Massachusetts CARTS FY2022 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Massachusetts

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

MassHealth

Who should we contact if we have any questions about your report?

4. Contact name:

Alison Kirchgasser

5. Job title:

Federal Policy and CHIP Director

6. Email:

alison.kirchgasser@mass.gov

7. Full mailing address:

Include city, state, and zip code.

Executive Office of Health and Human Services One Ashburton Place, 11th Floor Boston, MA 0108

8. Phone number:

857-207-2147

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather all 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.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ○ No

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☑ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Individuals receive FFS until they enroll with ACO/MCO/PCC, and may also receive Employer Sponsored Insurance (ESI) premium wrap assistance with a FFS benefit wrap for Medicaid Expansion CHIP services not covered by the ESI plan.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

◉ Yes

2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

- (●) Yes
- ( ) No

2b. Indicate the range of premiums and corresponding FPL ranges for one child.

Premiums for one child, tiered by FPL

FPL starts at 150 → **FPL ends at** 200

Premium starts at $ 12 → **Premium ends at** $ 36

FPL starts at 200 → **FPL ends at** 250

Premium starts at $ 20 → **Premium ends at** $ 60

FPL starts at 250 → **FPL ends at** 300

Premium starts at $ 28 → **Premium ends at** $ 84

- [ ] No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at 150 → **FPL ends at** 200

Premium starts at $ → **Premium ends at** $ 432

FPL starts at 200 → **FPL ends at** 250

Premium starts at $ → **Premium ends at** $ 720

FPL starts at 250 → **FPL ends at** 300

Premium starts at $ → **Premium ends at** $ 1,008

- ○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [x] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Individuals receive FFS until they enroll with ACO/MCO/PCC, and may also receive Employer Sponsored Insurance (ESI) premium wrap assistance with a FFS benefit wrap for Medicaid Expansion CHIP services not covered by the ESI plan.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ○ No
- ◉ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

We extended postpartum coverage for all pregnant members from 60 days to 12 months, effective 4/1/22. The extension of postpartum coverage will significantly improve access to health care and continuity of care, particularly in the vulnerable period after childbirth. Additionally, this will bring CHIP into alignment with the seamless insurance coverage experienced by postpartum enrollees in commercial insurance plans.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No
- ○ N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ○ Yes
- ◉ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- (●) Yes
- ( ) No
- ( ) N/A

5. Have you made any changes to the single streamlined application?

- ( ) Yes
- (●) No
- ( ) N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ( ) Yes
- (●) No
- ( ) N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ◉ Yes
- ○ No
- ○ N/A

16. Have you made any changes to coverage for your CHIP pregnant individuals eligibility group?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ○ No
- ◉ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant individuals?

- ○ Yes
- ○ No
- ◉ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- ○ Yes
- ◉ No
- ○ N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

We extended postpartum coverage for all pregnant members from 60 days to 12 months, effective 4/1/22. The extension of postpartum coverage will significantly improve access to health care and continuity of care, particularly in the vulnerable period after childbirth. Additionally, this will bring CHIP into alignment with the seamless insurance coverage experienced by postpartum enrollees in commercial insurance plan. We are applying the expansion to the "Conception to Birth" expansion population at state cost.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- ◉ Yes
- ○ No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2021	Number of children enrolled in FFY 2022	Percent change
Medicaid Expansion CHIP	118,465	124,394	5.005%
Separate CHIP	104,072	96,886	-6.905%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

The increase in Medicaid Expansion CHIP numbers is due to the Maintenance of Effort (MOE) as the number of new members enrolled is much larger than the small number of children terminated during the PHE for allowable reasons (moving out of state, death, or voluntary withdrawal). The decrease in Separate CHIP is due to redeterminations and guidance from CMS that we could terminate individuals aging out of Separate CHIP.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey. Due to the impacts of the COVID-19 PHE on collection of ACS data, the Census Bureau did not release standard one-year ACS estimates in 2020 and that row is intentionally left blank.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2013	Not Available	Not Available	Not Available	Not Available
2014	Not Available	Not Available	Not Available	Not Available
2015	7,000	2,000	0.5%	0.1%
2016	6,000	2,000	0.4%	0.2%
2017	7,000	2,000	0.5%	0.1%
2018	8,000	2,000	0.6%	0.2%
2019	6,000	2,000	0.4%	0.1%
2020	Not Available	Not Available	Not Available	Not Available
2021	5,000	3,000	0.4%	0.2%

Percent change between 2019 and 2021
0.00%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

No

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

- ○ Yes
- ◉ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

(●) Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

The Member Education Unit conducts in-service presentations to various organizations including but not limited to: Native American Indian Tribes; School Nurses; School-based Medicaid Programs; sister state agencies such as the Department of Public Health (DPH), Department of Mental Health, Department of Children and Families, Department of Developmental Services, Department of Veteran's Services, and the Bureau of Substance Addiction Services at DPH; advocates for the homeless, shelters, and other facilities working with the homeless population; and the Massachusetts Head Start Program. These presentations provide education on a variety of topics, including: MassHealth benefits, coverage types, covered services, rights and responsibilities, navigation tools such as website searching, how to access MAhealthconnector.org, how to access other state health insurance programs, the application process, and post-enrollment information on how to maintain health coverage once it has been obtained. Member Education offers continued support to these organizations via e-mail, telephone, and virtual communications in order to ensure proper procedure for application submission and other eligibility processes and expedited service to the members they serve. These efforts have been successful in encouraging new applicants, dispelling any myths about public programs, and assisting members with health insurance coverage retention.

