# CENTERS FOR MEDICARE & MEDICAID SERVICES
# SPECIAL TERMS AND CONDITIONS

**NUMBER:** **11-W-00030/1**

**TITLE:** **MassHealth Medicaid Section 1115 Demonstration**

**AWARDEE:** **Massachusetts Executive Office of Health and Human Services (EOHHS)**

## I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter "Demonstration"). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the Commonwealth's obligations to CMS during the life of the Demonstration. The STCs are effective as of the date of the approval letter, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the State's expenditures relating to dates of service during this Demonstration extension. This Demonstration extension is approved effective the date of the approval letter, through June 30, 2014, unless otherwise specified.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Demonstration Programs and Benefits
VI. Delivery System
VII. Cost Sharing
VIII. The Safety Net Care Pool
IX. General Reporting Requirements
X. General Financial Requirements Under Title XIX
XI. Monitoring Budget Neutrality for the Demonstration
XII. Evaluation of the Demonstration
XIII. Schedule of Deliverables for the Demonstration Extension Period
Attachment A. Overview of Children's Eligibility in MassHealth
Attachment B. Cost Sharing
Attachment C. Quarterly Operational Report Content and Format

Attachment D. MassHealth Historical Per Member/Per Month Limits
Attachment E. Safety Net Care Pool Payments
Attachment F. Reserved for Pediatric Asthma Pilot Program Protocols
Attachment G. Reserved for Autism Payment Protocol
Attachment H. Reserved for Safety Net Care Pool Uncompensated Care Cost Protocol
Attachment I. Hospitals Eligible for DSTI
Attachment J. Reserved for Master DSTI Plan and Payment and Funding Protocol

## II. PROGRAM DESCRIPTION AND OBJECTIVES

The MassHealth Demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The Demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility for certain categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons living with Human Immunodeficiency Virus (HIV). Finally, the Demonstration also authorized the Insurance Partnership program which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth's preferred mechanism for achieving coverage has consistently been employer-sponsored insurance, whenever available and cost-effective.

The implementation of mandatory managed care enrollment under MassHealth changed the way health care was delivered resulting in a new focus on primary care, rather than institutional care. In order to aid this transition to managed care, the Demonstration authorized financial support in the form of supplemental payments for two managed care organizations (MCOs) operated by safety net hospital providers in the Commonwealth to ensure continued access to care for Medicaid enrollees. These payments ended in 2006.

In the 2005 extension of the Demonstration, CMS and the Commonwealth agreed to use Federal and State Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). This restructuring laid the groundwork for health care reform in Massachusetts, because the SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting a new insurance program.

Massachusetts' health care reform legislation passed in April 2006. On July 26, 2006 CMS approved an amendment to the MassHealth Demonstration to incorporate those health reform changes. This amendment included:

- the authority to establish the Commonwealth Care program under the SNCP to provide sliding scale premium subsidies for the purchase of commercial health plan coverage for uninsured persons at or below 300 percent of the FPL;

- the development of payment methodologies for approved expenditures from the SNCP;
- an expansion of employee income eligibility to 300 percent of the FPL under the Insurance Partnership; and
- increased enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

At this time there was also an eligibility expansion in the Commonwealth's separate title XXI program for optional targeted low-income children between 200 percent and 300 percent of the FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families. With the combination of previous expansions and the recent health reform efforts, the MassHealth Medicaid section 1115 Demonstration now covers approximately 1.5 million low-income persons.

In the 2008 extension of the Demonstration, CMS and the Commonwealth agreed to reclassify three eligibility groups (those aged 19 and 20 under the Essential and Commonwealth Care programs and custodial parents and caretakers in the Commonwealth Care program) with a categorical link to the title XIX program as "hypotheticals" for budget neutrality purposes as the populations could be covered under the State plan. As part of the renewal, the SNCP was also restructured to allow expenditure flexibility through a 3-year aggregate spending limit rather than annual limits; a gradual phase out of Federal support for the Designated State Health Programs; and a prioritization in the SNCP to support the Commonwealth Care Program.

Three amendments were approved in 2010 and 2011 to allow for additional flexibility in the Demonstration. On September 30, 2010, CMS approved an amendment to allow Massachusetts to (1) increase the MassHealth pharmacy co-payment from $2 to $3 for generic prescription drugs; (2) provide relief payments to Cambridge Health Alliance totaling approximately $216 million; and (3) provide relief payments to private acute hospitals in the Commonwealth totaling approximately $270 million.

On January 19, 2011, CMS approved an amendment to: (1) increase authorization for Designated State Health Programs for State Fiscal Year 2011 to $385 million; (2) reclassification of Commonwealth Care adults without dependent children with income up to and including 133 percent of the Federal Poverty Level (FPL) as a "hypothetical" population for purposes of budget neutrality as the population could be covered under the State plan; and (3) allow the following populations to be enrolled into managed care: (a) participants in a Home and Community-Based Services Waiver; (b) Katie Beckett/ Kaileigh Mulligan children; and (c) children receiving title IV-E adoption assistance.

Additionally, on August 17, 2011, CMS approved an amendment to authorize expenditure authority for a maximum of $125.5 million for State fiscal year (SFY) 2012 for Cambridge Health Alliance through the SNCP for uncompensated care costs. This funding was approved with the condition that it be counted toward a budget neutrality limit eventually approved for SFY 2012 as part of the 2011 extension.

In the 2011 extension of the Demonstration, CMS and the Commonwealth agreed to use Federal and State Medicaid dollars for the following purposes:

- support a Pediatric Asthma Pilot Program focused on improving health outcomes and reducing associated Medicaid costs for children with high-risk asthma;
- offer early intervention services for children with autism who are not otherwise eligible through the Commonwealth's currently approved section 1915(c) home and community-based services waiver because the child has not been determined to meet institutional level of care requirements;
- utilize Express Lane eligibility to conduct renewals for parents and caretakers to coincide with the Commonwealth's intent to utilize Express Lane eligibility for children; and
- further expand the SNCP to provide incentive payments to participating hospitals for Delivery System Transformation Initiatives focused on efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

For this extension period, the Commonwealth's goals under the Demonstration are:

- Maintain near-universal health care coverage for all citizens of the Commonwealth and reduce barriers to coverage;
- Continue the redirection of spending from uncompensated care to insurance coverage;
- Implement delivery system reforms that promote care coordination, person-centered care planning, wellness, chronic disease management, successful care transitions, integration of services, and measurable health outcome improvements; and
- Advance payment reforms that will give incentives to providers to focus on quality, rather than volume, by introducing and supporting alternative payment structures that create and share savings throughout the system while holding providers accountable for quality care.

## III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and CHIP Law, Regulation, and Policy.** All requirements of the Medicaid program and Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the Demonstration as necessary to comply with such a change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

    b) If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments (SPAs) for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan may be required except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

    a) An explanation of the public process used by the Commonwealth consistent with the requirements of STC 14 to reach a decision regarding the requested amendment;

    b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent

actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;

c) An up-to-date CHIP allotment neutrality worksheet, if necessary;

d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State plan amendment, if necessary; and

e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of STC 9.

   As part of the Demonstration extension request, the State must provide documentation of compliance with the public notice requirements outlined in STC 14, as well as include the following supporting documentation:

   a) Demonstration Summary and Objectives. The State must provide a summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met.

   b) Special Terms and Conditions. The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

   c) Quality. The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.

   d) Compliance with the Budget Neutrality Cap. The State must provide financial data (as set forth in the current STCs) demonstrating that the State has maintained and will maintain budget neutrality for the requested period of extension. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension.

e) Interim Evaluation Report. The State must provide an evaluation report reflecting the hypotheses being tested and any results available.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this Demonstration in whole, or in part, consistent with the following requirements.

   a) Notification of Suspension or Termination. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the Demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received, the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

   b) The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

   c) Phase-out Plan Requirements. The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

   d) Phase-out Procedures. The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to Demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a Demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

   e) FFP. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the

project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to administratively and/or judicially challenge CMS' finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

14. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009 and the tribal consultation requirements at outlined in the State's approved State plan, when any program changes to the Demonstration including (but not limited to) those referenced in STC 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State must to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any amendment or extension of this Demonstration. The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in Statewide methods and standards for setting payment rates.

15. **Quality Review of Eligibility**. The Commonwealth will continue to submit by December 31st of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) as permitted by Federal regulations at 42 CFR 431.812(c). Based on the approved MEQC activities, the Commonwealth will be assigned a payment error rate equal to the FFY 1996 State error rate for the duration of this section 1115 demonstration project.

16. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

## IV. ELIGIBILITY AND ENROLLMENT

17. **Eligible Populations.** This Demonstration affects mandatory and optional Medicaid State plan populations as well as populations eligible for benefits only through the Demonstration.

    The criteria for MassHealth eligibility are outlined in a Table A at the end of section IV of the STCs which shows each specific group of individuals; under what authority they are made eligible for the demonstration; the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed; and the corresponding demonstration program under which benefits are provided. Attachment A provides a complete overview of MassHealth coverage for children, including the separate title XXI CHIP program, which is incorporated by reference.

    Eligibility is determined based on an application by the beneficiary.

18. **Retroactive Eligibility.** Retroactivity eligibility is provided only in accordance to Table D.

19. **Calculation of Financial Eligibility.** Financial eligibility for Demonstration programs is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage type. The monthly income standards are determined according to annual Federal Poverty Level (FPL) standard published in the *Federal Register.*

20. **Express Lane Eligibility.** The Medicaid State agency may rely on a finding from an Express lane agency when determining whether a parent or caretaker satisfies one or more components of eligibility derived through the Medicaid State plan or Demonstration at the time of redetermination. The authority to provide Express Lane eligibility procedures for parents and caretakers is not effective until the effective date of the companion Medicaid State plan amendment applicable to children. All procedures outlined in the companion Medicaid Express Lane Eligibility SPA must also apply to Express Lane eligibility determinations for parents and caretakers.

    The authority to provide Express Lane eligibility procedures will also remain in effect through the renewal period for children notwithstanding sunset dates for Express Lane Eligibility under title XIX and title XXI applicable to the companion State plan amendments. This authority is subject to approval of the Medicaid Express Lane Eligibility State plan amendment.

21. **Presumptive Eligibility.** Presumptive eligibility is offered to certain children who appear eligible for MassHealth Standard or Family Assistance as well as pregnant women who appear eligible for MassHealth Prenatal program.

    a) Presumptive eligibility begins 10 calendar days prior to the date the Medical Benefit Request (MBR) is received at the MassHealth Enrollment Center (MEC) or MassHealth outreach site and lasts until MassHealth makes an eligibility determination (but no longer than 60 days). If information necessary to make the eligibility determination is not

submitted within 60 days after the begin date, the MBR will be deactivated and presumptive eligibility will end.

b) A child may receive presumptive eligibility only once in a 12-month period.

c) A presumptively-eligible child receiving services under the Family Assistance program is not assessed a monthly health insurance MassHealth premium.

22. **Verification of Human Immunodeficiency Virus (HIV).** For individuals who indicate on the MBR that they have HIV, a determination of eligibility will be made once family group income has been verified. Persons who have not submitted verification of HIV diagnosis within 60 days of the eligibility determination shall subsequently have their eligibility redetermined as if they did not have HIV.

23. **Eligibility Exclusions.** Notwithstanding the eligibility criteria outlined in this section or in Table A, the following individuals are excluded from this Demonstration. Payments or expenditures related to uncompensated care for such individuals as defined in STC 49(c), however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP), including the Designated State Health Programs (DSHP).

| Individuals 65 years and older (unless a parent or caretaker relative of a child 18 years old or younger or an enrollee in the Medical Security Plan) |
|---|
| Individuals who are institutionalized |
| Participants in Program of All-Inclusive Care of the Elderly (PACE) |
| Refugees served through the Refugees Resettlement Program |

24. **Enrollment Caps.** The Commonwealth is authorized to impose enrollment caps on populations made eligible solely through the Demonstration, except that enrollment caps may not be imposed for the Demonstration Expansion Population Groups listed as "Hypotheticals" in Table A. Setting and implementing specific caps are considered amendments to the Demonstration and must be made consistent with section III, STC 7.

| Table A. MassHealth State Plan Base Populations* (See STC 63(f) for terminology) | | | | | |
|---|---|---|---|---|---|
| **Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)** | **Federal Poverty Level (FPL) and/or Other Qualifying Criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **MassHealth Demonstration Program** | **Comments** |
| AFDC-Poverty Level infants | < Age 1: 0 through 185% | Title XIX | **Base Families** | Standard** | Up to 60 days presumptive eligibility for children with unverified income |
| Medicaid Expansion infants | < Age 1: 185.1 through 200% | • Title XIX if insured at the time of application<br>• Title XXI if uninsured at the time of application<br>• Funded through title XIX if title XXI is exhausted | **1902(r)(2) Children**<br><br>**1902(r)(2) XXI RO** | Standard | Up to 60 days presumptive eligibility for children with unverified income |
| AFDC-Poverty Level Children and Independent Foster Care Adolescents | • Age 1 - 5: 0 through 133%<br><br>• Age 6 - 17: 0 through 114%<br><br>• Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets | Title XIX | **Base Families** | Standard | Up to 60 days presumptive eligibility for children with unverified income |
| AFDC-Poverty Level Children<br><br>Medicaid Expansion Children I | • Age 6 - 17: 114.1% through 133%<br><br>• Age 18: 0 through 133% | • Title XIX if insured at the time of application<br>• Title XXI if uninsured at the time of application<br>• Funded through title XIX if title XXI is exhausted | **Base Families**<br><br>**Base Families XXI RO** | Standard | Up to 60 days presumptive eligibility for children with unverified income |

| Table A. MassHealth State Plan Base Populations (continued)* | | | | | |
|---|---|---|---|---|---|
| **Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)** | **Federal Poverty Level (FPL) and/or Other Qualifying Criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **MassHealth Demonstration Program** | **Comments** |
| Medicaid Expansion Children II | Ages 1 - 18: 133.1 through 150% | • Title XIX if insured at the time of application<br>• Title XXI if uninsured at the time of application<br>• Funded through title XIX if title XXI is exhausted | **1902(r)(2) Children**<br><br>**1902(r)(2) XXI RO** | Standard | Up to 60 days presumptive eligibility for children with unverified income |
| Pregnant women | 0 through 185% | Title XIX | **Base Families** | Standard | |
| Pregnant women ages 19 and older considered presumptively eligible | 0 through 185% | Title XIX | **Base Families** | Prenatal | Presumptive eligibility for pregnant women with self-declared income |
| Parents and caretaker relatives ages 19 through 64 eligible under section 1931 and Transitional Medical Assistance | 0 through 133% | Title XIX | **Base Families** | Standard | |
| Disabled children under age 19 | 0 through 150% | Title XIX | **Base Disabled** | Standard | |
| Disabled adults ages 19 through 64 | 0 through 114% | Title XIX | **Base Disabled** | Standard | |
| Non-working disabled adults ages 19 through 64 | Above 133% | Title XIX | **Base Disabled** | CommonHealth | Must spend-down to medically needy income standard to become eligible as medically needy |
| Pregnant women | 185.1 through 200% | Title XIX | **1902(r)(2) Children** | Standard | |
| Pregnant women age 19 and older considered presumptively eligible | 185.1 through 200% | Title XIX | **1902(r)(2) Children** | Prenatal | Presumptive eligibility for pregnant women with self-declared income |

| Table A. MassHealth State Plan Base Populations (continued)* | | | | | |
|---|---|---|---|---|---|
| **Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)** | **Federal Poverty Level (FPL) and/or Other Qualifying Criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **MassHealth Demonstration Program** | **Comments** |
| "Non-qualified Aliens," "Protected Aliens," or "Aliens with Special Status" | Otherwise eligible for Medicaid under the State Plan | Title XIX | **Base Families**<br>**Base Disabled**<br>**1902(r)(2) Children**<br>**1902(r)( 2) Disabled** | Limited | Member eligible for emergency services only under the State Plan and the Demonstration.<br><br>Members who meet the definition and are determined to have a disability are included in the Base Disabled EG<br><br>Members who are determined eligible via 1902(r)2 criteria are included in the 1902(r)(2) EG |
| Disabled adults ages 19 through 64 | 114.1 through 133% | Title XIX | **1902(r)(2) Disabled** | Standard | |
| Women eligible under the Breast and Cervical Cancer Treatment Program | 0 through 250% | Title XIX | **BCCTP** | Standard | Women screened through the Centers for Disease Control and Prevention program |
| Children eligible under TEFRA section 134, SSA section 1902(e)(3) and 42 U.S.C. 1396a(e)(3) (Kaileigh Mulligan kids) | • Age 0 – 17<br>• Require hospital or nursing facility level of care<br>• Income < or = to $72.81, or deductible<br>• $0 through $2,000 in assets | Title XIX | **Base Disabled** | Standard | Income and assets of their parents are not considered in determination of eligibility |
| Children receiving title IV-E adoption assistance | • Age 0 through 18 | Title XIX | **Base Families** | Standard | Children placed in subsidized adoption under title IV-E of the Social Security Act |

| Table A. MassHealth State Plan Base Populations (continued)* | | | | | |
|---|---|---|---|---|---|
| **Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)** | **Federal Poverty Level (FPL) and/or Other Qualifying Criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **MassHealth Demonstration Program** | **Comments** |
| Special Home and Community-Based Waiver (HCBW) Group (individuals who without the HCBW would be eligible for Medicaid if in an institution) | • 0 through 300% SSI Federal Benefits Rate<br>• $0 through $2,000 in assets | Title XIX | **Base Disabled** | Standard | All other participants under age 65 in a HCBW are reflected in other Base Eligibility Groups in this chart. |

| Table A. MassHealth Demonstration Expansion Populations (continued)* | | | | | |
|---|---|---|---|---|---|
| **Groups with a Categorical Link Made Eligible through the Demonstration ("Hypotheticals")** | **Federal Poverty Level (FPL) and/or Other Qualifying Criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **MassHealth Demonstration Program** | **Comments** |
| Higher income children with disabilities | • < Age 1: 200.1 through 300%<br>• Ages 1 - 18: 150.1 through 300% | • Title XIX if insured at the time of application or in crowd-out status***<br>• Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted) | **CommonHealth**<br>**CommonHealth XXI** | CommonHealth | The CommonHealth program existed prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI State Plan and as authorized under this 1115 Demonstration. Certain children derive eligibility from both the authority granted under this demonstration and the separate XXI program. |
| Higher income children with disabilities ages 0 through 18 | Above 300% | Title XIX | **CommonHealth** | CommonHealth | Sliding scale premium responsibilities for those individuals above 150 percent of the FPL. |
| Higher income adults with disabilities ages 19 through 64 working 40 hours a month or more | Above 133% | Title XIX | **CommonHealth** | CommonHealth ("working") | Sliding scale premium responsibilities for those individuals above 150 percent of the FPL. |
| 19 and 20 year olds | 0 through 300% | Title XIX | **CommCare-19-20** | Commonwealth Care | |
| 19 and 20 year olds | 0 through 100% | Title XIX | **Essential-19-20** | Essential | |
| Parents and caretaker relatives eligible per above, except for income | 133.1 through 300% | Title XIX | **CommCareParents** | Commonwealth Care | |
| Low-income adults | At or below 133% | Title XIX | **CommCare-133** | Commonwealth Care | |

