassHealth, a child must be a citizen or a qualified alien, as defined in section 431 of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), as amended. Alternatively, a child must be otherwise eligible and lawfully residing in the United States as allowed for under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and as described in Section 4.1.10 below.

Verifications of Citizenship and Immigration Status

For aliens, a determination of eligibility will be made once the application is complete except for documentation of immigration status. Aliens who have not submitted documentation of immigration status within sixty days of the date of the eligibility determination, or whose verification cannot be confirmed by the U.S. Immigration and Naturalization Service, shall subsequently be ineligible. . An otherwise eligible lawfully residing individual as provided for in section 214 of CHIPRA will be verified to continue to lawfully reside in the United States using the documentation presented to the Commonwealth by the member on initial enrollment. If the Commonwealth cannot successfully verify that the member is lawfully residing in the United States in this manner, it shall require the member provide further documentation or other evidence.

For citizens, a determination of eligibility will be made once the application is complete except for documentation of citizenship and/or identity status. Citizens who have not submitted documentation of citizenship and identity status within sixty days of the date of the eligibility determination, shall subsequently be ineligible unless an extension is requested.

Title XXI MassHealth Specific Eligibility Requirements by Coverage Type

In addition to other requirements described in Section 4, a child must meet the specific Title XXI eligibility requirements of each coverage type. The requirements for MassHealth CommonHealth are described in Section 4.1.6. Eligibility requirements for MassHealth Standard, Family Assistance (direct coverage and premium assistance), and Prenatal follow.

(A) MassHealth Standard

MassHealth Standard is available to uninsured children under the

age of 19 subject to the following requirements.

Unborn Children
An unborn child is eligible if the gross income of the family group is less than or equal to 200% FPL and the unborn child's mother is otherwise ineligible for MassHealth Standard. The unborn child or children are counted as if born and living with the mother in determining family group size.

Children under One
A child under one is eligible if the gross income of the family group is greater than 185% FPL and less than or equal to 200% FPL.

A MassHealth Standard-eligible child who is receiving inpatient hospital services on the date of his or her first birthday shall remain eligible until the end of the stay for which the inpatient services are furnished.

Children Aged One through Eighteen
Children aged one through eighteen are eligible for MassHealth Standard if the gross income of the family group meets the income standards described in Attachment 4-1 (d). If the individual is pregnant, the unborn child or children are counted as if born and living with the mother in determining family group size.

Presumptive Eligibility for Standard
An uninsured child whose self-declared family group income meets the financial requirements of MassHealth Standard shall be determined presumptively eligible in accordance with the requirements described at Section 4.3.

(B) MassHealth Family Assistance (including FAEC) – Direct Coverage
Direct coverage under MassHealth Family Assistance is available to uninsured children aged one through eighteen provided:

- the gross income of the family group is greater than 150% but less than or equal to 300% FPL (before disregards)
- the child is ineligible for MassHealth Standard and MassHealth CommonHealth; and
- the child is not insured, does not have access to health

insurance, as defined in Section 4.1.7., and, for children between 200 and 300% FPL, has not been insured in the previous six months, except as provided in section 4.4.4.2.

If the individual is pregnant, the unborn child or children are counted as if born and living with the mother in determining family group size.

Time Limited MassHealth Family Assistance

A child may receive MassHealth Family Assistance benefits on a fee for service basis for a maximum of 60 days if a member of his or her family group has declared he or she has access to employer-sponsored health insurance benefits. During this 60-day period, MassHealth shall determine if the insurance meets HIPAA and basic benefit level requirements. If the insurance meets these requirements, MassHealth will subsequently require the child to be enrolled in the employer-sponsored health insurance plan and a premium assistance amount will be established as described below.

Presumptive Eligibility for MassHealth Family Assistance

An uninsured child whose self-declared family group income is greater than 150% FPL and less than or equal to 300% FPL (before disregards) shall be determined presumptively eligible in accordance with the requirements at Section 4.3.

MassHealth Family Assistance Premiums

MassHealth Family Assistance members may be assessed a monthly (health insurance) premium using the schedule below.

%FPL	Per child	Family maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

MassHealth Family Assistance members shall be responsible for monthly premium payments beginning with the calendar month following the date of their eligibility determination.

MassHealth Family Assistance members who self-identify as members of a federally recognized American Indian tribe or who are Alaskan Natives will not be charged a monthly premium.

MassHealth Family Assistance members who are determined

eligible for another coverage type shall cease to be responsible for the premium payment to MassHealth as of the calendar month in which the coverage type changes.

Members who are assessed a revised premium payment as the result of a reported change shall be responsible for the new monthly premium payment beginning with the calendar month following the reported change.

Delinquent Premium Payments

Any portion of a premium payment that is not made within sixty calendar days of the billing date will result in termination of coverage after advance notice. Another coverage period will not begin unless MassHealth collects all premiums that MassHealth determines to be outstanding unless a hardship exemption or payment plan has been granted in accordance with MassHealth regulations.

Once terminated for non-payment of a premium:

- if payment is made in full within thirty (30) calendar days of the date of the termination, coverage shall begin retroactive to the date of termination, if otherwise eligible; or
- if payment is made in full later than thirty (30) calendar days of the date of the termination, coverage shall begin retroactive to the date of the premium payment, if otherwise eligible.

Voluntary Withdrawal

In case of a member's voluntary withdrawal, coverage shall continue, and the member shall be responsible for payment of premiums through the end of the calendar month of withdrawal.

Change in Premium Calculation

The premium amount is recalculated when MassHealth is informed of changes in income, or family group size. The premiums may also be recalculated when an adjustment is made to the premium schedule.

(C) Family Assistance/Premium Assistance (including FAEC)

Premium assistance under MassHealth Family Assistance is available to children aged one through eighteen between 150 and 200% FPL, and to children aged zero through eighteen between 200 and 300% FPL (before disregards), provided:

- the child is ineligible for MassHealth Standard and MassHealth CommonHealth;
- the child has access to employer-sponsored health insurance where the employer contributes at least 50% of the premium cost, the insurance meets the basic benefit level;
- it is cost-effective to MassHealth to provide premium assistance; and,
- for children between 200 and 300% FPL, the child or children has been uninsured for a minimum of six months prior to application, except as specified in section 4.4.4.2.

In order to determine whether an employer –sponsored health plan meets the Basic Benefit Level, MassHealth reviews a copy of the summary of benefits and/or a copy of the policy from either the employee or employer. A Family Assistance coordinator compares the plan to MassHealth's basic benefit requirements to ensure that the plan includes all state-mandated benefits.

MassHealth makes monthly premium assistance payments on behalf of a child toward the cost of the employer-sponsored health insurance. The premium assistance payment is calculated by using the following information:

- the total health insurance premium;
- the employer share of the health insurance premium; and,
- the MassHealth-calculated member share of the health insurance premium (if applicable). The member share is

%FPL	Per child	Family maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

. Alaska Natives and American Indians who are members of federally recognized tribes will not have a calculated member share.

This information will be collected on the MBR. To verify the information, a MassHealth representative will contact the applicant's employer to collect the required data. Once the information is collected and verified, MassHealth will calculate a

premium assistance payment amount.

Estimated Premium Assistance Amount

The estimated premium assistance amount equals the total health insurance premium minus the employer share of the premium minus the MassHealth calculated member share of the premium. For example, if the total monthly health insurance premium is $500 and the employer is contributing 70% to the cost of the health insurance premium, then the current employee share is $150 per month. If the family's income is above 150% FPL, then MassHealth will calculate a member share of the premium based on the number of eligible children in the family ($12 per child, with a $36 maximum). If the MassHealth calculated member share is $24 (2 children X $12), then the MassHealth estimated premium assistance amount will be $126 per month.

Cost-effectiveness test

The estimated premium assistance amount will then be compared to the cost of covering eligible individuals under direct coverage.

The estimated premium assistance amount will be compared to the cost of covering the children in the family on MassHealth Family Assistance. Therefore, if a family with two children and one parent applies for coverage, the estimated premium assistance amount would be compared to covering two members on MassHealth's MCO program, or $300 per month ($150 pmpm[1] x 2 children).

Actual Premium Assistance Amount

Once the estimated premium assistance amount has been compared to the cost of covering eligible individuals on MassHealth Family Assistance, MassHealth will calculate an actual premium assistance amount.

If the estimated premium assistance amount is less than the cost effective amount (as defined in #2 above), then MassHealth will set the actual premium assistance amount at the estimated premium assistance amount.

If the estimated premium assistance amount is higher than the cost effective amount (as defined in #2 above), then MassHealth

1 For demonstration purposes only, represents the average MCO pmpm.

will set the actual premium assistance amount at the cost effective amount. If it is determined that the remainder of the health insurance premium is greater than 5% of the family's gross income, then the family will be given the choice of enrolling their children in the applicable direct coverage program.

Premium assistance payments are made directly each month on behalf of the children to the parent/policyholder or, if the parent works for a qualified small employer that participates in MassHealth's Insurance Partnership program, the payments may be made on behalf of the children to either the employer or the health insurance carrier. The qualified employer must reduce the member's payroll deduction for health insurance by the amount of the premium assistance payment.

In addition to premium assistance payments, MassHealth will pay copays, coinsurance, and deductibles for children eligible for premium assistance provided:

the copay, coinsurance or deductible was incurred as the result of a well baby/well-child care visit; or
the policyholder's annualized share of the employer-sponsored health insurance premiums, combined with copays, coinsurance, and deductibles incurred and paid by members, exceeds five percent of the family group's gross income in a 12-month period beginning with the date of eligibility for premium assistance.

