Table of Contents

State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 17-022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

September 25, 2018

Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Dear Secretary Sudders:

We are pleased to enclose a copy of approved Massachusetts State Plan Amendment (SPA) No. 17-022 submitted to CMS on December 29, 2017. This SPA was submitted to revise your approved Title XIX State plan to remove the sunset date of December 31, 2017 for the Student Health Insurance Premium Assistance program (SHIP), and to add a new section on Benefit Wrap and Cost Sharing for the premium assistance programs. This SPA has been approved effective October 1, 2017.

Enclosed are copies of the following approved State plan pages.

- Attachment 4.22-C, pages 1, 1a and 1b.

During the processing of SPA 17-022, CMS identified areas of concern regarding access to services and member notices for beneficiaries enrolled in premium assistance. In accordance with the State Medicaid Director's Letter (SMDL) #10-20, dated October 1, 2010, a separate companion letter is being issued concurrently with this SPA approval to address those concerns.

If you have any questions regarding this matter you may contact Julie McCarthy at (617) 565-1244 or by e-mail at Julie.McCarthy@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

Cc (via e-mail): Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Kaela Konefal, Federal Authority Policy Analyst/State Plan Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

September 25, 2018

Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Dear Secretary Sudders:

This letter is being sent as a companion to our approval of your State Plan Amendment (SPA) No. 17-022, approved on September 25, 2018. During our processing of SPA 17-022, we also reviewed the network adequacy analysis submitted by the State on June 27, 2018. This analysis was requested to demonstrate that the network of providers to which MassHealth premium assistance beneficiaries enrolled in employer-sponsored insurance (ESI) or student health insurance (SHIP) is limited is sufficient to meet the needs of MassHealth premium assistance beneficiaries. Based on that review, we have determined that the State's analysis has identified some areas of vulnerability with respect to home health and behavioral health services for premium assistance beneficiaries who are new patients. Additional information is required.

Access to Services

States with premium assistance programs have an obligation under Section 1906 of the Social Security Act as well as 42 CFR 435.1015 to ensure that individuals receiving benefits through their private insurance do not incur cost-sharing above the amounts that are authorized under the State plan for the traditional Medicaid population. States have flexibility with respect to how they implement this assurance. One approach is to limit a beneficiary's access only to providers who are dually contracted with both the Medicaid program as well as the private plan. In this way, the State leverages its Medicaid participating agreement with the contracted provider to pay only the Medicaid contracted rates, and the beneficiary is only charged the Medicaid permitted cost-sharing. If a beneficiary obtains services from a provider who does not participate in MassHealth, the beneficiary incurs the full cost-sharing obligation of the commercial plan. Massachusetts intends to implement this approach for the populations described in MA 17-022 through its MassHealth section 1115 demonstration (Project Number 11-W-00030/1), which will have a "freedom of choice" component contingent on approval of its pending demonstration amendment request.

In the State's analysis submitted on June 27, 2018, the State shared data that showed that the percentage of dually enrolled providers accepting new patients in the areas of behavioral health and home health were very low and could result in barriers to accessing care. On page 9, the analysis had the following data:

Percentage of Dually Participating Medicaid providers accepting new patients

% Dually Participating MassHealth Providers Accepting New Patients*	Barnstable	Berkshire	Bristol	Dukes	Essex	Franklin	Hampden	Hampshire	Middlesex	Nantucket	Norfolk	Plymouth	Suffolk	Worcester
Physicians (including specialists)	59 %	57 %	63 %	67 %	55 %	54 %	66 %	44 %	52 %	75 %	46 %	58 %	79 %	61 %
Behavioral Health Servicing Providers	10 %	11 %	11 %	19 %	14 %	22 %	10 %	31 %	19 %	5 %	20 %	14 %	9 %	12 %
Home Health Service Providers	0 %	0 %	1 %	0 %	0 %	0 %	1 %	0 %	0 %	0 %	0 %	0 %	0 %	0 %

CMS is concerned that this analysis indicates a potential in many parts of the State for beneficiaries to encounter difficulty locating a dually-participating home health or behavioral health provider who is accepting new patients.