( ) No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

MassHealth continues to fund and provide leadership for the Massachusetts Health Care Training Forum (MTF) program. MTF is a partnership between MassHealth and the UMass Chan Medical School. MTF utilizes a range of communication methods to reach health and human service workers in various fields to communicate State public health insurance related program and policy information, as well as information about related State programs. Communication methods include regional meetings held throughout the fiscal year in regions of the State, program updates/e-mail communications, and a regularly updated program website which features a number of resources and tools, including a growing number of State program webinar opportunities. The quarterly in-person meetings feature presentations (which are also catalogued online) to keep health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured informed of the latest changes in MassHealth and overall state and federal health care policies. MassHealth presents information about programmatic operations and policy changes and often leading community advocates share updates about policy developments in state and federal health care reform. During FFY2022, in response to the COVID-19 public health emergency (PHE), and to support the health and safety of our participants and staff, all MTF meetings were held virtually. To ensure continued communications and to keep health care organizations and community agencies informed of MassHealth's response to the COVID-19 public health emergency, MTF held a total of 36 virtual meetings. The meetings promoted information dissemination, sharing of best practices, and building of community and public sector linkages in order to increase targeted outreach and member education information about MassHealth. In SFY22, MTF program attendance experienced a decrease from previous years due to remote work and participants' varied access to webinar platforms and a total of 2,914 individuals attended. In SFY22, MTF outreached to listserv participants to identify 3,508 active members. MTF also provides information via the listserv, and a website offering resource information and meeting materials. In FFY22, the website had over 36,215 visitors with 69,038-page views in FFY22. In preparation for the end of the PHE and the corresponding unwinding of eligibility protections, MassHealth has been focused on preparing its systems, operations,

and outreach channels to support successful renewals, where individuals receive the best benefit for which they are eligible. This redetermination process will be the single largest health coverage transition event since the first open enrollment of the Affordable Care Act and Medicaid expansion. Members will need to know what to expect and how to keep their health coverage when MassHealth returns to our annual eligibility renewal processes. We expect that many members will either remain eligible for MassHealth or qualify for subsidies that will allow them to obtain affordable coverage through the Health Connector. MassHealth will communicate to members in 2 phases: • Phase 1: NOTIFY - Prepare for renewal of all MassHealth members o MassHealth will work with stakeholders and other partners to make sure members know how to avoid gaps in coverage when renewals begin. • Phase 2: Educate members about how to renew their coverage o MassHealth and its partners will directly outreach to members when they are selected for renewal to make sure that they complete their renewal and know their options for affordable health coverage (if applicable). MassHealth is releasing the toolkit for the first phase of Communications on November 15, 2022, and will also publish a companion webpage for members and stakeholders. The toolkit contains key messages and materials for stakeholders and partners to help them educate and outreach to members during Phase 1. This toolkit serves as a communications guide and provides resources to support the ongoing preparations for the upcoming end of the COVID-19 public health emergency. MassHealth is also working to develop the capability to contact members via text and email that will be stood up in 2023.

4. Is there anything else you'd like to add about your outreach efforts?

The Health Care Reform (HCR) Outreach and Education Unit coordinates statewide outreach activities, disseminates educational materials related to state and federal Health Care Reform, and collaborates with state and community-based agencies. This coordination helps prevent the duplication of outreach efforts in the community, strengthens the knowledge of providers and residents, and provides information to help individuals make smart choices about health coverage. The overall functions of the HCR Unit include the following activities: supporting and managing training and technical assistance for community providers, partners, certified assisters (including Certified Application Counselors (CACs) and Navigators) and coordinating and collaborating with state agencies around state and federal health care reform policies, messaging, and outreach activities. Activities throughout FFY22 continued to focus on ensuring our Certified Assister community stayed informed about the MassHealth health plan options, including the Accountable Care Organizations (ACOs), and MassHealth's response to the COVID-19 PHE. Efforts included a series of quarterly Lead CAC check-in calls and emails with reminders about important dates. Ongoing CAC education and training continued in earnest throughout the year consisting of over 70 CAC touchpoints (emails, conference calls, and webinars) and 17 new/updated online educational content (new/updated courses, job aids, access to recorded webinars, and Q&A).

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- (●) Yes

  1a. What percent of CHIP enrollees had access to private insurance at the time of application?

  9.11%

- ( ) No

- ( ) N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- (●) Yes

  2a. Which database do you use?

  The Premium Assistance vendor conducts a monthly state and national data match which identifies health insurance for all MassHealth members. In FFY22 Accenture handled all Premium Assistance activities, including monthly health insurance data matching for all MassHealth members.

- ( ) No

- ( ) N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

0 %

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting these data?

Question 3 from the template (3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?) seems to be missing above but the blank to add the percentage is there and for us it is 0% because MassHealth has authorization under an 1115 Demonstration to enroll children with employer sponsored insurance at CHIP income levels into MassHealth using Title XIX funding.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?

- (●) Yes

  1a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?

  0 %

  1b. Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?

  0 %

- ( ) No
- ( ) N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ( ) Yes
- (●) No

3. Do you send renewal reminder notices to families?

- ○ Yes
- ◉ No

4. What else have you done to simplify the eligibility renewal process for families?

MassHealth performs streamline renewals, annual renewals, and auto renewals to decrease the number of paper renewals that are sent to families. If a paper renewal is sent out the member can mail, fax, phone or complete the renewal online.

5. Which retention strategies have you found to be most effective?

The most effective is streamlined renewals.

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

We do not track retention. We track the percentage of auto renewals that was done by renewal data source.

7. Is there anything else you'd like to add that wasn't already covered?

Questions 1a (What percent of children are presumptively enrolled in CHIP pending a full eligibility determination?) and 1b (Of the children who are presumptively enrolled, what percent are determined fully eligible and enrolled in the program (upon completion of the full eligibility determination)?) appear to be missing above but the blanks to answer are there and our responses are 0% for both as the small number presumptively eligible round to 0%.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2022?
Don't include applicants being considered for redetermination - these data will be collected in Part 3.

654

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

21

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

633

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

0

4. How many applicants were denied CHIP coverage for other reasons?

0

5. Did you have any limitations in collecting these data?

The system will not allow us to enter "0" for Q3a or 4 but that is the correct response to those questions. Additional information for 3a - we have a joint application and determine applicants for the richest benefit for which they are eligible. Therefore, we do not deny applications for Title XXI and enroll them in Title XIX but rather just enroll them directly into Title XIX.

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	3.21%
Denied for eligibility reasons	96.79%
Denials for other reasons	0%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2022?

96868

2. Of the eligible children, how many were then screened for redetermination?

215197

3. How many children were retained in CHIP after redetermination?

208003

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

7194

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

2061

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

5133

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting these data?

The system will not allow us to enter 0 for 4c

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	96.66%
Children disenrolled after redetermination	3.34%

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	28.65%
Children disenrolled for eligibility reasons	71.35%
Children disenrolled for other reasons	0%

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2022?

2. Of the eligible children, how many were then screened for redetermination?

460778

3. How many children were retained in Medicaid after redetermination?

452057

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

8721

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

377

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

8344

4c. How many children were disenrolled for other reasons?

