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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: MA-22-0016

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

June 30, 2023

Mike Levine
Assistant Secretary for MassHealth
Commonwealth of Massachusetts,
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Mike:

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) number MA-22-0016, submitted on June 30, 2022 with additional information received on June 22, 2023, has been approved. MA-22-0016 was effective on July 1, 2021.

SPA MA-22-0016 increases the limits for inpatient rehabilitation, chronic disease hospital services, and nursing facility services from 100 days to six months before prior authorization is required. The SPA also makes the following changes to section 8 of the state plan related to cost sharing:

- Clarifies that enrollees in the conception to birth population are not assessed premiums, consistent with current state practice;
- Sets the income limit threshold for pregnant individuals that are not subject to premiums to 200 percent of the Federal Poverty Level (FPL);
- Applies premium payments to pregnant individuals in MassHealth Family Assistance and CommonHealth with incomes above 200 percent of the FPL;
- Describes in more detail the state's procedures to ensure that cost sharing for CHIP beneficiaries does not exceed 5% of the family's income; and
- Adds a financial hardship waiver that families may apply for to reduce their premium amount or exempt them from premium payments for a 12-month period.

Your Project Officer is Tess Hines. Tess is available to answer your questions concerning this amendment and other CHIP-related matters. Tess's contact information is as follows:

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

If you have additional 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 Sarah deLone/

Director

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

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

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

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

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

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

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

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

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

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

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

1.3 ☒ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age

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Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

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

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

SPA #27 (Policy Updates) (TN 022-016)
Submission date: June 30, 2022
Approval date:
Effective dates:
Cost Sharing Updates: July 1, 2021
CDRH and NF Services Update: November 1, 2021

Implementation dates:
Cost Sharing: July 1, 2021
CDRH and NF Services Update: November 1, 2021

1.4 Superseding Pages of MAGI CHIP State Plan Material

State: Massachusetts

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
MA-14-0013 **Approval Date: 09/22/2014** **Effective/Implementation Date: January 1, 2014**	MAGI Eligibility & Methods	CS7 CS9 CS15	Eligibility – Targeted Low Income Children Eligibility - Coverage From Conception to Birth MAGI-Based Income Methodologies	Supersedes sections Geographic Area 4.1.1, Age 4.1.2, all but the "transfer of income" language in Income 4.1.3 and the prenatal language in 4.1.9
MA-14-0003 **Approval Date: 12/22/2014** **Effective/Implementation Date: January 1, 2014**	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes Medicaid Expansion eligibility information in section 6
MA-14-0005 **Approval Date: 04/15/2014** **Effective/Implementation Date: January 1, 2014**	Establish 2101(f) Group	CS14	Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards	A reference to this SPA is included in the Medicaid Expansion eligibility portion of section 6
MA-13-0026 **Approval Date: 05/05/2014** **Effective/Implementation Date: October 1, 2013**	Eligibility Processing	CS24	Eligibility Process	Supersedes all of section 4.3 except for the precedence language pertaining to Medicaid and the richest benefits and all of section 4.4 except for the Express Lane Renewal language

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
MA-14-0006 **Approval Date: 09/22/2014** **Effective/Implementation Date: January 1, 2014**	Non-Financial Eligibility	CS17	Non-Financial Eligibility – Residency	Supersedes section 4.1.5, with the exception of the 2 scenario examples
		CS18	Non-Financial Eligibility – Citizenship	Supersedes the citizenship and immigration language in 4.1.9
		CS19	Non-Financial Eligibility – Social Security Number	Supersedes the social security number language in 4.1.9
		CS20	Non-Financial Eligibility – Substitution of Coverage	Supersedes section 4.4.4
		CS21	Non-Financial Eligibility – Non-Payment of Premiums	Supersedes section 8.7
		CS28	Non-Financial Eligibility – Presumptive Eligibility for Children	Supersedes the language on Presumptive Eligibility for Standard and Family Assistance in sections 4.1.9 and 4.3

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
MA-22-0015 **Approval Date: 07/26/2022** **Effective/Implementation Date: April 1, 2022**	Non-Financial Eligibility	CS27	General Eligibility – Continuous Eligibility	Supersedes language related to postpartum coverage timeframe in section 4.1.8

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.

Section 4. Eligibility Standards and Methodology

Guidance: States electing to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan or combination plan should check the appropriate box and provide the ages and income level for each eligibility group. If the State is electing to take up the option to expand Medicaid eligibility as allowed under section 214 of CHIPRA regarding lawfully residing, complete section 4.1-LR as well as update the budget to reflect the additional costs if the state will claim title XXI match for these children until and if the time comes that the children are eligible for Medicaid.

4.0. ☒ Medicaid Expansion

4.0.1. Ages of each eligibility group and the income standard for that group:

See approved MMDL CS3 which describes the age and income standards for Medicaid Expansion. Expansion children are eligible for Standard.

4.1. ☒ Separate Program Check all standards that will apply to the State plan. (42CFR 457.305(a) and 457.320(a))

4.1.0 ☒ Describe how the State meets the citizenship verification requirements. Include whether or not State has opted to use SSA verification option.

See approved MMDL CS18, which describes how the State meets the citizenship verification requirements.

4.1.1. ☐ Geographic area served by the Plan if less than statewide:

4.1.2. ☒ Ages of each eligibility group, including unborn children and pregnant women (if applicable) and the income standard for that group:

4.1.2.1-PC ☒ Age: through birth (SHO #02-004, issued November 12, 2002)

4.1.3. ☒ Income of each separate eligibility group (if applicable):

4.1.3.1-PC ☒ 0% of the FPL (and not eligible for Medicaid) through % of the FPL (SHO #02-004, issued November 12, 2002)

See approved MMDL CS7 and CS9, which describe the ages and income standards for targeted low-income and unborn children.

Uninsured pregnant women who are otherwise not eligible for Standard are eligible for Standard through the unborn child coverage type from 0% FPL up to and including 200% FPL.

