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## **Table of Contents**

**State/Territory Name:** Massachusetts

**State Plan Amendment (SPA) #:** MA-20-0016

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) State Plan Pages

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**

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February 8, 2021

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

Dear Ms. Kraft:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), MA-20-0016, submitted on June 30, 2020, has been approved. The purpose of this SPA is to update programmatic information to more accurately reflect existing practices and to transfer existing information to the most current version of the CHIP SPA template. This SPA has a July 1, 2019 effective date.

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

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

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

Sincerely,

/Signed by Amy Lutzky/

Amy Lutzky  
Deputy Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
CHILDREN'S HEALTH INSURANCE PROGRAM

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

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

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b)) \_\_\_\_\_ (Signature of Governor, or designee, of State/Territory, Date Signed)

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

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

Name: <u>Amanda Cassel Kraft</u>	Position/Title: <u>Acting Medicaid Director</u>
Name: <u>Mike Levine</u>	Position/Title: <u>Chief Financial and Strategy Officer</u>
Name: <u>Alison Kirchgasser</u>	Position/Title: <u>Deputy Policy Director for Federal Policy &amp; CHIP Director</u>

**Disclosure Statement** This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Introduction:** Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children’s Health Insurance Program (CHIP). In February 2009, the Children’s Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

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

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

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

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

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

The template includes the following sections:

1. **General Description and Purpose of the Children’s Health Insurance Plans and the Requirements-** This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination-** This section should provide general information related to the special characteristics of each state’s program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls-** This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)
6. **Coverage Requirements for Children’s Health Insurance-** Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided

must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))

7. **Quality and Appropriateness of Care-** This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration-** The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations-** Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity-** In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections-** This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan.

(Section 2101(a)); (42 CFR 457.1120)

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

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

#### **Medicaid Expansion- CHIP SPA Requirements**

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

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

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

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

#### **Medicaid Expansion- Medicaid SPA Requirements**

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

- 3 (Methods of Delivery and Utilization Controls)
  - 4 (Eligibility Standards and Methodology)
  - 6 (Coverage Requirements for Children's Health Insurance)
  - 7 (Quality and Appropriateness of Care)
  - 8 (Cost Sharing and Payment)
  - 11 (Program Integrity)
  - 12 (Applicant and Enrollee Protections)
- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that

level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under “Option to Expand Medicaid” would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in “Option to Create a Separate Program” would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state’s assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

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

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



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

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

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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

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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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 #23 (Conforming Edits) (TN 020-016)

Submission date: June 30, 2020

Approval date:

Effective date: July 1, 2019

Implementation date: July 1, 2019

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

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

## 1.4 Superseding Pages of MAGI CHIP State Plan Material

State: Massachusetts

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
<b>MA-14-0013</b> <b>Approval Date: 09/22/2014</b> <b>Effective/Implementation Date: January 1, 2014</b>	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
<b>MA-14-0003</b> <b>Approval Date: 12/22/2014</b> <b>Effective/Implementation Date: January 1, 2014</b>	XXI Medicaid Expansion	CS3	Eligibility for Medicaid Expansion Program	Supersedes Medicaid Expansion eligibility information in section 6
<b>MA-14-0005</b> <b>Approval Date: 04/15/2014</b> <b>Effective/Implementation Date: January 1, 2014</b>	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
<b>MA-13-0026</b> <b>Approval Date: 05/05/2014</b> <b>Effective/Implementation Date: October 1, 2013</b>	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

State Plan under title XXI of the Social Security Act  
Children's Health Insurance Program  
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**Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements**

Transmittal Number	SPA Group	PDF #	Description	Superseded Plan Section(s)
<b>MA-14-0006</b> <b>Approval Date: 09/22/2014</b> <b>Effective/Implementation Date: January 1, 2014</b>	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

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

Verification of Tribal Consultation is attached.

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

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

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**Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination**

Guidance: The demographic information requested in 2.1. can be used for State planning and will be used strictly for informational purposes. THESE NUMBERS WILL NOT BE USED AS A BASIS FOR THE ALLOTMENT.

Factors that the State may consider in the provision of this information are age breakouts, income brackets, definitions of insurability, and geographic location, as well as race and ethnicity. The State should describe its information sources and the assumptions it uses for the development of its description.

- Population
- Number of uninsured
- Race demographics
- Age Demographics
- Info per region/Geographic information

**2.1** Describe the extent to which, and manner in which, children in the State (including targeted low-income children and other ~~classes~~ groups of children ~~specified~~) identified, by income level and other relevant factors, such as race ~~and~~, ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, ~~make a distinction~~ distinguish between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (Section 2102(a)(1)); (42 CFR 457.80(a))

Below is demographic data from the American Community Survey (2017 and 2018, 1 year estimates) to describe the health insurance coverage of children in Massachusetts, based on race, ethnicity, geographic location, and insurance type by income to poverty level.

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

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

<b>MA Health Insurance Coverage Status for Children Under 19 by Age, Race and Hispanic/Latino Origin, 2018</b>							
	<u>Race</u>					<u>Hispanic Origin</u>	
	<u>White alone</u>	<u>Black/ African American alone</u>	<u>Asian alone</u>	<u>American Indian/ Alaska Native alone</u>	<u>Other*</u>	<u>Non-Hispanic White Alone</u>	<u>Hispanic or Latino (of any race)</u>
<u>Total:</u>	<u>5,280,185</u>	<u>528,301</u>	<u>471,373</u>	<u>14,810</u>	<u>480,029</u>	<u>4,831,114</u>	<u>838,741</u>
<u>Under 6 years:</u>	<u>289,427</u>	<u>42,178</u>	<u>30,172</u>	<u>1,575</u>	<u>64,710</u>	<u>244,733</u>	<u>88,622</u>
<u>With health insurance coverage:</u>	<u>286,451</u>	<u>42,178</u>	<u>29,962</u>	<u>1,466</u>	<u>63,118</u>	<u>242,317</u>	<u>87,370</u>
<u>No health insurance coverage</u>	<u>2,976</u>	<u>0</u>	<u>210</u>	<u>109</u>	<u>1,592</u>	<u>2,416</u>	<u>1,252</u>
<u>6 to 18 years:</u>	<u>743,686</u>	<u>99,481</u>	<u>70,267</u>	<u>3,425</u>	<u>116,520</u>	<u>644,925</u>	<u>184,543</u>
<u>With health insurance coverage:</u>	<u>733,950</u>	<u>98,807</u>	<u>68,523</u>	<u>3,425</u>	<u>113,851</u>	<u>637,987</u>	<u>180,502</u>
<u>No health insurance coverage</u>	<u>9,736</u>	<u>674</u>	<u>1,744</u>	<u>0</u>	<u>2,669</u>	<u>6,938</u>	<u>4,041</u>