0

5. Did you have any limitations in collecting these data?

The system will not allow us to answer "N/A due to the PHE MOE" for Question 1 or 0 for 4c.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	100%
Children retained after redetermination	98.11%
Children disenrolled after redetermination	1.89%

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	100%
Children disenrolled for procedural reasons	4.32%
Children disenrolled for eligibility reasons	95.68%
Children disenrolled for other reasons	0%

Part 5: Tracking a CHIP cohort over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2022) and six months later (July - Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2023) and 18 months later (July - Sept 2023). If data are unknown or unavailable, leave it blank - don't enter a zero unless these data are known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
392	728	1115	509

July - September 2022 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
268	502	747	356

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
19	20	38	<11

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	0	0	

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
105	206	330	143

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

9. Is there anything else you'd like to add about your data?

We are unable to enter zeros for questions 6 and 8

January - March 2023 (12 months later): to be completed next year
Next year you'll report data about your cohort for this section.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid Cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2022 (the second quarter of FFY 2022). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of

children identified at the start of the cohort (Jan-Mar 2022) and six months later (July-Sept 2022). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2023) and 18 months later (July-Sept 2023). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2022. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2022 must be born after January 2006. Similarly, children who are newly enrolled in February 2022 must be born after February 2006, and children newly enrolled in March 2022 must be born after March 2006.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in Medicaid in December 2021.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2022 weren't enrolled in CHIP or Medicaid in December 2021.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

○ Yes

○ No

January - March 2022 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2022?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
7740	3121	3228	1434

July - September 2022 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later? Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
7387	2727	2812	1219

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
43	72	78	35

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
310	322	338	180

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

9. Is there anything else you'd like to add about your data?

We are unable to enter zeros for questions 6 and 8

January - March 2023 (12 months later): to be completed next year
Next year, you'll report data about your cohort for this section.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2023 (18 months later): to be completed next year
Next year you'll report data about your cohort for this section.

15. How many children were continuously enrolled in Medicaid 18 months later?
Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
- Transferred to another health insurance program other than Medicaid
- Didn't meet eligibility criteria anymore
- Didn't complete documentation
- Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- ○ Families ("the shoebox method")
- ○ Health plans
- ◉ States
- ○ Third party administrator
- ○ Other

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

Massachusetts' eligibility verification system (EVS) enables providers to recognize no cost sharing is applicable for member via restrictive messaging that displays upon verification of eligibility.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

5,106

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add that wasn't already covered?

For #4 in this section the template asked how many children exceeded the 5% cap and our response is for the number of children (5,106) as that is the data we requested based on the language in the template. The online form now asks for how many families exceeded the 5% cap and that it likely a smaller number than 5,106.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- (●) Yes
- ( ) No

1. Under which authority and statutes does your state offer premium assistance? Check all that apply.

- [x] Purchase of Family Coverage under CHIP State Plan [2105(c)(3)]
- [ ] Additional Premium Assistance Option under CHIP State Plan [2105(c)(10)]
- [ ] Section 1115 Demonstration (Title XXI)

2. Does your premium assistance program include coverage for adults?

- (●) Yes
- ( ) No

3. What benefit package is offered as part of your premium assistance program, including any applicable minimum coverage requirements?

This only applies to states operating an 1115 demo.

Secretary approved per the State Plan amendment approved in March 2002

4. Does your premium assistance program provide wrap-around coverage for gaps in coverage?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No

5. Does your premium assistance program meet the same cost sharing requirements as that of the CHIP program?
This only applies to states operating an 1115 demo.

- (●) Yes
- ( ) No
- ( ) N/A

6. Are there protections on cost sharing for children (such as the 5% out-of-pocket maximum) in your premium assistance program?
This only applies to states operating an 1115 demo.

- (●) Yes

  6a. How do you track cost sharing to ensure families don't pay more than 5% of the aggregate household income in a year?

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

- ( ) No

7. How many children were enrolled in the premium assistance program on average each month in FFY 2022?

16571

8. What's the average monthly contribution the state pays towards coverage of a child?

$ 314

9. What's the average monthly contribution the employer pays towards coverage of a child?

$ 50

10. What's the average monthly contribution the employee pays towards coverage of a child?

$ 50

Table: Coverage breakdown

Child

State	Employer	Employee
314	50	50

11. What's the range in the average monthly contribution paid by the state on behalf of a child?

Average Monthly Contribution

Starts at		Ends at
$ 0	→	$ 3,802

12. What's the range in the average monthly contribution paid by the state on behalf of a parent?

Average Monthly Contribution

Starts at		Ends at
$ 0	→	$ 150

13. What's the range in income levels for children who receive premium assistance (if it's different from the range covering the general CHIP population)?

Federal Poverty Levels

Starts at		Ends at
0	→	300

14. What strategies have been most effective in reducing the administrative barriers in order to provide premium assistance?

Since Premium Assistance investigates employers and the insurance offered to employees, maintaining an employer database is critical in facilitating the investigation process. The process allows MassHealth to gather all of the ESI information that an employer offers including: the names of all health insurance plans the employer offers, premiums and tiers, annual open enrollment rates, and summary of benefits for each health insurance offered. This process of gathering and storing current employer insurance information streamlines the determination when other members are being reviewed and are employed by the same employer. The database is updated annually, during the open enrollment periods. Additionally, the Department of Revenue implemented the Health Insurance Responsibility Disclosure (HIRD) reporting requirement in 2018 that annually collects employer-level information about employer-sponsored insurance offerings and Premium Assistance leverages this data to streamline employer-sponsored insurance identification efforts. Other successful efforts to streamline Premium Assistance customer service and outreach included automated call campaigns, pre-call text messaging, and increased digital communications and website improvements to provide members easier access to information.

15. What challenges did you experience with your premium assistance program in FFY 2022?

The greatest challenge for the ESI program has been and continues to be the maintenance of household information relating to employment, health insurance plan benefits meeting the qualifying standards for coverage (ESI plans are steadily increasing deductibles and out of pocket maximums, health Insurance premiums are increasing, more employers are offering High Deductible Health Plans with Health Savings Accounts). The suspension of the ability to terminate members with confirmed access to ESI who do not enroll in such coverage due to the Public Health Emergency Maintenance of Eligibility in FFY2022 also hindered the program's ability to ensure member compliance with requests to enroll in affordable coverage.

16. What accomplishments did you experience with your premium assistance program in FFY 2022?

The Premium Assistance Unit continues work toward the goal of increasing enrollment into the program by making enhancements to streamline the process of investigating referrals for access to ESI. This includes targeted approaches to analyzing and working referral files and enhancing relationships with employers to get more timely and accurate updated information, as well as improving member outreach and communication methods. Premium Assistance has maintained enrollment numbers over the course of the year due to continuous improvement efforts.