Members receive an initial notice at the time of eligibility explaining MassHealth's policy on payment of copays, coinsurance and deductibles. Providers may bill MassHealth directly or members may seek reimbursement from MassHealth. MassHealth has developed a C.A.R.E. kit for families to use in this process. (See Attachment 4.2)

(D) MassHealth Prenatal
MassHealth Prenatal is available to uninsured pregnant women under the age of 19 whose self-declared income is greater than 185% FPL and less than or equal to 200% FPL. The unborn child or children are counted as if born and living with the mother in determining family group size.

Express Lane Renewal Option
Certain children under the age of 19 eligible for Medicaid Expansion CHIP and CHIP

will meet the criteria for Express Lane Renewal at the time of their annual renewal. The MassHealth agency will identify Medicaid Expansion CHIP children and unborn-CHIP children who have income at or below gross 150% of the federal poverty level (FPL) and are also eligible for SNAP as shown from a data match with the Massachusetts Department of Transitional Assistance. The Massachusetts Department of Transitional Assistance oversees SNAP and will be the designated Express Lane Agency. Children's Medicaid Expansion CHIP benefits and CHIP benefits will be renewed based on the child's eligibility for SNAP. This process will be used for renewals only. All members eligible for this process have completed an initial application and have been approved for either Medicaid Expansion CHIP or CHIP and for SNAP. These members will also have their SNAP eligibility recertified on an annual basis.

4.1.10 ☒ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is;

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. § 641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. § 1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa. .

☒ The State elects the CHIPRA section 214 option for children up to age 19
☐ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 ☒ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

Presumptive eligibility language superseded by TN-014-006 MMDL

Application and presumptive eligibility

To apply, a person must file a Medical Benefit Request (MBR).

MassHealth shall request all corroborative information necessary to determine eligibility generally within five (5) business days of receipt of the MBR. The applicant must provide such information within sixty (60) calendar days of the information request.

The request is considered complete on the date all required information with the exception of documentation of immigration status is received. When it is complete, it shall activate MassHealth's eligibility process of determining the appropriate coverage type providing the most comprehensive medical benefits.

If necessary information is received within the 60 calendar day period, the MBR is considered complete; if not received within the 60 calendar day period, MassHealth shall deactivate the MBR.

Reactivating the Medical Benefit Request

If all required information is submitted to MassHealth subsequent to the 60 calendar day period, MassHealth shall reactivate the MBR as of the date the information is submitted. A new MBR must be submitted if all required information is not received within one year of receipt of the previous MBR.

Presumptive Eligibility Process

A child may be determined presumptively eligible for Standard or Family Assistance through a presumptive eligibility process based on the household's self declaration of gross income on the Medical Benefit Request (MBR). A child may only be presumptively eligible for Family Assistance if he or she has no

health insurance coverage.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days of the begin date, the MBR will be deactivated in accordance with Section 2.2.1.1 and presumptive eligibility will end. A child may receive presumptive eligibility only once in a twelve-month period.

Data matching and verification

Process for Data Matching
MassHealth initiates matches with other agencies, health insurance carriers, and employers when an MBR is received. These agencies and matches include but are not limited to the following: The Division of Unemployment Assistance (DUA), Bureau of Vital Statistics, Veteran's Services, Department of Revenue (DOR), Bureau of Special Investigations (BSI), Internal Revenue Service (IRS), Social Security Administration (SSA), Alien Verification Information System, Department of Youth Services (DYS), Department of Social Services (DSS), Department of Correction (DOC) and the Department of Transitional Assistance (DTA).

Process for Agency Data Matches
Where possible, MassHealth's eligibility system attempts data verification through automated matching with other MassHealth systems (e.g., MMIS) and external agencies. Initial matching is performed during the MBR screening when the system, based on data entry of the request, checks MassHealth databases and MMIS, to confirm eligibility status and retrieve existing information.

The system also prepares and generates matching requests to other agencies for customer information that has not yet been verified, or is out of date or missing. These matching requests are generated automatically and do not require worker intervention. For applicants, a match is triggered at the time the MBR is received. For on-going cases, a match is triggered when a member reports changes to certain types of information or a report occurs when new employment is reported to DOR by the employer.

As soon as the worker has entered (and reviewed) new household members' names, dates-of-birth, and SSNs, the system will automatically trigger a request for SSN verification and SSA unearned income information. This information will be processed and returned that same night, for review the following morning by the worker.

The SSN verification processing will identify additional SSNs held by the member, as well as identify a transposition or minor data entry error in the original data entry of the SSN. Following SSN verification, 'Alerts' may be posted to a person's record to indicate an inconsistency.

Data to Match and Verify

Using a gross income test has eliminated the need to verify a host of work-related expenses while elimination of the asset test has obviated the need for the applicant to produce a more complex set of verifications. Verification only of the following (through either the customer or automated matching) is a prerequisite for eligibility determination:

- Income (for all except MassHealth Prenatal, and for presumptive eligibility determinations for MassHealth Standard and MassHealth Family Assistance, and for those without income);
- Disability (for CommonHealth);
- TPL (from accident or injury);
- SSN;
- Citizenship and immigration status; and
- Access to, and availability of, health insurance.

Matching Agencies

MassHealth works with the following agencies to verify eligibility information.

- DUA

MassHealth processes matches with DUA for unemployment information. Recipients of unemployment insurance are identified for income matching purposes, and for determining eligibility for Basic. These individuals are paid by DUA for up to thirty (30) weeks following job loss, providing the recipient is unemployment-insurance eligible.

- DOR

Provides information on employment status (new hires), and quarterly wages. New hires are reported by employers within fourteen (14) calendar days of their start date. This data will be used to determine eligibility for MassHealth, and to generate an inquiry by MassHealth to the member regarding their employment status and availability of health insurance.

The wage reporting system provides the wages an individual receives on a

quarterly basis from employers. If discrepancies regarding wages are noted between MassHealth's data and DOR's data regarding an individual, an inquiry will also be generated to the member.

- INS

The Alien Status Verification Index (ASVI) provides alien information. This database verifies alien immigration status, containing data for over 50 million aliens.

- SSA

SSA provides a variety of data. Social Security income and insurance (Medicare) data is provided on a regular basis through the BENDEX matching system. Social Security numbers are verified by SSA through the NUMIDENT match. SSI income is provided through the SDX match. Finally, Medicare Buy-in data is also transmitted through CMS to SSA. These data matches are considered to provide primary verification of social security and SSI income, and will update the individual's income directly and generate an eligibility determination.

Eligibility Review

MassHealth shall review eligibility with respect to circumstances that may change. MassHealth will update the file based on information received as the result of such review. Eligibility may be reviewed:

- As a result of a member's reported change in circumstances;
- By external matching with other agencies and health insurance carriers; and
- Where matching is not available, through a written update of the member's circumstances on a prescribed form.

If the member fails to provide a written update within thirty (30) calendar days of the request, MassHealth coverage may be terminated.

When there are no changes in the member's circumstances, eligibility shall be redetermined at least once annually.

Member enrollment

Introduction

MassHealth uses an enrollment Broker (EB) to educate and enroll all managed care eligible MassHealth members in a health plan. Customer service representatives (CSRs) are employees of the EB. A CSR's major responsibilities include: educating potential members or their representatives about managed care plans, enrolling managed care eligible MassHealth members into a health care plan, providing customer service to the entire MassHealth population, and administering

MassHealth's non-emergency transportation program for all eligible MassHealth members.

MassHealth members who are not eligible for managed care (e.g., persons with other insurance) do not need to enroll in a health plan because they will receive their care on a fee-for-service basis. Premium Assistance members will access services covered under an employer-sponsored plan according to the terms of those plans.

MassHealth has established processes for, and provided training to other state agencies in order to facilitate the enrollment into MassHealth of uninsured members serviced by these agencies. Referral and reporting processes have been established between MassHealth and the Department of Public Health, the Division of Unemployment Assistance, the Department of Transitional Assistance and the Commission for the Blind. In addition, all health care agencies and the Office of Refugees and Immigrants have received presentations on health care reform customized to meet the needs of their consumers. All agencies have been or will be provided with MBRs in large quantities.

<u>MassHealth Standard/MassHealth Family Assistance Members</u>
All MassHealth Standard/MassHealth Family Assistance members eligible to participate in managed care must enroll with either a MassHealth-contracted Managed Care Organization (MCO) or in the Primary Care Clinician (PCC) plan. During any period a managed care eligible Standard member is not enrolled in a managed care plan, such member will receive mental health and substance abuse services from any MassHealth provider.

Currently, MassHealth has no lock-in policy and members can transfer to another health care plan in their service area at any time.

<u>Description of Enrollment Process</u>
CSRs enroll MassHealth managed care eligible members into a health plan under either the PCC plan or an MCO according to MassHealth's policies, procedures, instructions and timeframes.

The EB tracks and manages all systems activities necessary to enroll all managed care-eligible members. These activities include, but are not limited to, tracking those members who have received enrollment and outreach materials and ensuring timely mailing of appropriate outreach materials.

<u>Receipt of Member Data</u>
The EB receives data regarding managed care eligible members from MMIS. Eligibility workers at MassHealth determine MassHealth eligibility. The system then

identifies members who meet managed care eligibility criteria and transmits this data to the EB for enrollment into a health plan.

The EB begins all enrollment and outreach mailing activities for Standard members within five (5) business days after receipt of member data from MassHealth.

Outreach Process

The EB must mail enrollment and outreach materials to all Standard and Family Assistance members who become eligible for managed care. Distribution or mailing must occur no later than five (5) business days after the EB receives from MassHealth member enrollment data including: the members' names, addresses, recipient identification (RID) numbers, categories of assistance, and casehead RIDS and names.