CMS is requesting a plan from the State to address the potential access deficiency. Please explain how the State will ensure access to services to any premium assistance beneficiary who has been unable to locate a dually-participating provider accepting new patients. For instance, as a mitigation, the State could allow the beneficiary to obtain services from a non-MassHealth-enrolled provider who participates in the commercial plan and reimburse the beneficiary for any out-of-pocket costs that exceed the permissible Medicaid cost-sharing amounts, or allow access to the full MassHealth provider network without requiring provider participation in the commercial plan, with an adjustment to the State's cost-effectiveness tests.

<u>Beneficiary Notices</u>

The requirements for beneficiaries to only see dually enrolled providers or risk having an out-of pocket expense may not be apparent to beneficiaries enrolled in a commercial plan. Generally, beneficiaries may expect that they have access to all providers in the commercial network. It is important to communicate clearly to beneficiaries that there may be a financial cost beyond Medicaid permitted cost-sharing to seeing commercial providers who are not also dually enrolled Medicaid providers.

During the SPA review, the State provided a copy of the "Member Resource ADD Letter (under 18) Layout" as a sample communication to beneficiaries that they are responsible for informing a provider that they participate in both MassHealth and a commercial insurance plan at the time they obtain services. This notice includes the following language:

> *When you obtain health care services from a doctor, hospital, pharmacy, dentist, or any other MassHealth provider, you must show your other insurance card along with your MassHealth card. MassHealth requires that you use the other insurance first, and follow the other insurer's policies and authorization rules before using your MassHealth benefits.*

Please explain how the State will enhance their beneficiary notices to more fully explain the general requirement that services for premium assistance beneficiaries should be obtained from a dually-participating provider. CMS is requesting a copy of the enhanced notice.

Similarly, if beneficiaries are informed that they should only see providers participating in both programs, beneficiaries who encounter access to care issues because they are new patients seeking behavioral health or home health services may not understand that there will be alternatives for them if they cannot locate a provider. Please also explain how the State will inform beneficiaries of the process to follow to obtain services if they encounter difficulty finding a dually-enrolled provider. CMS is requesting copies of such notices, which must adequately inform both those beneficiaries newly enrolled in the premium assistance program, as well as existing participants.

The State has 60 days from the date of this letter – until **November 25, 2018** – to address the issues described above. Within this 60-day period, the State may submit a SPA to address these issues or may submit a corrective action plan, whichever is appropriate, describing in detail how the State will resolve the issues identified above in a timely manner. Failure to respond within the 60 days will result in the initiation of a formal compliance process. During the 60-day period, CMS will provide any required technical assistance to assist you in resolving these issues.

If you have any questions regarding this matter you may contact Julie McCarthy at (617) 565-1244 or by e-mail at Julie.McCarthy@cms.hhs.gov. We look forward to working with you on these issues.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Cc (via e-mail): Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Kaela Konefal, Federal Authority Policy Analyst/State Plan Coordinator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 17-022

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/17

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ■ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $ 25.5 million
b. FFY 2019 $ 25.5 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.22-C page 1, 1a, 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.22-C, page 1- 1a

10. SUBJECT OF AMENDMENT

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
■ OTHER, AS SPECIFIED
Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL
/s/

13. TYPED NAME
Marylou Sudders

14. TITLE
Secretary

15. DATE SUBMITTED
12/29/17

16. RETURN TO
Kaela Konefal
State Plan Coordinator
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 12/29/2017

18. DATE APPROVED 09/25/2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 10/01/2017

20. SIGNATURE OF REGIONAL OFFICIAL
/s/

21. TYPED NAME Richard R. McGreal

22. TITLE Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

The Commonwealth of Massachusetts uses two alternative methods to determine cost effectiveness of paying for private health insurance for eligible Medicaid recipients:

1. Cost Effectiveness based on Expenditure Projection

Unless a member is identified as a high-cost member as described in the paragraph below, the Commonwealth uses this expenditure projection method to determine cost effectiveness. Under this method, the Commonwealth obtains a description of benefits of the member's private plan and performs a three-step review:

(a) First, a covered services review is performed to determine if the private plan offers adequately comprehensive services. The covered services in the description of benefits of the private plan is compared to the covered services required for a plan to meet minimum creditable coverage, which is the standard required in Massachusetts to be considered insured to avoid a tax penalty. If the services covered under the private plan are comparable to the services required to meet minimum creditable coverage, then the case moves onto the next level of review. If it is not comparable to minimum creditable coverage, the Commonwealth will not purchase the private plan.