* Massachusetts includes in the MassHealth Demonstration almost all the mandatory and optional populations aged under 65 eligible under the State Plan. The Massachusetts State Plan outlines all covered populations not specifically indicated here.
** All Standard and CommonHealth members who have access to qualifying private insurance may receive premium assistance plus wrap-around benefits.
*** Crowd out status refers to children made ineligible for CHIP due to the crowd out provisions contained within title XXI.

| Table A. MassHealth Demonstration Expansion Populations (See STC 63(f) for terminology) | | | | | |
|---|---|---|---|---|---|
| **Populations Made Eligible through the Demonstration** | **Federal Poverty Level (FPL) and other qualifying criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **Massachusetts Demonstration Program** | **Additional comments** |
| Children ages 1 through 18 (Non-disabled) | 150.1 through 200% | • Title XIX if insured at the time of application<br>• Title XXI via the separate XXI program if uninsured<br>(Funded through title XIX if title XXI is exhausted) | **e-Family Assistance**<br>**Fam Assist XXI** (if XXI is exhausted) | Family Assistance<br>• Premium Assistance<br>• Direct Coverage<br>The premium assistance payments and FFP will be based on the children's eligibility. Parents are covered incidental to the child. No additional wrap other than dental is provided to ESI. | Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the separate XXI program. |
| Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a qualified small employer and purchase ESI | At or below 300% | Title XIX | **IRP** | Family Assistance/ Insurance Partnership | Enrollment in Family Assistance allows an individual to receive premium assistance through the Insurance Partnership. No additional wraparound is provided.<br>Individuals whose spouse or noncustodial children are receiving MassHealth must enroll in a health plan that provides coverage to the dependents. |

| Table A. MassHealth Demonstration Expansion Populations (continued)* | | | | | |
|---|---|---|---|---|---|
| **Populations Made Eligible through the Demonstration** | **Federal Poverty Level (FPL) and other qualifying criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **Massachusetts Demonstration Program** | **Additional comments** |
| Aged 19 through 64 Long-term unemployed individuals or members of a couple and a client of DMH and/or receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC), not otherwise eligible for medical assistance | 0 through 100% | Title XIX | **Basic** | Basic | Premium assistance is offered in lieu of direct coverage when there is other insurance.<br><br>No additional wraparound is provided. |
| Aged 21through 64 Long-term unemployed individuals or members of a couple, and neither a client of DMH or receiving EAEDC, not otherwise eligible for medical assistance[2] | 0 through100% | Title XIX | **Essential** | Essential | Premium assistance is offered in lieu of direct coverage when there is other insurance.<br><br>No additional wraparound is provided. |
| Families receiving unemployment benefits, not otherwise eligible for medical assistance | At or below 400% | Title XIX | **MSP** | Medical Security Plan | |
| Individuals with HIV not otherwise eligible for medical assistance | 0 through 200% | Title XIX | **e-HIV/FA** | Family Assistance | Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided. |

[2] Individuals in MassHealth Essential aged 19 and 20 are counted as a hypothetical base population.

| Table A. MassHealth Demonstration Expansion Populations | | | | | |
|---|---|---|---|---|---|
| **Populations Made Eligible through the Demonstration (Additional populations)** | **Federal Poverty Level (FPL) and other qualifying criteria** | **Funding Stream** | **Expenditure and Eligibility Group (EG) Reporting** | **Massachusetts Demonstration Program** | **Additional comments** |
| Individuals aged 21and older, not otherwise eligible for medical assistance, with no access to ESI, Medicare, or other subsidized health insurance programs, and who are not otherwise eligible under MassHealth or the State plan, including the following groups:[3]<br>• Low-income adults;<br>• Pregnant women aged 21and older;<br>• Individuals living with HIV; and<br>• Adults working for an employer with 50 or fewer employees who offers no insurance or who contributes < 33% (or < 20% for family coverage) towards insurance costs | • 133.1% through 300%;<br>• 200.1 through 300%;<br>• 200.1 through 300%;<br>• At or below 300% | Title XIX | **SNCP-CommCare** | Commonwealth Care Program | |

[3] Parents and caretaker relatives in Commonwealth Care, individuals aged 19 and 20, and low-income adults with income at or below 133 percent of the FPL enrolled in Commonwealth Care are counted as hypothetical base populations and expenditures for these populations are reported under the EGs specified on page 15.

## V. DEMONSTRATION PROGRAMS AND BENEFITS

25. **Demonstration Programs.** The Demonstration provides health care benefits to eligible individuals and families through the following specific programs. The Demonstration program for which an individual is eligible is based on the criteria outlined in Table A of section IV of the STCs. Table B in STC 37, provides a side-by-side analysis of the benefits offered through these MassHealth programs.

26. **MassHealth Standard.** Individuals enrolled in Standard receive State plan services including for individuals under age 21, Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished in coordination with STC 44.

27. **MassHealth Breast and Cervical Cancer Treatment Program (BCCTP).** The BCCTP is a health insurance program for women in need of treatment for breast or cervical cancer. This program offers MassHealth Standard benefits to certain women under 65 who do not otherwise qualify for MassHealth.

28. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well. Benefits are provided either through direct coverage, cost effective premium assistance or a combination of both. Premium assistance will be furnished in coordination with STC 44.

29. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. There are two separate categories of eligibility under Family Assistance:

    a) **Family Assistance-HIV/AIDS**. Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a FFS basis.

    b) **Family Assistance-Children**. Children can be enrolled in Family Assistance if their family's gross income is between 150 percent and 200 percent of the FPL. Only premium assistance is provided if ESI is available to these children that is cost-effective, meets BBL and for which the employer contributes at least 50 percent of the premium cost. Parents of children eligible for Family Assistance may receive coverage themselves for ESI subsidized by Family Assistance if they work for a qualified employer. However, the premium assistance payment is based on the children's eligibility. Direct coverage is provided for children only during the presumptive eligibility period and the time span

while the Commonwealth is investigating availability of and enrolling the child in ESI. Direct coverage Family Assistance under the separate title XXI program is provided through an MCO or the PCC plan for children without access to ESI.

30. **MassHealth Insurance Partnership (IRP).** The Commonwealth makes premium assistance payments available to certain members (including adults without children) with a gross family income at or below 300 percent of the FPL, who have access to qualifying ESI, and where a qualified small employer contributes at least 50 percent toward the premium.

    This design creates an overlap between the Insurance Partnership and premium assistance offered under the Standard, CommonHealth, and Family Assistance programs. The Insurance Partnership program has two components: 1) assisting employers with their health insurance costs through an Insurance Partnership employer payment; and 2) assisting employees with payment of health insurance premiums through a premium assistance payment. The Insurance Partnership employee payment is based on amounts limited by State legislation to the value of the subsidies specified for the Commonwealth Care program.

    Qualified employers will receive Insurance Partnership payments for each MassHealth member who receives premium assistance from MassHealth, no matter which MassHealth coverage type the member receives. All premium assistance payments made on behalf of MassHealth eligible members are eligible for FFP at the appropriate Federal matching rate as well as IRP payments to employers offering "new" health insurance (insurance not offered prior to January 1, 1999).

31. **MassHealth Basic.** Individuals enrolled in Basic are receiving Emergency Aid to Elders, Disabled, and Children (EAEDC) or are Department of Mental Health (DMH) clients who are long-term or chronically unemployed. This Demonstration program provides either direct coverage through a managed care plan or premium assistance if qualified cost effective private insurance is available.

32. **MassHealth Essential**. Individuals enrolled in Essential are low-income, long-term unemployed individuals who are not eligible for Basic. This demonstration program provides either direct coverage through a managed care plan or premium assistance if qualified cost effective private insurance is available.

33. **MassHealth Limited.** Individuals are enrolled in Limited if they are Federally non-qualified non-citizens, whose immigration status makes them ineligible for other MassHealth programs. These individuals receive emergency medical services only.

34. **MassHealth Prenatal**. Pregnant women are enrolled in Prenatal if they have applied for Standard and are waiting for eligibility approval. These individuals receive short-term outpatient prenatal care (not including labor and delivery).

35. **Medical Security Plan (MSP).** Individuals are enrolled in MSP, a health plan provided by the Division of Unemployment Assistance (DUA), if they are receiving unemployment

compensation benefits under the provisions of Chapter 151A of the Massachusetts General Laws. MSP provides health insurance to enrollees through premium assistance and direct coverage. Under premium assistance, partial premiums are paid for continuation of qualified ESI which began while the individual was still employed. Direct coverage is provided by DUA through enrollment in a health plan for an individual who does not have continued ESI available, or if the individual qualifies for a hardship waiver. Premiums are required for those with incomes over 150 percent of the FPL on a sliding scale fee schedule.

36. **Commonwealth Care (CommCare).** CommCare is a commercial insurance-based premium assistance program administered by the Commonwealth Health Insurance Connector Authority (Connector or Connector Authority), an independent State agency. Premium assistance is offered for the purchase of health benefits from an MCO either licensed under MGL c. 175 by the Massachusetts Division of Insurance or substantially compliant with licensure requirements, as determined by the Connector Authority. Total payments to the MCO must be actuarially sound, in accordance with the standards outlined in 42 C.F.R. Part 438.6(c).

37. **Benefits Offered under Certain Demonstration Programs.**

**Table B. MassHealth Direct Coverage Benefits**

| Benefits | Standard | Common Health | Family Assistance | Basic | Essential |
|---|---|---|---|---|---|
| EPSDT | X | X | | | |
| Inpatient Acute Hospital | X | X | X | X | X |
| Adult Day Health | X | X | | | |
| Adult Foster Care* | X | X | | | |
| Ambulance (emergency) | X | X | X | X | X |
| Audiologist Services | X | X | X | X | |
| Behavioral Health Services (mental health and substance abuse) | X | X | X | X | X |
| Chapter 766 Home Assessment** | X | X | X | | |
| Chiropractic Care | X | X | X | X | |
| Chronic Disease and Rehabilitation Hospital Inpatient | X | X | X | | |
| Community Health Center (includes FQHC and RHC services) | X | X | X | X | X |
| Day Habilitation*** | X | X | | | |
| Dental Services | X | X | X | X | X |

| Benefits | Standard | Common Health | Family Assistance | Basic | Essential |
|---|---|---|---|---|---|
| **Diversionary Behavioral Health Services** | X | X | X | X | X |
| **Durable Medical Equipment and Supplies** | X | X | X | X | X |
| **Early Intervention** | X | X | X | | |
| **Intensive Early Intervention Services for Eligible Children with Autism Spectrum Disorder** | X | X | X | X | X |
| **Family Planning** | X | X | X | X | X |
| **Hearing Aids** | X | X | X | X | |
| **Home Health** | X | X | X | X | |
| **Hospice** | X | X | X | | |
| **Laboratory/X-ray/ Imaging** | X | X | X | X | X |
| **Medically Necessary Non-emergency Transport** | X | X | | | |
| **Nurse Midwife Services** | X | X | X | X | |
| **Nurse Practitioner Services** | X | X | X | X | X |
| **Orthotic Services** | X | X | X | X | |
| **Outpatient Hospital** | X | X | X | X | X |
| **Outpatient Surgery** | X | X | X | X | X |
| **Oxygen and Respiratory Therapy Equipment** | X | X | X | X | X |
| **Personal Care** | X | X | | | |
| **Pharmacy** | X | X | X | X | X |
| **Physician** | X | X | X | X | X |
| **Podiatry** | X | X | X | X | X |
| **Private Duty Nursing** | X | X | | | |
| **Prosthetics** | X | X | X | X | X |
| **Rehabilitation** | X | X | X | X | X |
| **Renal Dialysis Services** | X | X | X | X | X |
| **Skilled Nursing Facility** | X | X | | | |
| **Speech and Hearing Services** | X | X | X | X | X |

| Benefits | Standard | Common Health | Family Assistance | Basic | Essential |
|---|---|---|---|---|---|
| **Targeted Case Management** | X | X | | | |
| **Therapy: Physical, Occupational, and Speech/ Language** | X | X | X | X | X |
| **Vision Care** | X | X | X | X | Only exam and testing services provided by a physician or optometrist |

*Chart Notes:*

***Adult Foster Care Services –** These services are State plan services and the definition of these services may vary contingent upon the approved State plan. In general, the services are assistance with activities of daily living and instrumental activities daily living, supportive services, nursing oversight and care management provided in a qualified private home by a principal caregiver who lives in the home. Adult foster care is furnished to adults who receive the services in conjunction with residing in the home. The number of individuals living in the home unrelated to the principal caregiver may not exceed three Adult foster care does not include payment for room and board or payments to spouses, parents of minor children and other legally responsible relatives.

**** Chapter 766 Home Assessments –** These services may be provided by a social worker, nurse or counselor. The purpose of the home assessment is to identify and address behavioral needs that can be obtained by direct observation of the child in the home setting.

***** Day Habilitation Services** – These services are State plan services and the definition of these services may vary contingent upon the approved State plan. In general, the services are assistance with skill acquisition in the following developmental need areas: self-help, sensorimotor, communication, independent living, affective, behavior, socialization and adaptive skills. Services are provided in non-residential settings or Skilled Nursing Facilities when recommended through the PASRR process. Services include nursing, therapy and developmental skills training in environments designed to foster skill acquisition and greater independence. A day habilitation plan sets forth measurable goals and objectives, and prescribes an integrated program of developmental skills training and therapies necessary to reach the stated goals and objectives.

38. **Diversionary Behavioral Health Services.** Diversionary behavioral health services are home and community-based mental health services furnished as clinically appropriate alternatives to and diversions from inpatient mental health services in more community-based, less structured environments. Diversionary services are also provided to support an individual's return to the community following a 24-hour acute placement; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services, those provided in a 24-hour facility, and those which are provided on an outpatient basis in a non-24-hour setting or facility. Generally, 24-hour and non-24 hour diversionary behavioral health services are provided by free-standing (community-based) or hospital-based programs licensed by the Department of Mental Health or the Department of

Public Health. They are offered to provide interventions and stabilization to persons experiencing mental health or substance abuse crises in order to divert from acute inpatient hospitalization or to stabilize after discharge. These services do not include residential programs involving long-term residential stays. Managed care entities and the Prepaid Insurance Health Plan (PIHP) for behavioral health services identify appropriate individuals to receive diversionary services. Managed care entities maintain a network of diversionary services and arrange, coordinate, and oversee the provision of medically necessary diversionary services, as described in Table C.

**Table C. Diversionary Behavioral Health Services Provided Through Managed Care Under the Demonstration**

| Diversionary Behavioral Health Service | Setting | Definition of Service |
|---|---|---|
| Community Crisis Stabilization | 24-hour facility | Services provided as an alternative to hospitalization, including short-term psychiatric treatment in structured, community-based therapeutic environments. Community Crisis Stabilization provides continuous 24-hour observation and supervision for Covered Individuals who do not require Inpatient Services. |
| Community Support Program (CSP) | Non-24-hour facility | An array of services delivered by a community-based, mobile, multi-disciplinary team of professionals and paraprofessionals. These programs provide essential services to Covered Individuals with a long standing history of a psychiatric or substance use disorder and to their families, or to Covered Individuals who are at varying degrees of increased medical risk, or to children/adolescents who have behavioral health issues challenging their optimal level of functioning in the home/community setting. Services include outreach and supportive services, delivered in a community setting, which will vary with respect to hours, type and intensity of services depending on the changing needs of the Enrollee. |
| Partial Hospitalization** | Non-24-hour facility | An alternative to Inpatient Mental Health Services, PHP services offer short-term day mental health programming available seven days per week. These services consist of therapeutically intensive acute treatment within a stable therapeutic milieu and include |

| Diversionary Behavioral Health Service | Setting | Definition of Service |
|---|---|---|
| | | daily psychiatric management. |
| Acute Treatment Services for Substance Abuse | 24-hour facility | 24-hour, seven days week, medically monitored addiction treatment services that provide evaluation and withdrawal management. Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures and include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure substance use disorder treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions. These services may be provided in licensed freestanding or hospital-based programs. |
| Clinical Support Services for Substance Abuse | 24-hour facility | 24-hour treatment services, which can be used independently or following Acute Treatment Services for substance use disorders, and including intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care. |
| Transitional Care Unit Services addressing the needs of children and adolescents, under age 19, in the custody of the Department of Children and Families (DCF), who need group care or foster care and no longer meet the clinical criteria for continued stay at an acute level of care. | 24-hour facility | A community based therapeutic program offering high levels of supervision, structure and intensity of service within an unlocked setting. The TCU offers comprehensive services, including but not limited to, a therapeutic milieu**, psychiatry, aggressive case management, and multidisciplinary, multi-modal therapies. |
| Psychiatric Day Treatment* | Non-24-hour facility | Services which constitute a program of a planned combination of diagnostic, treatment |

| Diversionary Behavioral Health Service | Setting | Definition of Service |
|---|---|---|
| | | and rehabilitative services provided to a person with mental illness who needs more active or inclusive treatment than is typically available through a weekly visit to a mental health center, individual Provider's office or hospital outpatient department, but who does not need 24-hour hospitalization. |
| Intensive Outpatient Program | Non-24-hour facility | A clinically intensive service designed to improve functional status, provide stabilization in the community, divert an admission to an Inpatient Service, or facilitate a rapid and stable reintegration into the community following a discharge from an inpatient service. The IOP provides time-limited, comprehensive, and coordinated multidisciplinary treatment. |
| Structured Outpatient Addiction Program | Non-24-hour facility | Clinically intensive, structured day and/or evening substance use disorder services. These programs can be utilized as a transition service in the continuum of care for an Enrollee being discharged from Acute Substance Abuse Treatment, or can be utilized by individuals, who need Outpatient Services, but who also need more structured treatment for a substance use disorder. These programs may incorporate the evidence-based practice of Motivational Interviewing (as defined by Substance Abuse and Mental Health Services Administration) into clinical programming to promote individualized treatment planning. These programs may include specialized services and staffing for targeted populations including pregnant women, adolescents and adults requiring 24 monitoring. |
| Program of Assertive Community Treatment | Non-24-hour facility | A multi-disciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to Covered Individuals to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide |

| Diversionary Behavioral Health Service | Setting | Definition of Service |
|---|---|---|
| | | assistance in helping the individuals served become better integrated into the community. Services are provided in the community and are available, as needed by the individual, 24 hours a day, seven days a week, 365 days a year. |
| Emergency Services Program* | Non-24-hour facility | Services provided through designated contracted ESPs, and which are available seven days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health crisis. |
| Community Based Acute Treatment for Children and Adolescents | 24-hour facility | Mental health services provided in a staff-secure setting on a 24-hour basis, with sufficient clinical staffing to insure safety for the child or adolescent, while providing intensive therapeutic services including, but not limited to, daily medication monitoring; psychiatric assessment; nursing availability; Specialing (which is defined as one-on-one therapeutic monitoring as needed for individuals who may be at immediate risk for suicide or other self harming behavior); individual, group and family therapy; case management; family assessment and consultation; discharge planning; and psychological testing, as needed. This service may be used as an alternative to or transition from Inpatient services. |
| *Chart Notes:* | | |
| * This service is a service provided under the Medicaid State plan, and the definition may be changed pursuant to any State plan amendment. | | |
| ** In this context, "therapeutic mileau" refers to a structured, sub-acute setting, in which clinical services (therapies) are provided at both the individual and group level, and in which the common social/interpersonal interactions between each patient, and all others who are present in the setting, are incorporated into the treatment approach. | | |