Uninsured disabled children who are not eligible for Standard and have incomes within the limits described in CS7 are eligible for CommonHealth up to and including 300 % FPL.
*Note that disabled children are covered under the 1115 waiver regardless of income.

Uninsured non-disabled children who are not eligible for Standard and have incomes within the limits described in CS7 are eligible for Family Assistance up to and including 300% FPL.

See 4.4.4.1 and 6.4.2 which describes Premium Assistance.

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

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

See approved MMDL CS17, which describes the residency requirements.

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

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

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

See approved MMDL CS7, which describes eligibility standards related to disability.

See 4.1.3.1-PC above which describes CommonHealth children.

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

See approved MMDL CS20, which describes policies related to substitution of coverage.

The state operates a premium assistance program that is mandatory for all CHIP children, including their families, if proven to be cost effective.

4.1.8. ☒ Duration of eligibility, not to exceed 12 months:

A pregnant woman who has been determined eligible for MassHealth Standard, including under the unborn child option, shall continue to be eligible for the duration of her pregnancy and the twelve calendar months following the month in which her pregnancy ends, regardless of any subsequent changes in family group income.

4.1.9. ☒ Other Standards - Identify and describe - other standards for or affecting eligibility, including those standards in 457.310 and 457.320 that are not addressed above. For instance:

Transfer of Income

All family group members are required to avail themselves of all potential

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

Assignment of Rights to Medical Support and Third Party Payments

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

The applicant or member must provide MassHealth with information to help pursue any medical support and source of third party payment, including support available from the absent parent, who is legally obligated to pay for care and services for the applicant/member and/or for person(s) on whose behalf benefits are requested unless he or she can show good cause not to provide this information.

Refusing to comply with the requirements of this section will exclude the applicant or member from receipt of MassHealth benefits unless the applicant or member is a pregnant women/ mother of an unborn child.

The MassHealth agency will not deny or terminate eligibility of any applicant or member who cannot legally assign his or her own rights, including, but not limited to, a minor child, and who would otherwise be eligible but for the refusal, by a person legally able to assign the child's rights, to assign the child's rights or to cooperate.

Good Cause for Non-cooperation

(1) The MassHealth agency finds that cooperation is against the best interest of the child with respect to the obligation to establish paternity of a child born out of wedlock, obtain medical care support and payments, or identify or provide information to assist the MassHealth agency in pursuing a liable third party for a child for whom the applicant or member can legally assign rights; or
(2) the MassHealth agency finds that cooperation is not in the best interest of the applicant or member or the person for whom the benefit

is being requested or furnished because it is anticipated that cooperation will result in reprisal against, and cause serious physical or emotional harm to the applicant or member or another person with respect to the obligation to cooperate.

Good cause for non-cooperation includes, but is not limited to, any of the following circumstances regarding the child of the applicant or member:

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

Assignment for Third Party Recoveries

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

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

Guidance: States may only require the SSN of the child who is applying for coverage. If SSNs are required and the State covers unborn children,

indicate that the unborn children are exempt from providing a SSN. Other standards include, but are not limited to presumptive eligibility and deemed newborns.

4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN) are required.

See approved MMDL CS19 which describes requirements related to Social Security Numbers

See approved MMDL CS28 which excludes Social Security Numbers for Hospital Presumptive Eligibility

See approved MMDL CS9 which excludes Social Security Numbers for Unborn Children.

Guidance: States should describe their continuous eligibility process and populations that can be continuously eligible.

4.1.9.2 ☐ Continuous eligibility

4.1-PW ☐ **Pregnant Women Option** (section 2112)- The State includes eligibility for one or more populations of targeted low-income pregnant women under the plan. Describe the population of pregnant women that the State proposes to cover in this section. Include all eligibility criteria, such as those described in the above categories (for instance, income and resources) that will be applied to this population. Use the same reference number system for those criteria (for example, 4.1.1-P for a geographic restriction). Please remember to update sections 8.1.1-PW, 8.1.2-PW, and 9.10 when electing this option.

Guidance: States have the option to cover groups of "lawfully residing" children and/or pregnant women. States may elect to cover (1) "lawfully residing" children described at section 2107(e)(1)(J) of the Act; (2) "lawfully residing" pregnant women described at section 2107(e)(1)(J) of the Act; or (3) both. A state electing to cover children and/or pregnant women who are considered lawfully residing in the U.S. must offer coverage to all such individuals who meet the definition of lawfully residing, and may not cover a subgroup or only certain groups. In addition, states may not cover these new groups only in CHIP, but must also extend the coverage option to Medicaid. States will need

to update their budget to reflect the additional costs for coverage of these children. If a State has been covering these children with State only funds, it is helpful to indicate that so CMS understands the basis for the enrollment estimates and the projected cost of providing coverage. Please remember to update section 9.10 when electing this option.

4.1-LR ☒ **Lawfully Residing Option** (Sections 2107(e)(1)(J) and 1903(v)(4)(A); (CHIPRA # 17, SHO # 10-006 issued July 1, 2010) Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) regarding lawfully residing to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

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

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

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

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

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

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

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

(vi) Aliens currently in deferred action status; or

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

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
(6) An alien who has been granted withholding of removal under the Convention Against Torture;
(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa. .

☐ Elected for pregnant women.
☒ Elected for children under age _19__

4.1..1-LR ☒ The State provides assurance that for individuals whom it enrolls in Medicaid under the CHIPRA Lawfully Residing option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

4.1-DS ☐ **Supplemental Dental** (Section 2103(c)(5) - A child who is eligible to enroll in dental-only supplemental coverage, effective January 1, 2009. Eligibility is limited to only targeted low-income children who are otherwise eligible for CHIP but for the fact that they are enrolled in a group health plan or health insurance offered through an employer. The State's CHIP plan income eligibility level is at least the highest income eligibility standard under its approved State child health plan (or under a waiver) as of January 1, 2009. All who meet the eligibility standards and apply for dental-only supplemental coverage shall be provided benefits. States choosing this option must report these children separately in SEDS. Please update sections 1.1-DS, 4.2-DS, and

9.10 when electing this option.

