Table of Contents

State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: MA-18-0011-CHIP

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

July 19, 2021

Amanda Cassel Kraft
Assistant Secretary for MassHealth
Commonwealth of Massachusetts, Department of Health and Human Services, Office of Medicaid
1 Ashburn Place, 11th Floor Room 1109
Boston, MA 02108

Dear Ms. Kraft:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) MA-18-0011-CHIP submitted on June 26, 2018 has been approved. MA-18-0011-CHIP implements mental health parity requirements to ensure that treatment limitations applied to mental health (MH) and substance use disorder (SUD) benefits are no more restrictive than those applied to medical/surgical (M/S) benefits effective October 2, 2017.

MassHealth Family Assistance
Section 2103(c)(7)(A) of the Social Security Act (the Act), as implemented through regulations at 42 CFR 457.496(d)(3)-(5), requires states that provide both M/S and MH/SUD benefits to ensure that treatment limitations applied to MH/SUD benefits covered under the state child health plan are consistent with the mental health parity requirements of section 2705(a) of the Public Health Service Act, in the same manner that such requirements apply to a group health plan. For its MassHealth Family Assistance program, Massachusetts demonstrated compliance by providing the necessary assurances and supporting documentation that the state's application of non-quantitative treatment limitations to MH/SUD benefits are consistent with section 2103(c)(7)(A) of the Act.

CommonHealth and Unborn
Section 2103(c)(7)(B) of the Act, as implemented through regulations at 42 CFR 457.496(b), provides that if CHIP coverage includes Early, Periodic Screening, Diagnostic and Treatment (EPSDT) as defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the state plan will be deemed to satisfy parity requirements. For its CommonHealth and unborn programs, Massachusetts has provided the necessary assurances and supporting documentation that EPSDT is covered under Massachusetts's CHIP program and provided in accordance with sections 1905(r) and 1902(a)(43) of the Act.

This approval relates only to benefits provided under the CHIP state plan; Medicaid benefits will be analyzed separately.

Your title XXI project officer is Tess Hines. Tess is available to answer questions concerning this amendment and other CHIP-related issues. Tess's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-0435
Mary.Hines@cms.hhs.gov

If you have any questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky
Deputy Director

SPA #13 (in MMDL as 014-0013) (CS7, CS9, CS15 CHIP MAGI Eligibility and Income)
Submission date: March 28, 2014 through the MMDL
Approval date; September 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #14 (in MMDL as 014-0006) (CS17-21, CS28 CHIP non-financial eligibility)
Submission date: March 28, 2014 through the MMDL
Approval date: September 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

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

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

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

SPA #18 (Parity) (TN-018-0011)
Submission date: June 26, 2018
Approval date:
Effective date: October 2, 2017
Implementation date: October 2, 2017

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

Verification of Tribal Consultation is attached.

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

Our Title XXI Medicaid expansion group is newborns 185.1% FPL up to 200% FPL, children ages 1-5 133.1% FPL up to 150% FPL, children ages 6-17 114.1% FPL up to 150% FPL and children age 18 up to 150% FPL. These children are in MassHealth Standard and receive the Medicaid benefit package. **[MA-014-0003 MMDL (CS3) and MA-014-0005 (CS14) MMDL supersede the age and income language above].**

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

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

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

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

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

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

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

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

existing comprehensive state-based coverage.

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

6.1.4.1. ☒ Coverage of all benefits that are provided to children that is the same as the benefits provided under the Medicaid State plan, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) and applicable additional coverage described in the Services Related Expenditures and related Special Terms and Conditions in the Massachusetts 1115 demonstration project (no. 11-w-00030) for Medicaid expansion children who are in MassHealth Standard and unborn CHIP children who are in MassHealth Standard, except that unborn CHIP children are not eligible for Premium Assistance.

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

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

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

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

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

6.2.18. ☒ Vision screenings and services **(Section 2110(a)(24))**

6.2.19. ☒ Hearing screenings and services **(Section 2110(a)(24))**

6.2.~~18~~20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.~~19~~21. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.2~~0~~2. ☐ Case management services **(Section 2110(a)(20))**

6.2.2~~1~~3. ☐ Care coordination services **(Section 2110(a)(21))**

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6.2.2~~4~~4. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**
Includes individual treatment, comprehensive evaluation, and group therapy.