The member has fourteen (14) calendar days to choose a health plan or MassHealth will assign the member to a managed care plan.

Enrollment Package

The member receives an enrollment package inviting him or her to choose a health plan. The enrollment package includes information on how to enroll in a health plan, inserts that explain the various health plan options and enrollment form, a description of the member's legal rights, a self-addressed stamped envelope, and a notice translated into several different languages advising the member to have the information translated immediately.
The enrollment package materials indicate that the member has fourteen (14) calendar days to choose a health plan or MassHealth will choose one for the member.

Members may call either an EB or the plan directly for assistance in selecting a primary care physician. For members who are assigned to an MCO, the MCO will contact the member directly to assist them in selecting a PCP.

The EB also must mail enrollment materials to managed care-eligible members on request.

Assignment

Members who do not choose a health plan within the fourteen-(14) calendar day time limit will be assigned to a health plan. The term "assign" when used in this document refers to enrollment activities involving members who have not made an affirmative choice of a health plan.

Activities Associated with Non-Responding Members and Timeframes

Standard or Family Assistance members who have not responded to the enrollment and outreach materials within fourteen (14) calendar days will be assigned to a

managed care plan either systematically or manually. Manual assignments occur when computer assignment is not possible.

Algorithm

The assignment methodology takes into account the geographic location of the MCO and PCC plan providers relative to the member's residence and MassHealth assigns members based on the rate at which a given health plan is selected in a given service area, compared to each of the other available plans as well as other factors such as quality performance and/or enrollment volume.

The assignment algorithm applies only to Standard, Family Assistance, and Basic members who have not been determined to be disabled. MassHealth does not assign members who have been determined disabled to MCOs, but assigns them to a PCC based on disabling condition, geographic location, and, where possible, provider experience.

Manual Assignments

Manual assignments are done by EBs and occur when the system is unable to make a zip code, city/town or service area match between the member and an available health plan. Manual assignments, like automatic assignments, are made based on geography and voluntary selection rates.

Additionally, any member who loses and then within 1 year regains managed care eligibility may be automatically re-enrolled with the health plan with which the member was most recently enrolled.

Transfer Policy

MassHealth does not have a lock-in policy. Members who either choose or are assigned to a health plan may transfer to another available health plan in their geographic service are at any time for any reason. The transfer process begins when the member calls the Customer Service Center toll free number and requests a transfer. An EB helps the member identify a new health plan in his or her service area.

Member-Initiated Transfers

The member-initiated transfer process for members begins when the member calls the Customer Service Center toll free number and requests a transfer. An EB helps the member identify a new health plan in his or her service area. The transfer is processed by the EB within twenty-four (24) hours.

MassHealth-initiated Transfers

MassHealth may initiate the transfer of a member based on provider capacity, or if a health plan or primary care clinician terminates its agreement with MassHealth. When MassHealth-initiated transfers are required, MassHealth contacts the members to select a new health plan in their service area.

Provider-Requested Transfers

Provider-requested disenrollments begin with a written request sent by the provider to MassHealth. The written request is reviewed for complete information and compared against the Plan's criteria for member disenrollment. If the provider is able to demonstrate by written request that the member exhibited a pattern of disruptive or non-compliant behavior, the member may be transferred to another PCC or health plan.

Transfers To Another Health Plan

A member can transfer from one health plan to another available health plan at any time. The only restrictions are that: (1) the health plan must be in the members' geographic service area; (2) the members' request must meet the time and distance guidelines or (3) the member must request and receive approval for an out-of-area transfer using the process for an out-of-area enrollment.

PCC Disenrollment from the PCC Plan or PCP Voluntary Termination from an MCO Plan

If a PCC chooses to terminate from the PCC Plan, MassHealth requests that the PCC submit written notice to MassHealth at least thirty (30) days prior to the date of the intended termination. MassHealth sends a letter and enrollment package and asks the member to choose another health plan. The member is instructed to call the Customer Service Center toll free number for assistance in enrolling with a new managed care plan.

If a PCP chooses to terminate from an MCO, the MCO will facilitate informing the member of the termination and will help the member choose another PCP within the MCO. If the member would like to choose a PCP in another MCO plan or a PCC in the PCC Plan, the member is instructed to contact the Customer Service Center toll free number for assistance.

MassHealth Customer Service center

MassHealth's Enrollment Broker (EB) operates a toll-free customer service center for all MassHealth members. The customer service center is located at 55 Summer Street, 6th Floor, Boston, MA, 02111. The toll-free telephone number is 1-800-841-2900. The toll-free number is an enhanced telephone system with TTY transmission and reception capability and an automatic call distribution system. The EB is required to handle 95% of all incoming calls in three rings or fewer. Additionally, the EB must

operate this call center between the hours of 8 a.m. and 5 p.m. EST, Monday through Friday, with the exception of all Federal and designated Massachusetts State holidays.

The EB is required to have a sufficient number of multi-lingual CSRs to respond to all MassHealth- related calls, letters and occasional walk-in encounters. In addition, the EB must:

- Train all EB staff assigned to the MassHealth toll-free phone number to adequately and appropriately respond to questions relating to any MassHealth benefit package inquiries;

- Assist members eligible for Standard, Basic, or Family Assistance benefits in the resolution of problems relating to the accessibility of health care services, including but not limited to identifying transportation service issues, language barriers, and handicap accessibility issues;

- Respond to and make best efforts to resolve MassHealth-related inquiries and complaints by members, prospective members, people assisting members or acting on their behalf, including members' family members, other state agencies, advocates or private agency providers;

- Facilitate the resolution of non-clinical service disputes between MassHealth members participating in managed care and their providers;

- Establish procedures, subject to MassHealth's approval, by which to determine when MassHealth intervention or assistance should be sought and how it should be obtained;

- Maintain standard referral form(s) and procedures for each instance in which the EB determines that MassHealth assistance is required to adequately, appropriately, and correctly resolve or respond to any member-identified issue;

- Ensure call-backs to members within twenty-four (24) hours of receipt, including, but not limited to, after-hour messages received via after-hour voice mail messaging; and

- Ensure that all non-English speaking callers are provided translation services, e.g., EB staff answering telephone calls must speak the caller's language, or must be able to access interpreter services without disrupting the call by contacting other EBs or utilizing the AT&T Language Line service or similar telephone translation service.

New subsection (See CS15) per TN-014-013 MMDL

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A) and 2110(b)(2) (B)); (42CFR 457.310(b), 42CFR 457.350(a)(1) and 457.80(c)(3))**

The following section describes the process used to determine eligibility for the most comprehensive MassHealth coverage type for which the applicant is eligible.

Initially, eligibility information is collected on the Medical Benefit Request (MBR) form. Sufficient information is collected to assess if the applicant is eligible for any MassHealth coverage type. This information is then entered into MassHealth's computerized MA21 eligibility system, which then invokes decision trees to establish the most comprehensive coverage for which the individual is eligible.

The decision trees are used by the eligibility system to identify the benefits or programs for which a person is eligible based on his or her personal characteristics and circumstances. All charts assume that the individual meets the Massachusetts residency requirement.

All of the data collected from the MBR is stored on MA21 and when a subsequent change to the member's circumstances is reported, the Decision Tree process is again invoked to assess the impact of that change.

The change event may result in a change to a different coverage type, a change in MassHealth Family Assistance premium, a change in the premium assistance amount, a loss of eligibility, or no change. This process is performed automatically by MA21 and the member is automatically notified of any change in eligibility

status or coverage type. In making these determinations, MA21 will also update MMIS with the correct category of assistance, which in turn, dictates the funding source (Title XXI vs. Title XIX).

Children are not eligible for Title XXI MassHealth if they are: (1) an inmate of a public institution as defined at 42 CFR 435.1009; or (2) a patient in an institution for mental diseases as defined 42.CFR 435.1009, at the time of initial application or any redetermination of eligibility.

The Express Lane Renewal process For Medicaid Expansion CHIP and CHIP children who have income at or below gross 150% of the federal poverty level utilizes the current screen and enroll process, which is described above. They will remain enrolled in the most comprehensive coverage type for which they are eligible.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Once an eligibility determination is made by the MA21 system, MMIS is automatically updated to reflect the coverage type for which the child is eligible.

Since MassHealth offers a variety of programs to Massachusetts' residents, MA21 updates MMIS not only by coverage type but by funding source as well. A unique category of assistance is then assigned to ensure the accuracy of both coverage type and funding source.

These categories will also trigger a referral to MassHealth's enrollment broker, whenever the child is required to enroll with a primary care clinician or MCO.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

As described above in Section 4.4.1 and 4.4.2, MassHealth uses an automated eligibility system to place children in the richest benefit category for which they are eligible. A child who is eligible for Medicaid will automatically be placed in a Title XIX aid category.

Section 4.4.4. Superseded by TN-014-006 MMDL

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

MassHealth's premium assistance program, which is based on the combined authority of MassHealth's 1115 Waiver Insurance Partnership Program and Title XXI, will prevent families from dropping their private health insurance coverage. MassHealth covers children with family incomes at or below 200% of the Federal Poverty Level (FPL) regardless of insurance status at the time of application. Thus, there will be no financial incentive for families to drop private coverage to enroll in MassHealth. To discourage families from dropping their private coverage prior to applying for MassHealth, MassHealth emphasizes in its marketing and outreach materials the availability of premium assistance benefits for insured families. Additionally, when the family applies for MassHealth benefits, MassHealth uses the information included on the Medical Benefit Request (MBR) to complete an intensive health insurance investigation. This investigation includes matching the applicant's data against MassHealth's health insurance carrier database. This database includes subscriber lists representing approximately 90% of the health insurance market in the Commonwealth. The investigation also includes contact with the applicant's employer to determine whether employer-sponsored health insurance is available. The information provided by the employer includes: the total health insurance premium; the current employer contribution towards the premium; and the summary of benefits included in the plan. Through the health insurance investigation, MassHealth will be able to ensure that all applicants who have private health insurance and all applicants with access to employer-sponsored health insurance participate in private coverage.