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

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.
4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income. This applies to pregnant women included in the State plan as well as targeted low-income children.
4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition. This applies to pregnant women included in the State plan as well as targeted low-income children.

4.2-DS Supplemental Dental - Please update sections 1.1-DS, 4.1-DS, and 9.10 when electing this option. For dental-only supplemental coverage, the State assures that it has made the following findings with standards in its plan: (Section 2102(b)(1)(B) and 42 CFR 457.320(b))

4.2.1-DS ☐ These standards do not discriminate on the basis of diagnosis.
4.2.2-DS ☐ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3-DS ☐ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. **Methodology** Describe the methods of establishing eligibility and continuing enrollment. The description should address the procedures for applying the eligibility standards, the organization and infrastructure responsible for making and reviewing eligibility determinations, and the process for enrollment of individuals receiving covered services, and whether the State uses the same application form for Medicaid and/or other public benefit programs. (Section 2102)(b)(2)) (42CFR, 457.350) **(Section 2102)(b)(2)) (42CFR 457.350)**

See CS24 which describes eligibility processing.

The Commonwealth's single streamlined application for insurance

affordability programs can be submitted to the Massachusetts Health Insurance Exchange (HIX) via an online website, in person, by phone, by mail, or by fax. Regardless of point of entry all MassHealth applications are processed through the HIX.

The Agency also has a verification plan template which describes the data matching process for eligibility and redeterminations.

At the State's discretion, requirements related to timely processing of renewals and/or deadlines for families to respond to renewal requests may be temporarily waived for CHIP beneficiaries who reside and/or work in a State or Federally declared disaster area. Implementation date is 3/18/20 for COVID-19 public health emergency (PHE).

During the COVID-19 PHE only, the state will temporarily increase the number of Presumptive Eligibility (PE) periods from one to two within a 12-month period, beginning with the start date of the first PE period. Implementation date is 3/18/20 for COVID-19 public health emergency.

During the COVID-19 PHE and for the period through the last day of the month in which the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof) end, the State will temporarily delay acting on certain changes in circumstances for CHIP beneficiaries whom the state determines are impacted by the COVID-19 PHE such that processing the change in a timely manner is not feasible. The state will continue to act on the required changes in circumstance described in 42 CFR 457.342(a) cross-referencing 42 CFR 435.926(d).". Implementation date is 3/18/20 for COVID-19 public health emergency.

Guidance: The box below should be checked as related to children and pregnant women. Please note: A State providing dental-only supplemental coverage may not have a waiting list or limit eligibility in any way.

4.3.1. Limitations on Enrollment Describe the processes, if any, that a State will use for instituting enrollment caps, establishing waiting lists , and deciding which children will be given priority for enrollment. If this section does not apply to your state, check the box below. (Section 2102(b)(2)) (42CFR, 457.305(b))

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

Guidance: Note that for purposes of presumptive eligibility, States do not need to verify the citizenship status of the child. States electing this option should indicate so in the State plan. (42 CFR 457.355)

4.3.2. ☒ Check if the State elects to provide presumptive eligibility for children that meets the requirements of section 1920A of the Act. (Section 2107(e)(1)(L)); (42 CFR 457.355)

See approved MMDL CS28 for information on hospital presumptive eligibility for CHIP members.

Guidance: Describe how the State intends to implement the Express Lane option. Include information on the identified Express Lane agency or agencies, and whether the State will be using the Express Lane eligibility option for the initial eligibility determinations, redeterminations, or both.

4.3.3-EL Express Lane Eligibility ☒ Check here if the state elects the option to rely on a finding from an Express Lane agency when determining whether a child satisfies one or more components of CHIP eligibility. The state agrees to comply with the requirements of sections 2107(e)(1)(E) and 1902(e)(13) of the Act for this option. Please update sections 4.4-EL, 5.2-EL, 9.10, and 12.1 when electing this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2013. (Section 2107(e)(1)(E))

4.3.3.1-EL Also indicate whether the Express Lane option is applied to (1) initial eligibility determination, (2) redetermination, or (3) both.

(2) redetermination

4.3.3.2-EL List the public agencies approved by the State as Express Lane agencies.

The Massachusetts Department of Transitional Assistance in the administration of the Supplemental Nutrition Assistance Program (SNAP).

4.3.3.3-EL List the components/components of CHIP eligibility that are determined under the Express Lane. In this section, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between CHIP eligibility determinations for such children and the determination under the Express Lane option.

Massachusetts uses Express Lane Eligibility for renewals for Medicaid Expansion CHIP and CHIP-eligible unborn children up to 150% FPL for MassHealth eligibility and allows for an additional 30 percentage points to this FPL as allowed under the screen and enroll provision to set the SNAP eligibility threshold of 180% FPL.

The following summarizes differences in methodology between Medicaid and SNAP:

Budget Unit:
For Medicaid Expansion CHIP and CHIP unborn children

- The MassHealth agency uses Modified Adjusted Gross Income (MAGI) household composition subject to its state plan and 1115 demonstration waiver in determining eligibility.

For SNAP

The household consists of

(1) the individual;
(2) the individual's spouse if living with him or her;
(3) the individual's natural, adopted, and stepchildren younger than 22 years old if living with him or her;
(4) any child under 18 over whom the individual exercises care and control; and
(5) a group of individuals living together who purchase food and prepare meals together.

Income Limit:
For Medicaid Expansion CHIP - MAGI household income:

- Income above 133 % FPL to at or below 150% FPL for children age 1 to 6;
- Income above 114 % FPL to at or below 150 % FPL for children age 6 to 18; and
- Income 0 % FPL to at or below 150 % FPL for children age 18 to 19.

For CHIP Unborn Children – MAGI household income:
Unborn CHIP children are eligible at 0% FPL to at or below 200 %FPL but will be included in the Express Lane process only to at or below 150% FPL.