6.2.2~~3~~5. ☒ Hospice care **(Section 2110(a)(23))**

6.2.2~~4~~6. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**
Inpatient chronic or rehabilitation limited to 100 days, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services.

6.2.2~~5~~7. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.2~~6~~8. ☒ Medical transportation **(Section 2110(a)(26))**
Emergency ambulance only.

6.2.2~~7~~9. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.~~28~~30. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**
Chapter 766: home assessment and participation in team meetings
Chiropractic services
Applied Behavior Analysis services. .

See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.31. ☐ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

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Covered services for MassHealth CommonHealth

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

6.2.18. ☒ Vision screenings and services **(Section 2110(a)(24))**

6.2.19. ☒ Hearing screenings and services **(Section 2110(a)(24))**

6.2.~~18~~20. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.~~19~~21. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.2~~0~~2. ☒ Case management services **(Section 2110(a)(20))**

6.2.2~~1~~3. ☒ Care coordination services **(Section 2110(a)(21))**

6.2.2~~2~~4. ☒ Physical therapy, occupational therapy, and services for individuals with

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speech, hearing, and language disorders **(Section 2110(a)(22))**
Includes individual treatment, comprehensive evaluation, and group therapy.

6.2.2~~3~~5. ☒ Hospice care **(Section 2110(a)(23))**

6.2.2~~4~~6. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**
Includes inpatient and outpatient rehabilitation and chronic disease hospital services, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services

6.2.2~~5~~7. ☒ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.2~~6~~8. ☒ Medical transportation **(Section 2110(a)(26))**
Includes emergency and non-emergency ambulance.

6.2.2~~7~~9. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**
Medically necessary transportation by taxi, or chair car to a MassHealth provider for a MassHealth covered service.

6.2.~~28~~30. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**
Adult Day Health services
Chapter 766: home assessment and participation in team meetings
Chiropractic services
Applied Behavior Analysis services

See guidance for Section 6.1.4.1 for guidance on the statutory requirements for EPSDT under sections 1905(r) and 1902(a)(43) of the Act. If the benefit being provided does not meet the EPSDT statutory requirements, do not check the box below.

6.2.31. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

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6.2 Covered services for Unborn Children

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

~~MassHealth~~ The State uses a bundled payment methodology which pays for prenatal services, Labor and Delivery and one postpartum visit. The bundled payment is billed on the date of birth of the baby so the postpartum visit is prepaid. If the State~~MassHealth~~ is unable to use a bundled payment for any reason, the services are paid fee-for-service.

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

6.2- MHPAEA Section 2103(c)(6)(A) of the Social Security Act requires that, to the extent that it provides both medical/surgical benefits and mental health or substance use disorder benefits, a State child health plan ensures that financial requirements and treatment limitations applicable to mental health and substance use disorder benefits comply with the mental health parity requirements of section 2705(a) of the Public Health Service Act in the same manner that such requirements apply to a group health plan. If the state child health plan provides for delivery of services through a managed care arrangement, this requirement applies to both the state and managed care plans. These requirements are

also applicable to any additional benefits provided voluntarily to the child health plan population by managed care entities and will be considered as part of CMS's contract review process at 42 CFR 457.1201(l).

6.2.1- MHPAEA Before completing a parity analysis, the State must determine whether each covered benefit is a medical/surgical, mental health, or substance use disorder benefit based on a standard that is consistent with state and federal law and generally recognized independent standards of medical practice. (42 CFR 457.496(f)(1)(i))

6.2.1.1- MHPAEA Please choose the standard(s) the state uses to determine whether a covered benefit is a medical/surgical benefit, mental health benefit, or substance use disorder benefit. The most current version of the standard elected must be used. If different standards are used for different benefit types, please specify the benefit type(s) to which each standard is applied. If "Other" is selected, please provide a description of that standard.

☒ International Classification of Disease (ICD)

☐ Diagnostic and Statistical Manual of Mental Disorders (DSM)

☐ State guidelines (Describe:)

☒ Other (Describe: the State used a combination of ICD 10 diagnosis code and service level differentiation to distinguish behavioral health services from medical/surgical services.)

6.2.1.2- MHPAEA Does the State provide mental health and/or substance use disorder benefits?