Through these mechanisms MassHealth ensures that:

- Families with employer-sponsored coverage will be covered through premium assistance under MassHealth's 1115 Waiver.
- Families without private coverage, but with access to employer coverage, will be covered through premium assistance under Title XXI.
- Families without private coverage, and without access to employer coverage, will be covered through Title XXI direct coverage.

MassHealth continuously monitors the effectiveness of these policies. MassHealth monitors members who apply without insurance to determine: how many of those members are required to enroll in employer-sponsored health insurance; how many had no access to employer-sponsored health insurance; and how many had access to employer-sponsored health insurance but were enrolled in direct coverage because the employer-sponsored health insurance did not meet the minimum requirements.

The Commonwealth measures the overall changes in the employer-sponsored insurance market through employer surveys conducted by the Division of Health Care Finance and Policy. Through these surveys, MassHealth is able to monitor changes both in the overall ESI market and within the large and small group markets. These employer statistics may be used to determine whether changes in the MassHealth Family Assistance population are due to specific employer benefit changes or larger trends in the Commonwealth.

Additionally, MassHealth regularly examines movement between direct coverage and premium assistance within the caseload to measure substitution and determine if current crowd-out prevention strategies are effective.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

MassHealth will continue current crowd-out monitoring activities, with a particular focus on the higher income population of FAEC,

including;

(a) Evaluating the biannual employer survey, which is conducted by the Division of Health Care Finance and Policy, and includes information on employer offer rates, contribution rates, and premiums, by size of employer;

(b) Regularly examining movement between direct coverage and premium assistance within the caseload;

(c) Evaluating annual CPS data; and,

(d) Utilizing MassHealth's health insurance carrier and employer databases to monitor changes in employer offers.

Crowd-out provisions for FAEC (200-300% FPL)

MassHealth will not provide direct coverage or premium assistance if the family had employer-sponsored group coverage for applying children within the previous six months. Families which had employer-sponsored group coverage within the previous six months will be subject to a six-month waiting period, from the date of loss of coverage, before being allowed to enroll in FAEC. Exceptions from this waiting period will be made for situations in which:

(a) A child or children has special or serious health care needs;

(b) The prior coverage was involuntarily terminated, including withdrawal of benefits by an employer, involuntary job loss, or COBRA expiration;

(c) A parent in the family group died in the previous six months;

(d) The prior coverage was lost due to domestic violence;

(e) The prior coverage was lost due to becoming self-employed; or

(f) The existing coverage's lifetime benefits were reduced substantially within the previous six months, or prior employer-sponsored health insurance was cancelled for this reason.

If MassHealth finds a significant level of crowd-out, it will reevaluate the exceptions to the waiting period to determine if they are contributing to crowd-out, and modify them as necessary.

4.4.4.3. ☒ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.
See 4.4.4.2

4.4.4.4. ☒ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period

If a child with income below 200% FPL is uninsured at the time of application and has access to employer-sponsored insurance, the child may receive premium assistance. There is no waiting period. For children with income between 200 and 300% FPL who had employer-sponsored insurance in the previous six months, see section 4.4.4.2 for a description of the required waiting period and exceptions.

The minimum employer contribution
The minimum employer contribution is 50% of the total cost of the health insurance premium.

The cost-effectiveness determination
The cost effectiveness determination, as described in full detail earlier in Section 4, ensures that the premium assistance payment would not be greater than the amount it would cost for MassHealth to provide services to the member through the direct coverage option.

4.4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

MassHealth does not discriminate on the basis of ethnicity when determining eligibility for MassHealth programs. Alaska Native and American Indians who are members of a federally recognized

tribe are not required to pay premiums.

Generally, the MassHealth outreach "net" covers the four corners of the state, and should capture any AI/AN. Our MBRs and member handbooks, which are used in our outreach efforts, specifically address AI/AN. MassHealth has had a Taunton MEC outreach worker that makes regular trips out to the hospital on Martha's Vineyard, which is the primary health care provider for the Wampanoags of Aquinnah and other islanders. In addition, the Dukes County Health Commission was given a mini-grant to do general outreach, which would have included the AI/AN population on Martha's Vineyard.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 5. Outreach and Coordination

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

MassHealth will accomplish outreach, providing information, and assisting with program enrollment, using these procedures:

1. Enlist the support of community-based organizations, social service agencies, schools, and advocacy organizations to inform community residents of available health insurance programs; identify uninsured children; assist with the enrollment process; and support the promotion of educational strategies developed to help members utilize their health care services.

a) Periodically award mini-grants to community-based organizations to assist in enrollment of "hard-to-reach" uninsured individuals and families and support post enrollment education strategies. MassHealth and the Department of Public Health (DPH) will continue to collaborate on the issuance and monitoring of a joint RFR.

b) Perform targeted enrollment and member education campaigns for specific communities or vulnerable populations, such as immigrants and homeless populations, that have high numbers of "hard-to-reach" uninsured residents. MassHealth will make regional outreach coordinators available at each of its four MassHealth Enrollment Centers (MECs) to provide outreach, enrollment, and member education training to community-based organizations in these specified areas.

c) Conduct school-based outreach campaigns to distribute informational materials explaining the availability of health insurance to families of children attending public, private, and parochial schools and daycare centers and to work with school nurses and/or other school staff to facilitate the enrollment of uninsured children in the appropriate health insurance program. Special emphasis will be placed on pre-school through first grade settings to reach this statistically-higher uninsured group. MassHealth and DPH will coordinate all activities related to this initiative.

d) Create and distribute promotional materials to community-based agencies and school settings. Offer training and informational sessions at community sites, statewide, at least once per contracted year.

2. Collaborate with primary care providers (including family practice, adult medicine, and pediatric and adolescent health providers) in targeted communities and/or among populations that have high numbers of uninsured residents to furnish information about the availability of free or low-cost health insurance for children.

a) Coordinate MassHealth outreach efforts with the Massachusetts Hospital Association and the Massachusetts League of Community Health Centers.

b) Provide outreach assistance at community health centers, hospital outpatient clinics, WIC sites, Early Intervention programs, home visiting programs and school-based health centers, as requested.

c) Notify school nurses upon changes in eligibility guidelines and/or enrollment procedures.

d) Share informational articles describing recent health program expansions in provider and professional association publications.

e) Make informational presentations at conferences, workshops, and trainings attended by health care providers.

3. MassHealth will initiate and coordinate activities with other state agencies to provide information about health coverage to uninsured children and facilitate program enrollment, where appropriate.

a) Enrolling eligible unborn child enrollees in MassHealth.

b) Cross-training of staff at Department of Social Services (DSS), Department of Transitional Assistance (DTA), Department of Mental Health (DMH), Division of Insurance (DOI), Department of Youth Services (DYS), Department of Revenue (DOR), Office of Refugees and Immigrants (ORI), Division of Unemployment Assistance (DUA), Department of Mental Retardation (DMR), Department of Public Health (DPH), Children's Trust Fund (CSE), etc. who deliver direct-services to individuals, families and children.

4. MassHealth will develop a multi-media enrollment campaign for targeted underserved populations and promote member information on how to access MassHealth benefits.

a) Use a media consultant to assist with the design and implementation of a media campaign for non-English speaking populations.
b) Produce Public Service Announcements (PSAs) for distribution to local ethnic television and radio stations.

c) Solicit free media coverage through newspapers, television, radio, billboards and transit authorities, or make purchase of media coverage when appropriate.

d) Maintain ongoing communication with print media outlets (daily newspapers, weekly community newspapers, and magazines) in targeted communities, regarding outreach activities.

5. MassHealth will perform outreach and enrollment activities specifically related to the Express Lane Renewal option to rely on findings from SNAP to conduct simplified eligibility renewals. This will include the activities listed above as well as:

a. Providing detailed information about the Express Lane Renewal Process to stakeholders, including advocates, community outreach workers/grantees and providers to ensure education of the process to members.

b. Information sharing about Express Lane Renewal at Massachusetts Health Care Training Forums (MTFs)

c. Utilizing the Virtual Gateway listserv to update and educate providers about the Express Lane Renewal process

d. Coordinating with SNAP outreach programs and resources to promote Express Lane Renewal.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☒ **Check here if the state elects to use funds provided under Title XXI to provide expanded eligibility under the state's Medicaid plan**,

Our Title XXI Medicaid expansion group is newborns 185.1% FPL up to 200% FPL, children ages 1-5 133.1% FPL up to 150% FPL, children ages 6-17 114.1% FPL up to 150% FPL and children age 18 up to 150% FPL. These children are in MassHealth Standard and receive the Medicaid benefit package. **[See MMDL 014-003 approval for current percentages] and [MMDL 014-005 for language about 2101(f).**

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☒ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☒ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

This applies only to Direct Coverage programs, not Premium Assistance. See Section 6.1.4 below.

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☒ Coverage the same as Medicaid State plan and applicable additional coverage described in the Services Related Expenditures and related Special Terms and Conditions in the Massachusetts 1115 demonstration project (no. 11-w-00030) for Medicaid expansion children who are in MassHealth Standard and unborn CHIP children who are in MassHealth Standard, except that unborn CHIP children are not eligible for Premium Assistance.

6.1.4.2. ☒ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project for children in MassHealth Family Assistance and CommonHealth

The Basic Benefit Level, as approved by the Secretary under the Massachusetts 1115 Demonstration Project, for premium assistance toward employer sponsored health insurance.