For SNAP-
Gross income at or below 200% FPL for most households (see 106 CMR 365.180 for

exceptions). Households that contain an elderly or senior member do not have a gross income limit.

Income Disregards:
For Medicaid Expansion CHIP and CHIP Unborn Children-

- The MassHealth agency uses Modified Adjusted Gross income subject to its state plan and 1115 demonstration waiver in determining eligibility, including all authorized income disregards and exclusions.

For SNAP-

- Income disregards are used to determine benefit level, not eligibility, for all SNAP households included in this process except for those with an elderly or disabled member and gross household income above 200% FPL.
- For households with an elderly or disabled member and gross income above 200% FPL, a 100% net income threshold must be met by using the following disregards:
  - Standard disregard determined according to household size;
  - Earned income deduction equal to 20% of gross monthly earned income;
  - Excess medical deduction for unreimbursed medical expenses in excess of $35 a month for households with elderly or disabled members;
  - Amount of actual dependent care expenses;
  - Legally obligated child support payments;
  - If homeless, shelter/utility deduction of $143 per month;
  - If not homeless, shelter expenses and utility costs in excess of 50% of the household's income after all other deductions are allowed, up to a capped amount unless the household has an elderly/disabled member.

Income Exclusions:
For Medicaid Expansion CHIP and CHIP Unborn Children -
The MassHealth agency uses Modified Adjusted Gross Income (MAGI) subject to its state plan and 1115 demonstration waiver in determining eligibility, including all authorized income disregards and exclusions.

For SNAP-

- In-kind income and cash contributions;
- Vendor payments (money payment not payable directly to the household);
- Infrequent irregular incomes not in excess of $30 per recipient per quarter;
- Educational loans, grants, and scholarships;
- Other loans including loans from private individuals and commercial institutions;
- Reimbursements for past or future expenses that do not exceed actual expenses and do not represent a gain or benefit to the household;

- Monies received and used for the care and maintenance of a third party beneficiary who is not a household member;
- Earnings of elementary or secondary school students;
- Nonrecurring lump sum payments;
- Cost of producing self-employment income;
- Income excluded by law;
- Income of nonhousehold members, except when nonhousehold member has been disqualified per certain regulations;
- Payments made to SNAP/ET participants for education and/or training-related expenses;
- Income of SSI recipients necessary for fulfilment of PASS;
- Legally obligated child support payments.

4.3.3.4-EL Describe the option used to satisfy the screen and enrollment requirements before a child may be enrolled under title XXI.

Please see 4.4-EL

Guidance: States should describe the process they use to screen and enroll children required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 457.80(c). Describe the screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by an Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated. Describe whether the State is temporarily enrolling children in CHIP, based on the income finding from an Express Lane agency, pending the completion of the screen and enroll process.

In this section, states should describe their eligibility screening process in a way that addresses the five assurances specified below. The State should consider including important definitions, the relationship with affected Federal, State and local agencies, and other applicable criteria that will describe the State's ability to make assurances. (Sections

2102(b)(3)(A) and 2110(b)(2)(B)), (42 CFR 457.310(b)(2), 42CFR 457.350(a)(1) and 457.80(c)(3))

4.4. **Eligibility screening and coordination with other health coverage programs.** States must describe how they will assure that:

4.4.1. ☒ only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A) and 2110(b)(2) (B)); (42CFR 457.310(b), 42CFR 457.350(a)(1) and 457.80(c)(3))** . Confirm that the State does not apply a waiting period for pregnant women.

See approved MMDL CS24 for a description of eligibility screening that includes this assurance.

See approved MMDL CS20 which describes policies related to substitution of coverage

The state does not cover pregnant women through CHIP so the confirmation about not applying a waiting list for this population is N/A.

4.4.2. ☒ children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan are enrolled for assistance under such plan; **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

See approved MMDL CS24 for a description of screen and enroll.

4.4.3. ☒ children found through the screening process to be ineligible for Medicaid are enrolled in CHIP. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

See approved MMDL CS24

MassHealth uses an automated eligibility system to place children in the richest benefit category for which they are eligible. A child who is eligible for Medicaid

will automatically be placed in a Title XIX aid category.

4.4.4 ☒ The insurance provided under the state child health plan does not substitute for coverage under group health plans. **(Section 2102)(b)(3)(C)) (42CFR 457.805)**

See approved MMDL CS20, which describes policies related to substitution of coverage

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

1) The minimum period without coverage under a group health plan. This should include any allowable exceptions to the waiting period; 2) the expected minimum level of contribution employers will make; and 3) how cost effectiveness is determined. (42CFR 457.810(a)-(c).

See 6.4.2 for a description of Purchase of Family Coverage.

The state does not apply a waiting period to premium assistance.

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

MassHealth does not discriminate on the basis of ethnicity when determining eligibility for MassHealth programs. Alaska Native and American Indians who are members of a federally recognized tribe are not required to pay premiums, copays or any other cost sharing.

Guidance: When the State is using an income finding from an Express Lane agency, the State must still comply with screen and enroll requirements before enrolling children in CHIP. The State may either continue its current screen and enroll process, or elect one

of two new options to fulfill these requirements.

4.4-EL The State should designate the option it will be using to carry out screen and enroll requirements:

☐ The State will continue to use the screen and enroll procedures required under section 2102(b)(3)(A) and (B) of the Social Security Act and 42 CFR 457.350(a) and 42 CFR 457.80(c). Describe this process.

☒ The State is establishing a screening threshold set as a percentage of the Federal poverty level (FPL) that exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points. (NOTE: The State may set this threshold higher than 30 percentage points to account for any differences between the income calculation methodologies used by the Express Lane agency and those used by the State for its Medicaid program. The State may set one screening threshold for all children, based on the highest Medicaid income threshold, or it may set more than one screening threshold, based on its existing, age-related Medicaid eligibility thresholds.) Include the screening threshold(s) expressed as a percentage of the FPL, and provide an explanation of how this was calculated.