☒ Yes

☐ No

Guidance: If the State does not provide any mental health or substance use disorder benefits, the mental health parity requirements do not apply ((42 CFR 457.496(f)(1)). Continue on to Section 6.3.

6.2.2- MHPAEA Section 2103(c)(6)(B) of the Social Security Act (the Act) provides that to the extent a State child health plan includes coverage of early and periodic screening, diagnostic, and treatment

services (EPSDT) defined in section 1905(r) of the Act and provided in accordance with section 1902(a)(43) of the Act, the plan shall be deemed to satisfy the parity requirements of section 2103(c)(6)(A) of the Act.

6.2.2.1- MHPAEA Does the State child health plan provide coverage of EPSDT? The State must provide for coverage of EPSDT benefits, consistent with Medicaid statutory requirements, as indicated in section 6.2.26 of the State child health plan in order to answer "yes."

☒ Yes

☐ No

Guidance: If the State child health plan *does not* provide EPSDT consistent with Medicaid statutory requirements at sections 1902(a)(43) and 1905(r) of the Act, please go to Section 6.2.3- MHPAEA to complete the required parity analysis of the State child health plan.

If the state *does* provide EPSDT benefits consistent with Medicaid requirements, please continue this section to demonstrate compliance with the statutory requirements of section 2103(c)(6)(B) of the Act and the mental health parity regulations of 42 CFR 457.496(b) related to deemed compliance. Please provide supporting documentation, such as contract language, provider manuals, and/or member handbooks describing the state's provision of EPSDT.

6.2.2.2- MHPAEA EPSDT benefits are provided to the following:

☐ All children covered under the State child health plan.

☒ A subset of children covered under the State child health plan.

Please describe the different populations (if applicable) covered under the State child health plan that are provided EPSDT benefits consistent with Medicaid statutory requirements.

Unborn CHIP children and CHIP CommonHealth children are provided EPSDT benefits consistent with Medicaid statutory requirements.

Guidance: If only a subset of children are provided EPSDT benefits under the

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State child health plan, 42 CFR 457.496(b)(3) limits deemed compliance to those children only and Section 6.2.3- MHPAEA must be completed as well as the required parity analysis for the other children.

6.2.2.3- MHPAEA To be deemed compliant with the MHPAEA parity requirements, States must provide EPSDT in accordance with sections 1902(a)(43) and 1905(r) of the Act (42 CFR 457.496(b)). The State assures each of the following for children eligible for EPSDT under the separate State child health plan:

- All screening services, including screenings for mental health and substance use disorder conditions, are provided at intervals that align with a periodicity schedule that meets reasonable standards of medical or dental practice as well as when medically necessary to determine the existence of suspected illness or conditions. (Section 1905(r))

- All diagnostic services described in 1905(a) of the Act are provided as needed to diagnose suspected conditions or illnesses discovered through screening services, whether or not those services are covered under the Medicaid state plan. (Section 1905(r))

- All items and services described in section 1905(a) of the Act are provided when needed to correct or ameliorate a defect or any physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State plan. (Section 1905(r)(5))

- Treatment limitations applied to services provided under the EPSDT benefit are not limited based on a monetary cap or budgetary constraints and may be exceeded as medically necessary to correct or ameliorate a medical or physical condition or illness. (Section 1905(r)(5))

- Non-quantitative treatment limitations, such as definitions of medical necessity or criteria for medical necessity, are applied in an individualized manner that does not

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preclude coverage of any items or services necessary to correct or ameliorate any medical or physical condition or illness. (Section 1905(r)(5))

EPSDT benefits are not excluded on the basis of any condition, disorder, or diagnosis. (Section 1905(r)(5))

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The provision of all requested EPSDT screening services, as well as any corrective treatments needed based on those screening services, are provided or arranged for as necessary. (Section 1902(a)(43))

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All families with children eligible for the EPSDT benefit under the separate State child health plan are provided information and informed about the full range of services available to them. (Section 1902(a)(43)(A))

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Guidance: For states seeking deemed compliance for their entire State child health plan population, please continue to Section 6.3. If not all of the covered populations are offered EPSDT, the State must conduct a parity analysis of the benefit packages provided to those populations. Please continue to 6.2.3- MHPAEA.