\*Includes "Some other race alone" and "Two or more races"

<b>MA Health Insurance Coverage Status and Type for Children Under 19 by Income to Poverty Level, 2018</b>						
	<u>With employer-based health insurance</u>	<u>With direct-purchase health insurance</u>	<u>With Medicare coverage</u>	<u>With Medicaid/ means-tested public coverage</u>	<u>No health insurance coverage</u>	<u>Total</u>
<u>Under 0.50 of poverty threshold</u>	<u>15,141</u>	<u>4,244</u>	<u>974</u>	<u>86,490</u>	<u>2,510</u>	<u>101,102</u>
<u>0.50 to 0.99</u>	<u>15,691</u>	<u>3,462</u>	<u>1,211</u>	<u>78,963</u>	<u>1,150</u>	<u>91,521</u>
<u>1.00 to 1.37</u>	<u>12,740</u>	<u>4,610</u>	<u>724</u>	<u>67,341</u>	<u>1,535</u>	<u>80,206</u>
<u>1.38 to 1.49</u>	<u>5,122</u>	<u>1,215</u>	<u>770</u>	<u>19,575</u>	<u>308</u>	<u>24,879</u>
<u>1.50 to 1.99</u>	<u>31,889</u>	<u>7,321</u>	<u>801</u>	<u>62,205</u>	<u>1,688</u>	<u>93,773</u>
<u>2.00 to 2.49</u>	<u>48,407</u>	<u>5,823</u>	<u>226</u>	<u>52,829</u>	<u>2,508</u>	<u>99,532</u>
<u>2.50 to 2.99</u>	<u>49,407</u>	<u>5,795</u>	<u>293</u>	<u>34,087</u>	<u>1,657</u>	<u>85,683</u>
<u>3.00 to 3.99</u>	<u>119,464</u>	<u>12,124</u>	<u>255</u>	<u>39,418</u>	<u>3,034</u>	<u>164,469</u>
<u>4.00 and over</u>	<u>609,733</u>	<u>44,115</u>	<u>209</u>	<u>56,121</u>	<u>5,571</u>	<u>685,076</u>

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

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

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<b><u>MA Children Under 19 without Health Insurance by County, 2017</u></b>	
<u>Counties in Massachusetts</u>	<u>Percent Uninsured</u>
<u>Massachusetts:</u>	<u>1.5</u>
<u>Barnstable County</u>	<u>1.8</u>
<u>Berkshire County</u>	<u>0.7</u>
<u>Bristol County</u>	<u>1.6</u>
<u>Essex County</u>	<u>2.2</u>
<u>Franklin County</u>	<u>0.3</u>
<u>Hampden County</u>	<u>1.2</u>
<u>Hampshire County</u>	<u>0.5</u>
<u>Middlesex County</u>	<u>1.8</u>
<u>Norfolk County</u>	<u>1.0</u>
<u>Plymouth County</u>	<u>0.8</u>
<u>Suffolk County</u>	<u>0.8</u>
<u>Worcester County</u>	<u>1.9</u>

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

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

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

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

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Table 2a.

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

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

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

(2) Estimated based on CPS and Census data.



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Table 2b

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

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

(1) Based on 1995, 1996, and 1997 Merged Current Population Survey data.

(2) Estimated based on CPS and Census data.

(3) Includes Medicaid, Medicare, CHAMPUS, and Other Insurance.

Updated children's uninsurance data for the State Plan Amendment submitted on

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~~April 28, 2006:~~

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

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

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

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

**2.2 Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is

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proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii); (42 CFR 457.10)

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

- **Healthy Families**

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

- **School Based Health Programs**

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

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

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medication management; and screenings with respect to postural, height/weight, hearing, oral health, and vision.

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

- **Nutrition Programs for Children:**

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

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

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

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- **Smoking Prevention and Cessation Programs**

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

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

- **Family Planning Programs**

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

- Comprehensive family planning services, including complete gynecological and breast exams, cervical cancer screening, diagnosis and treatment of sexually transmitted diseases, contraceptive supplies including emergency contraception, pregnancy testing, follow-up and referral for identified medical problems, and other pre-conceptional care.
- Individual health education and counseling on reproductive anatomy and physiology, all contraceptive methods, AIDS/HIV, sexually transmitted diseases, all options for positive pregnancy tests, infertility, and other related health concerns.
- Outreach and education to local communities and populations. These activities vary with each program but may include classes in schools and community organizations on reproductive health, sexuality, and HIV prevention; training and resources for teachers, health care providers and parents; peer education programs; participation in community coalitions; and collaboration with other organizations serving high risk populations.

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

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

Services are provided through this project are based on the individual needs of youth and are planned in conjunction with the families. Most services are provided in the child's

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

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

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

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

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

- **Teen Pregnancy Prevention Program**

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

- **Failure to Thrive Program**

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

- **Youth Violence Prevention Program**

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

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

The SANE program is administered by the Department of Public Health and provides direct patient care to adolescents and children who disclose sexual assault and who go to SANE designated Emergency Departments or Children's Advocacy Centers across Massachusetts.

The nurses of the SANE program provide direct patient care to individuals who disclose sexual assault. This includes necessary medical exams, testing, and preventive treatment for HIV, STDs, and pregnancy. These services are the first step in psychological, physical, and emotional healing for the child.

- **Pediatric Palliative Care**

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

- **Young Parents Support program**

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

- **Safe and Successful Youth Program**

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

- **Services for Homeless Youth**

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

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

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

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

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

~~MassHealth~~

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

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

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

~~In the last quarter of FFY05, MassHealth awarded \$500,000 in mini-grants to 22 community-based organizations across the state to increase MassHealth enrollment. These grants will help provide critical access to people who are already eligible for MassHealth but not enrolled. MassHealth is working closely with these grantees to give them the knowledge and tools to enroll new MassHealth members. One component of this effort is training those grantees who are not already doing so to~~



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~~submit electronic applications for MassHealth. Each of the grantees has tailored programs specific to the people and regions they serve. To buttress training provided by MassHealth, grantees will use novel approaches for outreach, including health fairs, public notices, multi-lingual collaborations with YMCAs, YWCAs, hospitals, community service organizations, soup kitchens, homeless shelters, clinics, schools, and businesses, as well print, radio, and television marketing campaigns.~~

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

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

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

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Children's Medical Security Plan (CMSP)

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

Other EOHHS Programs

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

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

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

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

The Supplemental Nutrition Program for Women, Infants and Children (WIC): ~~WIC sites are operated under the auspices of the Department of Public Health. The program provides nutritious food to supplement the regular diet of pregnant women, infants and children under age five who meet federal and state income and adjunct eligibility requirements. Women and children under five years old qualify if the~~

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~~combined family income is at or below 185% FPL. WIC staff encourages uninsured pregnant women and parents and guardians of uninsured children to apply for MassHealth. Staff also refers uninsured clients with higher levels of income to CMSP.~~

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

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

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

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

~~2.2.2. The steps the state is currently taking to identify and enroll all uncovered children~~

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~~who are eligible to participate in health insurance programs that involve a public-private partnership:~~

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

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

**2.3-TC Tribal Consultation Requirements-** (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

MassHealth holds quarterly meetings with the federally recognized tribes, Indian Health Programs and Urban Indian Organizations either in-person or by conference call, with email contact as needed between meetings. These

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quarterly meetings serve as a formal mechanism to seek advice from and provide information to the tribes regarding state plan amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS that would directly impact tribe members.