39. **Pediatric Asthma Pilot Program.** This pilot program will utilize an integrated delivery system for preventive and treatment services through methodologies that may include a payment such as a per member/per month (PMPM) payment to participating providers for asthma-related services, equipment and supports for management of pediatric asthma for high-risk patients, to improve health outcomes, reduce asthma-related emergency department utilization and asthma-related hospitalizations, and to reduce associated Medicaid costs. These methodologies are subject to CMS approval of the pilot program protocol. The State must evaluate the degree to which such a payment and flexible use of funds enhances the

effects of delivery system transformation, as demonstrated by improved health outcomes at the same or lower costs.

a) Eligibility. The State must limit the pilot program to Demonstration eligible children, age 2 through 18 at the time of enrollment in the pilot, who are enrolled in the Primary Care Clinician Plan panel of a participating practice site, and who have high risk asthma. Children with high risk asthma are those children who have, in the last 12 months prior to enrollment in the pilot, had an asthma-related inpatient hospitalization, observation stay, or emergency department visit or an oral corticosteroid prescription for asthma. The State must utilize Medicaid claims data to identify eligible children.

b) Benefits. The benefits within a payment such as a PMPM may vary over the course of the pilot. Prior to enrolling beneficiaries in the Pediatric Asthma Program, CMS must approve the benefit package and any changes proposed to the benefit package over the course of the pilot through the protocol process outlined is subparagraph (g). For example, pending CMS approval, services may include for Phase 1: non-traditional services and supplies to mitigate environmental triggers of asthma and home visitation and care coordination services conducted by qualified Community Health Workers. In Phase II, the payment structure such as a PMPM, bundled, global, or episodic payment may be expanded to also include certain Medicaid State plan services with utilization that is particularly sensitive to uncontrolled asthma (i.e. treatment provided by physicians, nurse practitioners and hospitals, medical equipment such as a nebulizer, spacer, peak flow meter, etc.).

c) Delivery System. Provider Participation in the pilot must be limited to primary care clinician sites that participate or enroll in the Primary Care Clinician Plan (PCCP). The practices must be responsible for supervision and coordination of the medical team, including Community Health Workers; delivery of asthma-related services paid for by the PMPM payment; as well as the PMPM cost of each beneficiary enrolled.

   Provider participation in the pilot must be determined through a Request for Proposal (RFP) process. The State must prioritize participation by qualified practices that serve a high number of patients with high-risk asthma enrolled in PCCP and have the capacity to manage asthma in a coordinated manner. In addition, the State must seek to include qualified practices that are geographically dispersed across the State and represent a range of provider types, such as physician group practices, community health centers, and hospital outpatient departments, in order to explore a variety of infrastructure challenges.

d) Infrastructure Support for Participating Provider Sites. To defray the costs of implementing the financial, legal and information technology system infrastructure required to manage a payment such as PMPM and coordination of patient care, participating provider sites are eligible for up to $10,000 per practice site for the sole purpose of infrastructure changes and interventions related to this Pediatric Asthma Pilot only. The amount of infrastructure support is variable up to this maximum depending on the provider's readiness, the State's review and finding of such readiness, and CMS'

concurrence on the use of the proposed funding for the practice as per the protocol process outlined in subparagraph (g).

e) Pilot Expansion. Following initial implementation and evaluation of programmatic outcomes, and subsequent CMS approval, the State may request CMS approval to implement a payment such as a PMPM, bundled, global or episodic payment and/or shared savings methodology component to the Pediatric Asthma Pilot. Examples of favorable outcomes include the prevention of asthma-related emergency department utilization, and asthma-related hospitalizations and improved patient outcomes.

f) Extent of FFP in the Pilot. FFP is not available for this pilot program until the protocols and milestones outlined in subparagraph (g) below are approved by CMS. The infrastructure support described in subparagraph (d) above must be provided through the Infrastructure and Capacity-Building fund as part of the Safety Net Care Pool outlined in STC 49(d). CMS will provide FFP at the applicable Federal Medical Assistance Percentage for services and supplies outlined in the approved benefit package pursuant to subparagraph (g)(1), subject to reimbursement amounts identified in the payment methodology outlined in subparagraph (g)(5), demonstration budget neutrality limits and any applicable SNCP limits.

g) Required Protocols Prior to Claiming FFP. Before enrolling beneficiaries and claiming FFP under this pilot program, the State must meet the following milestones which require CMS preapproval. These protocols/milestones will be future Attachment F.
    1) A description and listing of the program specific asthma-related benefit package that will be provided to the pilot participants with rationale for the inclusion of each benefit;
    2) Eligibility, qualifications and selection criteria for participating providers, including the RFP for preapproval;
    3) A plan outlining how this pilot may interact with other Federal grants, such as for related research (e.g. NIH, HUD, etc.) and programmatic work (e.g. CHIPRA grant related to pediatric health care practices in multi-payer medical homes, etc.). This plan should ensure no duplication of Federal funds and outline the State's coordination activities across the various Federal support for related programmatic activities to address potential overlap in practice site selection, patient population, etc.
    4) A plan for the purchase and dissemination of supplies within the pilot specific benefit package, including procurement methods by the State and/or providers including volume discounts, etc;
    5) A payment rate setting methodology outlining the PMPM payment for the pilot services and supplies, consideration of risk adjustment and the estimated/expected cost of the pilot;
    6) A payment methodology outlining cost and reconciliation for the infrastructure payments to participating provider sites, and the eligibility and reporting requirements associated with the infrastructure payments; and
    7) An approved evaluation design for the pilot that is incorporated into the

evaluation design required per STC 84. The objective of the evaluation is to determine the benefits and savings of the pilot as well as design viability and inform broader implementation of the design. The evaluation design must include an evaluation of programmatic outcomes for purposes of subparagraph (e). As part of the evaluation, the State at a minimum must include the following requirements:

i. Collect baseline and post-intervention data on the service utilization and cost savings achieved through reduction in hospital services and related provider services for the population enrolled in the pilot. This data collection should include the quality measure on annual asthma-related emergency room visits outlined in the initial core set of children's health care quality measures authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA) beginning with a baseline set at the onset of the pilot, adjusted for the age range enrolled in the pilot program;
ii. A detailed analysis of how the pilot program affects the utilization of acute health services, such as asthma-related emergency department visits and hospitalizations by high risk pediatric asthma patients, and how the pilot program reduces or shifts Medicaid costs associated with treatment and management of pediatric asthma;
iii. An assessment of whether the cost projections for the provider payment were appropriate given the actual cost of rendering the benefits through the pilot program; and
iv. A detailed analysis of how the effects of the pilot interact with other related initiatives occurring in the State.

h) Changes to the Pediatric Asthma Program and/or Amendments to the Protocols. If the State proposes to amend the pilot benefits, payment structure, delivery system or other issues pursuant to the protocols it must seek CMS approval to amend its protocols as outlined in subparagraph (g) and (i). An amendment to protocols is not subject to STC 7 regarding demonstration amendments. Should the State choose to design and plan for payments such as bundled, global or episodic payments or shared savings to participating providers, methodology documents must be preapproved by CMS prior to contract changes or implementation of the changes; any shared savings or payment methodologies must be consistent with CMS policy and guidelines, including any quality reporting guidelines.

i) Reporting. The State must provide status updates on the pilot program within the quarterly and annual reports as required by STCs 58 and 59. At a minimum, reporting for the pilot program must provide an update on all pilot program related activities including:
   1) Current and future State activities related to the required deliverables as described in subparagraph (g), including anticipated changes to the benefit package, delivery system or payment methodology;

2) Services and supplies provided to beneficiaries, community outreach activities, increases and decreases in beneficiary enrollment or provider enrollment, and any complaints regarding quality or service delivery;
3) Pediatric asthma pilot program payments to participating providers that occurred in the quarter. Infrastructure payments made to providers under this pilot will be reported pursuant to STCs 49(d) and 50(b);
4) Expenditure projections reflecting the expected pace of future provider payments; and
5) Progress on the evaluation of the pilot program as required in subparagraph (g), including a summary of the baseline and pilot outcome data from Medicaid claims data associated with enrollee utilization and associated cost of treatment, including prescriptions, and primary care, emergency department and hospitalization visits.

40. **Intensive Early Intervention Services for Children with Autism Spectrum Disorder.** The State will provide medically necessary Applied Behavioral Analysis-based (ABA) treatment services to MassHealth eligible children as stipulated below. The early intervention services are highly structured, evidence based, individualized, person-centered treatment programs that address the core symptoms of autism spectrum disorder (ASD). A waiting list is not allowable for this program.

a) Eligibility. The State will limit eligibility to MassHealth eligible children, ages 0 through three years with a confirmed diagnosis of one of the following codes: Autistic Disorder – code 299.00; Childhood Disintegrative Disorder – code 299.10; Asperger's Disorder – code 299.80; Pervasive Development Disorder – code 299.10; Rett's Disorder – code 299.80 according to the most recent version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association or a diagnosis of autism in any updated version of this manual, and must be conferred by a physician or a licensed psychologist; have an Individualized Family Service Plan (IFSP) that identifies medically necessary ABA-based services; and who are not otherwise enrolled in the State's currently approved section 1915(c) HCBS waiver entitled "Children's Autism Spectrum Disorder Waiver," CMS base control number 40207, because the child has not been determined to meet institutional level of care requirements.

b) Individualized Family Service Plan (IFSP). Massachusetts will utilize a universal IFSP form approved by the Massachusetts Department of Public Health that includes the elements required under Part C of the Individuals with Disabilities Education Act (IDEA) and Massachusetts Early Intervention Operational Standards. The form will utilize a child-centered and family-directed planning process intended to identify the strengths, capacities, preferences, needs, and desired outcomes for the child.

The IFSP is a written plan that is developed for each eligible infant and toddler with a disability according to the Part C regulations under the IDEA. The IFSP specifies the child's: service coordinator; present levels of development; and family resources, priorities, and concerns. It also includes measurable results or outcomes and the criteria, procedures, and timelines used to determine the degree to which progress toward

achieving the results or outcomes identified in the IFSP is being made. There is also a statement of the specific early intervention services based on peer-reviewed research (to the extent practicable) that are necessary to meet the unique needs of the child and the family to achieve the results or outcomes identified including: beginning date, length, duration, frequency, intensity, method of delivering, and location of the services. The IFSP will also include a statement that the ABA-based treatment will be provided in the natural environment for that child to the maximum extent appropriate, or a justification as to why the service will not be provided in the natural environment. The IFSP must specify the identification of medical or other services such as ABA-based treatment the child needs or is receiving through other sources, including title XIX. The plan will be reviewed and updated at least annually.

c) Benefits. Participants are eligible to receive ABA-based services. All treatment must be evidence-based, and newer interventions for which there is no evidence of effectiveness may not be employed until such time as there is at least emerging evidence to fully support the intervention's appropriate usage and assure the health and safety of demonstration enrollees. There is no annual maximum benefit.

   The following services will be provided as ABA-based treatment:
   1) Assessment of child's functional skills across domains impacted by ASD:
   2) Development of individualized treatment plan to teach new skills;
   3) Direct child instruction to teach new skills;
   4) Functional behavioral assessment and support plan to decrease problematic behavior and increase appropriate behavior when indicated;
   5) Family training to assist family, extended family, and non-paid caregivers in generalization of skills into the child's natural routines and in management of behavior; and
   6) Supervisory session to ensure consistency in instructional practices, data collection accuracy, and to make program adjustments as needed.

d) Delivery System. MassHealth will provide ABA-based treatment services to children through the fee for service delivery system. Children who are enrolled in a contracted managed care organization (MCO) will receive the services as a fee for service "wrap" to the MassHealth covered services.

e) Behavioral Supports and Coordination. Provider specifications for each service specified above are as follows:
   1) Board-Certified Behavioral Analyst: hold a doctoral or master's degree and meet certification requirements of the Behavior Analyst Certification Board;
   2) Supervising Clinician: hold a master's degree in psychology, education or related field, and any related state licensure for the discipline;
   3) Therapist: hold a bachelor's degree and have one year experience with children with autism is preferred; and
   4) Specialty Associate: hold an associate degree and have one year experience providing care for a child on the autism spectrum.

f) Provider Participation. All providers must participate in MassHealth. The Department of Public Health shall require that direct care personnel providing the ABA-based treatment will attain provisional certification prior to billing Medicaid for any direct services. Entities or individuals that have responsibility for IFSP development may not provide ABA-based treatment to a demonstration enrollee.

g) Cost-Sharing. MassHealth cost sharing requirements will apply to children who are both eligible for MassHealth, and the ABA-based services. The annual fee assessed by the Massachusetts Department of Public Health for all children enrolled in its general early intervention services program will not apply to MassHealth eligible children. Cost-sharing requirements for MassHealth enrolled children who receive the ABA-based treatment will be the same as the cost-sharing requirements for all other section 1115 demonstration waiver participants as outlined in Attachment B.

h) Payment. Before providing the services outlined in subparagraph (c) and claiming FFP under this component of the Demonstration, the State must submit a protocol to CMS for CMS approval that outlines the methodology of the payment rate and the actual rates provided to Demonstration participants outlined in subparagraph (c) which are provided by providers specified in subparagraphs (e) and (f). This deliverable will be future Attachment G.

   Proposed rates and any proposed changes to such rates will be subject to public notice. Any changes to the payment protocol are subject to CMS approval as outlined above.

i) Self Direction. Families of children who are eligible to receive the ABA-based services may participate in electing the evidence based intervention treatment model for their child. Parents or other legally responsible relatives will be given the opportunity to interview providers before making the selection of a particular treatment model or provider.

j) Assurances. The State must meet the following requirements:
   1) Assure the CMS that Part C grant funds will not be used as the non-federal share for Medicaid purposes;
   2) Comply with all other requirements of Part 303 of the IDEA, Early Intervention Program for Infants and Toddlers with Disabilities in accordance with the provision of the ABA-based treatment;
   3) Must not permit restraint or seclusion during the course of service delivery; and
   4) Assure that direct service workers accused of abuse or neglect will not provide services to MassHealth enrollees receiving ABA-based treatment until the State's investigation process is completed.

k) Quality Strategy for ABA-Based Treatment Services. The State must implement an overall Quality Assurance and Improvement (QAI) strategy that assures the health and welfare of children receiving the ABA-based services. The strategy will be consistent

with the general quality requirements for Medicaid home and community-based services (HCBS) through other sections of the Act such as sections 1915(c) and 1915(i).

Through an ongoing discovery, remediation and improvement process the State will monitor, at a minimum:

1) IFSP determinations and service delivery;
2) Provider qualifications;
3) Enrollee health and welfare;
4) Financial oversight between the State and Federal programs; and
5) Administrative oversight.

The State must also monitor such items as medical necessity determinations for ABA-based treatment, timeliness of service delivery, improvement and sustainability of functional abilities of enrolled children, effectiveness of treatment type, and staff training. The State will submit its QAI strategy for ABA-based treatment by January 1, 2012. During the time the Demonstration is effective, the State assures CMS it will implement the strategy and update it as needed in part based on findings listed in the Annual Report described below.

l) Annual Report. The State shall provide the CMS with a draft annual HCBS report as part of the annual report requirement for the Demonstration as stipulated in STC 59. The first draft HCBS report will be due no later than October 1, 2012. The HCBS report will at a minimum include:

   1) An introduction;
   2) A description of each ABA-based treatment;
   3) An overarching QAI strategy that assures the health and welfare of enrollees receiving HCBS that addresses the: (a) enrollee's person-centered individual service plan development and monitoring, b) specific eligibility criteria for particular HCBS, c) provider qualifications and/or licensure, d) health and safety, d) financial oversight between State and Federal programs, and e) administrative oversight by the State Medicaid Agency;
   4) An update on services used by enrollees;
   5) The various treatment modalities employed by the State, including any emerging treatments, updated service models, opportunities for self-direction, etc.;
   6) Specific examples of how the services have been used to assist Demonstration enrollees;
   7) A description of the intersection between demonstration ABA-based treatment and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures; and
   8) Other topics of mutual interest between CMS and the State related to the ABA-based treatment.

The Report may also address workforce development, certification activity, self-direction, and capacity in the State to meet needs of the population receiving the services, and rebalancing goals related to HCBS. Additionally, the Report will also summarize the

outcomes of the State's Quality Strategy for HCBS as outlined above. The State may also choose to provide the CMS with any other information it believes pertinent to the provision of the ABA-based treatment services/HCBS and their inclusion in the Demonstration, including innovative practices, cost-effectiveness, and short and long-term outcomes.

## VI. DELIVERY SYSTEM

The MassHealth section 1115 Demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored insurance (ESI) when cost effective. These circumstances include the availability of ESI, the employer's contribution level meeting a State-specified minimum, and its cost-effectiveness. MassHealth pays for medical benefits directly (direct coverage) only when no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under most coverage types, to obtain or maintain private health insurance when MassHealth determines it is cost effective to do so, with the premium assistance necessary to make it affordable for the beneficiary. All Demonstration programs except MassHealth Prenatal and MassHealth Limited have a premium assistance component.

Under MassHealth premium assistance, the Commonwealth provides a contribution through reimbursement to the member or direct payment to the insurer, toward an employed individual's share of the premium for an ESI plan of which the individual is a beneficiary or covered dependent, and which meets a basic benefit level (BBL). The Commonwealth has identified the features of a qualified health insurance product, including covered benefits, deductibles and co-payments, which constitute the BBL. Each ESI plan is measured against the BBL, and a determination is then made regarding the cost-effectiveness of providing premium assistance rather than direct coverage. Premium assistance is the provided benefit under the Commonwealth Care for the purchase of a commercial health insurance product.

MassHealth benefits provided through direct coverage are delivered both on a fee for service (FFS) and capitated basis under the demonstration. See Table D within STC 45 for details on the Delivery System and Coverage for MassHealth Administered Programs. As described below in Table D, MassHealth may require members eligible for direct coverage under Standard, Family Assistance, CommonHealth, Basic and Essential to enroll in managed care. Most members can elect to receive services either through the statewide Primary Care Clinician (PCC) Plan or from a MassHealth-contracted managed care organization (MCO). Managed care enrollment is mandatory for CommonHealth members with no third party liability. In addition, children who are clients of the Departments of Children and Families (DCF) or Youth Services (DYS) who do not choose a managed care plan are required to enroll with the behavioral health contractor for behavioral health services and may choose to receive medical services on a fee-for-service basis.