Mental Health Parity Analysis Requirements for States Not Providing EPSDT to All Covered Populations

Guidance: The State must complete a parity analysis for each population under the State child health plan that is not provided the EPSDT benefit consistent with the requirements 42 CFR 457.496(b). If the State provides benefits or limitations that vary within the child or pregnant woman populations, states should perform a parity analysis for each of the benefit packages. For example, if different financial requirements are applied according to a beneficiary's income, a separate parity analysis is needed for the benefit package provided at each income level.

Please ensure that changes made to benefit limitations under the State child health plan as a result of the parity analysis are also made in Section 6.2.

6.2.3- MHPAEA In order to conduct the parity analysis, the State must place all medical/surgical and

mental health and substance use disorder benefits covered under the State child health plan into one of four classifications: Inpatient, outpatient, emergency care, and prescription drugs. (42 CFR 457.496(d)(2)(ii); 42 CFR 457.496(d)(3)(ii)(B))

6.2.3.1 MHPAEA Please describe below the standard(s) used to place covered benefits into one of the four classifications.

Our parity workgroup, composed of clinical, policy, program and legal representatives, reviewed the list of MassHealth covered services to determine whether they should be classified as inpatient, outpatient, emergency or prescription drug. The parity workgroup determined that traditional inpatient hospital services as well as other services provided in 24-hour facilities (e.g., 24-hour hospice, 24-hour diversionary services) should be categorized as "inpatient" while traditional outpatient and other services (e.g., office visits, supplies, non-24 hour diversionary services, etc.) should be categorized as "outpatient". Emergency care was classified to include those services needed to address emergency medical conditions and/or mental health crises (i.e., emergency services, emergent transportation, Emergency Services Program and Youth Mobile Crisis). In making these classifications, the parity workgroup was agnostic to whether the service was medical/surgical or behavioral health.

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The state classifies prescription medications based on therapeutic class codes identified in First Data Bank. The state uses evidence based medicine, and consensus guidelines to identify where drugs fit into treatment for a given disease state. The state uses ICD-10 codes to identify prescription drug benefits to treat mental health/substance use disorders vs. those to treat medical/surgical disorders.

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6.2.3.1.1 MHPAEA The State assures that:

☒ The State has classified all benefits covered under the State plan into one of the four classifications.

☒ The same reasonable standards are used for determining the classification for a mental health or substance use disorder benefit as are used for determining the classification of medical/surgical benefits.

6.2.3.1.2- MHPAEA Does the State use sub-classifications to distinguish between office visits and other outpatient services?

☐ Yes

☒ No

6.2.3.1.2.1- MHPAEA If the State uses sub-classifications to distinguish between outpatient office visits and other outpatient services, the State assures the following:

☐ The sub-classifications are only used to distinguish office visits from other outpatient items and services, and are not used to distinguish between similar services on other bases (ex: generalist vs. specialist visits).

Guidance: For purposes of this section, any reference to "classification(s)" includes sub-classification(s) in states using sub-classifications to distinguish between outpatient office visits from other outpatient services.

6.2.3.2 MHPAEA The State assures that:

☒ Mental health/ substance use disorder benefits are provided in all classifications in which medical/surgical benefits are provided under the State child health plan.

Guidance: States are not required to cover mental health or substance use disorder benefits (42 CFR 457.496(f)(2)). However if a state does provide any mental health or substance use disorder benefits, those mental health or substance use disorder benefits must be provided in all the same classifications in which medical/surgical benefits are covered under the State child health plan (42 CFR 457.496(d)(2)(ii).

Annual and Aggregate Lifetime Dollar Limits

6.2.4- MHPAEA A State that provides both medical/surgical benefits and mental health and/or substance use disorder benefits must comply with parity requirements related to annual and aggregate lifetime dollar limits for benefits covered under the State child health plan. (42 CFR 457.496(c))

6.2.4.1- MHPAEA Please indicate whether the State applies an aggregate lifetime dollar limit and/or an annual dollar limit on any mental health or substance abuse disorder benefits covered under the State child health plan.

☐ Aggregate lifetime dollar limit is applied

☐ Aggregate annual dollar limit is applied

☒ No dollar limit is applied

Guidance: A monetary coverage limit that applies to *all* CHIP services provided under the State child health plan is not subject to parity requirements.