The screening threshold is 180% FPL. Massachusetts uses Express Lane Eligibility for renewals for Medicaid Expansion CHIP and CHIP-eligible unborn children up to 150% FPL for MassHealth eligibility and allows for an additional 30 percentage points to this FPL as allowed under the screen and enroll provision to set the SNAP eligibility threshold of 180% FPL.

☐ The State is temporarily enrolling children in CHIP, based on the income finding from the Express Lane agency, pending the completion of the screen and enroll process.

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

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

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); **(42CFR 457.410(a))**

Guidance: Benchmark coverage is substantially equal to the benefits coverage in a benchmark benefit package (FEHBP-equivalent coverage, State employee coverage, and/or the HMO coverage plan that has the largest insured commercial, non-Medicaid enrollment in the state). If box below is checked, either 6.1.1.1., 6.1.1.2., or 6.1.1.3. must also be checked. (Section 2103(a)(1))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is the standard Blue Cross/Blue Shield preferred provider option service benefit plan, as described in and offered under Section 8903(1) of Title 5, United States Code. (Section 2103(b)(1) (42 CFR 457.420(b))

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

Guidance: Check box below if the benchmark benefit package to be offered by the State is State employee coverage, meaning a coverage plan that is offered and generally available to State employees in the state. (Section 2103(b)(2))

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

Guidance: Check box below if the benchmark benefit package to be offered by the State is offered by a health maintenance organization (as defined in Section 2791(b)(3) of the Public Health Services Act) and has the largest insured commercial, non-Medicaid enrollment of covered lives of such coverage plans offered by an HMO in the state. (Section 2103(b)(3) (42 CFR 457.420(c)))

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.

Guidance: States choosing Benchmark-equivalent coverage must check the box below and ensure that the coverage meets the following requirements:

- the coverage includes benefits for items and services within each of the categories of basic services described in 42 CFR 457.430:
  - dental services
  - inpatient and outpatient hospital services,
  - physicians' services,
  - surgical and medical services,
  - laboratory and x-ray services,
  - well-baby and well-child care, including age-appropriate immunizations, and
  - emergency services;
- the coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages (FEHBP-equivalent coverage, State employee coverage, or coverage offered through an HMO coverage plan that has the largest insured commercial enrollment in the state); and
- the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the additional categories in such package, if offered, as described in 42 CFR 457.430:
  - coverage of prescription drugs,
  - mental health services,
  - vision services and
  - hearing services.

If 6.1.2. is checked, a signed actuarial memorandum must be attached. The actuary who prepares the opinion must select and specify the standardized set and population to be used under paragraphs (b)(3) and (b)(4) of 42 CFR 457.431. The State must provide sufficient detail to explain the basis of the methodologies used to estimate the actuarial value or, if requested by CMS, to

replicate the State results.

The actuarial report must be prepared by an individual who is a member of the American Academy of Actuaries. This report must be prepared in accordance with the principles and standards of the American Academy of Actuaries. In preparing the report, the actuary must use generally accepted actuarial principles and methodologies, use a standardized set of utilization and price factors, use a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan, apply the same principles and factors in comparing the value of different coverage (or categories of services), without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used, and take into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage. (Section 2103(a)(2))

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. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

Guidance: A State approved under the provision below, may modify its program from time to time so long as it continues to provide coverage at least equal to the lower of the actuarial value of the coverage under the program as of August 5, 1997, or one of the benchmark programs. If "existing comprehensive state-based coverage" is modified, an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of August 5, 1997, or one of the benchmark plans must be attached. Also, the fiscal year 1996 State expenditures for "existing comprehensive state-based coverage" must be described in the space provided for all states. (Section 2103(a)(3))

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive state-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the

value as of August 5, 1997 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

Guidance: Secretary-approved coverage refers to any other health benefits coverage deemed appropriate and acceptable by the Secretary upon application by a state. (Section 2103(a)(4)) (42 CFR 457.250)

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

Guidance: Section 1905(r) of the Act defines EPSDT to require coverage of (1) any medically necessary screening, and diagnostic services, including vision, hearing, and dental screening and diagnostic services, consistent with a periodicity schedule based on current and reasonable medical practice standards or the health needs of an individual child to determine if a suspected condition or illness exists; and (2) all services listed in section 1905(a) of the Act that are necessary to correct or ameliorate any defects and mental and physical illnesses or conditions discovered by the screening services, whether or not those services are covered under the Medicaid state plan. Section 1902(a)(43) of the Act requires that the State (1) provide and arrange for all necessary services, including supportive services, such as transportation, needed to receive medical care included within the scope of the EPSDT benefit and (2) inform eligible beneficiaries about the services available under the EPSDT benefit.

If the coverage provided does not meet all of the statutory requirements for EPSDT contained in sections 1902(a)(43) and 1905(r) of the Act, do not check this box.

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 Diagnosis 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.

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

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

6.1.4.3. ☐ Coverage that the state has extended to the entire Medicaid population

Guidance: Check below if the coverage offered includes benchmark coverage, as specified in 457.420, plus additional coverage. Under this option, the State must clearly demonstrate that the coverage it provides includes the same coverage as the benchmark package, and also describes the services that are being added to the benchmark package.

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida (under 457.440)

Guidance: Check below if the State is purchasing coverage through a group health plan, and intends to demonstrate that the group health plan is substantially equivalent to or greater than to coverage under one of the benchmark plans specified in 457.420, through use of a benefit-by-benefit comparison of the coverage. Provide a sample of the comparison format that will be used. Under this option, if coverage for any benefit does not meet or exceed the coverage for that benefit under the benchmark, the State must provide an actuarial analysis as described in 457.431 to determine actuarial equivalence.

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

Guidance: Check below if the State elects to provide a source of coverage that is not described above. Describe the coverage that will be offered, including any benefit limitations or exclusions.