17. Is there anything else you'd like to add that wasn't already covered?

The responses for #9 and #10 are 50% of the total ESI premium but the response box will not allow us to note that this is a % and not a $ amount. Additional information for response to question 12: $150 is calculated into the cost-effective amount for a non-MassHealth eligible parent when the parent is the policyholder of the ESI-plan and the employer contributes 50% of the total cost of the insurance plan.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

The Provider Compliance Unit, operated within the University of Massachusetts Chan Medical School (UMass Chan), and managed by the MassHealth Program Integrity Unit, is our primary post-payment fraud detection unit. Utilizing algorithms and reports found in our data warehouse, and through data analysis, the Provider Compliance Unit reviews paid claims data to detect aberrant trends and outlier billing patterns that can indicate potential fraud. The Provider Compliance Unit works closely with Program Integrity to meet our federal regulatory obligation to establish a surveillance utilization control system to safeguard against fraudulent, abusive, and inappropriate use of the Medicaid program. The Financial Compliance Unit (FCU) also operated within UMass Chan, and managed by the MassHealth Program Integrity Unit, performs audits or reviews of providers' financial records. These audits focus on providers' accounting records, specifically accounts receivables. FCU analyzes charges, payments, and other account activity, leading to the identification of overpayments. The FCU works closely with Program Integrity to safeguard against inappropriate, abusive, and potential fraudulent use of the Medicaid program. Additionally, MassHealth oversees a Third-Party Administrator contract with Optum which is responsible for carrying out program integrity activities, including on-site audits, desk reviews and algorithms, focused on long-term supports and services (LTSS) providers. MassHealth Program Integrity works closely with Optum across multiple weekly coordination calls and provides detailed input on all audit findings of non-compliance and associated overpayments. MassHealth also oversees an Acute Hospital Utilization Management contract with Permedion, including both pre- and post-payment reviews carried out by the acute hospital utilization control vendor. In addition, the Office of Clinical Affairs Non-Institutional Provider Review Unit also operated within UMass Chan conducts post-pay utilization clinical peer review of non-institutional providers, including reviews of the paid claims, medical records, and other relevant records. MassHealth Program Integrity also works across units engaged in program integrity to coordinate activities, establish unit specific internal control plans and risk assessments, manage external audit activity, coordinate the CMS Payment Error Rate Measurement (PERM), and establish and monitor compliance with information privacy and security requirements. Our MMIS system processes provider claims and contains a significant number of sophisticated edits, rules, and other program integrity checks and balances. The

MMIS has been designed with enhanced Program Integrity capabilities, including expanded functionality to add claims edits as needed to keep abreast with the latest trends in aberrant or fraudulent claims submissions. Generally, information systems support to MassHealth remains a significant priority of the Executive Office of Health and Human Services, in large part because of the potential of leveraging technology to combat fraud, waste, and abuse in the Medicaid program. The EOHHS Data Warehouse, for example, is a consolidated repository of claims and eligibility data that provides program and financial managers with the ability to develop standard and ad-hoc management reports. The Claims Operations Unit manages our claims processing contractor and monitors claims activity weekly. The EOHHS Office of Financial Management organizes a weekly Cash Management Team made up of budget, program, and operations staff that closely monitors the weekly provider claims payroll and compares year-to-date cash spending with budgeted spending by both provider type and budget category. The prior authorization unit ensures that certain services are medically necessary before approving the service. Even more sophisticated measures are in place for the pharmacy program. The Drug Utilization Review program at UMass Chan monitors and audits pharmacy claims and is designed to prevent early refills, therapeutic duplication, ingredient duplication, and problematic drug-drug interaction. In February 2004, our Managed Care Program instituted required reporting on fraud and abuse protections for all of MassHealth's managed care organizations. Finally, MassHealth contracts with two vendors, one who supports LTSS and the other that supports the Office of Provider & Pharmacy Programs to support provider enrollment. These two vendors provide customer service to MassHealth members and providers. Our customer service contractors verify the credentials of all providers applying to participate in our program as well as re-credentialing existing providers and will work closely with the Board of Registration in Medicine, the Division of Professional Licensing, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against enrolled providers.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

- (●) Yes

  5a. What safeguards and procedures do the Managed Care plans have in place?

  All managed care plans that serve the CHIP population are required to have written program integrity plans and written fraud, waste, and abuse plans in place. Contract language for ACOs, MCOs and our behavioral health PIHP specifies program integrity and fraud and abuse prevention, detection, and reporting requirements for health plans contracting with MassHealth.

- ( ) No

- ( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2022?

6417

7. How many cases have been found in favor of the beneficiary in FFY 2022?

81

8. How many cases related to provider credentialing were investigated in FFY 2022?

119

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2022?

0

10. How many cases related to provider billing were investigated in FFY 2022?

156

11. How many cases were referred to appropriate law enforcement officials in FFY 2022?

13

12. How many cases related to beneficiary eligibility were investigated in FFY 2022?

5456

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2022?

731

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

◉ Yes

15a. How do you provide oversight of the contractors?

For each of the aforementioned vendors, MassHealth has contract management controls in place including regular reporting and meetings to review vendor activity. The MassHealth Program Integrity Unit oversees the UMass Chan Provider Compliance Unit (PCU) through numerous communications and documentation, including monthly meetings between MassHealth and PCU to review monthly activities, findings, and reports. MassHealth has developed and implemented a process for monitoring the UMass Chan PCU's monthly case report. MassHealth and PCU use a shared mailbox to document MassHealth sign-off on case openings, closings, mailing of findings and any other update in a case's status. On a quarterly basis, MassHealth reviews these emails against the monthly report to ensure cases are updated accurately. In addition, on a quarterly basis, MassHealth requests records for a sample of open cases as well as any cases closed in the fiscal year for a review for quality as well as accuracy against the monthly report. The MassHealth Program Integrity Unit oversees the UMass Chan Financial Compliance Unit (FCU) through numerous communications and documentation, including monthly meetings between MassHealth and FCU to review monthly activities, findings, and reports. MassHealth has implemented an updated monitoring process of the FCU audits of inpatient hospital and long-term care audits. At the beginning of each fiscal year, FCU sends a list of inpatient hospitals and long- term care facility audit candidates to the inpatient hospital and nursing facility program managers for their approval. On a quarterly basis, MassHealth will review the monthly report provided by FCU against the list of audit targets identified at the beginning of the fiscal year. At the monthly FCU meetings, MassHealth will raise any questions stemming from this review and resolve any open issues to ensure all audits planned for the fiscal year remain on track. In addition, MassHealth will provide an administrative review and approval of each audit's findings prior to FCU issuing to the provider. This review will focus on accuracy of cover letter against findings attachments and identify any inconsistencies to be corrected before sending to the provider. In addition, the Office of Long-Term Services and Supports (OLTSS) oversees Optum's program integrity activities. OLTSS requires Optum to report the