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:

Covered services for MassHealth Family Assistance - Direct Coverage (including FAEC)

Non-disabled children who are not eligible for MassHealth Standard and who are in families with income up to 300% FPL are enrolled in MassHealth Family Assistance . Those who do not have cost effective Employer Sponsored Insurance (ESI) receive direct coverage. This coverage is equivalent to the MassHealth Standard (Medicaid benefit package) covered services with the following exceptions: non-emergency transportation, long-term community-based services, personal care services, day habilitation, and adult day health services are not covered. Long-term care is limited to 100 days. Certain services listed below are covered only following prior authorization based on medical necessity.

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**
All acute inpatient hospital services such as daily physician intervention, surgery, obstetrics, radiology, laboratory and other diagnostic and treatment procedures.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**
Acute outpatient services include outpatient surgical, and related diagnostic and medical services.

6.2.3. ☒ Physician services **(Section 2110(a)(3))**
Physician services (primary and specialty) include all medical, radiological, laboratory, anesthesia and surgical.

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**
Surgical services include services provided in section 6.2.1, 6.2.2, and 6.2.3

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
Clinical services include services provided in section 6.2.2 and 6.2.3

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**
Legend drugs that are approved by the U.S. Food and Drug Administration

6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**
Non-legend drugs that are approved by the U.S. Food and Drug Administration.

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**
All laboratory services necessary for the diagnosis, treatment, and prevention of disease, and maintenance of health of MassHealth members. All x-rays, including portable x-rays and magnetic resonance imagery (MRI), and radiological services.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**
All prenatal care and family planning medical services, family planning counseling services, follow-up-care, outreach and community education.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
Durable medical equipment, orthotic and prosthetic devices, hearing aids, and eyeglasses are covered when medically necessary and according to the requirements described in the Provider Regulations.

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**
Home health nursing services such as skilled nursing and home health aide services.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
Includes nurse practitioner services and nurse midwife services.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))**
Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
Includes individual treatment, comprehensive evaluation, and group therapy.

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**
Inpatient chronic or rehabilitation limited to 100 days, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services.

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**
Emergency ambulance only.

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**
Chapter 766: home assessment and participation in team meetings
Chiropractic services
Applied Behavior Analysis services. .

Covered services for MassHealth Family Assistance- Premium Assistance

Children enrolled in Family Assistance who have access to cost effective Employer Sponsored Coverage (but are currently uninsured) receive Premium Assistance. In addition, if they do not have dental coverage through their ESI, they receive the Medicaid Standard dental benefit as a wrap service.

Covered services for MassHealth CommonHealth

Disabled children who do not qualify for MassHealth Standard are enrolled in CommonHealth. There is no income limit and premiums are based on income. MassHealth CommonHealth covered services are equivalent to MassHealth Standard (Medicaid benefit package) covered services with the following exception: out of state services are covered for emergencies only. Certain services listed below are covered only following prior authorization based on a funding of medical necessity.

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**
All acute inpatient hospital services such as daily physician intervention, surgery, obstetrics, radiology, laboratory and other diagnostic and treatment procedures.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**
Acute outpatient services include emergent and urgent care, clinic visits, and outpatient surgical, and related diagnostic and medical services.

6.2.3. ☒ Physician services **(Section 2110(a)(3))**
Physician services (primary and specialty) include all medical, radiological, laboratory, anesthesia and surgical

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

Surgical services include services provided in section 6.2.1, 6.2.2, and 6.2.3

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**
Clinical services include services provided in section 6.2.2 and 6.2.3

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**
Legend drugs that are approved by the U.S. Food and Drug Administration

6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**
Non-legend drugs that are approved by the U.S. Food and Drug Administration

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**
All laboratory services necessary for the diagnosis, treatment, and prevention of disease, and maintenance of health of MassHealth members. All x-rays, including portable x-rays and magnetic resonance imagery (MRI), and radiological services.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**
All prenatal care and family planning medical services, family planning counseling services, follow-up-care, outreach and community education.

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**
Durable medical equipment, orthotic and prosthetic devices, hearing aids, eyeglasses are covered when medically necessary and according to the

requirements described in the Provider Regulations.

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

6.2.14. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**
Includes personal care services and home health nursing services, such as skilled nursing and home health aide services.

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
Includes nurse practitioner services, nurse midwife services, and private duty nursing care.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. ☒ Dental services **(Section 2110(a)(17))**
Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
Includes individual treatment, comprehensive evaluation, and group therapy.

6.2.23. ☒ Hospice care **(Section 2110(a)(23))**

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**
Includes inpatient and outpatient rehabilitation and chronic disease hospital services, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services

6.2.25. ☒ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**
Includes emergency and non-emergency ambulance.

6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**
Medically necessary transportation by taxi, or chair car to a MassHealth provider for a MassHealth covered service.

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**
Adult Day Health services
Chapter 766: home assessment and participation in team meetings
Chiropractic services
Applied Behavior Analysis services

6.2 Covered services for Unborn Children

MassHealth provides coverage for "unborn children" in households with income up to 200% FPL whose mothers are not otherwise eligible for MassHealth Standard. Such unborn children are in MassHealth Standard and receive coverage that is the same as the Medicaid State Plan and the Massachusetts 1115 demonstration project for members in Standard. Benefits to unborn children are delivered through the same delivery and utilization control systems as those available to other Standard members under the 1115 waiver, except that unborn children are not eligible for Premium Assistance and are only eligible for direct coverage.

MassHealth uses a bundled payment methodology which pays for prenatal services, Labor and Delivery and one postpartum visit. The bundled payment is billed on the date

of birth of the baby so the postpartum visit is prepaid. If MassHealth is unable to use a bundled payment for any reason, the services are paid fee-for-service.

CHIP level FFP is available for all services provided during the pregnancy and for the bundled payment. 50% FFP under MassHealth Limited is available for emergency services provided during the postpartum period and no FFP is available for non-bundled non-emergency services provided during the postpartum period.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and

State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 8.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (Section 2102(a)(7)(A)) (42CFR 457.495(a))

MassHealth's MCO contract details the MCOs' qualifications and responsibilities. MassHealth's decision to contract with an MCO is largely based on that organization's ability to meet MassHealth-defined contract requirements concerning:

- Access, member services and utilization;
- Quality;
- Behavioral health; and,
- Financial stability

These requirements define what the MCOs must provide to MassHealth members enrolled in their plan, and are the cornerstone of all contract management activities. MassHealth's Purchasing Specifications for MCOs are designed to:

- Be consistent with generally accepted standards (e.g. NCQA);
- Address the specific needs of the MassHealth population;
- Address all significant aspects of the performance of MCOs;
- Be set at best practice level and be improvement-oriented; and,
- Be specific and measurable so that data from measures can be used by MassHealth and the MCO to identify opportunities for improving performance.

Will the State utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☒ Quality standards

MassHealth currently coordinates quality assurance efforts through the following types of activities:

The Medicaid Director and Executive staff lead an agency-wide goal setting process to develop improvement goals focused on the special needs of the plan members and the agency. Program-specific goals are then developed to address the agency-side improvement goals;

All contractors, including managed care plans and providers, are required to engage in quality improvement and monitoring activities. Each benefit plan (i.e., MCO Program, PCC Plan, Behavioral Health Plan) has quality management staff responsible for developing, implementing and monitoring quality-based initiatives to improve health care outcomes.

The staff coordinates activities to help ensure consistency in quality measurement across MassHealth and identify and adopt quality improvement initiatives. In addition, MassHealth's Medical Director provides direction on all clinically-related quality initiatives, including;

- Regular meetings with sister agencies, conducted to develop interagency quality improvement projects in areas such as clinical practice and to share information; and

7.1.2. ☒ Performance measurement

7.1.2 (a) ☐ CHIPRA Quality Core Set
7.1.2 (b) ☐ Other

MCO Program

Each MCO must participate in regular (semi-annual) contract status meetings with MassHealth. The primary purpose of these meetings is to review each MCO's progress toward the achievement of annual improvement goals. For purposes of these meetings, the MCO provides MassHealth with a written update, detailing progress toward meeting both MCO specific and standard Improvement Goals. MassHealth evaluates MCO performance on each goal and then produces an overall performance score for each MCO.

The MCO program conducts an annual external independent review of its contracted MCOs called the "Clinical Topic Review"(CTR). The goal of the CTR is to assess the MCOs in the areas of access and quality of care and to identify potential opportunities for improvement. The CTR topics focus on clinical issues that are of particular concern to MassHealth members as identified through other data sources, including HEDIS and the Member Satisfaction Survey. Data for the CTR is based on medical record reviews.

PCC Plan

MassHealth conducts PCC Plan quality management and improvement activities by working collaboratively within PCC Plan functional areas and across other MassHealth programs and units. MassHealth designs and coordinates the implementation of Plan-wide clinical quality improvement and measurement activities aimed at measuring and improving clinical care and member health and satisfaction. Some examples include:

Asthma Quality Improvement Projects: these projects focus on improving the delivery of health care and the self-management techniques of persons with asthma in order to achieve improvements in health outcomes, satisfaction, and reductions in emergency department visits and hospitalizations for asthma. Activities include educating clinicians about current asthma treatments and patient self-management, improving process and coordination of care between PCCs, hospitals, and members, and

member education. Measures of success include increased prescribing of anti-inflammatory medications, reduction in emergency department visits and hospital admissions for asthma, improvements in member self-management skills, and member satisfaction with asthma care.

HEDIS: in collaboration with the MCO Program and the BHP, the PCC Plan collects a subset of measures from the following "domains": Effectiveness of Care, Access/Availability of Care, Use of Services, and Health Plan Descriptive Information. HEDIS results will be used to evaluate contract performance, assess performance against program goals, and identify future clinical priority areas.