6.1.4.7. ☐ Other (Describe)

Guidance: All forms of coverage that the State elects to provide to children in its plan must be checked. The State should also describe the scope, amount and duration of services covered under its plan, as well as any exclusions or limitations. States that choose to cover unborn children under the State plan should include a separate section 6.2 that specifies benefits for the unborn child population. (Section 2110(a)) (42CFR, 457.490)

If the state elects to cover the new option of targeted low income pregnant women, but chooses to provide a different benefit package for these pregnant women under the CHIP plan, the state must include a separate section 6.2 describing the benefit package for pregnant women. (Section 2112)

6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

Covered services for MassHealth Family Assistance - Direct Coverage

Non-disabled children who are not eligible for MassHealth Standard and who are in families with income up to and including 300% FPL are enrolled in MassHealth Family Assistance. Those who do not have access to cost effective Employer Sponsored Insurance (ESI) may 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, private duty nursing (also known as independent nurse) and adult day health services are not covered and this population is not eligible for EPSDT. Inpatient rehabilitation and chronic disease hospital services and Nursing Facility services are limited to six months (after the six month limit is reached, prior authorization can be obtained to request additional services). Certain services listed below are covered only following prior authorization based on medical necessity.

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

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

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

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

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

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

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

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

imagery (MRI), and radiological services.

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

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

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

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

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

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

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

Guidance: Nursing services may include nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services in a home, school or other setting.

6.2.13. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**
Includes nurse practitioner services and nurse midwife services and excludes private duty nursing (also known as independent nurse).

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

6.2.15. ☒ Dental services **(Section 2110(a)(17))** States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.

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

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

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

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

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

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

6.2.20. ☒ 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.

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

Guidance: See guidance for section 6.1.4.1 for a 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 this box.

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

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. **(Section 2110(a)(24))**
Inpatient and outpatient rehabilitation and chronic disease hospital services (inpatient limited to six months, after the six month limit is reached, prior authorization can be obtained to request additional services), early intervention services, oxygen and respiratory therapy services, podiatry services, and chiropractic services.

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

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

Guidance: Enabling services, such as transportation, translation, and outreach services,

may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

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

6.2.27. ☒ 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.
Applied Behavior Analysis services.
Nursing Facility services (limited to six months, after the six month limit is reached, prior authorization can be obtained to request additional services).

Covered services for MassHealth CommonHealth – Direct Coverage

Disabled children with income up to and including 300% FPL who do not qualify for MassHealth Standard are enrolled in CommonHealth. Those who do not have access to cost effective Employer Sponsored Insurance (ESI) may receive direct coverage. Children above 300% FPL gain eligibility only through the 1115 waiver. 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. Certain services listed below are covered only following prior authorization based on a finding of medical necessity.

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

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

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

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

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

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

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

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

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

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

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

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

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

requirements described in the Provider Regulations.

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

Guidance: Home and community based services may include supportive services such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home.

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

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

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

6.2.15. ☒ Dental services **(Section 2110(a)(17))** States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)

Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.

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

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

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

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

6.2.18. ☒ Case management services **(Section 2110(a)(20))**

6.2.19. ☒ Care coordination services **(Section 2110(a)(21))**

6.2.20. ☒ 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.

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

Guidance: See guidance for section 6.1.4.1 for a 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 this box.

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

6.2.22.1 ☐ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

Guidance: Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic or rehabilitative service may be provided, whether in a facility, home, school, or other setting, if recognized by State law and only if the service is: 1) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as prescribed by State law; 2) performed under the general supervision or at the direction of a physician; or 3) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

6.2.23. ☒ 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, and chiropractic services

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

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

Guidance: Enabling services, such as transportation, translation, and outreach services, may be offered only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

6.2.26. ☒ 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.

6.2.27. ☒ 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
Applied Behavior Analysis services
Nursing Facility services

Covered services for MassHealth CHIP Members - Premium Assistance

Uninsured children enrolled in CommonHealth CHIP and Family Assistance, who have access to cost effective Employer Sponsored Insurance (ESI) may be eligible to receive Premium Assistance with wrap coverage for CommonHealth, and Family Assistance services not covered by the ESI plan for the benefits they would otherwise receive through direct coverage, upon enrollment in the ESI. They also receive cost sharing wrap assistance to ensure they are not required to contribute more towards the cost of their ESI than they would otherwise pay for MassHealth CommonHealth, and Family Assistance direct coverage.

[Note: Uninsured Medicaid Expansion Children who have access to cost effective ESI receive Premium Assistance as described in the Medicaid State Plan for Standard children.

Note: Premium Assistance for Children in Medicaid Expansion, CommonHealth and Family Assistance who are insured at time of application are described under the 1115 demonstration.]

6.2 Covered services for Unborn Children

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.

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 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-DC **Dental Coverage** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC Periodicity Schedule. The State has adopted the following periodicity schedule:

- ☐ State-developed Medicaid-specific
- ☒ American Academy of Pediatric Dentistry
- ☐ Other Nationally recognized periodicity schedule
- ☐ Other (description attached)

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT

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codes)

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2110(b)(5)(C)(ii)). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

Guidance: Under Title XXI, pre-existing condition exclusions are not allowed, with the only exception being in relation to another law in existence (HIPAA/ERISA). Indicate that the plan adheres to this requirement by checking the applicable description.

In the event that the State provides benefits through a group health plan or group health coverage, or provides family coverage through a group health plan under a waiver (see Section 6.4.2.), pre-existing condition limits are allowed to the extent permitted by HIPAA/ERISA. If the State is contracting with a group health plan or provides benefits through group health coverage, describe briefly any limitations on pre-existing conditions. (Formerly 8.6.)

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 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 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))

☒ 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))

☒ 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))

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.

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.