Children eligible under TEFRA section 134 (Kaileigh Mulligan) and children receiving title IV-E adoption assistance may opt to enroll in managed care or receive health services via fee-for-service. Children who choose managed care may choose a managed care organization (MCO) or

a PCC plan. Children who choose an MCO will receive their behavioral health services through the MCO. Children who choose the PCC Plan will receive their behavioral health services through the behavioral health contractor. Children who choose fee-for-service will be passively enrolled with the behavioral health contractor for behavioral health services, but have the ability to opt-out and receive behavioral health services through the fee-for-service provider network.

41. **Managed Care Arrangements.** MassHealth may implement, maintain, modify (without amendment to the Demonstration), and any managed care arrangements authorized under section 1932(a) of the Act or 42 CFR 438 et seq., including:

    a) PCC Plan. The PCC Plan is a primary care case management program administered by MassHealth. In the PCC Plan, members enroll with a PCC who provides most primary and preventive care and who is responsible for providing referrals for most specialty services. Members can access specialty services from any MassHealth provider, subject to PCC referral and other utilization management requirements. Members enrolled in the PCC Plan receive mental health and substance abuse services through a single Behavioral Health Program (BHP) contractor, which is a Prepaid Inpatient Health Plan (PIHP). The PCC Plan members are guaranteed freedom of choice of provider for family planning services and are able to obtain these services from any participating Medicaid provider without consulting their PCC or obtaining MassHealth's prior approval.

    b) Enhanced Primary Care Clinician Payments. In accordance with 42 CFR 438.6(c)(5)(iv) MassHealth may establish enhanced fee-for-service rate payments or capitated rate payments to Primary Care Clinicians for coordination of the care delivered to their enrolled PCC plan members. MassHealth may also establish pay-for-performance incentives using capitated or other payment arrangements for achieving certain quality of care benchmarks, for demonstrating certain levels of improvement for selected Healthcare Effectiveness Data and Information Set (HEDIS) or other quality indicators, and for implementing practice infrastructure designed to support the delivery of high-quality health care services to enrolled members.

    c) Patient Centered Medical Home Initiative (PCMHI). The PCMHI is a multi-payer initiative to transform selected primary care practice sites into PCMHs by 2015. MassHealth is a dominant public payer in the PCMHI and is assuming the same responsibilities as other participating payers both for enrollees in its PCC Plan and those in Medicaid contracted MCOs. The PCMHI practices must meet reporting requirements on clinical and operational measures, in addition to certain benchmarks to indicated continued progress towards medical home transformation, such as obtaining National Committee for Quality Assurance (NCQA) Physician Practice Connections-Patient Centered Medicaid Home (PPC®-PCMH™) Level One recognition. Any infrastructure support provided to Primary Care Clinicians who participate as PCMHI providers must be funded by the infrastructure and capacity-building component of the SNCP as referenced in STC 49(d). A formal evaluation of the PCMHI is also being conducted and should be included as relevant to the Demonstration in draft evaluation design as per STC 84.

d) MCO. MassHealth contracts with MCOs that provide comprehensive health coverage including behavioral health services to enrollees. MCO enrollees may receive family planning services from any 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 FFS basis and recoups the funds from the MCO. 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 area at any time for any reason.

42. **Exclusions from Managed Care Enrollment.** MassHealth may exclude the following individuals from enrollment in a MassHealth-contracted managed care plan:

a) Individuals for whom MassHealth is a secondary payer (i.e., a member with other health insurance). For purposes of exclusion from managed care, "other health insurance" is defined as any medical coverage plan available to the member, including, but not limited to Medicare, CHAMPUS, or a private health plan. However, MassHealth requires children eligible for MassHealth Standard and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;

b) Individuals who are receiving MassHealth Standard, CommonHealth, or Family Assistance benefits during the presumptive eligibility period or the time-limited period while MassHealth investigates and verifies access to qualified and cost-effective private health insurance or the time-limited period while the member is enrolling in such insurance;

c) Individuals receiving Prenatal and Limited coverage;

d) Individuals receiving Standard coverage who are receiving hospice care, or who are terminally ill as documented with a medical prognosis of a life expectancy of 6 months or less; and

e) Participants in a Home and Community-Based Services Waiver who are not eligible for SSI and for whom MassHealth is not a secondary payer. MassHealth may permit such individuals to enroll in managed care, including the option to enroll with the behavioral health contractor for behavioral health services and receive their medical services on a fee-for-service basis.

43. **Contracts.**

a) Managed Care Contracts. All contracts and modifications of existing contracts between the Commonwealth and MCOs must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 30 days to review and approve changes.

b) Public Contracts. Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contract is set at the same rate for both public and private providers. This requirement does not apply to contracts under the SNCP as outlined in STC 49(c) and STC 49(e) except as implemented by STC 50(f).

c) Selective Contracting. Procurement and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 CFR 431.54(d).

d) Patient Centered Medical Home Initiative (PCMHI). Details regarding the PCHMI may be found in the Commonwealth's PCC and MCO contracts.

44. **MassHealth Standard and CommonHealth Premium Assistance.** If available and cost effective, the Commonwealth will purchase cost-effective private health insurance on behalf of individuals eligible for Standard or CommonHealth coverage. The State will also provide coverage for additional services required to ensure that such individuals are receiving no less than the benefits they would receive through direct coverage under the State Plan. This coverage will be furnished, at the State option, on either a FFS basis or through managed care arrangements. These individuals are not required to contribute more towards the cost of their private health insurance than they would otherwise pay for MassHealth Standard or CommonHealth coverage. Cooperation with the Commonwealth to obtain or maintain available health insurance will be treated as a condition of eligibility for all of those in the family group, except those who are under the age of 19, or pregnant.

45. **Overview of Delivery System and Coverage for MassHealth Administered Programs.** The following chart provides further detail on the delivery system utilized for the MassHealth administered programs and the related start date for coverage:

**Table D. Delivery System and Coverage for MassHealth Demonstration Programs**

| Coverage Type | Delivery System Type | Mandatory | Voluntary | FFS Only | Start Date of Coverage**** |
|---|---|---|---|---|---|
| Standard* | | | | | |
| Individuals with no third party liability (TPL) | MCO or PCC Plan** | x | | | 10 days prior to date of application |
| Adults with TPL | Receive wrap benefits via FFS | | | x | 10 days prior to date of application |
| Children with TPL | Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP | x | | x | 10 days prior to date of application |
| Individuals with qualifying ESI | Premium assistance with wrap | | | x | 10 days prior to date of application |
| Kaileigh Mulligan eligible children and children receiving title IV-E adoption assistance | Behavioral health is typically provided via BHP PIHP, although a FFS alternative must be available; all other services are offered via MCO, PCCP Plan or FFS. | | x | | Kaileigh Mulligan - may be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided."<br><br>Title IV-E adoption assistance - start date of adoption |
| Medically complex children in the care/custody of the DCF | Special Kids Special Care MCO | | x | | Start date of State custody |
| Children in the care/custody of the DCF or DYS, including medically complex children in the care/custody of the DCF | All services are offered via MCO, PCC Plan or FFS, | x | x | x | Start date of State custody |

| Coverage Type | Delivery System Type | Mandatory | Voluntary | FFS Only | Start Date of Coverage**** |
|---|---|---|---|---|---|
| | with the exception of behavioral health which is provided via mandatory enrollment in BHP PIHP unless a child is enrolled in an MCO (in which case, behavioral health is provided through the MCO). | | | | |
| Presumptive children, for an up to 60-day period, before self-declared family income is verified | FFS | | | x | 10 days prior to date of application |
| Women in the Breast and Cervical Cancer Treatment Program | MCO or PCC Plan | x | | | 10 days prior to date of application |
| CommonHealth* | | | | | |
| Individuals with no TPL | MCO or PCC Plan** | x | | | 10 days prior to date of application |
| Adults with TPL | Receive wrap benefits via FFS | | | x | 10 days prior to date of application |
| Children with TPL | Receive benefits FFS except for behavioral health via mandatory enrollment in BHP PIHP | x | | x | 10 days prior to date of application |
| Individuals with qualifying ESI | Premium assistance | | | x | 10 days prior to date of application |

| Coverage Type | Delivery System Type | Mandatory | Voluntary | FFS Only | Start Date of Coverage**** |
|---|---|---|---|---|---|
| | with wrap | | | | |
| Family Assistance for HIV/AIDS* | | | | | |
| Individuals with no TPL | MCO or PCC Plan** | x | | | 10 days prior to date of application |
| Individuals with TPL | Receive wrap benefits via FFS | | | x | 10 days prior to date of application |
| Individuals with qualifying ESI | Premium assistance with wrap | | | x | 10 days prior to date of application |
| Family Assistance for Children*** | | | | | |
| Individuals with no TPL | MCO or PCC Plan** | x | | | 10 days prior to date of application |
| Individuals with qualifying ESI | Premium assistance with wrap | | | x | 10 days prior to date of application |
| Insurance Partnership | | | | | |
| Individuals with qualifying ESI | Premium assistance for employees and incentive payments for employers | | | N/A | First month's premium payment following determination of eligibility |
| Basic | | | | | |
| Individuals with no TPL | MCO or PCC Plan | x | | | Coverage starts when managed care enrollment is effective, there is no retroactive coverage |
| Individuals with TPL | Premium assistance only | | | N/A | First month's premium payment following determination of eligibility |
| Essential | | | | | |
| Individuals with no TPL | MCO or PCC Plan | x | | | Coverage starts when managed care enrollment is effective, there is no retroactive coverage |
| Individuals with TPL | Premium assistance only | | | N/A | First month's premium payment following determination of eligibility |
| Limited | | | | | |

| Coverage Type | Delivery System Type | Mandatory | Voluntary | FFS Only | Start Date of Coverage**** |
|---|---|---|---|---|---|
| Individuals receiving emergency services only | FFS | | | x | 10 days prior to date of application |
| Prenatal | FFS | | | x | 10 days prior to date of application |
| Home and Community-Based Waiver, under age 65 | Generally FFS, but also available through voluntary MCO or PCC Plan | | x | | May be retroactive to first day of third month before month of application, if covered medical services were received during such period, and the applicant would have been eligible at the time services were provided. |
| Medical Security Plan | | | | | |
| Direct Coverage | MCO | x | | | Start date of unemployment benefits |
| Premium Assistance | Premium assistance only | | | N/A | Start date of unemployment benefits |
| Commonwealth Care Premium Assistance | MCO | x | | | First day of month following enrollment |
| | | | | | |
| *Chart Notes* | | | | | |
| *TPL wrap could include premium payments | | | | | |
| **FFS until member selects or is auto-assigned to MCO or PCC Plan | | | | | |
| ***Presumptive and time-limited during health insurance investigation | | | | | |
| ****All retroactive eligibility is made on a FFP basis | | | | | |

## VII. COST SHARING

46. **Overview.** Cost-sharing imposed upon individuals enrolled in the Demonstration varies across Demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 19 or pregnant women. Additionally, no premium payments are required for any individual enrolled in the Demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the Demonstration for MassHealth-administered programs. The Commonwealth has the authority to change cost-sharing for the Commonwealth Care and Medical Security Plan program without amendment. Updates to the cost-sharing will be provided upon request and in the annual reports.

## VIII. THE SAFETY NET CARE POOL (SNCP)

47. **Description.** The Safety Net Care Pool (SNCP) was established effective July 1, 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth while providing residual provider funding for uncompensated care, and care for Medicaid FFS, Medicaid managed care, Commonwealth Care and low-income uninsured individuals, as well as infrastructure expenditures and access to certain State health programs related to vulnerable individuals, including low-income populations as described in Attachment E.

48. **SNCP Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other Demonstration documentation, all STCs, waivers and expenditure authorities relating to the SNCP are effective for dates of services beginning on the date of the approval letter through June 30, 2014. For the period operating under temporary extension from July 1, 2011, through the period prior to the date of the approval letter, all SNCP expenditures were authorized up to the amount of the DSH allotment for SFY 2012, with the exception of Commonwealth Care which was funded through budget neutrality savings. The aggregate SNCP cap must be reduced by Commonwealth Care expenditures for the temporary extension period to reflect this exception.

49. **Expenditures Authorized under the SNCP.** The Commonwealth is authorized to claim as allowable expenditures under the demonstration, to the extent permitted under the SNCP limits under STC 50, the following categories of payments and expenditures. The Commonwealth must identify the provider and the source of non-Federal share for each component of the SNCP. Federally-approved payments and expenditures within these categories are specified in Attachment E.

    a) Commonwealth Care. For dates of services through December 31, 2013, the Commonwealth may claim as allowable expenditures under the Demonstration to the extent permitted under the SNCP limits under STC 50 premium assistance under the Commonwealth Care health insurance program for individuals ages 21 and older without dependent children with income above 133 percent of the FPL through 300 percent of the FPL.

    b) Designated State Health Programs (DSHP). For dates of service through December 31, 2013, the Commonwealth may claim as allowable expenditures under the Demonstration to the extent permitted under the SNCP limits under STC 50 DSHP, which are otherwise State-funded programs that provide health services.

    c) Providers. As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the Demonstration to the extent permitted under the SNCP limits under STC 50, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, Medicaid managed care, Commonwealth Care, and low-income uninsured individuals. The Commonwealth may also claim as an allowable expenditure payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).

d) Infrastructure and capacity-building. The Commonwealth may claim as allowable expenditures under the Demonstration to the extent permitted under the SNCP limits under STC 50 expenditures that support capacity-building and infrastructure for the improvement or continuation of health care services that benefit the uninsured, underinsured, MassHealth, Demonstration and SNCP populations. Infrastructure and capacity-building funding may also support the improvement of health care services that benefit the Demonstration populations as outlined in STCs 39 and 41(c). Activities related to Delivery System Transformation Initiatives are prohibited from also being claimed as infrastructure and capacity-building. In the annual report as required by STC 59, the Commonwealth must provide the actual amount, purpose and the entity each associated payment was made to for this component of the SNCP.

e) Delivery System Transformation Initiatives (DSTI). The Commonwealth may claim as allowable expenditures under the Demonstration, to the extent permitted under the SNCP limits under STC 50, incentive payments to providers for the development and implementation of a program that support hospitals' efforts to enhance access to health care, improve the quality of care and the health of the patients and families they serve and the development of payment reform strategies and models.

1) Eligibility. The program of activity funded by the DSTI shall be based in public and private acute hospitals, with a high, documented Medicaid patient volume, that are directly responsive to the needs and characteristics of the populations and communities. Therefore, providers eligible for incentive payments are defined as public or private acute hospitals with a Medicaid payer mix more than one standard deviation above average and a commercial payer mix more than one standard deviation below average based on FY 2009 cost report data. The hospitals eligible for incentive payments, over this Demonstration period, based on this criterion, are listed in Attachment I.

2) Master DSTI Plan. The Commonwealth must develop and submit to CMS for approval a "master" DSTI plan. CMS shall render a decision on the master DSTI plan within 45 days of the Commonwealth's submission of the plan to CMS. The master plan must:

i. Outline the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
ii. Specify the DSTI categories consistent with subparagraph (4) below, and detail the associated projects, population-focused objectives and evaluation metrics from which each eligible hospital will select to create its own plan;
iii. Detail the requirements of the hospital-specific plans discussed in subparagraph (3) and STC 52; and
iv. Specify all requirements for the DSTI plans and funding protocol pursuant to STC 52.

3) Hospital-specific Plans. Upon CMS approval of the Commonwealth's master DSTI plan, each participating hospital must submit an individual DSTI plan that identifies the projects, population-focused objectives, and specific metrics adopted from the master DSTI plan and meets all requirements pursuant to STC 52. CMS shall approve each hospital's DSTI plan within 45 days of the Commonwealth's submission of the hospital's plan to CMS for final approval following the State review process pursuant to STC 52(a)(6), provided that the plan(s) meet all requirements of the approved master DSTI plan outlined in STC 52(a)(2) and STC 52(a)(3) in addition the requirements outlined for the hospital specific DSTI plans pursuant to STC 52(b) and the approved DSTI payment and funding protocol pursuant to STC 52 (c).

   Participating hospitals must implement new, or significantly enhance existing health care initiatives. The hospital-specific DSTI plans must address all four categories, as outlined in subparagraph (4) below, but each hospital is not required to select all projects within a given category. Each individual hospital DSTI plan must include a minimum number of projects selected within each category as outlined in the master DSTI plan and report on progress to receive DSTI funding. Eligibility for DSTI payments will be based on successfully meeting metrics associated with approved projects as outlined in subparagraph (6) and the submission of required progress reports outlined in STC 53(c)(1).

4) DSTI Categories and Projects. Each participating hospital must select a minimum number of projects from each category as outlined in the master DSTI plan. Additionally, the projects must be consistent with the overarching approach of improving health care through the simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The selected projects will be detailed in the hospital-specific plans described in subparagraph (3) and STC 52. Each project, depending on the purpose and scope of the project, may include a mix of process-oriented metrics to measure progress in the development and implementation of infrastructure and outcome metrics to measure the impact of the investment. Metrics are further discussed in subparagraph (5) and STC 52.

   There are four categories for which funding authority is available under the DSTI, each of which has explicit connection to the achievement of the Three Part Aim mentioned in the preceding paragraph:

   Category 1: **Development of a fully integrated delivery system:** This category includes investments in projects that are the foundation of delivery system change to encompass the concepts of the patient-centered medical home (PCMH) model to increase delivery system efficiency and capacity. Examples include:

      i. Investments in communication systems to improve data exchange with medical home sites
      ii. Integration of physical and behavioral health care

iii. Development of integrated care networks across the continuum of care
iv. Investment in patient care redesign efforts, such as patient navigators, alternative delivery sites, alternative office hours, etc.

Category 2: **Improved Health Outcomes and Quality**: This category includes development, implementation and expansion of innovative care models which have the potential to make significant demonstrated improvements in patient experience, cost and care management. Examples include:

i. Implementation of Enterprise-wide Care Management or Chronic Care Management initiatives, which may include implementation and use of disease management registries
ii. Improvement of care transitions, and coordination of care across inpatient, outpatient, post-acute care, and home care settings
iii. Adoption of Process Improvement Methodologies to improve safety, quality, and efficiency

Category 3: **Ability to respond to statewide transformation to value-based purchasing and to accept alternatives to fee-for-service payments** that promote system sustainability. Examples include:

i. Enhancement of Performance Improvement and Reporting Capabilities
ii. Development of enhanced infrastructure and operating and systems capabilities that would support new integrated care networks and alternative payment models to manage within new delivery and payment models
iii. Development of risk stratification capabilities/functionalities

Category 4: **Population-Focused Improvements.** This category involves evaluating the investments and system changes described in categories 1, 2 and 3 through population-focused objectives. Metrics must evaluate the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers. Metrics must also evaluate the impact of the payment redesign and infrastructure investments to improve areas such as cost efficiency, systems of care, and coordination of care in community settings. Metrics may vary across participating providers, but should be consistent within projects developed in the DSTI master plan to facilitate evaluation.