If there are no aggregate lifetime or annual dollar limits on any mental health or substance use disorder benefits, please go to section 6.2.5- MHPAEA.

6.2.4.2- MHPAEA Are there any medical/surgical benefits covered under the State child health plan that have either an aggregate lifetime dollar limit or an annual dollar limit? If yes, please specify what type of limits apply.

☐ Yes (Type(s) of limit:)

☒ No

Guidance: If no aggregate lifetime dollar limit is applied to medical/ surgical benefits, the State may not impose an aggregate lifetime dollar limit on *any* mental health or substance use disorder benefits. If no aggregate annual dollar limit is applied to medical/surgical benefits, the State may not impose an aggregate annual dollar limit on *any* mental health or substance use disorder benefits. (42 CFR 457.496(c)(1))

6.2.4.3 – MHPAEA. States applying an aggregate lifetime or annual dollar limit on medical/surgical benefits and mental health or substance use disorder benefits must determine whether the portion of the medical/surgical benefits to which the limit applies is less than one-third, at least one-third but less than two-thirds, or at least two-thirds of all medical/surgical benefits covered under the State plan (42 CFR 457.496(c)). The portion of medical/surgical benefits subject to the limit is based on the dollar amount expected to be paid for all medical/surgical benefits under the State plan for the State plan year or portion of the plan year after a change in benefits that affects the applicability of the aggregate lifetime or annual dollar

limits. (42 CFR 457.496(c)(3))

☐ The State assures that it has developed a reasonable methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit, as applicable.

Guidance: Please include the state's methodology to calculate the portion of covered medical/surgical benefits which are subject to the aggregate lifetime and/or annual dollar limit and the results as an attachment to the State child health plan.

6.2.4.3.1- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to a lifetime dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

6.2.4.3.2- MHPAEA Please indicate the portion of the total costs for medical and surgical benefits covered under the State plan which are subject to an annual dollar limit:

☐ Less than 1/3

☐ At least 1/3 and less than 2/3

☐ At least 2/3

Guidance: If an aggregate lifetime limit is applied to less than one-third of all medical/surgical benefits, the State may not impose an aggregate lifetime limit on *any* mental health or substance use disorder benefits. If an annual dollar limit is applied to less than one-third of all medical surgical benefits, the State may not impose an annual dollar limit on *any* mental health or substance use disorder benefits (42 CFR 457.496(c)(1)). Skip to section 6.2.5-MHPAEA.

If the State applies an aggregate lifetime or annual dollar limit to at least

one-third of all medical/surgical benefits, please continue below to provide the assurances related to the determination of the portion of total costs for medical/surgical benefits that are subject to either an annual or lifetime limit.

6.2.4.3.2.1- MHPAEA If the State applies an aggregate lifetime or annual dollar limit to at least 1/3 and less than 2/3 of all medical/surgical benefits, the State assures the following (42 CFR 457.496(c)(4)(i)(B)); (42 CFR 457.496(c)(4)(ii)):

☐ The State applies an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits.

Guidance: The state's methodology for calculating the average limit for medical/surgical benefits must be consistent with 42 CFR 457.496(c)(4)(i)(B) and 42 CFR 457.496(c)(4)(ii). Please include the state's methodology and results as an attachment to the State child health plan.

6.2.4.3.2.2- MHPAEA If at least 2/3 of all medical/surgical benefits are subject to an annual or lifetime limit, the State assures either of the following (42 CFR 457.496(c)(2)(i)); (42 CFR 457.496(c)(2)(ii)):

☐ The aggregate lifetime or annual dollar limit is applied to both medical/surgical benefits and mental health and substance use disorder benefits in a manner that does not distinguish between medical/surgical benefits and mental health and substance use disorder benefits; or

☐ The aggregate lifetime or annual dollar limit placed on mental health and substance use disorder benefits is no more restrictive than the aggregate lifetime or annual dollar limit on medical/surgical benefits.

Quantitative Treatment Limitations

6.2.5- MHPAEA Does the State apply quantitative treatment limitations (QTLs) on any mental health or substance use disorder benefits in any classification of benefits? If yes, specify the classification(s) of benefits in which the State applies one or more QTLs on any mental health or substance use disorder benefits.