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.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the

following two statements applies to its plan: **(42CFR 457.480)**

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

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.6.2 (formerly 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA. (Formerly 8.6) (Section 2103(f)). Describe:

Guidance: States may request two additional purchase options in Title XXI: cost effective coverage through a community-based health delivery system and for the purchase of family coverage. (Section 2105(c)(2) and (3)) (457.1005 and 457.1010)

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

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

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

6.4.1.2. The cost of such coverage must not be greater, on an average per

child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

Guidance: Check below if the State is requesting to provide cost-effective coverage through a community-based health delivery system. This allows the State to waive the 10 percent limitation on expenditures not used for Medicaid or health insurance assistance if coverage provided to targeted low-income children through such expenditures meets the requirements of Section 2103; the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under Section 2103; and such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under Section 330 of the Public Health Services Act or with hospitals such as those that receive disproportionate share payment adjustments under Section 1886(c)(5)(F) or 1923.

If the cost-effective alternative waiver is requested, the State must demonstrate that payments in excess of the 10 percent limitation will be used for other child health assistance for targeted low-income children; expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); expenditures for outreach activities as provided in Section 2102(c)(1) under the plan; and other reasonable costs incurred by the State to administer the plan. (42CFR, 457.1005(a))

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

Guidance: Check 6.4.2.if the State is requesting to purchase family coverage. Any State requesting to purchase such coverage will need to include information that establishes to the Secretary's satisfaction that: 1) when compared to the amount of money that would have been paid to cover only the children involved with a comparable package, the purchase of family coverage is cost effective; and 2) the purchase of family coverage is not a substitution for coverage already being provided to the child. (Section 2105(c)(3)) (42CFR 457.1010)

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

Access to Health Insurance

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

The Basic Benefit Level requires that a Premium Assistance-eligible health insurance plan include a broad range of medical benefits as defined in the minimum creditable coverage core services requirements in state regulations. In addition, any services provided under the CHIP state plan, but not covered under the range of medical benefits defined in the minimum creditable coverage core services requirements, would be wrapped by MassHealth.

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

- MassHealth has determined it is cost effective for both MassHealth and the policy holder to purchase the insurance.

If it is determined that, after the MassHealth estimated premium assistance amount has been applied to the cost of the health insurance premium, the remaining cost to the family is greater than 5% of the family's gross income, then the family will be given the choice of enrolling their children in the applicable direct coverage program.

MassHealth will provide premium assistance toward the child's private health insurance premium payment, along with benefit wraps and cost sharing assistance.

There is no waiting period.

The minimum employer contribution

For Family Assistance and CommonHealth the minimum employer contribution is 50% of the total cost of the health insurance premium. For CommonHealth MassHealth will continue paying the premium under the 1115 Demonstration even if the employer contribution falls below 50%, as long as the plan remains cost effective.

In cases where the private health insurance does not cover a MassHealth covered service, MassHealth will cover direct services for Premium Assistance members as long as the service is a covered MassHealth service. If a member needs help coordinating these benefits, the MassHealth Enhanced Coordination of Benefits unit can assist the member in coordinating their private insurance and MassHealth benefits.

All Premium Assistance members are instructed to go to providers that participate in both their private health insurance network and the MassHealth network, and that they show both their private insurance card and MassHealth card when they go to a provider. This ensures that if the member would owe a copay or out of pocket expense when going to a provider, that expense will be wrapped by MassHealth.

[Note: See the Title XIX Medicaid state plan for Premium Assistance requirements relating to Standard income level children, including Medicaid Expansion children.]

6.4.2.1. Purchase of family coverage is cost-effective. The State's cost of purchasing family coverage, including administrative expenditures, that includes coverage for the targeted low-income children involved or the family involved (as applicable) under premium assistance programs must not be greater than the cost of obtaining coverage under the State plan for all eligible targeted low-income children or families involved; and (2) The State may base its demonstration of cost effectiveness on an assessment of the cost of coverage, including administrative costs, for children or families under premium assistance programs to the cost of other CHIP coverage for these children or families, done on a case-by-case basis, or on the cost of premium assisted coverage in the aggregate.

The cost-effectiveness determination

The cost effectiveness determination ensures that the premium assistance payment would not be greater than the amount it would cost for MassHealth to provide services to the member through the direct coverage option.

Estimated Premium Assistance Amount

Example: For ESI plans where the employer contributes 50% or more of the premium, the estimated premium assistance payment amount is calculated by subtracting the employer share of the policyholder's health-insurance premium and the MassHealth required member contribution of the health-insurance premium from the total cost of the health-insurance premium.

Example. A parent and two children apply for MassHealth. The two children are eligible for MassHealth, but the parent is not eligible. Their health insurance is an ESI 50% plan.

1. The total monthly cost of the health-insurance premium = S.
2. The employer's monthly share of the health-insurance premium = T.
3. The MassHealth estimated member share of the monthly health-insurance premium = U.
4. Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (employer's share of the cost)

V = (employee's share of the cost)
- U = (the MassHealth estimated member share of the cost)
W = (estimated premium assistance payment amount)

ESI 50% Plans cost-effective amount: W is compared to the MassHealth cost of covering the two children who are eligible for MassHealth (X).

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

If W is less than X, the MassHealth agency sets the actual premium assistance payment amount at W (the actual premium assistance payment amount will be equal to the estimated premium assistance payment amount).

If W is equal to or greater than X, the MassHealth agency sets the actual premium assistance payment amount at X (the cost of covering the two children who are eligible for MassHealth).

Premium assistance payments are made directly each month on behalf of the children to the parent/policyholder.

In addition to premium assistance payments, MassHealth 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. MassHealth will also provide cost sharing assistance so that these individuals are not required to contribute more towards the cost of their private health insurance than they would otherwise pay for MassHealth Standard, Family Assistance or CommonHealth coverage.

Premium assistance may exceed the cost of child-only coverage and include family coverage if cost effective based on the child's coverage.

6.4.2.2. The state assures that the family coverage would not otherwise

substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

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

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010) A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☐ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified

employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA **Purchasing Pool**- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance

subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☐ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA **Notice of Availability of Premium Assistance**- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

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

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

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)** Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

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

8.1.1-PW ☐ Yes
8.1.2-PW ☐ No, skip to question 8.8.