5) DSTI Metrics and Evaluation. Each eligible provider must develop process-oriented and outcome metrics for each of the Categories 1, 2 and 3 that demonstrate clear project goals and objectives to achieve systematic progress. Examples of such project metrics may include: identification and purchase of system, programming of system, going live on a system, contracting with a payer using a bundled payment system, enrollment of a defined percentage of patients to a Medical Home model, increase by a defined amount the number of primary care clinics using a Care Management model, improve by a defined percentage patients with self-management goals, increase by a defined amount the number of patients that have an assigned care manager team, etc.

Metrics related to Category 4 shall recognize that the population-focused objectives/projects do not guarantee outcomes, but that the objectives/projects must result in learning, adaptation and progress toward the desired impact. These metrics must quantitatively measure the impact of the projects in Categories 1, 2 and 3 (e.g. disease measurements, ER admissions, cost management, etc.) on each participating provider's patient population.

6) DSTI Payments. DSTI payments for each participating provider are contingent on that provider meeting project metrics as defined in the approved hospital-specific plans. As further discussed in subparagraph (7) below, the final master DSTI plan and payment and funding protocol as required by STC 52 must include an incentive payment formula. Within this formula, approval of the hospital-specific plans may be considered an appropriate metric for the first incentive payment of the initiative in DY 15, and may equal up to 50 percent of the DY 15 total annual amount of DSTI funding a hospital may be eligible for based upon incentive payments. Payment cycles to providers will be described in final approved DSTI funding protocol but will be made at a minimum on a semi-annual basis contingent upon providers meeting the associated metrics. The actual metrics for incentive payments and the amount of incentive payments dispersed in a given year will be outlined pursuant to the approved master DSTI plan, hospital-specific plans and funding protocol requirements outlined in STC 52 and the reporting requirements outlined in STC 53.

   DSTI payments are not direct reimbursement for expenditures or payments for services. DSTI payments are intended to support and reward hospital systems for improvements in their delivery systems and payment models that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The payments are not direct reimbursement for expenditures incurred by hospitals in implementing reforms. The DSTI payments are not reimbursement for health care services that are recognized under these STCs or under the State plan.

   DSTI payments should not be considered patient care revenue and will not be offset against other Medicaid reimbursements to hospital systems, including payments funded through approved intergovernmental transfers, or approved certified public expenditures incurred by government owned or operated hospital systems and their affiliated government entity providers for health care services, infrastructure and capacity-building, administrative activities, or other non-DSTI payment types authorized under these STCs and/or under the State plan.

7) Distribution of DSTI Funds among Hospitals: Attachment I specifies the hospitals eligible for DSTI over the Demonstration approval period and outlines the initial proportional allowance of available DSTI funds for participating providers to earn through DSTI incentive payments for SFY2012-2014. This initial proportional allowance is based upon a foundational amount of funding of $4 million for each

hospital over the Demonstration approval period that is necessary for hospitals to undertake transformation initiatives, regardless of hospital size. Beyond this foundational amount, the initial allotment of available funds is based on the relative size of each hospital's Medicaid and low-income public payer patient population, as measured by each hospital's patient services charges as indicated in the Medicaid and Low-Income Public Payer Gross Patient Services Revenue (GPSR), published in the SFY 2009 Massachusetts 403 acute hospital cost reports filed with the Division of Health Care Finance and Policy. "Public payers" in this instance include Medicaid, Medicaid managed care, Commonwealth Care and the Health Safety Net. The public payers and base year data are consistent with the eligibility criteria for participating providers.

The final master DSTI plan, and payment and funding protocol, as outlined in STC 52, must specify the DSTI incentive payment formula and denote the total annual amount of DSTI incentive payments each participating hospital may be eligible for based upon the projects and metrics it selects. The incentive payment formula must identify per metric the following: (1) the annual base amount of funding per metric associated with the each category pursuant to STC 49(e)(4); (2) increases to that base amount associated with a hospital's proportional annual DSTI allowance; and (3) a rationale for any percentage adjustments made to a hospitals calculated DSTI allowance to account for factors such as differences in quality infrastructure, differences in external supports for improvements, and differences in patient populations to be identified in the master DSTI plan.

8) FFP. FFP is not available for DSTI payments to a participating provider until the DSTI master plan, the individual provider's plan and the funding protocol outlined in STC 52 are approved by CMS. DSTI payments to a particular provider are contingent upon whether that participating provider meets project metrics as defined in its hospital-specific plan, and are subject to legislative appropriation and availability of funds.

50. **Expenditure Limits under the SNCP.**

a) Aggregate SNCP Cap. From the date of the approval letter through June 30, 2014 (SNCP extension period), the SNCP will be subject to an aggregate cap of $4.4 billion, as well as the overall budget neutrality limit established in section XI of the STCs. Because the aggregate SNCP cap is based in part on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment, any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the Demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as described in subparagraph c. Such a change shall be reflected in STCs 50(a) and 50(c), and shall not require a Demonstration amendment. The aggregate SNCP cap of $4.4 billion is based on an annual DSH allotment of $624,691,018 (Total Computable), the Commonwealth's projected annual DSH allotment for FFY 2012 and budget neutrality savings. For the period operating

under temporary extension from July 1, 2011, through the period prior to the date of the approval letter, all SNCP expenditures were authorized up to the amount of the DSH allotment for SFY 2012, with the exception of Commonwealth Care which was funded through budget neutrality savings. The aggregate SNCP cap was reduced by Commonwealth Care expenditures for the temporary extension period to reflect this exception.

b) Infrastructure Cap. The Commonwealth may expend an amount equal to no more than five percent of the aggregate SNCP cap over the SNCP extension period for infrastructure and capacity building, as described in STC 49(d). No FFP will be available to reimburse the Commonwealth for infrastructure and capacity-building until the Commonwealth notifies CMS and obtains subsequent CMS approval, of the specific activities that will be undertaken to improve the delivery of health care to the uninsured, underinsured or SNCP populations. No Demonstration amendment is required for CMS approval of the specific activities for infrastructure and capacity-building. The Commonwealth must update Attachment E to reflect these activities; no Demonstration amendment is required. Progress reports on all such activities must be included in the quarterly and annual reports outlined in STCs 58 and 59, respectively. Infrastructure projects for which FFP is claimed under this expenditure authority are not eligible for DSTI incentive payments.

c) Provider Cap. The Commonwealth may expend an amount for purposes specified in STC 49(c) equal to no more than the cumulative amount of the Commonwealth's annual DSH allotments for the SNCP extension period. Any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the Demonstration shall result in an equal change to the provider cap. Such change shall not require a Demonstration amendment. The provider cap is based on an annual DSH allotment of $624,691,018 (total computable), the Commonwealth's projected annual DSH allotment for SFY 2012.

d) DSHP Cap. Expenditure authority for DSHP is limited to $360 million in SFY 2012, $310 million in SFY 2013 and $130 million in SFY 2014 through December 31, 2013. Total computable expenditures for DSHP shall be reduced by a fixed amount of 5.3 percent annually to determine allowable DSHP expenditures under the demonstration to account for the unknown immigration status of certain program recipients.

e) Budget Neutrality Reconciliation. The Commonwealth is bound by the budget neutrality agreement described in section XI of the STCs. The Commonwealth agrees to reduce spending in the SNCP to comply with budget neutrality in the event that expenditures under the demonstration exceed the budget neutrality ceiling outlined in section XI, STC 80. In that event, the Commonwealth must reduce expenditures for items 1 through 7 and 9 in chart A of Attachment E before reducing expenditures to item 8, Commonwealth Care.

f) Transition to Cost for Uncompensated Care. The SNCP payments pursuant to STC 49(c) support providers for furnishing uncompensated care. Currently these payments are not limited to the documented cost of providing such care. Over this extension period, CMS will work with the Commonwealth to develop a cost protocol, to be approved by CMS and included as future Attachment H. This protocol will ensure that beginning on July 1, 2014 all provider payments for uncompensated care pursuant to STC 49(c) will be limited on a provider-specific basis to the cost of providing Medicaid State plan services and any other additional allowable uncompensated costs of care provided to Medicaid eligible individuals and uninsured individuals, less payment received by or on behalf of such individuals for such services. The DSH audit rule definition of allowable inpatient and outpatient services and allowable uninsured costs and revenues will serve at the initial framework for discussions on the cost protocol. Any additional costs to be included as allowable as uncompensated care must be identified and included in the resulting approved cost protocol.

Therefore, over this extension period, the following milestones outlined in subparagraph (a) must be completed to develop and receive CMS approval for a cost protocol. If there is no approved protocol in place by October 1, 2013, then default cost limit methodologies pursuant to subparagraph (b) will be applied to all provider payments under STC 49(c) for uncompensated Medicaid or uninsured services beginning on July 1, 2014 through any extension of the Demonstration.

a. Protocol Development
   i. By January 1, 2012 CMS will provide sample cost report protocols to the Commonwealth for physician, clinic and hospital services as well as any other provider receiving payments for services under the SNCP provider payments for uncompensated care.
   ii. By March 30, 2012, the Commonwealth must provide CMS for CMS approval a cost protocol development tool that includes a description of all specific data including data sources it proposes to include in the cost-limit protocol, including the scope of services and costs for each provider type (e.g. inpatient, outpatient, physician services, clinic services, non-hospital services, etc.). Massachusetts must use the same definition for inpatient and outpatient services as described in its approved Medicaid State plan for an initial framework and identify other uncompensated care costs that are not included in the State plan definitions. The Commonwealth must also identify any costs that would not be captured using Medicare cost principles but for which it will seek reimbursement under the SNCP (an example would be unreimbursed translation services associated with Medicaid or uninsured individuals).
   iii. By May 31, 2012, CMS will approve this cost protocol development tool. This approval will inform the scope of services and costs in subparagraph (iv) below and in the final protocol.
   iv. By July 1, 2012, the Commonwealth must develop an impact analysis of the cost limit protocol (will require hospitals to report necessary data on a

preliminary basis). This impact analysis must identify the sources of data used, the dates associated with the available data and any adjustments or modifications that have been made to the data along with the methodology and rationale.

v. By August 30, 2012, CMS will provide comments on the cost-limit impact analysis.

vi. By December 1, 2012, the Commonwealth must submit to CMS a draft cost protocol for each provider type receiving SNCP payments under STC 49(c) that describes the methodology to calculate the annual cost of uncompensated care for Medicaid and uninsured populations for all services provided beginning on July 1, 2014 through any extension of the Demonstration. Payments to providers under STC 49(c) will be limited by this annual provider specific cost limit beginning July 1, 2014 through any extension of the Demonstration.

vii. CMS will review and submit initial comments and questions on the draft protocol by January 1, 2013.

viii. The Commonwealth will work with CMS to finalize the cost protocol by October 1, 2013.

ix. Hospitals will be required to certify and report necessary data to the Commonwealth by January 1, 2014.

x. Hospital-specific cost limits for SNCP Provider Cap payments will be implemented for all services provided beginning on July 1, 2014 through any extension of the Demonstration.

b. Default Cost Limit Methodologies

i. If there is no approved protocol pursuant to subparagraph (a) above by October 1, 2013, then the following default cost limit methodologies will apply based on provider type for all providers receiving payments for uncompensated Medicaid or uninsured services under STC 49(c) provided beginning July 1, 2014 through any extension of the Demonstration:

1. Hospitals will be limited to unreimbursed cost as determined using a cost-to-charge ratio utilizing the most recent Medicare cost report data by cost-center available through the CMS Medicare reporting system (HCRIS);
2. Physician uncompensated care payments will be limited to the amount Medicare would have paid for the services based on the Medicare fee schedule in effect when the services were rendered; and
3. Clinics will be limited to the amount of uncompensated care demonstrated using the HRSA 330 grantees cost-reports.

ii. The default methodologies pursuant to subparagraph (i) above do not include any additional costs not identified in the standard reports gathered by Medicare or HRSA.

51. **Priority Expenditures under the SNCP.** The Commonwealth must support expenditures for premium assistance under Commonwealth Care as its first priority.

52. **DSTI Plan and Funding Protocol.** The State must meet the following milestones before it can claim FFP for DSTI funding:

    a) Commonwealth Master DSTI Plan. The Commonwealth must develop an overarching master DSTI plan to be submitted to CMS for approval. The master plan will be future Attachment J and must at a minimum include:

        1) Identification of community needs, health care challenges, the delivery system, payment reform, and population-focused improvements that DSTI will address in addition to baseline data to justify assumptions;

        2) Identification of the projects and objectives that fall within the four categories, as outlined in STC 49(e)(4),from which each participating hospital will develop its hospital-specific DSTI plan, and identify the minimum level of projects and population-focused objectives that each hospital must select;

        3) In coordination with subparagraph (a)(2) above, identification of the metrics and data sources for specific projects and population-focused objectives that each participating hospital will utilize in developing a hospital-specific DSTI plan to ensure that all hospitals adhere to a uniform progress reporting requirement;

        4) With regard to Category 3, the State must also identify its actions and timelines for driving payment reform;

        5) Guidelines requiring hospitals to develop individual hospital DSTI plans as outlined in STC 49(e)(3) and STC 52(b);

        6) A State review process and criteria to evaluate each hospital's individual DSTI plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;

        7) A reporting protocol outlining the requirements, process and timeline for a hospital to submit its interim progress on DSTI plan metrics and for the State to provide CMS with information documenting progress;

        8) A State review process and timeline to evaluate hospital progress on its DSTI plan metrics and assure a hospital has met its approved metrics prior to the release of associated DSTI funds;

        9) A process that allows for hospital plan modification and an identification of under what issues a modification plan may be considered including for carry-forward/reclamation, pending State and CMS approval; and

10) A State process of developing an evaluation of DSTI as a component of the draft evaluation design as required by STC 84. When developing the master DSTI plan, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XII of the STCs. The State must select a preferred research plan for the applicable research question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, DSTI master plan must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating provider chooses not to undertake that project. The intent of this data set is to enable cross provider comparison even if the provider did not elect the intervention.

b) Hospital DSTI Plans. At a minimum, the individual hospital DSTI plans should include the following, in addition to the requirements pursuant to STCs 52(b) and 53(c).

1) A background section on the hospital system(s) covered by the DSTI plan that includes an overview of the patients served by the hospital;

2) An executive summary for the DSTI plan that summarizes the high-level challenges the DSTI plan is intended to address and the target goals and objectives included in the plan for the Demonstration approval period;

3) Sections on each of the four categories as specified in the STC 49(e)(4), and include:
   - i. For Categories 1, 2 and 3 –
     - a. Each hospital must select a minimum number of projects, with associated metrics, milestones and data sources in accordance with the master DSTI plan.
     - b. For each project selected, the hospital at a minimum must include:
       - i. A description of the goal(s) of the project, which describes the challenges of the hospital system and the major delivery or payment redesign system solution identified to address those challenges by implementing the particular project;
       - ii. A description of the target goal over the Demonstration approval period and metrics associated with the project and the significance of that goal to the hospital system and its patients;
       - iii. A narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevancy to the hospital system's population and circumstances,

community need, and hospital system priority and starting point with baseline data;

iv. A narrative describing how this project supports, reinforces, enables and is related to other projects and interventions within the hospital system plan; and

v. Any other hospital reporting guidelines stipulated in the master DSTI Plan.

ii. In addition to requirements addressed in the above subparagraph (i), Category 2 must also include:

a. A description of how the selected project can refine innovations, test new ways of meeting the needs of target populations and disseminate findings in order to spread promising practices.

iii. Category 4 – Population-Focused Improvements

a. Projects within this category must focus on evaluation of the population-focused improvements associated with Categories 1, 2 and 3 projects and associated incentive payments. Each hospital must select a minimum number of projects in accordance with in the master DSTI plan. The projects must be hospital-specific and need not be uniform across all the hospitals, but must be uniform across projects that are selected by multiple hospitals.

c) DSTI Payment and Funding Protocol. The State must develop and submit in conjunction or as part of the master DSTI plan, an incentive payment methodology for each of the four categories to determine an annual maximum budget for each participating provider. The State also must identify an allowable non-Federal share for the DSTI pool, which must approved by CMS. The following principles must also be incorporated into the funding protocol that will be incorporated in future Attachment J:

1) Each hospital will be individually responsible for progress towards and achievement of its metrics to receive its potential incentive funding related to any metric from DSTI.

2) In order to receive incentive funding related to any metric, the hospital must submit all required reporting as described in STC 53(c).

3) Funding Allocation Guidelines. The master DSTI plan must specify a formula for determining incentive payment amounts. Hospital-specific DSTI plan submissions must use this formula to specify the hospital-specific incentive payment amounts associated with the achievement of approved transformation metrics for approval by the Commonwealth and CMS pursuant to STC 52(a)(6). Category metrics will have a base value. Each category may have a different base value but metrics within categories will be based on a starting dollar point. Given the varied nature of the projects and hospital systems, the total incentive payment amounts available to an individual hospital for each category depend upon the

size of the hospital, total projects and metrics selected in the hospital specific DSTI. The submission must describe how the factors effect each hospitals maximum allowable payment.

4) Carry-Forward/Reclamation. The protocol must describe the ability of a hospital to earn payment for any missed metric within a defined time period. Carry-forward/reclamation of incentive payments is only available to the hospital associate with a given incentive payment and is not available for redistribution to other hospitals. Carry-forward/reclamation is limited to this Demonstration approval period ending June 30, 2014.
   i. If a participating hospital system does not fully achieve a metric that was specified in its plan for completion in a particular year, the payment associated with that metric may be rolled over for 12 months and be available if the hospital meets the missed metric in addition to the metric associated with the year in which the payment is made.
   ii. In the case of a participating hospital that is close to meeting a metric in a particular year, the hospital may be granted a grace period to the reporting deadline set for a particular payment cycle by which to meet a metric associated with the incentive payment if it has an approved plan modification pursuant to STC 52(a)(9) above. The allowable time period for such a grace period may vary based on the type and scope of the project associated with such metric and may be up to 180 days. The plan modification must be approved by the Commonwealth and CMS 30 days prior to the deadline of the incentive payment reporting pursuant to STCs 52 and 53(c). The plan modification must outline how the hospital plans to meet the metric within the given grace period. The process for hospital plan modification, including the modification requirements, deadline by which a hospital must submit a requested modification and the Commonwealth and CMS approval process will be outlined within the master DSTI plan pursuant to STC 52(a)(9).
   iii. Projects that focus primarily on infrastructure will have further limited rollover ability as defined in the master DSTI plan.

53. **SNCP Additional Reporting Requirements**. All SNCP expenditures must be reported as specified in section X, STC 63. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

   a) <u>Charts A – B of Attachment E</u>. The Commonwealth must submit to CMS for approval, updates to Charts A – B of Attachment E that reflect projected SNCP payments and expenditures for State Fiscal Year (SFY) 2012-2014 and identify the non-Federal share for each line item, no later than 45 days after enactment of the State budget for each SFY. CMS shall approve the Commonwealth's projected SNCP payments and expenditures within 30 days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 50.