Behavioral Health Program

MassHealth holds weekly and monthly meetings with the vendor. The purpose of the meeting is to evaluate the progress the vendor is making toward meeting its short-term improvement goals, and to provide the vendor with direction toward meeting its long term-goals.

The vendor is asked to present supporting documentation prior to these meetings. The vendor is required to review with MassHealth the details regarding the progress it is making toward meeting contract requirements and all short-term and long-term goals. One example of such documentation is the vendor's Annual Quality Program and Plan Evaluation.

The BHP requires the vendor to conduct annual satisfaction assessments and a variety of tools are implemented to conduct such surveys. The vendor surveys and analyzes the results of the member satisfaction surveys for those who have utilized services. The vendor conducts an annual survey to assess the level of provider satisfaction within their provider network and the vendor hires a consumer-run organization that conducts face-to-face surveys (conducted by consumers who interview consumers currently receiving services) to gain a different perspective of member satisfaction with the services the vendor has provided. The analysis of these three surveys is reported to MassHealth.

HEDIS: on an annual basis, HEDIS data is collected by the PCC Plan and the MCO Program. MassHealth endorses a rotation of measures strategy whereby a subset of HEDIS measures is collected by each participating health plan. HEDIS behavioral health measures are included in the set of measures collected. The data is analyzed and the results used for quality improvements by MassHealth and the plans. A comprehensive HEDIS MassHealth Report, which includes plan-specific and MassHealth results, is produced each year.

Independent External Review: each year, MassHealth retains the services of an independent auditing firm to perform a review of its BHP vendor. The purpose of this review is to obtain a report on the appropriateness of the vendor's controls over the administration of the BHP for the past contract year. MassHealth agrees to a focused consultant review in the following areas:

- Internal control and contract compliance;
- Prior year audit findings and corrective action plan;
- Claims administration;
- BHP financial reports and capitation rate payment reconciliation statement;
- Vendor's administrative functions and DSTRA activities;
- Vendor's contract performance standards; and,
- Provider accounts receivable confirmation

The consultants conduct on-site visits, review vendor's electronic and paper claims, review relevant contracts and other documentation, and interview vendor personnel responsible for the BHP administration. The detailed report and the report specifications are submitted to MassHealth upon completion of the annual review.

7.1.3. ☒ Information strategies

MCO Program

In order to help MCOs meet the standard improvement goals, MassHealth conducts periodic workgroups related to each goal to assist the MCOs in developing strategies to attain the goals. Both MassHealth and MCO representatives participate in these workgroups. The workgroups maximize both MassHealth and the MCO resources by providing a mechanism for coordination initiatives across provider networks and other state agencies. (For example: DPH participates in the Child and Adolescent Workgroup). These meetings are excellent opportunities to discuss the specific needs of the Medicaid population and for MCOs to share best practices.

PCC Plan

The PCC Plan is a member of the MassHealth Medical Directors' Workgroup. The workgroup is made up of Medical Directors of each of the MCOs with which MassHealth contracts and other health care professionals. The Medical Directors' Workgroup advises and guides MassHealth and the PCC Plan on clinical and practice management issues that determine the quality of health care received by PCC Plan members.

MassHealth currently works with two contractors (MBHP and the Enrollment Broker) to provide member enrollment and education. In collaboration with MassHealth, MBHP produces and distributes a quarterly newsletter in English and Spanish for PCC Plan members. The newsletter incorporates easy-to-read principles and covers topics such as key managed care concepts, health education, national health observances, and important health and safety messages.

Targeted member education activities are also conducted by the Enrollment Broker's community representatives through participation in local health fairs and lobby activities in PCC offices. Member education is supported by the PCC Plan Quarterly Management Improvement Projects for conditions such as diabetes and asthma. The PCC Plan works collaboratively with PCCs to distribute member fact sheets, wallet cards, and related care management support materials to educate members.

Behavioral Health Program

The Quality Council is composed of MassHealth and the vendor's staff, service providers and consumers. Its purpose is to monitor the vendor's progress in meeting the BHP annual improvement goals and contract requirements as well as to provide feedback to the vendor regarding clinical and service delivery issues. Other council meetings that provide a monitoring and feedback loop include the Behavioral Health Advisory Council (every second month), Family Advisory Council (monthly), and the Consumer Advisory Council (monthly).

7.1.4. ☒ Quality improvement strategies

MCO Program

MassHealth currently negotiates annual improvement goals and measures with contracted MCOs. The improvement goals are used to evaluate contract performance. The MCO improvement goals are also related to MassHealth's quality improvement goals and are designed to ensure that MassHealth achieves these goals for its members. The need for improvement goals is identified from several data sources including:

- Annual MCO data submissions, including HEDIS and Member Satisfaction reporting;
- MCO data collected during the prior year's improvement goal efforts;
- Data from the annual Independent External Review; and,
- Findings from the annual external review conducted with each MCO around specific clinical topic areas.

MassHealth uses this information to identify opportunities to improve compliance with the requirements in the contract and suggests improvement goals. MassHealth currently develops two types of improvement goals:

(1) Standard improvement goals, applicable to all MCOs. These goals reflect a common need for improved performance in a particular area across MCOs. Examples of standard improvement goals for prior years include:

- Reducing inappropriate emergency room use;
- Increasing services delivered to children and adolescents (EPSDT and school based health center linkages);

- Increasing both the penetration and duration of mental health and substance abuse services delivered; and,
- Improving coordination between MassHealth and the MCO for noncapitated services.

(2) MCO-specific improvement goals. MassHealth negotiates the specific goal and measure language with each MCO based on the MCO's individual need for improvement.

MassHealth-sponsored workgroups

In order to help MCOs meet the standard improvement goals, MassHealth facilitates monthly workgroups related to each goal to assist the MCOs in developing strategies to attain the goals. Both MassHealth and MCO representatives participate in these workgroups. The workgroups maximize both MassHealth and the MCO resources by providing a mechanism to coordinate initiatives across provider networks and other state agencies. (For example: DPH participates in the Maternal and Child Health Workgroup). These meetings are excellent opportunities to discuss the specific needs of the MassHealth population and for MCOs to share best practices.

Contract Status Meetings

Each MCO must participate in regular (semi-annual) contract status meetings with MassHealth. The primary purpose of these meetings is to review MCO progress towards the achievement of annual improvement goals. During this meeting, the MCO provides MassHealth with a written update, detailing progress toward meeting both MCO specific and standard improvement goals. MassHealth evaluates MCO performance on each goal annually; MassHealth produces an overall performance score for each MCO. This score includes the results of both the Quality Improvement goal process and the Contract Management Reporting requirement process.

PCC Program

The PCC Plan currently sets annual goals to guide the development of its programs and initiatives. The PCC Plan goals focus on continuous improvement with respect to clinical programs and administrative aspects of service delivery and address each of the functional areas involved in quality monitoring and improvement activities (Quality Management, Operations and Provider Communication, Member

Education, and Maternal and Child Health). Progress towards goal attainment is measured at regular intervals.

BH Program
MassHealth no longer negotiates annual improvement goals and measures with the vendor. Instead, the various projects and activities which were formerly categorized as "improvement goals" have subsequently become incorporated into the amended contract as "requirements," and any new improvement goals are currently categorized as "performance standards." The focus of these projects and activities is aimed at improving access to care and improving quality of care.

Fee-for-service
Quality Improvement projects are designed to increase hospital compliance with clinical standards of care. MassHealth's contractor gathers hospital data through record review and other analytic means in order to assist hospitals to achieve individual goals of improved care. The contractor conducts educational sessions to share information. Outcomes are measured via project-specific clinical indicators gathered primarily from medical record review

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The PCC Plan Maternal and Child Health activities currently focus on improvement of primary and preventive health care service delivery for children and adolescents. Current initiatives include member education activities, provider education activities, and coordination with other state

agencies involved in the health care of children and adolescents. MassHealth leads a maternal and child health advisory group comprised of providers, child advocates, and other state agencies to assist in identifying and prioritizing policies and activities to improve the managed care system for children and adolescents. The group also reviews progress and data related to the identified initiatives.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

MassHealth requires that members' access to services is consistent with the degree of urgency as set forth below:

- emergency services must be provided immediately;
- urgent care must be provided within 48 hours; and,
- non-urgent care must be provided within 10 working days.

MassHealth currently has contracts with four MCOs. MCOs are available to members throughout most of the state, although not all contracting MCOs are statewide. Similar to the Behavioral Health Program, MassHealth's MCO contracts detail the MCOs' responsibilities regarding member access to medical care. All the MCOs must meet, through their contractual obligation with MassHealth, member access requirements that are specified in the MCO contract. (See Attachment 7.1 Provider/Patient Ratios.)

MassHealth currently has contracts with approximately 1,100 PCC practices, in the PCC Plan network. This network includes clinicians in various practice settings; individual physicians, group practices, community health canters, independent nurse practitioners, and hospital outpatient departments. The PCC Plan Provider Contract also requires that each PCC practice comply with certain access requirements ensuring prompt access to medical care. (See Attachment 7.1 Provider/Patient Ratios.)