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

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

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

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~~EOHHS will assess children's eligibility for both Title XIX and Title XXI programs. EOHHS is the Commonwealth's Title XIX agency and has been charged with expanding its health programs to cover Title XXI populations. Eligibility for MassHealth Title XIX and MassHealth Title XXI will be determined simultaneously. The Medical Benefit Request (MBR) is used to assess eligibility for all MassHealth programs (Title XIX and Title XXI), as well as the Children's Medical Security Plan. Sufficient information is collected on the MBR to assess if the applicant is eligible for any MassHealth coverage type (e.g. MassHealth Standard, CommonHealth or Family Assistance). The MBR information is data entered into MassHealth's eligibility system (MA21) to invoke an eligibility determination. MA21 is designed to assign the most comprehensive coverage type to the eligible applicant. See Section 4.4.1 for a more detailed description of the eligibility process.~~

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

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

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

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☐

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

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

~~**MA-014-0013 MMDL (CS7, CS9 and CS15) supersedes sections 4.1.1., 4.1.2, all but the transfer of income language in section 4.1.3, and the prenatal language in section 4.1.9**~~



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**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:

~~MassHealth is available statewide.~~

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

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

**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.

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Uninsured disabled children who are not eligible for Standard and have incomes within the limits described in CS7 are eligible for Commonwealth 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.

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

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

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

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

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

~~Countability of Income~~

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

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~~(A) Earned Income~~

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

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

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

~~(B) Gross Unearned Income~~

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

~~(C) Rental Income~~

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

~~(D) Non-Countable Income~~

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

- ~~• Income received by a TAFDC, EAEDC, or SSI recipient;~~
- ~~• Sheltered workshop earnings;~~
- ~~• The portion of Federal veterans benefits identified as aid and attendance benefits, unreimbursed medical expenses, housebound~~

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benefits, or enhanced benefits;

- ~~Income in kind;~~
- ~~Temporary income from U.S. Census Bureau related to Census 2000 activities, or federal unemployment benefits related to the termination of that temporary income.~~
- ~~Roomer and boarder income; and~~
- ~~Any other income excluded as provided by federal laws other than the Social Security Act (see 42 C.F.R. Part 416, Appendix to Subpart K).~~

#### Verification of Income

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

#### Earned Income

~~The following are required to verify earned income:~~

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

#### Unearned Income

~~The following are required to verify unearned income:~~

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

#### Rental Income

~~The following are required to verify rental income~~

- ~~Most recent U.S. tax return~~

#### Transfer of Income

~~All family group members are required to avail themselves of all potential income. If MassHealth determines that income has been transferred for~~

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

~~Calculation of Financial Eligibility~~

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

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

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

~~Cost of Living Adjustment (COLA) Protections~~

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

~~Income Disregards~~

<del>_____ Gross Income as % of FPL</del>	<del>_____ Income Disregards _____ (as a % of FPL)</del>
<del>_____ Below 200%</del>	<del>_____ 0</del>
<del>_____ 200</del>	<del>_____ 0</del>
<del>_____ 250</del>	<del>_____ 50</del>
<del>_____ 300</del>	<del>_____ 100</del>

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

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**~~MA-014-0006 MMDL (CS17) supersedes  
section 4.1.5, with the exception of the 2  
scenario examples~~**

- 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.

~~As a condition of eligibility an applicant or member must:~~

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

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

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

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

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

See 4.1.3.1-PC above which describes Commonwealth children.

~~Children under age 19 may establish eligibility for MassHealth~~

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~~CommonHealth under Title XXI provided they:~~

~~Are uninsured;~~

~~Are ineligible for MassHealth Standard;~~

~~Have family gross income that is less than or equal to 300% of the federal poverty level; and,~~

~~• Are permanently and totally disabled as defined below~~

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

~~Permanent and Total Disability~~

~~Children meeting the following requirements shall be considered permanently and totally disabled.~~

~~(A) For 18 Year Old Children~~

~~(1) The child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:~~

~~(a) can be expected to result in death; or~~

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

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

~~For Children Under 18~~

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

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Verification of Disability

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

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

4.1.7. ☒

Access to or coverage under other health coverage:

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.

Other Health Coverage

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

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

Access to Health Insurance

A child has access to health insurance, for the purpose of determining eligibility for Title XXI MassHealth 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.



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

- ~~• the child is ineligible for MassHealth Standard or CommonHealth;~~
- ~~• the family group gross income is between 150% and 300% FPL (before disregards); and~~
- ~~• MassHealth has determined it is cost effective 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, through MassHealth Family Assistance.~~

~~See 4.4.4.1 for standards related to Premium Assistance and cost effectiveness.~~

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 two calendar months following the month in which her pregnancy ends, regardless of any subsequent changes in family group income. ~~No other children will receive a durational guarantee of eligibility. They will be subject to a periodic review of eligibility.~~

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

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

**MA-014-0006 MMDL (CS19) supersedes the**

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## Social Security Number (SSN) language in 4.1.9

### Social Security Number (SSN) Requirements

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

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

### Right to Know Uses of Social Security Numbers

~~All household members will be given written notice in a booklet accompanying their MassHealth Benefit Request of the following:~~

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

### 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.

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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/a pregnant woman who is eligible for Mass Health Standard or the mother of an unborn child. eligible for MassHealth Healthy Start.

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.