The Commonwealth must notify CMS and receive CMS approval, before it can claim FFP, for any SNCP payments and expenditures outlined in Charts A-B of Attachment E that are in excess of the approved projected SNCP payments and expenditures by a variance greater than 10 percent. Any variance in SNCP payments and expenditures must adhere to the SNCP expenditure limits pursuant to STC 50. The Commonwealth must submit to CMS for approval updates to Charts A – B that include these variations in projected SNCP payments and expenditures. CMS shall approve the Commonwealth's revised projected SNCP payments and expenditures within 30 days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in STC 50.

The Commonwealth must submit to CMS for approval updates to Charts A – B of Attachment E that reflect actual payments and expenditures for each SFY, within 180 days after the close of the SFY. CMS shall approve the Commonwealth's actual SNCP expenditures within 45 days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in STC 50.

The Commonwealth must submit to CMS for approval further updates to any or all of these charts as part of the quarterly operational report and at such other times as may be required to reflect projected or actual changes in SNCP payments and expenditures. CMS must approve the Commonwealth's updated charts within 45 days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in STC 50.

No Demonstration amendment is required to update Charts A-B in Attachment E, with the exception of any new types of payments or expenditures in Charts A and B, or for any increase to Public Service Hospital Safety Net Care.

b) <u>DSHP</u>. The Commonwealth must submit to CMS for approval a table of projected DSHP spending by approved program, no later than 45 days after enactment of the State budget for each SFY. CMS must approve the Commonwealth's projected DSHP expenditures within 15 days of the Commonwealth's submission of the update, provided that all DSHP projections are within the applicable SNCP limits specified in STC 50.

The Commonwealth must submit to CMS for approval an update to the table of projected DSHP spending that reflects actual DSHP expenditures for each SFY, within 180 days after the close of the SFY. CMS must approve the Commonwealth's actual DSHP expenditures within 45 days of the Commonwealth's submission of the update, provided that all DSHP expenditures are within applicable limits.

The Commonwealth may submit to CMS for approval further updates to the table of projected DSHP spending by approved program at such other times as may be required to reflect projected or actual changes in DSHP expenditures. CMS must approve the Commonwealth's updated charts within 45 days of the Commonwealth's submission of the update, provided that all DSHP expenditures are within applicable limits.

No Demonstration amendment is required to update the table of projected DSHP spending by approved program within the expenditure limits specified in STC 50(d). The Commonwealth is required to amend the Demonstration in order to add to the list of DSHP programs in Chart C of Attachment E.

c) DSTI Reporting. The participating providers and the State must report the following:

1) Hospital Reporting. The reporting protocol within the master DSTI must outline the hospitals' reporting requirements, process and timelines that must be consistent with the following principles:

   i. Hospital Reporting for Payment. Participating providers seeking payment under DSTI must submit reports to the State demonstrating progress, measured by Category specific metrics. The reports must include the incentive payment amount being requested for the progress achieved in accordance with the payment mechanisms outlined in the master DSTI plans. The required hospital reporting requirements, process and timeline are pursuant to the reporting protocol, State review process and funding protocol as outlined in STC 52(a)(7) and STC 52(a)(8) and STC 52(c) and must be consistent with the following principles:
      1. The hospital reports must be submitted using a standardized reporting form approved by the State and CMS;
      2. The State must use this documentation in support of DSTI claims made on the MBES/CBES 64.9 Waiver form.

   ii. Hospital System Annual Report. Hospital systems must submit an annual report, based on the timeline approved in the reporting protocol component of the master DSTI plan. The reports must at a minimum:
      1. Be submitted using a standardized reporting form approved by the State and CMS;
      2. Provide information included in the semi-annual reports, including data on the progress made for all milestones; and
      3. Provide a narrative description of the progress made, lessons learned, challenges faced and other pertinent findings.

   iii. Documentation. The hospital system must have available for review by the State or CMS, upon request, all supporting data and back-up documentation.

2) Commonwealth Reporting. STC 58 and 59 require DSTI reporting as a component of the quarterly operational reports and annual reports. The DSTI reporting must at a minimum include:

   i. All DSTI payments made to specific hospitals that occurred in the quarter;
   ii. Expenditure projections reflecting the expected pace of future disbursements for each participating hospital;
   iii. An assessment by summarizing each hospital's DSTI activities during the given period; and

iv. Evaluation activities and interim findings of the evaluation design pursuant to STC 84.

## IX. GENERAL REPORTING REQUIREMENTS

54. **General Financial Reporting Requirements.** The State must comply with all general financial requirements under title XIX of the Social Security Act in section X of the STCs.

55. **Compliance with Managed Care Reporting** Requirements. The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

56. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in section XI of the STCs, including the submission of corrected budget neutrality data upon request.

57. **Bi-Monthly Calls.** The State must participate in monitoring calls with CMS. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, quality of care, access, the benefit packages, activities related to the Safety Net Care Pool, audits, lawsuits, financial reporting and budget neutrality issues, proposed changes to payment rates, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

58. **Quarterly Operational Reports.** The Commonwealth must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the Commonwealth's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a) Updated budget neutrality monitoring spreadsheets;

    b) Events occurring during the quarter or anticipated to occur in the near future that effect health care delivery including approval and contracting with new plans, benefits, enrollment, grievances, quality of care, access, proposed changes to payment rates, health plan financial performance that is relevant to the Demonstration, payment reform initiatives or delivery system reforms impacting Demonstration population and/or undertaken in relation to the SNCP, updates on activities related to the pediatric bundled payment pilot program, pertinent legislative activity, and other operational issues;

c) Action plans for addressing any policy and administrative issues identified;

d) Quarterly enrollment reports that include the member months for each Demonstration population;

e) Updates on any State health care reform activities to coordinate the transition of coverage through the Affordable Care Act;

f) Activities and planning related to payments made under the Safety Net Care Pool pursuant to reporting requirements outlined in section VIII of the STCs; and

g) Evaluation activities and interim findings.

59. **Annual Report**. The Commonwealth must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under STC 58 in addition to the annual HCBS report as stipulated in STC 40(l). The Commonwealth must submit the draft annual report no later than October 1st of each year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

60. **Transition Plan**. On or before July 1, 2012, the State is required to submit a draft and incrementally revise a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs (a)-(e) outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

    a) Required Authorities. The State must conduct an assessment of which Demonstration authorities outlined in the waivers and expenditure authorities should expire on December 31, 2013 consistent with the provisions of the Affordable Care Act and submit a plan outlining the process for submission of any necessary Demonstration amendment(s). For example, this may include authorities related to specific Demonstration populations (e.g. Commonwealth Care, hypothetical populations, etc.) in addition to processes and activities such as eligibility procedures and standards, financial responsibility/deeming, retroactive eligibility, cost sharing, etc.

    b) Seamless Transitions. Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State plans to obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the

Demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Conduct an analysis that identifies populations in the Demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.

c) <u>Access to Care and Provider Payments and System Development or Remediation</u>. The State should assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. Additionally, the Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

d) <u>Progress Updates</u>. After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

e) <u>Implementation</u>.

i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the Demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.

ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

61. **Final Report.** Within 120 days following the end of the Demonstration, the Commonwealth must submit a draft final report to CMS for comments. The Commonwealth must take into consideration CMS' comments for incorporation into the final report. The final report is due

to CMS no later than 120 days after receipt of CMS' comments.

## X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

62. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using Form CMS-64 to report total expenditures for services provided through this Demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures as specified in section XI of the STCs.

63. **Reporting Expenditures Under the Demonstration.** The following describes the reporting of expenditures subject to the budget neutrality agreement:

    a) Tracking Expenditures. In order to track expenditures under this demonstration, the State must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number (11-W-00030/1) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered.

    b) Cost Settlements. For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this Demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

    c) Pharmacy Rebates. The Commonwealth may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

    d) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the Demonstration must be reported to CMS each

quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

e) Demonstration year reporting. Notwithstanding the two-year filing rule, the Commonwealth may report adjustments to particular demonstration years as described below:

i. Beginning July 1, 2005 (SFY 2006/ DY, 9) all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, and separate schedules will be completed for demonstration years 6, 7, 8, and 9.

ii. Beginning July 1, 2006 (SFY 2007/ DY 10), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-7 will be reported as demonstration year 7, and separate schedules will be completed for demonstration years 8, 9, and 10.

iii. Beginning July 1, 2007 (SFY 2008/ DY 11), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, and separate schedules will be completed for demonstration years 9, 10, and 11.

iv. Beginning July 1, 2008 (SFY 2009/ DY 12), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-10 will be reported as demonstration year 10, and separate schedules will be completed for demonstration years 11 and 12. Demonstration year 12 includes dates of service from July 1, 2008, through June 30, 2009.

v. Beginning July 1, 2009 (SFY 2010/ DY 13), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. Demonstration year 13 includes dates of service from July 1, 2009, through June 30, 2010.

vi. Beginning July 1, 2010 (SFY 2011/ DY 14), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be

reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. Demonstration year 14 includes dates of service from July 1, 2010, through June 30, 2011.

vii. Beginning July 1, 2011 (SFY 2012/ DY 15), all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration 11, all expenditures and adjustments for demonstration years 12-14 will be reported as demonstration year 14 and separate schedules will be completed for demonstration years 15 and 16 and 17. All expenditures and adjustments for dates of service beginning July 1, 2011, will be reported on separate schedules corresponding with the appropriate demonstration year.

f) Use of Waiver Forms

. For each Demonstration year as described in subparagraph (e) above, 29 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following EGs and the Safety Net Care Pool. Expenditures should be allocated to these forms based on the guidance found below.

| | | |
|---|---|---|
| i. | **Base Families:** | Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only) |
| ii. | **Base Disabled:** | Eligible individuals with disabilities enrolled in Standard, individuals enrolled in CommonHealth who spend down to eligibility, as well as eligible disabled individuals enrolled in Limited (emergency services only) |
| iii. | **1902(r)(2) Children:** | Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible children and pregnant women enrolled in MassHealth Limited (emergency services only) |
| iv. | **1902(r)(2) Disabled:** | Eligible individuals with disabilities enrolled in Standard with income between 114.1 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency |

services only)

| | | |
|---|---|---|
| v. | **BCCTP:** | Women eligible under the Breast and Cervical Cancer Treatment Program who are enrolled in Standard |
| vi. | **CommonHealth:** | Higher income working adults and children with disabilities enrolled in CommonHealth |
| vii. | **e-Family Assistance** | Eligible children receiving premium assistance or direct coverage through 200 percent of the FPL enrolled in Family Assistance |
| viii. | **CommCare-19-20** | 19 and 20 year olds receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority |
| ix. | **Essential-19-20** | Eligible 19 and 20 year olds who are long-term unemployed and not receiving EAEDC or a client of DMH |
| x. | **CommCareParents** | Parents receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority |
| xi. | **CommCare-133** | Individuals 21 years old and over without dependent children with income at or below 133 percent of the FPL receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority |
| xii. | **Base Fam XXI RO** | Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted |
| xiii. | **1902 (r)(2) XXI RO** | Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted |

| | | |
|---|---|---|
| xiv. | **CommonHealth XXI** | Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted |
| xv. | **Fam Assist XXI** | Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted |
| xvi. | **e-HIV/FA** | Eligible individuals with HIV/AIDS through 200 percent of the FPL who are enrolled in Family Assistance |
| xvii. | **IRP:** | Subsidies or reimbursement for ESI made to eligible individuals and/or eligible employers, not including subsidies for individuals in other eligible groups |
| xviii. | **Basic:** | Eligible individuals who are long-term unemployed receiving EAEDC and/or a client of DMH |
| xix. | **Essential:** | Eligible individuals who are long-term unemployed and not receiving EAEDC or a client of DMH |
| xx. | **MSP:** | Eligible individuals receiving unemployment benefits from the DUA |
| xxi. | **SNCP-CommCare:** | Individuals ages 21 and over with income above 133 percent of the FPL receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority |
| xxii. | **SNCP-HSNTF:** | Expenditures authorized under the Demonstration for payments held to the provider sub-cap to support uncompensated care |
| xxiii. | **SNCP-DSHP:** | Expenditures authorized under the Demonstration for the Designated State Health Programs (DSHP) |

| | | |
|---|---|---|
| xxiv. | **SNCP-DSTI:** | Expenditures authorized under the Demonstration for Delivery System Transformation Initiatives (DSTI) |
| xxv. | **SNCP-OTHER:** | All other expenditures authorized under the SNCP |
| xxvi. | **Asthma**: | All expenditures authorized through the pediatric asthma bundled pilot program |
| xxvii. | **Autism:** | All expenditures authorized for early intervention services for children with autism |

64. **Reporting Expenditures under the Demonstration for Groups that are Eligible First under the Separate Title XXI Program.** The Commonwealth is entitled to claim title XXI funds for expenditures for certain children that are also eligible under this title XIX Demonstration included within the Base Families EG, the 1902(r)(2) Children EG, the CommonHealth EG and the Family Assistance EG. These groups are included in the Commonwealth's title XXI State Plan and therefore can be funded through the separate title XXI program up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual. If the title XXI allotment has been exhausted, including any reallocations or redistributions, these children are then eligible under this title XIX Demonstration and the following reporting requirements for these EGs under the title XIX Demonstration apply:

**Base Families XXI RO, 1902(r)(2) RO, CommonHealth XXI, and Fam Assist XXI:**

a) Exhaustion of Title XXI Funds. If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid State plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with STC 63 (Reporting Expenditures Under the Demonstration).

b) Exhaustion of Title XXI Funds Notification. The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.

c) If the Commonwealth chooses to claim expenditures for **Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI** groups under title XIX, the expenditures and caseload attributable to these EGs will:

i. Count toward the budget neutrality expenditure limit calculated under section XI, STC 80 ( Budget Neutrality Annual Expenditure Limit); and

ii. Be considered expenditures subject to the budget neutrality agreement as defined in STC 80, so that the Commonwealth is not at risk for caseload while claiming title XIX Federal matching funds when title XXI funds are exhausted.

d) If the Commonwealth chooses to claim expenditures for **Fam Assist XXI** under title XIX, the expenditures and caseload attributable to this EG will be considered expenditures subject to the budget neutrality agreement as defined in STC 80. The Commonwealth is at risk for both caseload and expenditures while claiming Title XIX Federal matching funds for this population when title XXI funds are exhausted.

65. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in section IV of the STCs, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

66. **Premium Collection Adjustment.** The Commonwealth must include Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis on the CMS-64 Summary Sheet and on the budget neutrality monitoring workbook submitted on a quarterly basis.

67. **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

68. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms, in order to properly account for these expenditures in determining budget neutrality.

69. **Reporting Member Months.** The following describes the reporting of member months for

Demonstration populations:

a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under STC 58, the actual number of eligible member months for the EGs i-xxi and EGs xxvi and xxvii defined in STC 63(f). The Commonwealth must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

   To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

70. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. Massachusetts must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each FFY on the Form CMS-37 (narrative section) for both the Medical Assistance Payments (MAP) and State and Local Administrative Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

71. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole for the following, subject to the limits described in section XI of the STCs:

    a) Administrative costs, including those associated with the administration of the Demonstration;

    b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

    c) Net medical assistance expenditures and prior period adjustments made under section 1115 Demonstration authority with dates of service during the Demonstration extension period, including expenditures under the Safety Net Care Pool.

72. **Sources of Non-Federal Share.** The Commonwealth provides assurance that the matching non-Federal share of funds for the Demonstration is State/local monies. The Commonwealth further assures that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

    a) CMS may review at any time the sources of the non-Federal share of funding for the Demonstration. The Commonwealth agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

    b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

    c) The Commonwealth assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable Federal statutory and regulatory provisions, as well as the approved Medicaid State plan.

73. **State Certification of Funding Conditions.** The Commonwealth must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

    a) Units of government, including governmentally operated health care providers, may certify that State or local monies have been expended as the non-Federal share of funds under the Demonstration.

    b) To the extent the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

    c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim Federal match for expenditures under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such State or local monies as allowable under 42 CFR 433.51 used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match;

    d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from State or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments.

e) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect to the Commonwealth any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

74. **Monitoring the Demonstration.** The Commonwealth will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

75. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration.

## XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

76. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in section I of the STCs or in any other Demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2011.

77. **Limit on Title XIX Funding**. Massachusetts will be subject to a limit on the amount of Federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the Demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in section X, STC 63. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

78. **Risk.** Massachusetts shall be at risk for the per capita cost for Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

79. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on behalf of enrollees under age 65 who are institutionalized in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for the mentally retarded, or a State psychiatric hospital for other than a short-term rehabilitative stay;

b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient, and home and community-based waiver services, except pursuant to STC 40;

c) Expenditures for covered services currently provided to Medicaid recipients by other State agencies or cities and towns, whether or not these services are currently claimed for Federal reimbursement; and

d) Allowable administrative expenditures.

80. **Budget Neutrality Annual Expenditure Limit.** For each DY, two annual limits are calculated.

a) Limit A. For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section X, STC 69 for each EG, including the hypothetical populations, times the appropriate estimated per member/per month (PMPM) costs from the table in subparagraph (v) below;

ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs 2012-2014;

iii. Starting in SFY 2009, actual expenditures for the CommCare-19-20, Essential-19-20 and CommCare Parents EGs will be included in the expenditure limit for the Commonwealth. Starting April 1, 2010, actual expenditures for the CommCare-133 EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2012-2014;

iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior Demonstration periods are provided in Attachment D; and

v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

| Eligibility Group (EG) | Trend Rate | DY 15 PMPM | DY 16 PMPM | DY 17 PMPM |
|---|---|---|---|---|
| **Mandatory and Optional State Plan Groups** | | | | |
| Base Families | 5.3 percent | $562.02 | $591.81 | $623.17 |
| Base Disabled | 6.0 percent | $1,224.88 | $1,298.38 | $1,376.28 |
| BCCTP | 5.3 percent | $3,674.67 | $3,869.43 | $4,074.51 |
| 1902(r)2 Children | 4.9 percent | $457.59 | $480.02 | $503.54 |
| 1902(r)2 Disabled | 6.0 percent | $959.04 | $1,016.59 | $1,077.58 |
| Essential | 5.3 percent | $351.85 | $370.50 | $390.14 |
| **Hypothetical Populations*** | | | | |
| CommonHealth | 6.0 percent | $563.46 | $597.27 | $633.11 |
| CommCare-19 and 20 year olds | 5.3 percent | $447.13 | $470.83 | $495.78 |
| CommCare Parents | 5.3 percent | $498.35 | $524.77 | $552.58 |
| Essential-19 and 20 year olds | 5.3 percent | $378.31 | $398.36 | $419.47 |
| CommCare-133 | 5.3 percent | $498.36 | $524.77 | $552.58 |

* "These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit, according to the process listed in STC 80(a) (ii) and (iii)."

b) Limit B. The Commonwealth's annual DSH allotment.

c) The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure limits. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of Demonstration populations as well as Demonstration services described in Table B in STC 37 during the Demonstration period.

d) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment:

i. The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:

1. Baseline measurement of EPSDT service utilization prior to the EPSDT court-ordered remedial plan in Rosie D. v Romney (the Order) final judgment and final remedial plan established on July 16, 2007;

2. Increase, following entry of the Order, in utilization of :
   a) EPSDT screenings;

b) Standardized behavioral health assessments utilizing the Child and Adolescent Needs and Strengths (CANS),or other standardized assessment tool in accordance with the Order; and
c) State Plan services available prior to the entry of the Court Order.