results of those activities monthly through monthly meetings and reports. The monthly meetings and reports focus on algorithms, site audits, and desk audits, as well as management minutes questionnaire (MMQ) audits of nursing facilities. To ensure that Optum is conducting MMQ audits correctly and appropriately, the OLTSS Clinical Team audits Optum's findings on a subsample of providers within each of the MMQ audit cycles. The results of these audits are presented to Optum and training opportunities are identified, either for the Optum RN team generally or with individual nurses. The Optum Clinical Manager also has a monthly call with OLTSS Clinical team to review any questions or concerns that arise from Optum's monthly audits. With regard to the Acute Hospital Utilization Management contract, MassHealth manages a contract with Permedion, whereby there are regular reports to review monthly activity and annual meetings to review performance and goals. With regard to the Non-Institutional Provider Review activities, MassHealth manages a contract with the Umass Chan Medical School Office of Clinical Affairs, whereby there are monthly meetings to review cases, findings, reports, letters and actions taken arising out of Umass Chan activities. There is also a monthly status report that is reviewed.

○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

(●) Yes

16a. What specifically are the contractors responsible for in terms of oversight?

MassHealth's contracted managed health care plans provide oversight of their own safeguards and procedures, including any material subcontractors performing program integrity functions for the managed care population of members/providers. As noted in response to #5 above, managed care health plans are required by contract to have written program integrity plans and written fraud, waste, and abuse plans in place. MassHealth provides direct oversight of the EOHHS-contracted vendors, as noted in the response to #4 above, performing program integrity functions.

( ) No

17. Is there anything else you'd like to add that wasn't already covered?

For Q6 and Q7 the numbers are for all members. We don't have breakdowns for children but the numbers for members under 65 are 1,927 and 19 respectively. The response to Q9 is 0.

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5' group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
713	2973	16881	32121	43382	34811

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
15	450	5520	12221	16309	11783

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2022?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	423	5352	11698	14902	9909

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2022?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
14	48	1549	5801	9226	7315

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2022?

3665

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction. For the 2022 CARTS report, the only option for reporting

CAHPS results will be through the submission of raw data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database.

1. Did you collect the CAHPS survey?

- ○ Yes
- ◉ No

Part 2: You didn't collect the CAHPS survey

Since you didn't collect the CAHPS survey, please complete Part 2.

1. Why didn't you collect the CAHPS survey?
Check all that apply.

- [ ] Entire population wasn't included in the survey
- [ ] Part of the population wasn't included in the survey
- [x] Data wasn't available due to budget constraints
- [ ] Data wasn't available due to staff constraints
- [ ] Data wasn't consistent or accurate
- [ ] Data source wasn't easily accessible
- [ ] Data source wasn't easily accessible: requires medical records
- [ ] Data source wasn't easily accessible: requires data linkage that doesn't currently exist
- [ ] Data wasn't collected by a provider
- [ ] Sample size was too small (fewer than 30)
- [x] Other

2. Explain in more detail why you weren't able to collect the CAHPS survey.

MassHealth administers and collects a CAHPS-based survey instrument developed and used statewide in Massachusetts. It is based on the 3.0 CAHPS Clinician and Group survey and is administered for the managed care (specifically ACO) and PCCM population. The FFS population is not surveyed given limited population, budget, and staff constraints. The MCO-only (non-ACO) managed care population is not administered by MassHealth but surveyed through MassHealth contracted plans (sampled as part of their overall managed care population). Plans are encouraged to submit these raw data (for their overall managed care population) directly to the AHRQ CAHPS database. Additional information for 1a. - Although the response to "Did you submit your CAHPS raw data to the AHRQ CAHPS database" is no, we encourage MH contracted managed care plans that collect the CAHPS survey to submit raw data directly to the AHRQ CAHPS database where available.

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of the total computable amount of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act, 42 CFR 457.10 and 457.618.] States may only claim HSI expenditures after funding other costs to administer their CHIP State Plan.

1. Does your state operate Health Services Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

Healthy Families - Newborn Home Visiting Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Families with at-risk newborns

4. How many children do you estimate are being served by the HSI program?

4869

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the percentage of children with a primary care provider.

7. What outcomes have you found when measuring the impact?

95% of children have a primary care provider.

8. Is there anything else you'd like to add about this HSI program?

Healthy Families provides a neonatal and postnatal parenting education and home visiting program. For #5 - this statistic is not captured.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Essential School Health Services (ESHS)

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Students in elementary school (K-12) who receive school nurse services

4. How many children do you estimate are being served by the HSI program?

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the proportion of students at funded ESHS programs with special health care needs who have an Individual Health Care Plan.

7. What outcomes have you found when measuring the impact?

18% have an Individual Health Care Plan.

8. Is there anything else you'd like to add about this HSI program?

This program provides school nurse services. For #4 - This statistic is not available. While more than 4.6 million student health encounters are recorded annually, there is no data available on the number of unduplicated users. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Safe Spaces

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Young LGBT people throughout the Commonwealth

4. How many children do you estimate are being served by the HSI program?

624

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The number of youth who receive direct services to decrease risk for suicidal (and self-harm) behaviors or exposure to violence.

7. What outcomes have you found when measuring the impact?

All youth within the program are receiving direct services.

8. Is there anything else you'd like to add about this HSI program?

Through this program, community agencies provide suicide prevention and violence prevention services for Gay, Lesbian, Bisexual, and Transgender youth. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

State Funded Women, Infant, and Children (WIC) Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Pregnant women and mothers with children under age 5

4. How many children do you estimate are being served by the HSI program?

22491

5. How many children in the HSI program are below your state's FPL threshold?

22491

Computed: 100%

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the percentage of WIC infants breastfeeding at 3 months.

7. What outcomes have you found when measuring the impact?

46.7% of WIC infants are breastfeeding at 3 months.