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Good cause for non-cooperation ~~is present if at least one of~~ includes, but is not limited to, any of the following circumstances ~~exists~~ regarding the child of the applicant or member:

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

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## ~~MA-014-0006 MMDL (CS18) supersedes the Citizenship and Immigration language in 4.1.9~~

### ~~Citizenship and Immigration Requirements~~

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

### ~~Verifications of Citizenship and Immigration Status~~

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

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

### ~~Title XXI MassHealth Specific Eligibility Requirements by Coverage Type~~

~~In addition to other requirements described in Section 4, a child must meet the specific Title XXI eligibility requirements of each coverage type. The requirements for MassHealth CommonHealth are described in Section~~

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~~4.1.6. Eligibility requirements for MassHealth Standard, Family Assistance  
(direct coverage and premium assistance), and Prenatal follow.~~

~~(A) MassHealth Standard~~

~~MassHealth Standard is available to uninsured children under the  
age of 19 subject to the following requirements.~~

~~Unborn Children~~

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

~~Children under One~~

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

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

~~Children Aged One through Eighteen~~

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

**~~MA 14-0006 MMDL (CS28) supersedes the  
language on Presumptive eligibility for  
Standard and Family Assistance in section  
4.1.9~~**

~~Presumptive Eligibility for Standard~~

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

~~(B) MassHealth Family Assistance (including FAEC) — Direct Coverage~~

~~Direct coverage under MassHealth Family Assistance is available to uninsured children aged one through eighteen provided:~~

- ~~• the gross income of the family group is greater than 150% but less than or equal to 300% FPL (before disregards)~~
- ~~• the child is ineligible for MassHealth Standard and MassHealth CommonHealth; and~~
- ~~• the child is not insured, does not have access to health insurance, as defined in Section 4.1.7., and, for children between 200 and 300% FPL, has not been insured in the previous six months, except as provided in section 4.4.4.2.~~

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

~~Time Limited MassHealth Family Assistance~~

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

~~Presumptive Eligibility for MassHealth Family Assistance~~

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

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MassHealth Family Assistance Premiums

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

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

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

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

~~MassHealth Family Assistance members who are determined eligible for another coverage type shall cease to be responsible for the premium payment to MassHealth as of the calendar month in which the coverage type changes.~~

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

Delinquent Premium Payments

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

~~Once terminated for non payment of a premium:~~

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



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Voluntary Withdrawal

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

Change in Premium Calculation

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

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

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

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

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

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

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

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

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

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

Estimated Premium Assistance Amount

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

Cost effectiveness test

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

~~The estimated premium assistance amount will be compared to the cost of covering the children in the family on MassHealth Family Assistance. Therefore, if a family with two children and one parent applies for coverage, the estimated premium~~

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~~assistance amount would be compared to covering two members on MassHealth's MCO program, or \$300 per month (\$150 pmpm<sup>†</sup> × 2 children).~~

~~Actual Premium Assistance Amount~~

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

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

~~If the estimated premium assistance amount is higher than the cost effective amount (as defined in #2 above), then MassHealth will set the actual premium assistance amount at the cost effective amount. If it is determined that the remainder of the health insurance premium is greater than 5% of the family's gross income, then the family will be given the choice of enrolling their children in the applicable direct coverage program.~~

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

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

~~the copay, coinsurance or deductible was incurred as the result of a well baby/well child care visit; or  
the policyholder's annualized share of the employer sponsored health insurance premiums, combined with copays, coinsurance, and deductibles incurred and paid by members, exceeds five~~

<sup>†</sup> For demonstration purposes only, represents the average MCO pmpm.

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~~percent of the family group's gross income in a 12-month period beginning with the date of eligibility for premium assistance.~~

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

## ~~MA-14-0013 (CS9) supersedes the prenatal language in section 4.1.9~~

### ~~(D) MassHealth Prenatal~~

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

### ~~Express Lane Renewal Option~~

~~Certain children under the age of 19 eligible for Medicaid Expansion CHIP and CHIP will meet the criteria for Express Lane Renewal at the time of their annual renewal. The MassHealth agency will identify Medicaid Expansion CHIP children and unborn CHIP children who have income at or below gross 150% of the federal poverty level (FPL) and are also eligible for SNAP as shown from a data match with the Massachusetts Department of Transitional Assistance. The Massachusetts Department of Transitional Assistance oversees SNAP and will be the designated Express Lane Agency. Children's Medicaid Expansion CHIP benefits and CHIP benefits will be renewed based on the child's eligibility for SNAP. This process will be used for renewals only. All members eligible for this process have completed an initial application and have been approved for either Medicaid Expansion CHIP or CHIP and for SNAP. These members will also have their SNAP eligibility recertified on an annual basis.~~

**4.1.9.1 ☒ States should specify whether Social Security Numbers (SSN)**

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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.

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4.1-~~10-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)

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

☐ ~~The State elects the CHIPRA section 214 option~~ Elected for pregnant women.  
☒ ~~The State elects the CHIPRA section 214 option for~~ Elected for children under ~~up~~  
~~to~~ age 19

- 4.1.~~40.1~~~~LR~~ ☒ The State provides assurance that for individuals whom it enrolls in CHIP Medicaid under the CHIPRA ~~section 214~~ 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



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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.



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

~~MA-014-0006 MMDL (CS28) supersedes the language on Presumptive eligibility for Standard and Family Assistance in section 4.3~~

~~MA-013-0026 MMDL (CS24) supersedes all of section 4.3 except for the precedence language pertaining to Medicaid and richest benefit and all of section 4.4 with the exception of Express Lane Renewal Option language in 4.4.1~~

Application and presumptive eligibility

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

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

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

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

Reactivating the Medical Benefit Request

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

Presumptive Eligibility Process

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

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

Data matching and verification

Process for Data Matching

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

Process for Agency Data Matches

~~Where possible, MassHealth's eligibility system attempts data verification through automated matching with other MassHealth systems (e.g., MMIS) and external agencies. Initial matching is performed during the MBR screening when the system, based on data entry of the request, checks MassHealth databases and~~

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~~MMIS, to confirm eligibility status and retrieve existing information.~~

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

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

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

~~Data to Match and Verify~~

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

- ~~• Income (for all except MassHealth Prenatal, and for presumptive eligibility determinations for MassHealth Standard and MassHealth Family Assistance, and for those without income);~~
- ~~• Disability (for CommonHealth);~~
- ~~• TPL (from accident or injury);~~
- ~~• SSN;~~
- ~~• Citizenship and immigration status; and~~
- ~~• Access to, and availability of, health insurance.~~
- ~~•~~
- ~~• **Matching Agencies**~~
- ~~• MassHealth works with the following agencies to verify eligibility information:~~

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• DUA

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

• DOR

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

~~The wage reporting system provides the wages an individual receives on a quarterly basis from employers. If discrepancies regarding wages are noted between MassHealth's data and DOR's data regarding an individual, an inquiry will also be generated to the member.~~

INS

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

SSA

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

**Eligibility Review**

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

~~As a result of a member's reported change in circumstances;~~

~~By external matching with other agencies and health insurance carriers; and~~

~~Where matching is not available, through a written update of the member's circumstances on a prescribed form.~~

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

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

~~Member enrollment~~

~~Introduction~~

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

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

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

~~MassHealth Standard/MassHealth Family Assistance Members~~

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

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

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Description of Enrollment Process

~~CSRs enroll MassHealth managed care eligible members into a health plan under either the PCC plan or an MCO according to MassHealth's policies, procedures, instructions and timeframes.~~