3. Cost and utilization of services contained in State Plan amendments submitted by the Commonwealth in accordance with the Order and approved by CMS; and

4. Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.

ii. The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in STC 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

81. **Composite Federal Share Ratio.** The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable Demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

82. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the Demonstration as adjusted July 1, 2008, rather than on an annual basis. However, if the Commonwealth exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the Commonwealth must submit a corrective action plan to CMS for approval.

| Demonstration Year | Cumulative Target Definition | Percentage |
|---|---|---|
| DY 15 | Cumulative budget neutrality limit plus: | 1 percent |
| DY 15 through DY 16 | Cumulative budget neutrality limit plus: | 0.5 percent |
| DY 15 through DY 17 | Cumulative budget neutrality limit plus: | 0 percent |

In addition, the Commonwealth may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap

indicates a possibility that the Demonstration will exceed the cap during this extension.

83. **Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds must be returned to CMS using the methodology outlined in STC 81, composite Federal share ratio. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

## XII. EVALUATION OF THE DEMONSTRATION

84. **Submission of a Draft Evaluation Design.** The Commonwealth must submit to CMS for approval a draft evaluation design no later than 120 days after CMS' approval of the Demonstration.

    At a minimum, the draft evaluation design must include a discussion of the goals, objectives, and evaluation questions specific to the entire health care reform Demonstration set forth in section II of these STCs. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the Commonwealth. The draft design must identify whether the Commonwealth will conduct the evaluation, or select an outside contractor for the evaluation.

    a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
        - The number of uninsured in the Commonwealth;
        - The number of demonstration eligibles accessing ESI;
        - Growth in the Commonwealth Care Program;
        - Decrease in uncompensated care and supplemental payments to hospitals;
        - The number of individuals accessing the Health Safety Net Trust Fund;
        - The impact of DSTI payments to participating providers on the Commonwealth's goals and objectives outlined in its master plan including:
            - Were the participating hospitals able to show statistically significant improvements on measures within Categories 1-3 related to the goals of the three-part aim as discussed in STC 49(e)(4) and pursuant to STC 52?
            - Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three-part aim as discussed in STC 49(e)(4) and pursuant to STC 52?
            - What is the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers?
            - What is the impact of the payment redesign and infrastructure investments to improve cost efficiency?

- What is the impact of DSTI on managing short and long term per-capita costs of health care?
- How did the amount paid in incentives compare with the amount of improvement achieved?

- The benefits, savings, and design viability of the Pediatric Asthma Pilot Program;
- The benefits, cost and savings of providing early intervention services for Demonstration eligible children with autism;
- The impact of utilization of Express Lane Eligibility procedures for parents and caretakers; and
- Availability of access to primary care providers.

b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the master DSTI plan, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section X of the STCs. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option considered:

i. Quantitative or qualitative outcome measures;
ii. Proposed baseline and/or control comparisons;
iii. Proposed process and improvement outcome measures and specifications;
iv. Data sources and collection frequency;
v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
vi. Cost estimates;
vii. Timelines for deliverables.

c. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

85. **Interim Evaluation Reports.** In the event the Commonwealth requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the Commonwealth must submit an interim evaluation report as part of its request for each subsequent renewal.

86. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design described in STC 84 within 60 days of receipt, and the Commonwealth shall submit a final design within 60 days after receipt of CMS comments. The

Commonwealth must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The Commonwealth must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The Commonwealth must submit the final evaluation report within 60 days after receipt of CMS comments.

87. **Cooperation with Federal Evaluators**. Should CMS undertake an evaluation of the Demonstration, the Commonwealth must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.

## XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

The State is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

| Date - Specific | Deliverable | STC Reference |
|---|---|---|
| Within 120 days from the award of the Demonstration | Draft Evaluation Design | Section XII, STC 84 |
| Within 60 days of receipt of CMS comments | Final Evaluation Design and Implementation | Section XII, STC 86 |
| January 1, 2012 | Sample Cost Report Protocols | Section VIII, STC 50(f) |
| March 30, 2012 | Cost Protocol Development Tool | Section VIII, STC 50(f) |
| July 1, 2012 | Impact Analysis of the Cost Limit Protocol | Section VIII, STC 50(f) |
| December 1, 2012 | Draft Cost Protocol | Section VIII, STC 50(f) |
| July 1, 2012 | Draft Transition Plan | Section IX, STC 60 |
| October 1, 2013 | Final Cost Limit Protocol | Section VIII, STC 50(f) |
| Within 180 days after the expiration of the Demonstration | Final Report | Section IX, STC 61 |
| **Annually** | | |
| October 1st | Draft Annual Report, including HCBS report beginning in 2012 | Section IX, STC 59<br>Section V, STC 41 |
| 30 days of the receipt of CMS comments | Final Annual Report, including DSTI reporting, and HCBS report beginning in 2012 | Section IX, STC 59<br>Section VIII, STC 53(c)<br>Section V, STC 41 |
| No later than 45 days after enactment of the State budget for each SFY | Updates to Charts A-B of Attachment E that reflect projected annual SNCP expenditures and identify the non-Federal share for each line item | Section VIII, STC 53(a) |
| No later than 45 days after enactment of the State budget for each SFY | Projected annual DSHP expenditures | Section VIII, STC 53(b) |
| 180 days after the close of the SFY (December 31st) | Updates to Charts A-B of Attachment E that reflect actual SNCP payments and expenditures | Section VIII, STC 53(a) |
| **At Least Semi-Annually** | | |
| | DSTI Hospital Reporting | Section VIII, STC 53(c) |
| **Quarterly** | | |
| 60 days following the end of the quarter | Quarterly Operational Reports, including DSTI reporting and eligible member months | Section IX, STC 58<br>Section VIII, STC 53(c)<br>Section X, STC 69 |
| | Quarterly Expenditure Reports | Section X, STC 62 |

## ATTACHMENT A
## OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

| | **Federal Poverty Level (FPL) and/or Other qualifying Criteria** | **Insurance Status upon application** | **Part of MassHealth Demonstration?** | **Funding Stream title XIX/XXI** | **Budget Neutrality Expenditure Eligibility Group (EG) Reporting** | **Demonstratio n Program** | **Comments** |
|---|---|---|---|---|---|---|---|
| Unborn Targeted Low Income Child | 0 through 200% | Uninsured | No | Separate XXI | | Healthy Start | |
| Newborn Children Under age 1 | AFDC-Poverty Level Infants<br><br>0 through 185% | Any | Yes | XIX via Medicaid State Plan | **Base Families**<br><br>*Without Waiver* | Standard | |
| | 185.1 through 200% | Insured | Yes | XIX via Medicaid State Plan | **1902(r)(2) Children**<br><br>*Without Waiver* | Standard | |
| | | Uninsured at the time of application | Yes (if XXI is exhausted) | XXI Medicaid Expansion (via Medicaid State Plan and XXI State Plan)<br><br>Funded through title XIX if XXI is exhausted | **1902(r)(2) XXI RO**<br><br>*Without Waiver*<br><br>(member months and expenditures for these children are only reported if XXI funds are exhausted) | Standard | |
| | 200.1 through 300% | Insured or in crowd-out status* | No Federally Funded eligible program | | | | |
| | | Uninsured at the time of application | No | Separate XXI | | Family Assistance | |

This chart is provided for informational purposes only.
*Crowd out status refers to children made ineligible for CHIP due to the crowd out provisions contained within title XXI.

## ATTACHMENT A
## OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

| Population | Federal Poverty Level (FPL) and/or Other qualifying Criteria | Insurance Status upon application | Part of MassHealth Demonstration? | Funding Stream title XIX/XXI | Budget Neutrality Expenditure Eligibility Group (EG) Reporting | Demonstration Program | Comments |
|---|---|---|---|---|---|---|---|
| Newborn Children Under Age 1 and Disabled | 200.1-300% | Insured or in crowd-out status* | Yes | XIX via demonstration authority only | **CommonHealth**<br><br>*Hypothetical* | CommonHealth/ Premium Assistance with wraparound to direct coverage CommonHealth | |
| | | Uninsured at the time of application | Yes (if XXI is exhausted) | Separate XXI<br><br>Funded through XIX if XXI is exhausted via demonstration authority | **CommonHealth XXI**<br><br>*Hypothetical*<br><br>(member months and expenditures for these children are only reported if XXI funds are exhausted) | CommonHealth | The CommonHealth program was in existence prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the Separate title XXI State Plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate title XXI program but expenditures are claimed under title XXI until the title XXI allotment is exhausted. |

## ATTACHMENT A
## OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

| Population | Federal Poverty Level (FPL) and/or Other qualifying Criteria | Insurance Status upon application | Part of MassHealth Demonstration? | Funding Stream title XIX/XXI | Budget Neutrality Expenditure Eligibility Group (EG) Reporting | Demonstration Program | Comments |
|---|---|---|---|---|---|---|---|
| Newborn Children Under Age 1 and Disabled (continued) | Above 300% | Any | Yes | XIX via demonstration authority only | **CommonHealth**<br><br>*Hypothetical* | CommonHealth or CommonHealth Premium Assistance With wraparound to direct coverage CommonHealth | |
| Children Ages 1 through 18<br><br>Non-disabled | AFDC-Poverty Level Children<br><br>Age 1-5: 0 through 133% FPL<br>Age 6 through 17: 0 through 114%<br>Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets | Any | Yes | XIX | **Base Families**<br><br>*Without waiver* | Standard | |
| | AFDC-Poverty Level Children<br><br>Age 6 through 17: 114.1% through 133%<br>Age 18: 0 through 133% | Insured | Yes | XIX | **Base Families**<br><br>*Without waiver* | Standard | |
| | | Uninsured | Yes (if XXI is exhausted) | XXI<br><br>XIX if XXI is exhausted | **Base Fam XXI**<br><br>(member months and expenditures for these children are only reported if XXI funds are exhausted) | Standard | |

## ATTACHMENT A
## OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

| Population | Federal Poverty Level (FPL) and/or Other qualifying Criteria | Insurance Status upon application | Part of MassHealth Demonstration? | Funding Stream title XIX/XXI | Budget Neutrality Expenditure Eligibility Group (EG) Reporting | Demonstration Program | Comments |
|---|---|---|---|---|---|---|---|
| Children Ages 1 through 18<br><br>Non-disabled (continued) | Medicaid Expansion Children Ages 1 through 18: 133.1 through 150% | Insured | Yes | XIX | **1902(r)(2) Children**<br><br>*Without waiver* | Standard | |
| | | Uninsured at the time of application | Yes (if XXI is exhausted) | XXI XIX if XXI is exhausted | **1902(r)(2) Children RO** (member months and expenditures for these children are only reported if XXI funds are exhausted) | Standard | |
| | All children Age 1 through 18: 150.1 through 200% | Insured | Yes | XIX via demonstration authority only | **E-Family Assistance** | Family Assistance Premium Assistance Direct Coverage | No additional wraparound is provided to ESI |

## ATTACHMENT A
## OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

| Population | Federal Poverty Level (FPL) and/or Other qualifying Criteria | Insurance Status upon application | Part of MassHealth Demonstration? | Funding Stream title XIX/XXI | Budget Neutrality Expenditure Eligibility Group (EG) Reporting | Demonstration Program | Comments |
|---|---|---|---|---|---|---|---|
| Children Ages 1 through 18<br><br>Non-disabled (continued) | All children Age 1 through 18: 150.1 through 200% (continued) | Uninsured at the time of application | Yes | Separate XXI<br><br>Funded through XIX if XXI is exhausted | **Fam Assist XXI RO**<br><br>(member months and expenditures for these children are only reported if XXI funds are exhausted) | Family Assistance Premium Assistance Direct Coverage | No additional wrap is provided to ESI Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the title XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under the 1115 demonstration and as authorized under the separate title XXI program, but expenditures are claimed under title XXI until the title XXI allotment is exhausted. |

## ATTACHMENT A
## OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

| Population | Federal Poverty Level (FPL) and/or Other qualifying Criteria | Insurance Status upon application | Part of MassHealth Demonstration? | Funding Stream title XIX/XXI | Budget Neutrality Expenditure Eligibility Group (EG) Reporting | Demonstration Program | Comments |
|---|---|---|---|---|---|---|---|
| Children Ages 1 through 18<br><br>Non-disabled (continued) | All children Age 1 through 18: 200.1 through 300% | Insured or in crowd-out status* | No Federally Funded eligible program | | | | |
| | | Uninsured at the time of application | No | Separate XXI | | | |
| Children Aged 1 through 18 and Disabled | 0 through 150% | Any | Yes | XIX via Medicaid State Plan | **Base Disabled**<br>*Without Waiver* | Standard | |
| | 150.1 through 300% | Insured or in crowd-out status* | Yes | XIX via Demonstration authority only | **CommonHealth**<br><br>*Hypothetical* | CommonHealth/ Premium Assistance<br><br>With wrap to direct coverage CommonHealth | |

**ATTACHMENT A**
**OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH**

| Population | Federal Poverty Level (FPL) and/or Other qualifying Criteria | Insurance Status upon application | Part of MassHealth Demonstration? | Funding Stream title XIX/XXI | Budget Neutrality Expenditure Eligibility Group (EG) Reporting | Demonstration Program | Comments |
|---|---|---|---|---|---|---|---|
| Children Aged 1 through 18 and Disabled (continued) | 150.1 through 300% (continued) | Uninsured at the time of application | Yes | Separate XXI<br><br>Funded through XIX if XXI is exhausted | **CommonHealth XXI**<br><br>*Hypothetical*<br><br>(member months and expenditures for these children are only reported if XXI funds are exhausted) | CommonHealth | The CommonHealth program was in existence prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the Separate XXI State Plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate XXI program, but expenditures are claimed under title XXI until the title XXI allotment is exhausted. |
| Children Aged 1 through 18 and Disabled | Above 300% | Any | Yes | XXI via Demonstration authority only | **CommonHealth**<br><br>*Hypothetical* | CommonHealth/ Premium Assisistance With wraparound to direct coverage CommonHealth | |

**ATTACHMENT B**
**COST SHARING**

Cost-sharing imposed upon individuals enrolled in the Demonstration varies across coverage types and by FPL. However, in general, no co-payments are charged for any benefits rendered to children under age 19 or pregnant women. Additionally, no premiums are charged to any individual enrolled in the Demonstration whose gross income is less than 150 percent of the FPL. In the event a family group contains at least two members who are eligible for different coverage types and who would otherwise be assessed two different premiums, the family shall be assessed only the highest applicable premium.

| Demonstration Program | Premiums (only for persons with family income above 150 percent of the FPL) | Co-payments |
|---|---|---|
| MassHealth Standard | $0 | All co-payments and co-payment caps are specified in the Medicaid State plan. |
| MassHealth Breast and Cervical Cancer Treatment Program | $15-$72 depending on income | MassHealth Standard co-payments apply. |
| MassHealth CommonHealth | $15 and above depending on income and family group size | MassHealth Standard co-payments apply. |
| CommonHealth Children through 300% FPL<br><br>Children with income above 300% FPL adhere to the regular CommonHealth schedule | $12-$84 depending on income and family group size | MassHealth Standard co-payments apply. |
| MassHealth Family Assistance: HIV/AIDS | $15-$35 depending on income | MassHealth Standard co-payments apply. |
| MassHealth Family Assistance: Premium Assistance | $12 per child, $36 max per family group | Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5 percent of family income |
| MassHealth Family Assistance: Direct Coverage | $12 per child, $36 max per family group | Children only-no copayments. |
| MassHealth Basic and Essential | $0 | MassHealth Standard co-payments apply |

## ATTACHMENT B
## COST SHARING

| Breast and Cervical Cancer Treatment Program Premium Schedule | |
|---|---|
| **Percent of FPL** | **Premium Cost** |
| Above 150 to 160 | $15 |
| Above 160 to 170 | $20 |
| Above 170 to 180 | $25 |
| Above 180 to 190 | $30 |
| Above 190 to 200 | $35 |
| Above 200 to 210 | $40 |
| Above 210 to 220 | $48 |
| Above 220 to 230 | $56 |
| Above 230 to 240 | $64 |
| Above 240 to 250 | $72 |

| CommonHealth Full Premium Schedule | | |
|---|---|---|
| **Base Premium** | **Additional Premium Cost** | **Range of Premium Cost** |
| Above 150% FPL—start at $15 | Add $5 for each additional 10% FPL until 200% FPL | $15 — $35 |
| Above 200% FPL—start at $40 | Add $8 for each additional 10% FPL until 400% FPL | $40 — $192 |
| Above 400% FPL—start at $202 | Add $10 for each additional 10% FPL until 600% FPL | $202 — $392 |
| Above 600% FPL—start at $404 | Add $12 for each additional 10% FPL until 800% FPL | $404 — $632 |
| Above 800% FPL—start at $646 | Add $14 for each additional 10% FPL until 1000% FPL | $646 — $912 |
| Above 1000% FPL—start at $928 | Add $16 for each additional 10% FPL | $928 + greater |

*A lower premium is required of CommonHealth members who have access to other health insurance per the schedule below.

| CommonHealth Supplemental Premium Schedule | |
|---|---|
| **% of FPL** | **Premium requirement** |
| Above 150% to 200% | 60% of full premium per listed premium costs above |
| Above 200% to 400% | 65% per above |
| Above 400% to 600% | 70% per above |
| Above 600% to 800% | 75% per above |
| Above 800% to 1000% | 80% per above |
| Above 1000% | 85% per above |

**ATTACHMENT B**
**COST SHARING**

| Insurance Partnership: Employer Subsidy | Tier of Coverage | Monthly Employer Subsidy |
|---|---|---|
| The insurance partnership also provides a monthly subsidy to qualified small employers | Individual | $33.33 |
| | Couple | $66.66 |
| | One adult, one child | $66.66 |
| | Family | $86.33 |

| Insurance Partnership: Employee Contribution | % of FPL | Premium Requirement for Individual | Premium Requirement for Couples |
|---|---|---|---|
| **Family Assistance via the Insurance Partnership** | Above 150% to 200% | $27.00 | $54.00 |
| The Insurance Partnership provides premium assistance (via the Family Assistance program) to certain employees who work for a small employer | Above 200% to 250% | $53.00 | $106.00 |
| | Above 250% to 300% | $80.00 | $160.00 |

**ATTACHMENT C**
**QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT**

Under section IX, STC 58, the Commonwealth is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration.

The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the Commonwealth. A complete quarterly progress report must include an updated budget neutrality monitoring workbook as well as updated Attachment E, Charts A-C.