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

MassHealth has several methods in place to monitor and assure access to covered services, in addition to what is described above, MassHealth contracts with a vendor to administer and manage the Behavioral Health Program. The Behavioral Health Program offers a comprehensive provider network that includes a broad spectrum of mental health and substance abuse providers across the full-continuum of care. The vendor is responsible for all provider network management activities. Through its contracted provider network, the vendor is responsible for providing all medically necessary care, 24 hours a day with the most clinically appropriate provider, and at the most clinically appropriate level of care. The vendor must ensure that members have access to all covered services utilizing the following standards:

- non-emergency inpatient services - within 60 miles or 45 minutes travel time;
- all other covered services - within 20 miles or 30 minutes travel time.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

MassHealth assures that prior authorization of health services are completed in a timely manner and in accordance with State law. MassHealth takes into consideration the urgency of care in responding to prior authorization requests. Members may appeal any service denials to MassHealth's Board of Hearings

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 8. Cost Sharing and Payment (Section 2103 (e))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES
8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums

If a family's gross income is determined to be above 150% of the poverty level, the family will be required to share in the cost of coverage. This requirement is waived for pregnant women and children under age one eligible for MassHealth Standard. For children covered through MassHealth Family Assistance and disabled children covered through MassHealth CommonHealth, the cost sharing will be a monthly premium payment.

The monthly premium payment for Family Assistance direct coverage and CommonHealth members is:

%FPL	Per child	Family maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

For households with families enrolled in different coverage types, the family pays the highest of the premiums (rather than the sum of all the premiums).

As discussed in Section 4, American Indians and Alaskan Natives are exempt from payment of premiums.

8.2.2. Deductibles, Coinsurance or copayments:

Children under 19 years of age, including unborn children, are excluded from MassHealth copayment requirements.

8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

All of MassHealth's outreach and enrollment materials will display the eligibility requirements, coverage types and any cost sharing requirements. The member booklet sent to all potential applicants along with the Medical Benefit Request (MBR) displays the cost sharing required for families with gross income between 150% and 300% FPL (before disregards). Additionally, families who complete an MBR and apply for benefits will be notified in writing of any cost sharing requirements once eligibility is determined.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

Direct coverage
Premiums amounts never exceed 5% of family income. Copays are not required for children.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 8. Cost Sharing and Payment (Section 2103 (e))

Premium assistance

As required by Title XXI, MassHealth will cover well-child care in full and set a family cap on the amount of total cost sharing for Title XXI children receiving premium assistance. MassHealth will cover cost sharing for well-baby and well-child care services by paying the provider or the family for any well-child or well-baby care co-payments and/or deductibles. Additionally, MassHealth will set a family cap on cost sharing at 5% of the family gross income. Once these families have incurred and paid bills on behalf of their children exceeding 5% of the family income, they will cease to be responsible for any additional co-payments or deductibles relative to their children's health care for that eligibility year.

After the eligibility determination is complete, MassHealth will notify the families of the cost sharing limits for both well child care and expenses exceeding the family cap and the payment procedures. This notice will also include a definition of well-child care services. The 5% cap will be calculated based on the gross family income used for the eligibility determination; any cost sharing in the form of premiums will be deducted from that amount and the family will be notified of the amount of co-payments and deductibles for which they will be responsible.

For example: A family of four with $29,000 in gross income and two children is determined eligible for MassHealth Family Assistance premium assistance payments. Based on the cost of their health insurance and their employer contribution, they are responsible for $24 of the health insurance premium each month, or $288 annually. Five percent of their gross family income is $1,450. MassHealth will automatically deduct the $288 and notify the family that once they incur and pay $1162 in co-payments or deductibles relative to their children's health care for that eligibility year, any additional out of pocket expenses toward covered services will be paid by MassHealth.

MassHealth will make every effort to generate manual payments directly to the providers. A substantial number of providers are already on the state's vendor file. However, if the provider is not included on the state's vendor file, MassHealth will make the payment to the family and outreach to the provider. The outreach process will assure that the providers are given the opportunity to become a state vendor. To ensure that members are not required to pay the bill at the point of service MassHealth will educate the provider community regarding the procedures for payment through bulletins and newsletters.

Consistent with MassHealth's policies, after MassHealth notifies the family of the 5% cap, it becomes the family's responsibility to track their expenditures and submit appropriate bills for payment. Once the family has incurred and paid out of pocket expenses totaling their family cap, they will be required to submit proof of payment to a MassHealth representative who will review the submitted bills in a timely manner. The representative will review that

the payments were made for the children and for health services covered by the family's policy. Once the review is complete, the family will be notified of the procedures for submitting all future bills to MassHealth. The family will be able to use this notification as documentation to show the provider. After the family cap has been reached, families will be directed to submit the provider co-payment or deductible bill to MassHealth for payment. MassHealth will review the bill and generate a payment to the provider or the member within one to two weeks of receiving the bill.

Whether or not the family has reached their family cap, they will not be responsible for any co-payments or deductibles they incur for well-child or well-baby care. On average, the co-payments for well-child care range from $5 to $10 per visit. The family will be directed to submit the well-child care bills to MassHealth for payment. Once MassHealth receives the bills for well-child care co-payments, payments will be generated to the provider or the member within one to two weeks.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

MassHealth Family Assistance members who self-identify as members of a federally recognized American Indian tribe or who are Alaska Natives will not be charged a monthly premium.

AI/AN who are applying for MassHealth are notified of their exclusion to cost-sharing from information provided in the MBR and member booklet. For AI/AN who are already MassHealth members, a mailing explaining the exclusion from cost-sharing was done to the single federally recognized tribe in Massachusetts, and through some assistance from the tribe, to those members who could be identified as possibly being AI/AN. The cost-sharing exclusion has been implemented through a manual process. Currently, MassHealth captures the self-declared ethnicity information provided on the MBRs and regularly runs a report identifying potential AI/AN. Then, those individuals are flagged by a manual process so that they will be excluded from cost-sharing.

Section 8.7 superseded by TN-014-006 MMDL

8.7 Please provide a description of the consequences for an enrollee or applicant who does not

pay a charge. **(42CFR 457.570 and 457.505(c))**

A child's coverage under Family Assistance will end if premiums remain unpaid for a 60-day period. The family will receive advance notice of the termination and may appeal the decision. Coverage will be reinstated retroactive to the date of termination if delinquent premiums are paid within 30 days of the termination. If payment is made after the 30-day period, coverage will be reinstated as of the date of the premium payment. However, in order for MassHealth to insure that there is no gap in coverage, a pay-back plan will be established if the family is interested. The payback plan may be extended for up to 12 months to assist families who have difficulty paying the outstanding balance. The family is not required to submit a new application or submit any other verification to have coverage reinstated.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- ☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**
- ☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**
- ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**
- ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.

8.8.4. ☒ **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))** Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

- Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children.
- Expand access to health coverage for low income uninsured children.
- Improve the efficiency of the eligibility determination process.
- Improve the health status and well-being of children enrolled in MassHealth direct coverage programs.
- Coordinate with other health care programs -- specifically the state-funded Children's Medical Security Plan (CMSP), to create a seamless system for low-income children in need of health care.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age

bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children.
  - Implement MassHealth Family Assistance Expansion for Children in SFY 2006.
- Expand access to health coverage for low-income children.
  - Reduce the number of uninsured children in the Commonwealth.
- Improve the efficiency of the eligibility determination process.
  - Develop a streamlined eligibility process by eliminating certain verifications.
  - Further enhance the fully automated eligibility determination system.
- Improve the health status and well-being of children enrolled in MassHealth direct coverage programs.
  - Improve the delivery of well child care by measuring the number of well child visits and implementing improvement activities as appropriate.
  - Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate.
- Coordinate with other health care programs, specifically the state funded Children's Medical Security Plan (CMSP) to create a seamless system for low-income children in need of health care.
  - Enroll all CMSP members eligible for MassHealth prior to July 1, 1998.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the State's performance, taking into account suggested performance indicators as specified below or other indicators the State develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

As described in (.5), an independent annual evaluation of the state plan will be conducted by the University of Massachusetts Medical Center (UMMC).

Check the applicable suggested performance measurements listed below that the State plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. ☒ The reduction in the percentage of uninsured children.
9.3.3. ☐ The increase in the percentage of children with a usual source of care.
9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☒ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☐ Other child appropriate measurement set. List or describe the set used.
9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- **9.3.7.1.** ☐ Immunizations
- **9.3.7.2.** ☐ Well childcare
- **9.3.7.3.** ☐ Adolescent well visits
- **9.3.7.4.** ☐ Satisfaction with care
- **9.3.7.5.** ☐ Mental health
- **9.3.7.6.** ☐ Dental care
- **9.3.7.7.** ☐ Other, list:

9.3.8. ☒ Performance measures for special targeted populations.

1. Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low income children.

Implement MassHealth Family Assistance Expansion for Children in State Fiscal Year 2006.

MassHealth will measure the number of applicants with access to employer-sponsored health insurance that enrolled in their employer-sponsored health insurance plan. MassHealth will also measure the increase in children who are insured through employer-sponsored health insurance, and the reduction in the number of children in the free care pool.

2. Expand access to health coverage for low income uninsured children.

Reduce the number of uninsured children in the Commonwealth.

Decrease in the ratio of uninsured to insured children from 2:3 to 1:9.

3. Improve the efficiency of the eligibility determination process.

Develop a streamlined eligibility process by enhancing matching activities.

Expand Virtual Gateway capabilities.

Determine 90% of applicants the eligibility status within 15 days receipt of a completed MassHealth Benefit Request (MBR).

4. Improve the health status and well being of children enrolled in MassHealth direct coverage programs.

Improve the delivery of well child care by measuring the number of well child visits and implementing improvement activities as appropriate.

Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate.

MassHealth will measure improvements in well child visits rate and immunization status rates through the use of HEDIS data, encounter data and PCC Profile Reports.

5. Coordinate with other health care programs - specifically the state-funded Children's Medical Security Plan (CMSP), to create a seamless system for low income children in need of health care.
Automatically enroll all newly-eligible CMSP members eligible for MassHealth July-September 2006. Provide advance notice and information about new comprehensive benefits. Expedite enrollment into health plans.