☐ Yes (Specify:

☒ No

Guidance: If the state does not apply any type of QTLs on any mental health or substance use disorder benefits in any classification, the state meets parity requirements for QTLs and should continue to Section 6.2.6 - MHPAEA. If the state does apply QTLs to any mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue.

6.2.5.1- MHPAEA Does the State apply any type of QTL on any medical/surgical benefits?

☐ Yes

☐ No

Guidance: If the State does not apply QTLs on any medical/surgical benefits, the State may not impose quantitative treatment limitations on mental health or substance use disorder benefits, please go to Section 6.2.6- MHPAEA related to non-quantitative treatment limitations.

6.2.5.2- MHPAEA Within each classification of benefits in which the State applies a type of QTL on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the classification which are subject to the limitation. More specifically, the State must determine the ratio of (a) the dollar amount of all payments expected to be paid under the State plan for medical and surgical benefits within a classification which are subject to the type of quantitative treatment limitation for the plan year (or portion of the plan year after a mid-year change affecting the applicability of a type of quantitative

treatment limitation to any medical/surgical benefits in the class) to (b) the dollar amount expected to be paid for all medical and surgical benefits within the classification for the plan year. For purposes of this paragraph, all payments expected to be paid under the State plan includes payments expected to be made directly by the State and payments which are expected to be made by MCEs contracting with the State. (42 CFR 457.496(d)(3)(i)(C))

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above for each classification within which the State applies QTLs to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results as an attachment to the State child health plan.

6.2.5.3- MHPAEA For each type of QTL applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of QTL to "substantially all" (defined as at least two-thirds) of the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of QTL to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose that type of QTL on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

6.2.5.3.1- MHPAEA For each type of QTL applied to mental health or substance use disorder benefits, the State must determine the predominant level of that type which is applied to medical/surgical benefits in the classification. The "predominant level" of a type of QTL in a classification is the level (or least restrictive of a combination of levels) that applies to more than one-half of the medical/surgical benefits in that classification, as described in 42 CFR 457.496(d)(3)(i)(B). The portion of medical/surgical benefits in a classification to which a given level of a QTL type is applied is based on the dollar amount of payments expected to be paid for medical/surgical benefits subject to that level as compared to all medical/surgical benefits in the classification, as described in 42 CFR 457.496(d)(3)(i)(C). For each type of quantitative treatment limitation applied to mental

health or substance use disorder benefits, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used to determine whether substantially all medical/surgical benefits within a classification are subject to a type of quantitative treatment limitation also is applied in determining the dollar amounts used to determine the predominant level of a type of quantitative treatment limitation applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of quantitative treatment limitation applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of QTL that exceeds the one-half threshold, the State may combine levels within a type of QTL such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

Non-Quantitative Treatment Limitations

6.2.6- MHPAEA The State may utilize non-quantitative treatment limitations (NQTLs) for mental health or substance use disorder benefits, but the State must ensure that those NQTLs comply with all the mental health parity requirements. (42 CFR 457.496(d)(4)); (42 CFR 457.496(d)(5))

6.2.6.1 – MHPAEA If the State imposes any NQTLs, complete this subsection. If the State does not impose NQTLs, please go to Section 6.2.7-MHPAEA.

☒ The State assures that the processes, strategies, evidentiary standards or other factors used in the application of any NQTL to mental health or substance use disorder benefits are no more stringent than the processes, strategies, evidentiary standards or other factors used in the application of NQTLs to medical/surgical benefits within the same classification.

Guidance: Examples of NQTLs include medical management standards to limit or exclude benefits based on medical necessity, restrictions based on geographic location, provider specialty, or other criteria to limit the scope or duration of benefits and provider network design (ex: preferred providers vs. participating providers). Additional examples of possible NQTLs are provided in 42 CFR 457.496(d)(4)(ii). States will need to provide a summary of its NQTL analysis, as well as supporting documentation as requested.

6.2.6.2 – MHPAEA The State or MCE contracting with the State must comply with parity if they provide coverage of medical or surgical benefits furnished by out-of-network providers.

6.2.6.2.1- MHPAEA Does the State or MCE contracting with the State provide coverage of medical or surgical benefits provided by out-of-network providers?