(b) Second, a review of the member's deductibles and out-of-pocket maximums under the private plan is performed to determine whether the private plan's deductibles or out-of-pocket maximums are greater than the thresholds prescribed at IRC §223(c)(2) for high deductible health plans (HDHP). If the deductibles and out-of-pocket maximums amounts are lower than the thresholds set by the IRS for HDHPs, the case moves onto the next level of review. If the amounts are higher, the Commonwealth will not purchase the plan.

(c) Third, the total member responsibility for the private plan's premium, inclusive of administrative costs and member cost sharing responsibilities, is compared to a per member per month MassHealth managed care rating category that represents what the Commonwealth would otherwise be paying for that member based on their specific coverage type if no private insurance were available. The different rating categories include administrative costs and account for differences due to disability status.

Cost-effective: A member's private insurance is determined to be cost effective if it passes the first two steps of the review and the total member premium responsibility is less than the modified MassHealth managed care rate for that member's coverage type, age, and disability status. For private family plans that cover more than one individual member, a rate per eligible individual is used to determine cost effectiveness.

2. **Cost Effectiveness based on Actual Expenditures or Client Diagnosis**

The Commonwealth identifies certain members as high-cost members through not only referrals from providers based on the member's diagnosis, but also through MMIS claims reports that identify the members with the top claims payments being made.

For high-cost members, the Commonwealth uses a cost effectiveness method based on actual expenditures or client diagnosis and performs a three-step review:

(a) First, a covered services review is performed to determine if the private plan offers adequately comprehensive services. The covered services in the description of benefits of the private plan is compared to the covered services required for a plan to meet minimum creditable coverage, which is the standard required in Massachusetts to be considered insured to avoid a tax penalty. If the services covered under the private plan is comparable to the services required to meet minimum creditable coverage, then the case moves onto the next level of review. If it is not comparable to minimum creditable coverage, the Commonwealth will not purchase the private plan.

(b) Second, a review of the member's deductibles and out-of-pocket maximums under the private plan is performed to determine whether the private plan's deductibles or out-of-pocket maximums are greater than the thresholds prescribed at IRC §223(c)(2) for high deductible health plans (HDHP). If the deductibles and out-of-pocket maximums amounts are lower than the thresholds set by the IRS for HDHPs, the case moves onto the next level of review. If the amounts are higher, the Commonwealth will not purchase the plan.

(c) Third, the total cost of the member premium responsibility is compared to either the projected costs based on diagnosis or actual costs of claims for that member from the prior year, plus Commonwealth administrative costs.

Cost-effective: A member's private insurance is determined to be cost effective if the total cost of the member's premium responsibility under the private plan is less than what the Commonwealth has paid for that member in the last year or would otherwise pay directly for a member with a similar diagnosis.

3. Once enrolled in private insurance, members receive fee for service benefits, and the Commonwealth will pay the Medicaid allowable amount for all items and services provided to the member and covered under the State plan but are not covered under the private health insurance plan.

4. The Commonwealth will pay for the payment of premiums when cost effective to do so for non-Medicaid eligible family members within the same household, in order to enroll a MassHealth eligible member in the private health insurance plan.

5. This cost effectiveness test is used for both employer sponsored plans and other group plans, and student health plans available in the individual market.

6. Benefit Wrap and Cost Sharing

Individuals enrolled in the state's premium assistance program must be afforded the member protections available to all other Medicaid enrollees.

(a) The state will provide a benefits wrap to all services and benefits available under the Medicaid State plan that are not provided through the premium assistance group health plans and student health plans available in the individual market.

(b) The state will ensure that individuals enrolled in the premium assistance program will not incur cost sharing amounts that exceed the cost sharing limits described in the state plan for a Medicaid covered service. To effectuate this policy, the state has elected to limit the providers from whom premium assistance beneficiaries can receive services to ones that are contracted with both the private insurer and the Medicaid state agency. These dually contracted providers will limit cost-sharing charges to the amounts allowed under the state plan. The State will submit to CMS an analysis demonstrating the overlap of providers participating in both Medicaid and group/individual health insurance plans is adequate to meet the health needs of premium assistance beneficiaries.