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

Receipt of Member Data

~~The EB receives data regarding managed care eligible members from MMIS. Eligibility workers at MassHealth determine MassHealth eligibility. The system then identifies members who meet managed care eligibility criteria and transmits this data to the EB for enrollment into a health plan.~~

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

Outreach Process

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

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

Enrollment Package

~~The member receives an enrollment package inviting him or her to choose a health plan. The enrollment package includes information on how to enroll in a health plan, inserts that explain the various health plan options and enrollment form, a description of the member's legal rights, a self-addressed stamped envelope, and a notice translated into several different languages advising the member to have the information translated immediately.~~

~~The enrollment package materials indicate that the member has fourteen (14) calendar days to choose a health plan or MassHealth will choose one for the member.~~

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

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

~~Assignment~~

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

~~Activities Associated with Non Responding Members and Timeframes~~

~~Standard or Family Assistance members who have not responded to the enrollment and outreach materials within fourteen (14) calendar days will be assigned to a managed care plan either systematically or manually. Manual assignments occur when computer assignment is not possible.~~

~~Algorithm~~

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

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

~~Manual Assignments~~

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

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



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Transfer Policy

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

Member-Initiated Transfers

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

MassHealth-initiated Transfers

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

Provider-Requested Transfers

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

Transfers To Another Health Plan

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

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

~~If a PCC chooses to terminate from the PCC Plan, MassHealth requests that the PCC submit written notice to MassHealth at least thirty (30) days prior to the date of the intended termination. MassHealth sends a letter and enrollment package and asks the member to choose another health plan. The member is instructed to call the~~



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~~Customer Service Center toll free number for assistance in enrolling with a new managed care plan.~~

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

MassHealth Customer Service center

~~MassHealth's Enrollment Broker (EB) operates a toll-free customer service center for all MassHealth members. The customer service center is located at 55 Summer Street, 6<sup>th</sup> Floor, Boston, MA, 02111. The toll-free telephone number is 1-800-841-2900. The toll-free number is an enhanced telephone system with TTY transmission and reception capability and an automatic call distribution system. The EB is required to handle 95% of all incoming calls in three rings or fewer. Additionally, the EB must operate this call center between the hours of 8 a.m. and 5 p.m. EST, Monday through Friday, with the exception of all Federal and designated Massachusetts State holidays.~~

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

- ~~• Train all EB staff assigned to the MassHealth toll-free phone number to adequately and appropriately respond to questions relating to any MassHealth benefit package inquiries;~~
- ~~• Assist members eligible for Standard, Basic, or Family Assistance benefits in the resolution of problems relating to the accessibility of health care services, including but not limited to identifying transportation service issues, language barriers, and handicap accessibility issues;~~
- ~~• Respond to and make best efforts to resolve MassHealth-related inquiries and complaints by members, prospective members, people assisting members or acting on their behalf, including members' family members, other state agencies, advocates or private agency providers;~~
- ~~• Facilitate the resolution of non-clinical service disputes between MassHealth members participating in managed care and their providers;~~

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- ~~Establish procedures, subject to MassHealth's approval, by which to determine when MassHealth intervention or assistance should be sought and how it should be obtained;~~
- ~~Maintain standard referral form(s) and procedures for each instance in which the EB determines that MassHealth assistance is required to adequately, appropriately, and correctly resolve or respond to any member identified issue;~~
- ~~Ensure call backs to members within twenty four (24) hours of receipt, including, but not limited to, after hour messages received via after hour voice mail messaging; and~~
- ~~Ensure that all non-English speaking callers are provided translation services, e.g., EB staff answering telephone calls must speak the caller's language, or must be able to access interpreter services without disrupting the call by contacting other EBs or utilizing the AT&T Language Line service or similar telephone translation service.~~

**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 ~~state's policies governing the processes, if any, that a State will use for instituting enrollment caps, establishing and waiting lists (if any), 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)

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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 has added 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

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- 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-

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- 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;

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- 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 ~~the procedures that~~ assure that:

4.4.1. ☒ ~~Through the screening procedures used at intake and follow-up eligibility~~

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

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

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

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

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

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

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~~by MA21 and the member is automatically notified of any change in eligibility status or coverage type. In making these determinations, MA21 will also update MMIS with the correct category of assistance, which in turn, dictates the funding source (Title XXI vs. Title XIX).~~

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

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

- 4.4.2. ☒ ~~The Medicaid application and enrollment process is initiated and facilitated for~~ children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan ~~under Title XIX~~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.

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

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

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

- 4.4.3. ☒ ~~The State is taking steps to assist in the enrollment in SCHIP of~~ children ~~found through the screening process to be determined~~ 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



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

## ~~MA-014-0006 MMDL (CS20)~~ ~~supersedes all of section 4.4.4.~~

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

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

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

~~MassHealth's premium assistance program, which is based on the combined authority of MassHealth's 1115 Waiver Insurance Partnership Program and Title XXI, will prevent families from dropping their private health insurance coverage. MassHealth covers children with family incomes at or below 300% of the Federal Poverty Level (FPL) regardless of insurance status at the time of application. Thus, there will be no financial incentive for families to drop private coverage to enroll in MassHealth. To discourage families from dropping their private coverage prior to applying for MassHealth, MassHealth emphasizes in its marketing and outreach materials the availability of premium assistance benefits for insured families. Additionally, when the family applies for MassHealth benefits, MassHealth uses the information included on the Application Medical Benefit Request (MBR) to complete an intensive health insurance investigation. This investigation includes matching the applicant's data against MassHealth's health insurance carrier database. This database includes subscriber lists representing approximately 90% of the health insurance market in the Commonwealth. The investigation also includes contact with the applicant's employer to determine whether employer-sponsored health insurance is available. The~~

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information provided by the employer includes: the total health insurance premium; the current employer contribution towards the premium; and the summary of benefits included in the plan. Through the health insurance investigation, MassHealth will be able to ensure that all applicants who have private health insurance and all applicants with access to employer sponsored health insurance participate in private coverage.

~~Through these mechanisms~~ Through its substitution of coverage mechanisms, MassHealth ensures that:

- ~~Children at CHIP income levels, including Medicaid Expansion, Family Assistance and Commonwealth children in Families with employer-sponsored coverage at application may will be covered through premium assistance under MassHealth's 1115 Waiver.~~
- ~~Children at CHIP income levels, including Medicaid Expansion, Family Assistance and Commonwealth children, in Families without private coverage employer-sponsored insurance coverage at application, but with access to employer-sponsored coverage, will be covered through premium assistance under Title XXI.~~
- ~~Children at CHIP income levels, including Medicaid Expansion, Family Assistance and Commonwealth Children, in Families without private coverage at application, and without access to employer-sponsored insurance coverage, may will be covered through Title XXI direct coverage.~~

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

The Commonwealth measures the overall changes in the employer-sponsored insurance market through employer surveys conducted by the Division of Health Care Finance and Policy. Through these surveys, MassHealth is able to monitor changes

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~~both in the overall ESI market and within the large and small group markets. These employer statistics may be used to determine whether changes in the MassHealth Family Assistance population are due to specific employer benefit changes or larger trends in the Commonwealth.~~

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

4.4.4.1. ☒ (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 below. Also see 6.4.2 for a description of Purchase of Family Coverage.