☒ Yes

☐ No

Guidance: The State can answer no if the State or MCE only provides out of network services in specific circumstances, such as emergency care, or when the network is unable to provide a necessary service covered under the contract.

6.2.6.2.2- MHPAEA If yes, the State must provide access to out-of-network providers for mental health or substance use disorder benefits. Please assure the following:

☒ The State attests that when determining access to out-of-network providers within a benefit classification, the processes, strategies, evidentiary standards, or other factors used to determine access to those providers for mental health/ substance use disorder benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards or other factors used to determine access for out- of-network providers for medical/surgical benefits.

Availability of Plan Information

6.2.7- MHPAEA The State must provide beneficiaries, potential enrollees, and providers with information related to medical necessity criteria and denials of payment or reimbursement for mental health or substance use disorder services (42 CFR 457.496(e)) in addition to existing notice requirements at 42 CFR 457.1180.

6.2.7.1- MHPAEA Medical necessity criteria determinations must be made available to any current or potential enrollee or contracting provider, upon request. The state attests that the following entities provide this information:

- ☐ State
- ☒ Managed Care entities
- ☐ Both
- ☐ Other

Guidance: If other is selected, please specify the entity.

6.2.7.2- MHPAEA Reason for any denial for reimbursement or payment for mental health or substance use disorder benefits must be made available to the enrollee by the health plan or the State. The state attests that the following entities provide denial information:

- ☐ State
- ☒ Managed Care entities
- ☐ Both
- ☐ Other

Guidance: If other is selected, please specify the entity.

8.4.1- MHPAEA ☒ There is no separate accumulation of cumulative financial requirements, as defined in 42 CFR 457.496(a), for mental health and substance abuse disorder benefits compared to medical/surgical benefits. (42 CFR 457.496(d)(3)(iii))

8.4.2- MHPAEA ☒ If applicable, any different levels of financial requirements that are applied to different tiers of prescription drugs are determined based on reasonable factors, regardless of whether a drug is generally prescribed for medical/surgical benefits or mental health/substance use disorder benefits. (42 CFR 457.496(d)(3)(ii)(A))

8.4.3- MHPAEA ☒ Cost sharing applied to benefits provided under the State child health plan will remain capped at five percent of the beneficiary's income as required by 42 CFR 457.560 (42 CFR 457.496(d)(3)(i)(D)).

8.4.4- MHPAEA Does the State apply financial requirements to any mental health or substance use disorder benefits? If yes, specify the classification(s) of benefits in which the State applies financial requirements on any mental health or substance use disorder benefits.

☐ Yes (Specify:)

☒ No

Guidance: For the purposes of parity, financial requirements include deductibles, copayments, coinsurance, and out of pocket maximums; premiums are excluded from the definition. If the state does not apply financial requirements on any mental health or substance use disorder benefits, the state meets parity requirements for financial requirements. If the state does apply financial requirements to mental health or substance use disorder benefits, the state must conduct a parity analysis. Please continue below.

Please ensure that changes made to financial requirements under the State child health plan as a result of the parity analysis are also made in Section 8.2.

8.4.5- MHPAEA Does the State apply any type of financial requirements on any medical/surgical benefits?

☐ Yes

☒ No

Guidance: If the State does not apply financial requirements on any medical/surgical benefits, the State may not impose financial requirements on mental health or substance use disorder benefits.

8.4.6- MHPAEA Within each classification of benefits in which the State applies a type of financial requirement on any mental health or substance use disorder benefits, the State must determine the portion of medical and surgical benefits in the class which are subject to the limitation.

☐ The State assures it has applied a reasonable methodology to determine the dollar amounts used in the ratio described above (Section 6.2.5.2-MHPAEA) for each classification or within which the State applies financial requirements to mental health or substance use disorder benefits. (42 CFR 457.496(d)(3)(i)(E))

Guidance: Please include the state's methodology and results of the parity analysis as an attachment to the State child health plan.