N/A

Guidance: It is important to note that for families below 150 percent of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50 - 447.59). For families with incomes of 150 percent of poverty and above, cost sharing for all children in the family cannot exceed 5 percent of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) and (c), 457.515(a) and (c))

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

8.2.1. ☒ Premiums

If a family's gross income is determined to be above 150% of the poverty level, the family will be required to share in the cost of coverage. This requirement is waived for pregnant CHIP members up to 200% FPL who are transitioned to MassHealth Standard, unborn children and children under age one eligible for MassHealth Standard. For children covered through MassHealth Family Assistance and disabled children covered through MassHealth CommonHealth (including pregnant members in both programs with income over 200% FPL), the cost sharing will be a monthly premium payment.

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

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

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

American Indians and Alaskan Natives are exempt from payment of premiums.

Households may apply for a waiver or reduction of premiums for undue financial hardship. MassHealth, in its sole discretion, will determine if the requirement to pay a premium results in undue financial hardship for a member. Hardship waivers may be authorized for 12 months. At the end of the 12-month period, the member may submit another hardship application.

A member may be granted a financial hardship waiver, whereby MassHealth may waive or reduce the premium, provided the individual meets one of the following conditions:

(a) is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice;

(b) has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone);

(c) has medical and/or dental expenses, totaling more than 7.5% of the family's annual income, that are not subject to payment by the Health Safety Net, and have not been paid by a third-party insurance, including MassHealth (note that this includes medical expenses not covered in CHIP through MassHealth Family

Assistance);
(d) has experienced a significant, unavoidable increase in essential expenses within the last six months;
(e) is a CommonHealth member where the total monthly premium charged for CommonHealth will cause extreme financial hardship the family, such that the paying of premiums could cause the family difficulty in paying for housing, food, utilities, transportation, other essential expenses, or would otherwise materially interfere MassHealth's goal of providing affordable health insurance to low-income persons; or
(f) has suffered within the six months prior to the date of application for a waiver economic hardship because of a state or federally declared disaster or public health emergency.

8.2.2. ☐ Deductibles

8.2.3. ☐ Coinsurance or copayments

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

8.2.4. ☐ Other:

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance. (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

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

8.2.1-DS ☐ Premiums:

8.2.2-DS ☐ Deductibles:

8.2.3-DS ☐ Coinsurance or copayments:

8.2.4-DS ☐ Other:

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

MassHealth's outreach and enrollment materials display the eligibility requirements, coverage types and any cost sharing requirements. The member booklet which is available to all potential applicants, displays the cost sharing required for families with Modified Adjusted Gross Income between 150% and 300% FPL. Additionally, families who complete an Application and apply for benefits will be notified in writing of any cost sharing requirements once eligibility is determined.

Guidance: The State should be able to demonstrate upon request its rationale and justification regarding these assurances. This section also addresses limitations on payments for certain expenditures and requirements for maintenance of effort.

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

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

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

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

8.4.1- 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))

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

Direct coverage

MassHealth eligibility systems calculate a monthly individual cost sharing cap amount for each member based on their family income. A single 5% cap on cost-sharing is applied to the total cost of applicable premiums and cost-sharing combined. The information is then sent to MMIS which also tracks copays accumulation across various systems (pharmacy, managed care) and will stop copays when the member reaches their cap. The members are sent a letter notifying them of their cap amount and the start date. Additionally, a letter is sent when the member reaches their cap each month.

Copays are not required for children.

Premium billing is handled by our third-party (Maximus) vendor and is not within MMIS. The eligibility systems calculate the premium amount and sends that amount to MMIS, but then Maximus applies secondary suppression rules as described in our regulations and determines the final billed amount to ensure that members are not assessed any additional costs for premiums and cost sharing after the 5% cap is reached for either or both payments. The final billed amount may be different from the amount calculated by the eligibility systems and what is stored in MMIS. Additionally, neither premium billed amounts or paid tracking are recorded in MMIS. All premium billing is handled outside MMIS in the vendor's system. If a premium needs to be suppressed for any month(s) because the 5% cap has been reached, no invoice will be sent.

Premium assistance

MassHealth will provide cost sharing wrap assistance to CHIP members receiving Premium Assistance so that these individuals are not required to contribute more towards the cost of their employer sponsored insurance than they would otherwise pay for MassHealth Standard, Family Assistance or CommonHealth coverage

See 6.4.2 and 6.4.2.1 for a description of the premium assistance and cost sharing assistance wrap.

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

MassHealth Family Assistance members who are members of a federally recognized American Indian (AI) tribe or who are Alaska Natives (AN) will not be charged a monthly premium.

AI/AN who are applying for MassHealth are notified of their exclusion to cost-sharing from information provided in the Application and member booklet.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

Please see CS21 for a description of the consequences for an enrollee or applicant who does not pay a charge.

Guidance: Section 8.7.1 is based on Section 2101(a) of the Act provides that the purpose of title XXI is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

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

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (Section 2103(e)(3)(C))

8.7.7.1. ☒ State has established a process that gives enrollees reasonable notice of

and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

8.7.1.2 .☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. **(42CFR 457.570(b))**

8.7.1.3. ☒ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

8.7.1.4. ☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

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

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

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

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))

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

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the

mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)

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

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

STATE: Massachusetts	**FFY Budget**
Federal Fiscal Year	**2022**
State's enhanced FMAP rate	69.34%
Benefit Costs	
Insurance payments	10,452,929
Managed care	403,569,311
per member/per month rate	311.03
Fee for Service	445,654,851
Total Benefit Costs	859,677,091
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	859,677,091
Cost of Proposed SPA Changes – Benefit	1,098,826
Administration Costs	
Personnel	
General administration	26,033,605
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	60,976,779
Other	
Total Administration Costs	87,010,384
10% Administrative Cap	95,519,677
Cost of Proposed SPA Changes	1,098,826
Federal Share	656,433,095

STATE: Massachusetts	FFY Budget
State Share	290,254,380
Total Costs of Approved CHIP Plan	946,687,475

NOTE: Include the costs associated with the current SPA.

The Source of State Share Funds: General Appropriations