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

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

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

2) The minimum employer contribution

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

~~5) The cost-effectiveness determination~~

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

~~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~~

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

In addition to premium assistance payments, MassHealth will 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.

4.4.4.2. ☒ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify

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~~specific strategies to limit substitution if levels become unacceptable.~~

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

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

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

~~(c) Evaluating annual CPS data; and,~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~The minimum employer contribution~~

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

~~The cost effectiveness determination~~

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

4.4.4.5 ☒ Child health assistance is provided to targeted low-income children in

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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.

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

**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,



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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 has added 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.

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**5.1** (formerly 2.2) Describe the current State efforts to provide or obtain creditable health coverage for uninsured children by addressing section 5.1.1 and 5.1.2 (Section 2102)(a)(2) (42CFR 457.80(b))

**Guidance:** The information below may include whether the state elects express lane eligibility a description of the State's outreach efforts through Medicaid and state-only programs.

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

**Guidance:** The State may address the coordination between the public-private outreach and the public health programs that is occurring statewide. This section will provide a historic record of the steps the State is taking to identify and enroll all uninsured children from the time the State's plan was initially approved. States do not have to rewrite this section but may instead update this section as appropriate.

Massachusetts has many efforts currently underway to identify and enroll eligible children in ~~either~~ MassHealth or other appropriate public coverage programs. These efforts are described below.

### MassHealth

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

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Currently there are over 1,300 "Assisters" – CACs and Navigators – available across the Commonwealth to provide free help for individuals with applying for and maintaining health coverage. The Assisters are across 240+ locations throughout the Commonwealth including 75 hospitals, 64 community health centers, and over 50 community service organizations.

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

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

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

~~Massachusetts continues as a Robert Wood Johnson Foundation Covering Kids' site, collaborating with Health Care for All. MassHealth also continues to work with the medical community including the Massachusetts Hospital Association, the Massachusetts Medical Society, and the American Academy of Pediatrics to promote the MassHealth program. Providers are encouraged to participate in training sessions on MassHealth and are supplied with enrollment kits titled~~

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~~"What to do when an Uninsured Child Shows up at your Door".~~

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

Children's Medical Security Plan (CMSP)

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

Health Safety Net (HSN)

The Health Safety Net reimburses Acute Hospitals and Community Health Centers for eligible services rendered to eligible uninsured or underinsured individuals, provided that such services are not eligible for reimbursement by any other public or third party payer. If a child is determined ineligible for MassHealth and CMSP, an eligibility determination is automatically made for HSN.

Other EOHHS Programs

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

- Early Intervention Programs: Early Intervention Programs (EIPs), certified by

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the Department of Public Health, offer developmental services to both insured and uninsured children. EIPs are able to bill MassHealth for eligible children or are reimbursed by the Department of Public Health for services delivered to uninsured children. EIP staff provides information about CMSP and MassHealth to families with uninsured children.

- School-Based Health Centers: Thirty-~~onethree~~ school-based health centers in the Commonwealth are funded by the Department of Public Health to offer comprehensive primary care services to children and adolescents who are students at the schools served by the centers. The sites are able to bill MassHealth, CMSP and other insurers for services delivered, and also provide services to uninsured children. Additionally, these sites are required to provide information about CMSP and MassHealth to children who indicate they are uninsured.
- ~~Community Based Primary Care: Forty-nine community-based primary care sites are funded by the Department of Public Health to offer supportive services to ease access to medical primary care. These services, which include social services, nutrition and health education, outreach, case management and transportation, are available to both insured and uninsured children. Medical services provided to uninsured children are billed to the Commonwealth's uncompensated care pool. Additionally, these 49 primary care sites are required to provide information about CMSP and MassHealth to children who are uninsured.~~
- The Supplemental Nutrition Program for Women, Infants and Children (WIC): WIC sites are operated under the auspices of the Department of Public Health. The program provides nutritious food to supplement the regular diet of pregnant women, infants and children under age five who meet federal and state income and adjunct eligibility requirements. Women and children under five years old qualify if the combined family income is at or below 185% FPL. WIC staff encourages uninsured pregnant women and parents and guardians of uninsured children to apply for MassHealth. ~~Staff also refers uninsured clients with higher levels of income to CMSP. Note that MassHealth approval notices include information regarding the WIC program if a family member is~~

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pregnant or under age five.

- Safety Net Disproportionate Share Hospitals: These hospitals are MassHealth providers that serve a disproportionate share of low income and uninsured people. The hospitals are entitled to apply to the Commonwealth's free-safety net care pool for payment for health care services delivered to uninsured or underinsured patients. In addition, staff at these hospitals is able to assist uninsured patients in applying for CMSP and MassHealth benefits.
- Case ManagementCare Coordination Program for Children and Youth with Special Health Care Needs: The Department of Public Health employs regionally-based case-managers-care coordinators who offer case-care management services and supports to children and youth with special health care needs and their families using a medical home approach. These case managerscare coordinators often assist families with MassHealth or CMSPand other insurance and public benefits applications, if the child is uninsured. Case managersCare coordinators also provide other social services that may increase access to medical primary care services, including identification of providers with experience in treating children with special health care needs and assisting the family with accessing transportation, durable medical equipment, orand other necessary services. They also educate and assist families with health transition and emergency preparedness.
- Early Intervention Partnerships and Healthy Families Home Visiting Programs: Under these home visiting programs operated by the Department of Public Health, community-based providers perform home visiting services for high-risk pregnant women, and first-time teen mothers. Home visitors perform many activities, including assisting the pregnant women or mothers in accessing health insurance through either CMSP or MassHealth, as well as facilitating the child's access to primary medical care services.
- The Municipal School Based Medicaid Program: MassHealth contracts with municipalities to provide direct health care services to special education students and to assist with administration of the Medicaid program in general.

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One of the activities that is included in the administration is identification of potential MassHealth eligibles, and referral of those eligibles to MassHealth. In addition, under the Municipal Medicaid program, school health personnel are working to increase coordination with the MassHealth managed care system.