8.4.7- MHPAEA For each type of financial requirement applied to any mental health or substance use disorder benefits within a given classification, does the State apply the same type of financial requirement to at least two-thirds ("substantially all") of all the medical/surgical benefits within the same classification? (42 CFR 457.496(d)(3)(i)(A))

☐ Yes

☐ No

Guidance: If the State does not apply a type of financial requirement to substantially all medical/surgical benefits in a given classification of benefits, the State may *not* impose financial requirements on mental health or substance use disorder benefits in that classification. (42 CFR 457.496(d)(3)(i)(A))

8.4.8- MHPAEA For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State must determine the predominant level (as defined in 42 CFR 457.496(d)(3)(i)(B)) of that type which is applied to medical/surgical benefits in the classification. For each type of financial requirement applied to substantially all medical/surgical benefits in a classification, the State assures:

☐ The same reasonable methodology applied in determining the dollar amounts used in determining whether substantially all medical/surgical benefits within a classification are subject to a type of financial requirement also is applied in determining the dollar amounts used to determine the predominant level of a type of financial requirement applied to medical/surgical benefits within a classification. (42 CFR 457.496(d)(3)(i)(E))

☐ The level of each type of financial requirement applied by the State to mental health or substance use disorder benefits in any classification is no more restrictive than the predominant level of that type which is applied by the State to medical/surgical benefits within the same classification. (42 CFR 457.496(d)(2)(i))

Guidance: If there is no single level of a type of financial requirement that exceeds the one-half threshold, the State may combine levels within a type of financial requirement such that the combined levels are applied to at least half of all medical/surgical benefits within a classification; the predominant level is the least restrictive level of the levels combined to meet the one-half threshold. (42 CFR 457.496(d)(3)(i)(B)(2))

9.10 Provide a 1-year projected budget.
A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

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

Table 9-1 on page ~~11~~ 12 provides projected CHIP expenditures for FFY 2018~~2012~~ The non-federal share of the funds is all state funds. ~~with one exception: The Commonwealth received a four year grant on February 17, 2009 from the Robert Wood Johnson (RWJ) Foundation to support MassHealth's increased enrollment and retention of children. The Commonwealth will use the RWJ grant as state matching funds.~~ The state funds are appropriated annually from the Commonwealth's General Fund.

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

Section 9. Strategic Objectives and Performance Goals and Plan Administration

CHIP Amendment #17	CHIP Parity~~ABA~~	Cost Projections of Approved CHIP Plan	Total
	FFY20186	FFY 20186	FFY 20186
State's enhanced FMAP rate	88.00%	88.00%	88.00%
Benefit Costs			
Insurance payments	~~$421,060~~	$~~8,982,350~~4,429,177	$4,429,177 ~~$9,403,409~~
Managed Care	~~$10,105,428~~	$~~284,042,058~~341,796,439	$341,796,439 ~~$294,147,486~~
per member/per month rate @ # of eligible	~~$9~~	$~~338~~323	$323 ~~$347~~
Fee for Service	~~$0~~	$~~207,276,783~~354,026,096	$354,026,096 ~~$207,276,783~~
Total Benefit Costs	~~$10,526,488~~	$~~500,301,191~~700,251,712	$700,251,712 ~~$510,827,679~~
(offsetting beneficiary cost sharing payments)	~~$0~~	$0	$0
Net Benefit Costs	~~$10,526,488~~$0	$~~500,301,191~~700,251,712	$~~510,827,679~~700,251,712
Administrative Costs			
Personnel	~~$0~~	$0	$0
General Administration	~~$0~~	$~~10,007,508~~22,323,494	$~~10,007,508~~22,323,494
Contractors/Brokers	~~$0~~	$0	$0
Claims Processing	~~$0~~	$0	$0
Outreach/marketing costs	~~$0~~	$0	$0
Other (H.S.I.)	~~$0~~	$~~43,000,000~~54,561,970	$54,561,970 ~~$43,000,000~~
Total Administrative Costs	$0	$~~53,007,508~~76,885,464	$76,885,464 ~~$53,007,508~~
10% Administrative Cap	~~$1,169,610~~	$~~55,589,021~~77,805,746	$77,805,746 ~~$56,758,631~~
Federal Share	~~$9,263,309~~	$~~486,911,655~~683,880,715	$683,880,715 ~~$496,174,965~~
State Share	~~$1,263,179~~	$~~66,397,044~~93,256,461	$93,256,461~~67,660,222~~
TOTAL COSTS OF APPROVED CHIP PLAN	$~~10,526,488~~0	$~~553,308,699~~777,137,176	$~~563,835,187~~777,137,176

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