**NARRATIVE REPORT FORMAT:**

**Title Line One** – MassHealth
**Title Line Two –** Section 1115 Quarterly Report

**Demonstration/Quarter Reporting Period:**
Example:
Demonstration Year: 16 (7/1/2012 – 6/30/2013)
Quarter 1: (7/12 – 09/12)

**Introduction**

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

**Enrollment Information**

Please complete the following table that outlines all enrollment activity under the demonstration. The Commonwealth should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the Commonwealth should indicate that by "0".

**Note:** Enrollment counts should be person counts, not member months.

| Eligibility Group | Current Enrollees (to date) |
|---|---|
| Base Families | |
| Base Disabled | |
| 1902(r)(2) Children | |
| 1902(r)(2) Disabled | |
| BCCTP | |
| CommonHealth | |
| Essential 19-20 | |
| CommCare 19-20 | |
| CommCareParents | |
| CommCare-133 | |

**ATTACHMENT C**
**QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT**

| Eligibility Group | Current Enrollees (to date) |
|---|---|
| **e-Family Assistance** | |
| **e-HIV/FA** | |
| **IRP** | |
| **Basic** | |
| **Essential** | |
| **MSP** | |
| **SNCP-CommCare** | |
| **Base Fam XXI RO** | |
| **1902(r)(2) XXI RO** | |
| **CommonHealth XXI** | |
| **Fam Assist XXI** | |
| **Asthma** | |
| **Autism** | |
| **Total Demonstration** | |

## Enrollment in Managed Care Organizations and Primary Care Clinician Plan

Comparative managed care enrollments for the previous quarter and reporting quarter are as follows:

Delivery System for MassHealth-Administered Demonstration Populations

| Plan Type | June 30, 2008 | September 30, 2008 | Difference |
|---|---|---|---|
| MCO | | | |
| PCC | | | |
| MBHP | | | |
| FFS | | | |
| PA | | | |

## Enrollment in Premium Assistance and Insurance Partnership Program

## Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

## Safety Net Care Pool

Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms impacting demonstration population and/or undertaken in relation to the SNCP. As per STC 58, include projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that the annual report must also include SNCP reporting as required by STCs 50 and 53.

## Operational/Issues

# ATTACHMENT C
# QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Identify all significant program developments that have occurred in the current quarter or near future, including but not limited to, approval and contracting with new plans, the operation of MassHealth and operation of the Commonwealth Health Insurance Connector Authority. Any changes to the benefits, enrollment, grievances, quality of care, access, proposed changes to payment rates, health plan financial performance that is relevant to the Demonstration, cost-sharing or delivery system for demonstration populations receiving premium assistance to purchase health insurance via the Commonwealth Health Insurance Connector Authority must be reported here.

**Policy Developments/Issues**

Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any State health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

**Financial/Budget Neutrality Development/Issues**

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the Commonwealth's actions to address these issues.

**Member Month Reporting**
Enter the member months for each of the EGs for the quarter.

**A. For Use in Budget Neutrality Calculations**

| Expenditure and Eligibility Group (EG) Reporting | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| **Base Families** | | | | |
| **Base Disabled** | | | | |
| **1902(r)(2) Children** | | | | |
| **1902(r)(2) Disabled** | | | | |
| **BCCTP** | | | | |
| **CommonHealth** | | | | |
| **Essential 19-20** | | | | |
| **CommCare 19-20** | | | | |
| **CommCareParents** | | | | |
| **CommCare133** | | | | |

**B. For Informational Purposes Only**

| Expenditure and Eligibility Group (EG) Reporting | Month 1 | Month 2 | Month 3 | Total for Quarter Ending XX/XX |
|---|---|---|---|---|
| e-HIV/FA | | | | |
| IRP | | | | |
| Basic | | | | |
| Essential | | | | |
| MSP | | | | |
| SNCP-CommCare | | | | |
| Base Fam XXI RO | | | | |
| 1902(r)(2) RO | | | | |
| CommonHealth XXI | | | | |
| Fam Assist XXI | | | | |

**Consumer Issues**

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from other consumer groups.

**Quality Assurance/Monitoring Activity**

Identify any quality assurance/monitoring activity in the current quarter.

**Demonstration Evaluation**

Discuss progress of evaluation design and planning.

**Enclosures/Attachments**

Identify by title any attachments along with a brief description of what information the document contains.

**State Contact(s)**

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

**Date Submitted to CMS**

## ATTACHMENT D
## MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

The table below lists the calculated per-member per-month (PMPM) figures by eligibility group (EG) used to develop the Demonstration budget neutrality expenditure limits for the first 14 years of the MassHealth Demonstration. All Demonstration years are consistent with the Commonwealth's fiscal year (July 1 – June 30).

After DY 5, the following changes were made to the per member/per month limits:

1. MCB EG was subsumed into the Disabled EG;
2. A new EG, BCCTP, was added; and
3. the 1902(r )(2) EG was split between children and the disabled

| DY | Time Period | Families | | Disabled | | MCB | | 1902(r)(2) Children | | 1902(r )(2) Disabled | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate |
| 1 | SFY 1998 | $199.06 | 7.71% | $491.04 | 5.83% | $438.39 | 5.83% | $177.02 | 5.33% | $471.87 | 4.40% |
| 2 | SFY 1999 | $214.41 | 7.71% | $519.67 | 5.83% | $463.95 | 5.83% | $186.49 | 5.35% | $497.12 | 4.80% |
| 3 | SFY 2000 | $230.94 | 7.71% | $549.97 | 5.83% | $491.00 | 5.83% | $196.93 | 5.60% | $524.96 | 5.50% |
| 4 | SFY 2001 | $248.74 | 7.71% | $582.03 | 5.83% | $519.62 | 5.83% | $208.16 | 5.70% | $554.88 | 5.30% |
| 5 | SFY 2002 | $267.92 | 7.71% | $615.96 | 5.83% | $549.91 | 5.83% | $220.02 | 5.70% | $586.51 | 5.70% |

| DY | Time Period | Families | | Disabled | | 1902(r)(2) Children | | 1902(r )(2) Disabled | | BCCTP | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate |
| 6 | SFY 2003 | $288.58 | 7.71% | $677.56 | 10.0% | $236.98 | 7.71% | $645.16 | 10.0% | $1,891.62 | 10.0% |
| 7 | SFY 2004 | $310.83 | 7.71% | $745.32 | 10.0% | $255.26 | 7.71% | $709.67 | 10.0% | $2,080.78 | 10.0% |
| 8 | SFY 2005 | $334.79 | 7.71% | $819.85 | 10.0% | $274.94 | 7.71% | $780.64 | 10.0% | $2,288.86 | 10.0% |
| 9 | SFY 2006 | $359.23 | 7.30% | $824.79 | 7.00% | $295.01 | 7.30% | $718.13 | 7.00% | $2,449.08 | 7.00% |
| 10 | SFY 2007 | $385.46 | 7.30% | $834.71 | 7.00% | $316.54 | 7.30% | $660.60 | 7.00% | $2,620.52 | 7.00% |
| 11 | SFY 2008 | $413.60 | 7.30% | $901.39 | 7.00% | $339.65 | 7.30% | $724.31 | 7.00% | $2,803.95 | 7.00% |

| DY | Time Period | Families | | Disabled | | 1902(r)(2) Children | | 1902(r )(2) Disabled | | BCCTP | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate | PMPM | Trend Rate |
| 12 | SFY 2009 | $466.84 | 6.95% | $1,011.95 | 6.86% | $382.45 | 6.95% | $791.46 | 6.86% | $3,052.78 | 6.86% |
| 13 | SFY 2010 | $499.05 | 6.95% | $1,081.37 | 6.86% | $407.87 | 6.95% | $846.68 | 6.86% | $3,265.69 | 6.86% |
| 14 | SFY 2011 | $533.73 | 6.95% | $1,1155.55 | 6.86% | $436.22 | 6.95% | $904.76 | 6.86% | $3,489.72 | 6.86% |

## ATTACHMENT E
## SAFETY NET CARE POOL PAYMENTS

**Safety Net Care Pool.** The following charts reflect approved payments under Safety Net Care Pool (SNCP) for the date of the approval letter through June 30, 2014, unless otherwise specified in STCs 48 and 49, consistent with and pursuant to section VIII of the STCs, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. This chart shall be updated pursuant to the process described in STC 53(a).

**Chart A: Approved SNCP Payments for the period from the date of the approval letter through June 30, 2014, unless otherwise specified in STCs 48 and 49(projected and rounded)**

| # | Type | Applicable caps | State law or regulation | Eligible providers | Total SNCP Payments per SFY | | | Total | Applicable footnotes |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | SFY 2012 | SFY 2013 | SFY 2014 | | |
| 1 | Public Service Hospital Safety Net Care Payment | Provider | | Boston Medical Center<br>Cambridge Health Alliance | $332.0 | $332.0 | $332.0 | $996.0 | (1) |
| 2 | Health Safety Net Trust Fund Safety Net Care Payment | Provider | 114.6 CMR 13.00, 14.00 | All acute hospitals | $147.4 | $159.4 | $156.3 | $463.1 | (2) |
| 3 | Institutions for Mental Disease (IMD) | Provider | 130 CMR 425.408, 114.3 CMR 46.04 | Psychiatric inpatient hospitals<br>Community-based detoxification centers | $20.0 | $22.0 | $24.0 | $66.0 | (3) |
| 4 | Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health | Provider | | Shattuck Hospital<br>Tewksbury Hospital<br>Massachusetts Hospital School<br>Western Massachusetts Hospital | $40.0 | $43.0 | $45.0 | $128.0 | (4) |
| 5 | State-Owned Non-Acute Hospitals Operated by the Department of Mental Health | Provider | | Cape Cod and Islands Mental Health Center<br>Corrigan Mental Health Center<br>Lindemann Mental Health Center<br>Quincy Mental Health Center<br>SC Fuller Mental Health Center<br>Taunton State Hospital<br>Worcester State Hospital | $70.0 | $74.0 | $77.0 | $221.0 | |
| 6 | Delivery System Transformation Initiatives | n/a | | Eligible hospitals outlined in Attachment I | $209.3 | $209.3 | $209.3 | $628.0 | (5) |
| 7 | Designated State Health Programs | DSHP | | n/a | $360.0 | $310.0 | $130.0 | $800.0 | |
| 8 | Commonwealth Care | n/a | C. 58 (2006) | n/a | $364.9 | $387.7 | $255.3 | $1,007.9 | (6) |
| 9 | Infrastructure and Capacity-Building | Infrastructure | | Hospitals and CHCs | $30.0 | $30.0 | $30.0 | $90.0 | (7) |
| | Total | | | | | | | $4,400.0 | |

# ATTACHMENT E
# SAFETY NET CARE POOL PAYMENTS

The following notes are incorporated by reference into chart A

(1) The provider-specific Public Service Hospital Safety Net Care payments approved by CMS are as follows:
For dates of service in SFY 2012: BMC, $52,000,000; CHA, $154,500,000. An additional $125,500,000 for CHA was authorized through a Demonstration amendment approved on August 17, 2011.
For dates of service in SFY 2013: BMC, $52,000,000; CHA, $280,000,000.
For dates of service in SFY 2014: BMC, $52,000,000; CHA, $280,000,000
The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment.

(2) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding.

(3) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category:; inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.

(4) Expenditures for items #4-5 in chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth.

(5) Delivery System Transformation Initiative funds will be distributed to participating hospitals pursuant to STCs 49(e) and 52.

(6) Expenditures for Commonwealth Care Premium Assistance are based on actual enrollment, capitation rates, and expected enrollee contributions, and are approved by CMS on an aggregate basis. Consequently, the amount for each year may vary. Expenditures for Commonwealth Care Premium Assistance for Hypothetical populations (CommCare-19-20, CommCareParents, and CommCare-133 EGs) are excluded from the SNCP. For the period operating under temporary extension from July 1, 2011, Commonwealth Care expenditures were funded through budget neutrality savings rather than through the SNCP expenditure authority. Therefore, the aggregate SNCP cap must be reduced by Commonwealth Care expenditures for the temporary extension period to reflect this exception.

(7) Infrastructure and Capacity-Building (ICB) funds support Commonwealth-defined health systems improvement projects, and are approved by CMS pursuant to STCs 49(d) and 50(b). Participating providers (including hospitals, community health centers, primary care practices and physicians) and provider-specific amounts are determined based on a formal request for responses (RFR) process. Spending for ICB is subject to the limit described in STC 50(b).

## ATTACHMENT E
## SAFETY NET CARE POOL PAYMENTS

**Chart B: Sources of Funding for Approved SNCP payments for the period from the date of the approval letter through June 30, 2014, unless otherwise specified in STCs 48 and 49 (projected and rounded)**

| # | Type | State law or regulation | Eligible providers | Total SNCP payments per SFY | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | SFY 2012 | Source of Non-federal share | SFY 2013 | Source of Non-federal share | SFY 2014 | Source of Non-federal share |
| 1 | Public Service Hospital Safety Net Care Payment | | Boston Medical Center<br>Cambridge Health Alliance | $332.0 | | $332.0 | | $332.0 | |
| 2 | Health Safety Net Trust Fund Safety Net Care Payment | 114.6 CMR 13.00, 14.00 | All acute hospitals | $147.4 | | $159.4 | | $156.3 | |
| 3 | Institutions for Mental Disease (IMD) | 130 CMR 425.408, 114.3 CMR 46.04 | Psychiatric inpatient hospitals<br>Community-based detoxification centers | $20.0 | | $22.0 | | $24.0 | |
| 4 | Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health | | Shattuck Hospital<br>Tewksbury Hospital<br>Massachusetts Hospital School<br>Western Massachusetts Hospital | $40.0 | | $43.0 | | $45.0 | |
| 5 | State-Owned Non-Acute Hospitals Operated by the Department of Mental Health | | Cape Cod and Islands Mental Health Center<br>Corrigan Mental Health Center<br>Lindemann Mental Health Center<br>Quincy Mental Health Center<br>SC Fuller Mental Health Center<br>Taunton State Hospital<br>Worcester State Hospital | $70.0 | | $74.0 | | $77.0 | |
| 6 | Delivery System Transformation Initiatives | | Eligible hospitals outlined in Attachment I | $209.3 | | $209.3 | | $209.3 | |
| 7 | Designated State Health Programs | | n/a | $360.0 | | $310.0 | | $130.0 | |
| 8 | Commonwealth Care | C. 58 (2006) | n/a | $364.9 | | $387.7 | | $255.3 | |
| 9 | Infrastructure and Capacity-Building for Hospitals and Community Health Centers | | Hospitals, community health centers, primary care practices and physicians | $30.0 | | $30.0 | | $30.0 | |
| | Total | | | | | | | | |

## ATTACHMENT E
## SAFETY NET CARE POOL PAYMENTS

**Designated State Health Programs (DSHP).** The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII of the STCs. Any changes to the list of programs will require an amendment pursuant to the process outlined in STC 7. This chart shall be updated pursuant to the process described in STC 53(b).

**Chart C: Approved Designated State Health Programs (DSHP)**

| Agency | Program Name |
|---|---|
| DMH | Recreational therapy services |
| DMH | Occupational therapy services |
| DMH | Individual support |
| DMH | Community Mental Health Center (CMHC) continuing care (non-inpatient) |
| DMH | Homeless support services |
| DMH | Individual and family flexible support |
| DMH | Comprehensive psychiatric services |
| DMH | Day services |
| DMH | Child/adolescent respite care services |
| DMH | Day Rehabilitation |
| DMH | Community rehabilitative support |
| DMH | Adult respite care services |
| DOC | Department of Corrections - DPH/Shattuck Hospital Services |
| DPH | Community Health Centers |
| DPH | CenterCare |
| DPH | Renal Disease |
| DPH | SANE program |
| DPH | Growth and nutrition programs |
| DPH | Prostate Cancer Prevention - Screening component |
| DPH | Hepatitis C |
| DPH | Multiple Sclerosis |
| DPH | Stroke Education and Public Awareness |
| DPH | Ovarian Cancer Screening, Education, and Prevention |
| DPH | Diabetes Screening and Outreach |
| DPH | Breast Cancer Prevention |
| DPH | Universal Immunization Program |
| DPH | Pediatric Palliative Care |
| EHS | Children's Medical Security Plan |
| ELD | Prescription Advantage |
| ELD | Enhanced Community Options (ECOP) |
| ELD | Home Care Services |
| ELD | Home Care Case Mgmt and Admin |
| ELD | Grants to Councils on Aging |
| HCF | Fisherman's Partnership |
| HCF | Community Health Center Uncompensated Care Payments |
| MCB | Turning 22 Program - personal vocational adjustment |
| MCB | Turning 22 Program - respite |
| MCB | Turning 22 Program - training |

**ATTACHMENT E**
**SAFETY NET CARE POOL PAYMENTS**

| Agency | Program Name |
|---|---|
| MCB | Turning 22 Program - co-op funding |
| MCB | Turning 22 Program - mobility |
| MCB | Turning 22 Program - homemaker |
| MCB | Turning 22 Program - client supplies |
| MCB | Turning 22 Program - vision aids |
| MCB | Turning 22 Program - medical evaluations |
| MRC | Turning 22 Services |
| MRC | Head Injured Programs |
| VET | Veterans' Benefits |

# ATTACHMENT F
# RESERVED FOR PEDIATRIC ASTHMA PILOT PROGRAM PROTOCOLS

# ATTACHMENT G
# RESERVED FOR AUTISM PAYMENT PROTOCOL

# ATTACHMENT H
# RESERVED FOR SAFETY NET CARE POOL UNCOMPENSATED CARE COST PROTOCOL

# ATTACHMENT I
# HOSPITALS ELIGIBILE FOR DSTI

Based on the eligibility criterion specified in STC 49(e)(1), the hospitals listed below are the providers who are eligible to participate in DSTI for the term of this Demonstration approval period, and may be eligible to earn incentive payments based on an initial proportional allotment indicated below as outlined in STC 49(e)(7). This is not a guarantee of funding for DSTI providers, but an initial estimate of potential allocation and actual funding will be based upon incentive payments as outlined in an approved DSTI master plan, approved hospital specific DSTI plan and approved DSTI payment and funding protocol pursuant to STC 52,

| **Participating Hospital** | **Initial Proportional Allotment Participating Hospitals Maybe Eligible to Earn through Incentive Payments** | |
|---|---|---|
| | Foundational Amount of Funding | Relative Share of Medicaid and Low-Income Public Payer GPSR |
| Public Acute Hospital: | | |
| Cambridge Health Alliance | $4 million | $130.6 million |
| | | |
| Private Acute Hospitals: | | |
| Boston Medical Center | $4 million | $306.7 million |
| Holyoke Medical Center | $4 million | $20.5 million |
| Lawrence General Hospital | $4 million | $39.3 million |
| Mercy Medical Center | $4 million | $41.6 million |
| Signature Healthcare Brockton Hospital | $4 million | $46.1 million |
| Steward Carney Hospital | $4 million | $15.2 million |

# ATTACHMENT J
# RESERVED FOR MASTER DSTI PLAN AND REIMSBURSEMENT AND FUNDING PROTOCOL