**5.1.2.** (formerly 2.2.2.) The steps the State is currently taking to identify and enroll all ~~uncovered~~ uninsured children who are eligible to participate in health insurance programs that involve a public-private partnership:

- Guidance: The State should describe below how it's Title XXI program will closely coordinate the enrollment with Medicaid because under Title XXI, children identified as Medicaid-eligible are required to be enrolled in Medicaid. Specific information related to Medicaid screen and enroll procedures is requested in Section 4.4. (42CFR 457.80(c))

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

Massachusetts administers a combination CHIP program and MassHealth is the name for both Medicaid and CHIP in the state. The state has a joint application for both Medicaid and CHIP and, if children are found to be ineligible for Medicaid, their eligibility for CHIP is then automatically determined. As a result, all outreach and enrollment activities are geared to both programs and both programs are coordinated closely.

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

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



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A health insurance investigation is done on all MassHealth applicants to determine whether there is access to cost effective health insurance and periodic investigations are done on enrolled members. If applicants/ members are found to have access to cost effective health insurance MassHealth requires them to enroll into the health insurance and MassHealth will provide premium assistance.

- 5.2.** (formerly 2.3) Describe ~~the procedures the state uses to accomplish coordination of SCHIP~~ how CHIP coordinates with other public and private health insurance programs, other sources of health benefits coverage for children, ~~and other~~ relevant child health programs, (such as title V), that provide health care services for low-income children to increase the number of children with creditable health coverage. ~~(Previously 4.4.5.)~~ (Section 2102(a)(3), 2102(b)(3)(E) and 2102(c)(2)) (42CFR 457.80(c)). This item requires a brief overview of how Title XXI efforts – particularly new enrollment outreach efforts – will be coordinated with and improve upon existing State efforts.

EOHHS will assess children's eligibility for both Title XIX and Title XXI programs. ~~EOHHS is the Commonwealth's Title XIX agency and has been charged with expanding its health programs to cover Title XXI populations. Eligibility for MassHealth Title XIX and MassHealth Title XXI will be determined simultaneously. The Medical Benefit Request (MBR) Massachusetts Application for Health and Dental Coverage and Help Paying Costs (Application) is used to assess eligibility for all MassHealth programs (Title XIX and Title XXI), as well as the Children's Medical Security Plan and Health Safety Net. Sufficient information is collected on the MBR to assess if the applicant is eligible for any MassHealth coverage type (e.g. MassHealth Standard, CommonHealth or Family Assistance). The MBR Application information is data entered into MassHealth's eligibility system(s) (HIX and/or MA21) to invoke an eligibility determination. HIX and MA21 is are designed to assign the most comprehensive coverage type to the eligible applicant. See Section 4.4.1 for a more detailed description of the eligibility process.~~

As noted above a health insurance investigation is done on all MassHealth applicants to determine whether there is access to cost effective health insurance and periodic investigations are done on enrolled members. If applicants/ members



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are found to have access to cost effective health insurance MassHealth requires them to enroll into the health insurance and MassHealth will provide premium assistance.

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

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

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

**5.2-EL** The State should include a description of its election of the Express Lane eligibility option to provide a simplified eligibility determination process and expedited enrollment of eligible children into Medicaid or CHIP.

MassHealth has also elected the Express Lane Renewal option to provide a simplified renewal process for eligible Medicaid Expansion CHIP children (133% to at or below 150% of the federal poverty level for children aged 1 to 5 years old; 114% to at or below 150% of the federal poverty level for children aged 6 to 17 years old; and 0% to at or below 150% of the federal poverty level for children aged 18 years old). This option is also provided for unborn-CHIP children from 0% to at or below 150% of the federal poverty level. Modified Adjusted Gross Income (MAGI) ~~Gross income~~ is used for all income calculations. The Express Lane renewal process allows Medicaid Expansion CHIP and CHIP children who are

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also receiving Supplemental Nutrition Assistance Program (SNAP) benefits to have their eligibility renewed through an automatic process that will not require a paper renewal form. This process promotes retention of children in health benefits

**Guidance:** Outreach strategies may include, but are not limited to, community outreach workers, outstationed eligibility workers, translation and transportation services, assistance with enrollment forms, case management and other targeting activities to inform families of low-income children of the availability of the health insurance program under the plan or other private or public health coverage.

The description should include information on how the State will inform the target of the availability of the programs, including American Indians and Alaska Natives, and assist them in enrolling in the appropriate program.

**5.3 Strategies** Describe the procedures used by the state to accomplish outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program. (Section 2102(c)(1)) (42CFR 457.90)

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

1. Enlist the support of community-based organizations, social service agencies, schools, and advocacy organizations to inform community residents of available health insurance programs; identify uninsured children; assist with the enrollment process; and support the promotion of educational strategies developed to help members utilize their health care services.
- a) Periodically award mini-grants to community-based organizations to assist in enrollment of "hard-to-reach" uninsured individuals and families and support post enrollment education strategies. ~~MassHealth and the Department of Public Health (DPH) will continue to collaborate on the issuance and monitoring of a joint RFR.~~

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- b) Perform targeted enrollment events and member education campaigns for specific communities or vulnerable populations, such as immigrants and homeless populations, that have high numbers of "hard-to-reach" uninsured residents. ~~MassHealth will make regional outreach coordinators available at each of its four MassHealth Enrollment Centers (MECs) to provide outreach, enrollment, and member education training to community-based organizations in these specified areas. A dedicated MassHealth telephone line was established in 2018 through collaboration between MassHealth and several key homeless shelters in the Boston area on a pilot basis, with the goal of expanding to other areas in the future. This population is inherently transient and do not always receive their mail, making it difficult to maintain their MassHealth coverage, which can create obstacles in their receiving much-needed health care. The homeless line is designed to address this, by providing a "one call resolution" process for homeless shelter workers when they have a client at their location, and need to help him or her with their MassHealth case. Shelter workers can use this line to assist their clients with MassHealth needs including eligibility and health plan management.~~
- c) ~~Conduct school-based outreach campaigns to distribute informational materials explaining the availability of health insurance to families of children attending public, private, and parochial schools and daycare centers and to work with school nurses and/or other school staff to facilitate the enrollment of uninsured children in the appropriate health insurance program. Special emphasis will be placed on pre-school through first grade settings to reach this statistically higher uninsured group. MassHealth and DPH will coordinate all activities related to this initiative.~~
- d) ~~Create and distribute promotional materials to community-based agencies and school settings. Offer training and informational sessions at community sites, statewide, at least once per contracted year.~~
2. Collaborate with primary care providers (including family practice, adult medicine, and pediatric and adolescent health providers) in targeted communities and/or among populations that have high numbers of uninsured residents to furnish information about the availability of free or low-cost health insurance for children.
- a) Coordinate MassHealth outreach and enrollment events efforts with the Massachusetts Health and Hospital Association, ~~and~~ the Massachusetts League of Community Health Centers and certified application "Assisters" (CACs and
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Navigators).

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

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

~~d) —~~

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

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

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

- a) Enrolling eligible unborn child enrollees in MassHealth.