8. Is there anything else you'd like to add about this HSI program?

This program provides the same services as the federally funded Women, Infants and Children program. For #5 - The program uses WIC eligibility criteria which is 185% FPL, so all served by this program are under our CHIP threshold of 300% FPL.

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Smoking Prevention and Cessation Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Youth in Massachusetts who report using tobacco products

4. How many children do you estimate are being served by the HSI program?

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the percentage of youth in Massachusetts who report using tobacco products.

7. What outcomes have you found when measuring the impact?

18.4%

8. Is there anything else you'd like to add about this HSI program?

This program funds media campaigns and youth training initiatives to discourage tobacco use among young people. For #4 - This statistic is not captured. This program primarily funds media campaigns, outreach programs and youth training initiatives to combat youth tobacco use. Therefore, there is no specific client count. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Family Planning Programs

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Clients of community-based organizations including clinics, health centers, etc.

4. How many children do you estimate are being served by the HSI program?

10752

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Percentage of female clients who were pregnant at the time they sought services at a funded site.

7. What outcomes have you found when measuring the impact?

4.8% of all female clients

8. Is there anything else you'd like to add about this HSI program?

For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Project to Prevent Out of Home Residential Placements

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Clients of the Massachusetts Department of Developmental Services who are at high-risk of needing an institutional level of care

4. How many children do you estimate are being served by the HSI program?

554

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The percent of individuals being served that avoid out-of-home placements.

7. What outcomes have you found when measuring the impact?

98% of clients served (544) avoided out-of-home placements.

8. Is there anything else you'd like to add about this HSI program?

Provides an array of family-driven community-based services to help young people continue to live at home with their families. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

School Breakfast

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Children in K-12 schools

4. How many children do you estimate are being served by the HSI program?

224790

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the number of school children in Massachusetts who receive nutritious breakfast.

7. What outcomes have you found when measuring the impact?

224,790 children received nutritious breakfasts.

8. Is there anything else you'd like to add about this HSI program?

For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Safe and Successful Youth

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Young men (age 14-24) identified by their communities as the highest risk individuals for being perpetrators of or victims of violence and their families.

4. How many children do you estimate are being served by the HSI program?

1897

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Number of clients enrolled in SSY Case Management Services.

7. What outcomes have you found when measuring the impact?

963 clients enrolled in Case Management.

8. Is there anything else you'd like to add about this HSI program?

For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Teen Pregnancy Prevention

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Teens at risk of becoming pregnant

4. How many children do you estimate are being served by the HSI program?

3683

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The number of youths provided evidence-based sexuality education programming.

7. What outcomes have you found when measuring the impact?

3,683 youth received the above-mentioned services.

8. Is there anything else you'd like to add about this HSI program?

For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Youth Violence Prevention

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Youth at elevated risk for violence but who are not yet engaging in serious acts of violence

4. How many children do you estimate are being served by the HSI program?

2646

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the number of youths aged 18 or younger who receive direct services.

7. What outcomes have you found when measuring the impact?

2,646 youth aged 18 or younger received direct services.

8. Is there anything else you'd like to add about this HSI program?

This program provides funding to community-based organizations which provide activities aimed at preventing and reducing at-risk behavior among young people. These prevention interventions include, but are not limited to: The promotion of family and community environments that support healthy youth development; quality out-of-school-education programs; strengthening youth skills through Positive Youth Development, and, intervening to lessen harm and prevent future violence. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Young Parent Support Program

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

High-risk families

4. How many children do you estimate are being served by the HSI program?

685

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Number of children whose parents received parenting education services.

7. What outcomes have you found when measuring the impact?

580 received parenting education services.

8. Is there anything else you'd like to add about this HSI program?

This program provides funding for community-based organizations that provide outreach, home visits, mentoring, and parent groups in order to strengthen the skills of young parents. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Child-at-Risk Hotline

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Children at risk of abuse and neglect

4. How many children do you estimate are being served by the HSI program?

74452

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the percentage of the hotline calls that are answered and processed.

7. What outcomes have you found when measuring the impact?

85.06 % of the calls to the hotline are answered and processed.

8. Is there anything else you'd like to add about this HSI program?

For #4 - this reflects the number of calls that come in over the course of the year to the child abuse and neglect hotline. This is not an unduplicated child count. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Services for Homeless Youth

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Homeless youth in the Commonwealth of Massachusetts

4. How many children do you estimate are being served by the HSI program?

355

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

The number of monthly child care slots with support services made available during the year for homeless youth.

7. What outcomes have you found when measuring the impact?

4,264 monthly child care slots for homeless youth were made available.

8. Is there anything else you'd like to add about this HSI program?

Under this HSI, the Department of Early Education and Care provides funds to community organizations that provide childcare slots and related support services for homeless youth so their families can secure housing, employment, and/or attend necessary appointments. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Children's Medical Security Plan

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Uninsured children under the age of 19

4. How many children do you estimate are being served by the HSI program?

64338

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as percent of eligible children receiving covered services per month.

7. What outcomes have you found when measuring the impact?

18% of eligible children received covered services per month.

8. Is there anything else you'd like to add about this HSI program?

This program provides preventive and primary care services to uninsured children under the age of 19 who are not eligible for Medicaid or CHIP. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Pediatric Sexual Assault Nurse Examiner Program (SANE)

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Adolescents and children who disclose sexual assault and report to SANE designated emergency departments or Children's Advocacy Centers in MA.

4. How many children do you estimate are being served by the HSI program?

1358

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

Children and youth under age 19 that received a consult from a pediatric Sexual Assault Nurse Examiner (SANE).

7. What outcomes have you found when measuring the impact?

1,358 Individuals served.

8. Is there anything else you'd like to add about this HSI program?

The funding for this program is used to provide targeted, developmentally appropriate intervention to assist children and adolescents who have disclosed sexual assault. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. What is the name of your HSI program?

Pediatric Palliative Care Program (PPC)

2. Are you currently operating the HSI program, or plan to in the future?

- (●) Yes
- ( ) No

3. Which populations does the HSI program serve?

Children age 18 and younger with life-limiting illnesses

4. How many children do you estimate are being served by the HSI program?

700

5. How many children in the HSI program are below your state's FPL threshold?

Computed:

Skip to the next section if you're already reporting HSI metrics and outcomes to CMS, such as in quarterly or monthly reports.

6. How do you measure the HSI program's impact on the health of low-income children in your state? Define a metric to measure the impact.

This is defined as the number of children age 18 and under determined by a physician to have a life-limiting illness

7. What outcomes have you found when measuring the impact?

700 children age 18 and under determined by a physician to have a life-limiting illness.