MassHealth will measure the number of children who were enrolled in CMSP prior to July 1, 2006 to those who enroll with MassHealth after July 1, 2006.

9.4. ☒ The State assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

9.5. ☒ The State assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the State's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

MassHealth will conduct an annual assessment of the effectiveness of the state plan by measuring the increase in the number of children with employer-sponsored health coverage. MassHealth will use the Current Population Survey (CPS) to calculate the baseline number of uncovered low income children.

An independent annual evaluation of the state plan will be coordinated by the University of Massachusetts Medical Center (UMMC). This evaluation will:

- measure the effectiveness of the state plan according the goals and measurements described in sections 9.1, 9.2 and 9.3.
- evaluate the characteristics of the children and families assisted in the state plan. These characteristics include age, family income, health insurance status before and after implementation.
- assess the length of time a member is eligible for the Family Assistance as compared to the length of time the member is enrolled in the plan.
- measure the quality of health coverage for members of MassHealth Family Assistance and MassHealth Standard along with MassHealth's overall quality assurance program, described in section 7.1.
- collect and evaluate summary information from employer sponsored health insurance plans for those members who receive premium assistance from MassHealth.

9.6. ☒ The State assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

9.7. ☒ The State assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

MassHealth involved the public in the design and implementation of the Title XXI State Plan at various forums. The state legislative process which authorized the basic design and funding for Massachusetts's Health Care Reform of 2006 included robust public exchange allowing various constituencies to voice their concerns.

To implement the 2006 changes MassHealth conducted a number of meetings throughout the state to obtain feedback on: the proposed benefit packages, the cost sharing proposal, the coordination strategy with the Children's Medical Security Plan, and various outreach activities. These groups included:

- Children's health care advocates such as: Health Care For All, Mass. Law Reform Legal Services, and other advocacy organizations;

- Health care providers such as: the Massachusetts Medical Society, the Massachusetts Hospital Association, and Primary Care Clinicians (PCCs) at various regional meetings;

- EOHHS's Child and Adolescent workgroup (consisting of representatives from: Department of Public Health, Department of Youth Services, Massachusetts Chapter of the Academy of Pediatrics, Alliance for Young Families, Boston Medical Center, Department of Social Services, Mass. Advocacy, Martha Elliot Health Center, Boston Department of Health and Hospitals, Children's League of Massachusetts, and Children's Hospital);

- School nurses;

- State agencies such as: the Department of Public Health, the Division of Health Care Finance and Policy, the Executive Office of Health and Human Services, and the Executive Office of Administration and Finance.

Since implementing the CHIP program in August 1998, MassHealth has continued to involve the public in the program. MassHealth also holds a quarterly meeting of its Medical Care Advisory Committee to discuss pertinent issues regarding Medicaid and CHIP and hosts a monthly meeting of health care advocates. In addition, MassHealth continues to actively involve the provider community in the MassHealth program. For example, MassHealth is part of the Massachusetts Health Quality Partners, and meets as needed with the Massachusetts Medical Society and the Massachusetts Hospital Association. . MassHealth continues to sponsor and provide leadership for the Massachusetts Health Care Training Forum (MTF) program, which provides an opportunity to share information on MassHealth operations and policy changes and health care reform program and policy updates to health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured.

9.9.1 Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Mashpee Wampanoag Tribe: The MassHealth Director of Outreach and Education sent an email on 7/28/10 to the tribe's Health Director, MassHealth Insurance Coordinator and Outreach and Enrollment Specialist, suggesting a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Health Director, the Health and Human Services Liaison to the Tribal Council, the MassHealth Insurance Coordinator, and the Outreach and Enrollment Specialist, sent an email to the MassHealth Director of Outreach and Education on 8/2/10 confirming that the tribe agrees with this approach.

Wampanoag Tribe of Gay Head (Aquinnah): During a conference call on 9/15/10 with the Chairwoman and the Acting Health Director of the tribe, the MassHealth Director of Outreach and Education and the Member Education Clinical Coordinator suggested a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Chairwoman and the Acting Health Director confirmed on the call that they agreed with this approach.
During quarterly consultation calls on January 19, 2011, the representatives from the Mashpee Wampanoag Tribe, the Wampanoag Tribe of Gay Head (Aquinnah) and the Indian Health Programs confirmed that they considered any State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects to have a direct effect on Tribal members. The Commonwealth will therefore seek advice and feedback from the Tribes and Indian Health Program on all such changes to be submitted to CMS.

Native American Lifelines of Boston: During a conference call on 10/27/11 with the Acting Site Director, the MassHealth Director of Outreach and Education suggested a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Acting Site Director confirmed on the call that he agreed with this approach.

During quarterly consultation calls on January 19, 2011, the representatives from the Mashpee Wampanoag Tribe, the Wampanoag Tribe of Gay Head (Aquinnah) and the Indian Health Programs confirmed that the Commonwealth will raise

issues identified as having a direct effect on the Tribes in the quarterly consultation calls or via email at least a month in advance of submission to CMS; and when notice is provided in calls or via email, the Tribes will have at least two weeks to respond with advice to the Commonwealth. For major initiatives the Commonwealth will notify the Tribes early in the process of development through the stakeholder processes associated with each initiative. These stakeholder processes ask stakeholders, including the Tribes, to give us their advice and feedback on the initiatives.

During the call on October 27, 2011 with Native American Lifelines of Boston, the Acting Site Director indicated he agreed with the approach and timeframes for consultation as described above.

In addition, MassHealth attends "consultation model" regional meetings that states, CMS, and the local tribes and tribal organizations attend. These meetings have been very beneficial to convey and address current issues and tribal needs. Also, MassHealth has a designated staff member in our Member Services Unit who deals with and is responsible for Indian and tribal issues.

MassHealth is also committed to consulting with the Tribes in Massachusetts to share its goals of increasing retention. MassHealth will solicit the Tribes' input on how to make their members aware of the Express Lane Renewal process. The Tribes will be provided with updates on Express Lane Renewal during quarterly conference calls. In addition, MassHealth will remain in full compliance with this State Plan Amendment by obtaining the Tribes' advice and responding to their concerns within the required timelines. MassHealth will work cooperatively with the Tribes on Express Lane Renewal.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

MassHealth provided talking points on applied behavior analysis (ABA) coverage to customer service staff, to Navigators and to advocates to help get notice out to parents that medically necessary ABA services were available to their children. MassHealth's managed care entities will begin coverage of ABA in October of 2015 and the plan materials will include information about ABA coverage.

9.10 Provide a 1-year projected budget.

A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

Table 9-1 on page 11 provides projected CHIP expenditures for FFY 2012 The non-federal share of the funds is all state funds with one exception: The Commonwealth received a four year grant on February 17, 2009 from the Robert Wood Johnson (RWJ) Foundation to support MassHealth's increased enrollment and retention of children. The Commonwealth will use the RWJ grant as state matching funds. The state funds are appropriated annually from the Commonwealth's General Fund.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 9. Strategic Objectives and Performance Goals and Plan Administration

CHIP Amendment #17	CHIP ABA	Cost Projections of Approved CHIP Plan	Total
	FFY2016	FFY 2016	FFY 2016
State's enhanced FMAP rate	88.00%	88.00%	88.00%
Benefit Costs			
Insurance payments	$421,060	$8,982,350	$9,403,409
Managed Care	$10,105,428	$284,042,058	$294,147,486
per member/per month rate @ # of eligible	$9	$338	$347
Fee for Service	$0	$207,276,783	$207,276,783
Total Benefit Costs	$10,526,488	$500,301,191	$510,827,679
(offsetting beneficiary cost sharing payments)	$0	$0	$0
Net Benefit Costs	$10,526,488	$500,301,191	$510,827,679
Administrative Costs			
Personnel	$0	$0	$0
General Administration	$0	$10,007,508	$10,007,508
Contractors/Brokers	$0	$0	$0
Claims Processing	$0	$0	$0
Outreach/marketing costs	$0	$0	$0
Other (H.S.I.)	$0	$43,000,000	$43,000,000
Total Administrative Costs	$0	$53,007,508	$53,007,508
10% Administrative Cap	$1,169,610	$55,589,021	$56,758,631
Federal Share	$9,263,309	$486,911,655	$496,174,965
State Share	$1,263,179	$66,397,044	$67,660,222
TOTAL COSTS OF APPROVED CHIP PLAN	$10,526,488	$553,308,699	$563,835,187

Note: MassHealth will not claim administrative costs for approved Health Service Initiative programs in excess of the 10% cap. The H.S.I. expenditures are direct services and the administrative costs directly related to provision of services.

As with all collections, MassHealth will reduce the expenditures by the amount collected for premiums by returning to CMS the FFP associated with the premiums for children in Family Assistance direct coverage.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

10.1. Annual Reports. The State assures that it will assess the operation of the State plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uninsured low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The State assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The State assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 11. Program Integrity (Section 2101 (a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue to Section 12.

11.1. ☒ The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The State assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a State under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 12. Applicant and Enrollee Protections (Section 2101 (a))

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

MassHealth's review process for eligibility and enrollment matters is consistent with standard Medicaid procedures.

Medicaid Expansion CHIP children and unborn-CHIP children eligible for MassHealth Standard are not subject to premiums and will not be charged premiums as a result of Express Lane Renewal. They will remain eligible in their current benefit category.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR 457.1120.

MassHealth's review process for health service matters is consistent with standard Medicaid procedures

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, describe how the State will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

MassHealth assures that is will offer individuals receiving premium assistance coverage through group health plans that do not meet the requirements of 42 CFR 457.1120 the option of enrolling in direct coverage