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

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

- ~~a) Use a media consultant to assist with the design and implementation of a media campaign for non-English speaking populations.~~

- ~~b) Produce Public Service Announcements (PSAs) for distribution to local ethnic television and radio stations.~~

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

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

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

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

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

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

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

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**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.

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

- 6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.) (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.)

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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

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- 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. ~~Please a~~Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**

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"



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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}. Please attach a description of the benefits package, administration, and date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 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.

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6.1.4.1. ☒ Coverage ~~the same as~~ 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.

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- 6.1.4.3. ☐ Coverage that ~~either includes the full EPSDT benefit or 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 (~~Please p~~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.

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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 (including FAEC)

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. Long-term care Inpatient rehabilitation and chronic disease hospital services and Nursing Facility services are is limited to 100 days. Certain services listed below are covered only following prior authorization based on medical necessity.

6.2.1. ☒ Inpatient services (Section 2110(a)(1))  
All acute inpatient hospital services such as daily physician intervention,

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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.
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- 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~~~~12~~. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**  
Durable medical equipment, orthotic and prosthetic devices, hearing aids, and eyeglasses are covered when medically necessary and according to the requirements described in the Provider Regulations.
- 6.2.~~11~~~~13~~. ☒ Disposable medical supplies **(Section 2110(a)(13))**

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

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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~~~~15~~. ☒ 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~~~~16~~. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (**Section 2110(a)(16)**)

6.2.~~15~~~~17~~. ☒ 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~~~~20~~. ☐ Case management services (**Section 2110(a)(20)**)

6.2.~~19~~~~21~~. ☐ Care coordination services (**Section 2110(a)(21)**)

6.2.~~20~~~~22~~. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (**Section 2110(a)(22)**)  
Includes individual treatment, comprehensive evaluation, and group therapy.

6.2.~~21~~~~23~~. ☒ 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

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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.

6.2.2324. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. ~~(See instructions)~~ **(Section 2110(a)(24))**  
Inpatient and outpatient chronic or rehabilitation and chronic disease hospital services (inpatient limited to 100 days), early intervention services, oxygen and respiratory therapy services, podiatry services, and chiropractic services. vision care services.

6.2.2425. ☒ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.2526. ☒ 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.



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- 6.2.~~2627~~. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) (**Section 2110(a)(27)**)
- 6.2.~~2728~~. ☒ Any other health care services or items specified by the Secretary and not included under this section (**Section 2110(a)(28)**)  
Chapter 766: home assessment and participation in team meetings  
~~Chiropractic services~~  
Applied Behavior Analysis services.  
Nursing Facility services (limited to 100 days)

~~Covered services for MassHealth Family Assistance-Premium Assistance-~~

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

Covered services for MassHealth CommonHealth – 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  
~~with the following exception: out of state services are covered for emergencies only.~~ Certain services listed below are covered only following prior authorization based on a 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,

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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 nNon-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)**)
- 6.2.1012. ☒ Durable medical equipment and other medically-related or remedial
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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~~~~13~~. ☒ 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~~~~14~~. ☒ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

Includes personal care services and home health nursing services, such as skilled nursing and home health aide services.

6.2.~~13~~~~15~~. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

Includes nurse practitioner services, nurse midwife services, and private duty nursing care.

6.2.~~14~~~~16~~. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16))**

6.2.~~15~~~~17~~. ☒ 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))

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- 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)**)
- 6.2.1820. ☒ ☐ Case management services (**Section 2110(a)(20)**)
- 6.2.1921. ☐ Care coordination services (**Section 2110(a)(21)**)
- 6.2.2022. ☒ 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.
- 6.2.2321. ☒ 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.

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- 6.2.~~24~~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 ~~vision care services~~
- 6.2.~~24~~25. ☒ Premiums for private health care insurance coverage **(Section 2110(a)(25))**
- 6.2.~~25~~26. ☒ 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.~~27~~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~~28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**  
Adult Day Health services  
Chapter 766: home assessment and participation in team meetings  
~~Chiropractic services~~  
Applied Behavior Analysis services  
Nursing Facility services

Covered services for MassHealth CHIP Members ~~Family Assistance-~~ Premium Assistance

Uninsured ~~C~~children enrolled in Medicaid Expansion, CommonHealth CHIP and Family Assistance, who have access to cost effective Employer Sponsored Insurance (ESI) ~~Coverage (but~~

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~~are currently uninsured) may be eligible to receive Premium Assistance with wrap coverage for CommonHealth, and Family Assistance and Medicaid Expansion services not covered by the ESI plan for the benefits they would otherwise receive through direct coverage, upon enrollment in the ESI subject to the state plan and 1115 waiver. 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 and Medicaid Expansion direct coverage. In addition, if they do not have dental coverage through their ESI, they receive the Medicaid Standard dental benefit as a wrap service.~~

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

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

**6.2-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

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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<sup>1</sup>) 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<sup>2</sup> codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

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**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 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.)

6.3 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



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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)). ~~Please describe:~~  
*Previously 8.6*

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 ~~s~~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

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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))

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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 ~~s~~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)

Premium assistance may exceed the cost of child-only coverage and include family coverage if cost effective based on the child's coverage. Please see Section 4.4.4.1 for a description of the State's cost effectiveness test.

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.

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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 and Medicaid Expansion the minimum employer contribution is 50% of the total cost of the health insurance premium. For CommonHealth and Medicaid Expansion 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.

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

Premium assistance may exceed the cost of child-only coverage and include family coverage if cost effective based on the child's coverage. Please see Section 4.4.4.1 for a description of the State's cost effectiveness test.

- 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-

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

**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

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$S$  = (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.

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- 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.**

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**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).

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**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

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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.

**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

<b>STATE: Massachusetts</b>	<b>FFY Budget</b>
<b>Federal Fiscal Year</b>	<b>2020</b>
State's enhanced FMAP rate	76.5%
<b>Benefit Costs</b>	
Insurance payments	21,103,932
Managed care	299,900,400
per member/per month rate	254.49
Fee for Service	431,593,589
<b>Total Benefit Costs</b>	752,597,921
(Offsetting beneficiary cost sharing payments)	
<b>Net Benefit Costs</b>	752,597,921
<b>Cost of Proposed SPA Changes – Benefit</b>	<b>\$0</b>
<b>Administration Costs</b>	
Personnel	
General administration	29,099,153
Contractors/Brokers	
Claims Processing	
Outreach/marketing costs	
Health Services Initiatives	49,090,613
Other	
<b>Total Administration Costs</b>	78,189,766
10% Administrative Cap	83,621,991
<b>Cost of Proposed SPA Changes</b>	<b>\$0</b>
Federal Share	635,552,581
State Share	195,235,106
<b>Total Costs of Approved CHIP Plan</b>	830,787,687

**NOTE: Include the costs associated with the current SPA.**  
\$0

**The Source of State Share Funds:** General Appropriations