8. Is there anything else you'd like to add about this HSI program?

This program provides funding to assist children with life limiting illnesses and their families. For #5 - this statistic is not captured

9. Optional: Attach any additional documents.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them

are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Maintain an overall children's uninsurance rate of no more than 1.5%.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Number of uninsured children under age 19 in Massachusetts at all income levels.

4. Numerator (total number)

18000

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

Total number of children under the age of 19 in Massachusetts at all income levels.

6. Denominator (total number)

1469000

Computed: 1.23%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2021

End

mm/yyyy

12 / 2021

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ◉ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The uninsurance rate for children in Massachusetts is 1.2% which is under the goal of 1.5% (and under the 1.15% rate in 2020, this measure was not reported in the American Community Survey in FFY21 due to COVID-19).

10. What are you doing to continually make progress towards your goal?

Massachusetts will continue efforts to enroll every child eligible for health insurance.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal.

For example: In an effort to reduce the number of uninsured children, our goal is to increase enrollment by 1.5% annually until the state achieves 90% enrollment of all eligible children in the CHIP program.

Maintain or reduce the uninsurance rate for Hispanic children under the age of 18 at or below 1.5%

2. What type of goal is it?

- ○ New goal
- ○ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total estimated number of children eligible for CHIP within the state in the last federal fiscal year.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start
mm/yyyy

/

End
mm/yyyy

/

8. Which data source did you use?

- Eligibility or enrollment data
- Survey data
- Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

We are not able to report on this goal as the American Community survey did not include breakdowns of the uninsured population by age and race

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Increase access to care We do not report on this objective due to overlap with the Child Core Set and we do not list this in our CHIP State Plan.

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase access to care for underserved populations, our goal is to increase the number of children of Hispanic ethnicity who have visited a primary care physician by 5% annually over the next five years (ending in 2028).

2. What type of goal is it?

- ○ New goal
- ○ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children of Hispanic ethnicity enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children of Hispanic ethnicity enrolled in CHIP in the last federal fiscal year.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

/

End

mm/yyyy

/

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increase the use of preventative care We do not report on this objective due to overlap with the Child Core Set and we do not list this in our CHIP State Plan.

1. Briefly describe your goal as it relates to this objective.

For example: In an effort to increase the use of preventive care in rural communities, our goal is to increase the number of rural children who receive one or more well child visits by 5% annually until relative utilization is equivalent to all other CHIP populations within the state.

2. What type of goal is it?

- ○ New goal
- ○ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of rural children who received one or more well child visits in the last federal fiscal year.

4. Numerator (total number)

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of rural children enrolled in CHIP.

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

/

End

mm/yyyy

/

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ○ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

10. What are you doing to continually make progress towards your goal?

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Objectives related to CHIP Enrollment

1. Briefly describe your goal as it relates to this objective.

Maintain or increase the number of Affordable Care Act (ACA) Certified Application Counselor (CAC) Assister sites at 100 or higher statewide

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The number of organizations that successfully met ACA CAC requirements and executed a CAC contract with both the Office of Medicaid and the Massachusetts Health Connector during FFY22.

4. Numerator (total number)

268

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

N/A

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ( ) Eligibility or enrollment data
- ( ) Survey data
- (•) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The number of organizations meeting this standard went from 261 to 268 organizations at the end of 9/30/21 and 9/30/22. The number of CAC organizations throughout the Commonwealth far surpass this particular goal of 100.

10. What are you doing to continually make progress towards your goal?

We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

Maintain or increase the percentage of CHIP children enrolled in premium assistance at 2.5% or more of overall MassHealth CHIP child enrollment.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

All CHIP children ever enrolled in CHIP Premium Assistance during the fiscal year

4. Numerator (total number)

4519

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

All children ever enrolled in CHIP during the fiscal year

6. Denominator (total number)

219360

Computed: 2.06%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The percentage of CHIP children ever enrolled in Premium Assistance during the year was 2.1%. This is below the goal and lower than the 2.13% rate for FFY21.

10. What are you doing to continually make progress towards your goal?

The Commonwealth's efforts towards universal coverage continue to succeed despite increases in health insurance premiums. Providing subsidies to employees so that they can participate in their employer-sponsored insurance is a valuable and cost-effective tool for MassHealth in decreasing uninsurance and increasing enrollment in health insurance of children, particularly within higher income ranges. Enrollment in employer sponsored insurance in Massachusetts continues to be strong and has remained steady since the implementation of health care reform, showing no signs that MassHealth has crowded out private insurance.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal as it relates to this objective.

We will continue to maintain or increase the number of ACA Certified Application Counselor (CAC) Assisters at 1,000 individuals or more statewide.

2. What type of goal is it?

- ( ) New goal
- (•) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

The total number of ACA Certified Application Counselor (CAC) Assisters located at CAC designated organizations during FFY22.

4. Numerator (total number)

1268

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

N/A

6. Denominator (total number)

Computed:

7. What is the date range of your data?

Start

mm/yyyy

10 / 2021

End

mm/yyyy

09 / 2022

8. Which data source did you use?

- ○ Eligibility or enrollment data
- ○ Survey data
- ◉ Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The number this year decreased from last year but we still exceeded our goal of 1,000 or more ACA Certified Application Counselor (CAC) Assisters statewide during FY22.

10. What are you doing to continually make progress towards your goal?

We will continue to devote resources in order to maintain or increase the number of web-based health benefit application organizational access sites, known as "CACs" under the Affordable Care Act.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

To further support and inform measurement and reporting goals, other strategies and activities include: · Implementing a MassHealth Childhood Immunization Initiative where MassHealth has entered into a data-sharing agreement with the Department of Public Health (DPH) to get Massachusetts Immunization Information System (MIIS) data on Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA). These data are mapped to member data so that MassHealth can better track immunization trends for our members under 21 and respond with focused intervention as needed. · MassHealth is currently creating immunization 'overdue' and 'soon to be due' member-level reports in order to better identify members with which plans/providers should work to get vaccinated. This work is particularly essential in light of the concern for decreased childhood immunizations during the COVID-19 pandemic.

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will these data become available?

Parent, Child and Family (PCF) Dashboard A Tableau data dashboard has been developed in order to better understand trends for members <21 years of age and pregnant people. This PCF Dashboard is intended to provide data that will in turn assist the PCF team in providing subject matter expertise across the agency. MassHealth member data and claims and encounters data were used the create interactive and interconnected data visuals that can be used for deeper internal analytic investigations. Version 1 of the dashboard went live on Nov 1, 2022 and included: · Demographic data (age, race/ethnicity, sex), coverage, rate category, and agency flags so that PCF can better see demographic trends year over year. · Spend overviews by plan type, demographic data · Categories of service utilization data by age and age groups o Including ED, inpatient, behavioral health, pharmacy, DME, · For perinatal population only, pregnancy outcomes Future version updates are planned to include: · Prevalence of conditions for MassHealth members <21-years-of-age and pregnant people, with further analysis potential by select demographic characteristics · Birth outcomes Core Set Measure Reporting Continued use of the core measures annual reporting process to support evaluation of related metrices for monitoring of goals and objectives. Data are anticipated to be available and submitted by the end of the year through the updated CARTS/MACPro tool. Assessment and preparation also continue for anticipated required reporting of the child core measure set in FFY2024.

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, behavioral health services access, health care equity, special health care needs, or other emerging health care needs.) What have you discovered through this research?

No, not in 2022.

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2022, and how much you anticipate spending in FFY 2023 and 2024.

Part 1: Benefit Costs

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 372,355,350	**$** 402,065,777	**$** 406,493,457

2. How much did you spend on Fee for Service in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 414,344,042	**$** 402,779,912	**$** 407,215,457

3. How much did you spend on anything else related to benefit costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 9,379,614	**$** 9,500,019	**$** 9,621,969

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2022	FFY 2023	FFY 2024
Managed Care	372355350	402065777	406493457
Fee for Service	414344042	402779912	407215457
Other benefit costs	9379614	9500019	9621969
Cost sharing payments from beneficiaries			
Total benefit costs	796079006	814345708	823330883

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?
This includes wages, salaries, and other employee costs.

2022	2023	2024
$	**$**	**$**

2. How much did you spend on general administration in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 24,834,744	**$** 24,834,744	**$** 24,834,744

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

4. How much did you spend on claims processing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

5. How much did you spend on outreach and marketing in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$ 77,265,611	**$** 80,000,000	**$** 83,000,000

7. How much did you spend on anything else related to administrative costs in FFY 2022? How much do you anticipate spending in FFY 2023 and 2024?

2022	2023	2024
$	**$**	**$**

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2022	FFY 2023	FFY 2024
Personnel			
General administration	24834744	24834744	24834744
Contractors and brokers			
Claims processing			
Outreach and marketing			
Health Services Initiatives (HSI)	77265611	80000000	83000000
Other administrative costs			
Total administrative costs	102100355	104834744	107834744
10% administrative cap	88453222.89	90482856.44	91481209.22

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2022	**FFY 2023**	**FFY 2024**
Total program costs	Not Available	Not Available	931165627
eFMAP	65	65	65
Federal share	Not Available	Not Available	605257657.55
State share	Not Available	Not Available	325907969.45

8. What were your state funding sources in FFY 2022?
Select all that apply.

- [x] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a managed care delivery system.

1. How many children were eligible for managed care in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 108,734	**$** 104,735	**$** 100,884

2. What was your per member per month (PMPM) cost based on the number of children eligible for managed care in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 323	**$** 339	**$** 356

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	323	339	356

Part 4: Fee for Service Costs

Complete this section only if you have a fee for service delivery system.

1. How many children were eligible for fee for service in FFY 2022? How many do you anticipate will be eligible in FFY 2023 and 2024?

2022	2023	2024
$ 110,626	**$** 106,558	**$** 102,639

2. What was your per member per month (PMPM) cost based on the number of children eligible for fee for service in FFY 2022? What is your projected PMPM cost for FFY 2023 and 2024?
Round to the nearest whole number.

2022	2023	2024
$ 317	**$** 333	**$** 350

	FFY 2022	FFY 2023	FFY 2024
PMPM cost	317	333	350

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

Despite the continuing impact of the COVID-19 pandemic, Massachusetts has maintained its strong culture of support for near universal healthcare coverage for all its residents, including low-income children and families.

2. What's the greatest challenge your CHIP program has faced in FFY 2022?

The greatest challenge has been the continued response to the COVID-19 pandemic and ensuring that individuals have coverage for healthcare services they need and that they are able to access those services.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2022?

We extended postpartum coverage for all pregnant members (including CHIP members that happen to be pregnant) from 60 days to 12 months, effective 4/1/22. The extension of postpartum coverage will significantly improve access to health care and continuity of care, particularly in the vulnerable period after childbirth. Additionally, this will bring CHIP into alignment with the seamless insurance coverage experienced by postpartum enrollees in commercial insurance plans. We are applying the expansion to the "Conception to Birth" expansion population at state cost.

4. What changes have you made to your CHIP program in FFY 2022 or plan to make in FFY 2023? Why have you decided to make these changes?

This year, MassHealth developed a strategic plan for children, youth, and pregnant and perinatal members, with a focus on preventive care as well as enhanced focus on some of our most vulnerable populations, such as children with medical complexity. See above for information about our postpartum expansion in FFY2022. In FFY2023 we plan to add coverage of doula services as well as a targeted case management (TCM) benefit for children with medical complexity. Also in FFY 2023, as part of the Section 1115 Demonstration waiver renewal, we will have new contractual requirements related to the provision of care for children and youth. Plans will have specific contractual obligations to stratify high-needs children separately from adults and to develop care coordination supports to meet their specific needs. Additionally, we have new authority to provide additional meal support to the household of a child through the Flexible Services Program and enhanced contractual requirements related to the provision of case management for high-risk children and youth. The primary care sub-capitation that is central to the 1115 Demonstration waiver has clinical requirements that are specific to providing care for children and youth. Also, the ACO quality slate has an increased focus on preventive and primary care, essential to the well- being of our members under 21. Also, ACOs will be required to develop an enhanced care management strategy for high-risk perinatal enrollees (e.g., enrollees with a history of complex or severe behavioral health diagnosis, adverse perinatal or neonatal outcomes in previous pregnancies) throughout pregnancy and up to 12 months postpartum.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

We have worked closely in partnership with the state Department of Public Health to address pediatric vaccines inequities and also to bolster connection with their Title V program to address the needs of pregnant and postpartum populations and children with medical complexities. MassHealth also has implemented several quality improvement changes to ensure a safe and equitable maternal health environment for pregnant and birthing people. For example, the 2022 MassHealth Comprehensive Quality Strategy includes a statewide benchmark for the timeliness of prenatal and postpartum care.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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