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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 16-0011

This file contains the following documents in the order listed:

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

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

November 18, 2016

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

Dear Secretary Sudders:

We are pleased to enclose a copy of approved Massachusetts State Plan Amendment (SPA) No. 16-011 submitted to CMS on June 17, 2016. This SPA was submitted to revise your approved Title XIX State plan to provide premium assistance for student health insurance offered in the individual market. This SPA has been approved effective June 1, 2016.

Individuals enrolled in premium assistance arrangements must be afforded the same beneficiary protections provided to all other Medicaid enrollees. In addition to the benefits wrap, which is provided to ensure that individuals enrolled in premium assistance receive all services and benefits available under the Medicaid State plan, States must also provide a wrap to any cost-sharing that exceeds the cost-sharing described in their State plan. During our review of this State plan amendment, CMS learned that the State has not fully implemented the cost-sharing wrap. To ensure that premium assistance enrollees are afforded all of the protections to which they are entitled, the State has elected to evaluate the overlap of providers participating in both Medicaid and group/individual health insurance plans to ensure that the network is adequate to meet the health needs of premium assistance beneficiaries.

The State agreed to conduct its review of the networks and, if the networks are adequate, to submit a freedom of choice waiver request to CMS by May 1, 2017. In the interim, the State will allow individuals in the student health insurance plan to submit claims to be reimbursed for any out of pocket cost-sharing that exceeds the amount described in the cost-sharing section of the State plan. This process is similar to a cost-sharing reimbursement process that the state already conducts for its CHIP program. Authority to continue the SHIP premium assistance beyond the sunset date of December 31, 2017 is linked to CMS approval of the freedom of choice waiver by this date.

Enclosed are copies of the following approved State plan pages.

- Attachment 4.22-C, pages 1 and 1a; and
- Section 3, page 29d.

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

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Kaela Konefal, Federal Authority Policy Analyst/State Plan Coordinator

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **MA-016-011**

2. STATE: **MA**

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

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

4. PROPOSED EFFECTIVE DATE: **June 1, 2016**

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

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

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

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 435.1015

7. FEDERAL BUDGET IMPACT:

a. FFY 2016 $(3,000,000)

b. FFY 2017 $(9,000,000)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Section 3.0 page 29d
Attachment 4.22-C pages 1, 1a ~~and 1b~~

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Section 3.0 page 29d
Attachment 4.22-C pages 1, 1a and 1b

10. SUBJECT OF AMENDMENT:

Premium Assistance for Student Health Insurance Coverage

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

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

12. SIGNATURE OF STATE AGENCY OFFICIAL:

/s/

13. TYPED NAME: **Marylou Sudders**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **June 17, 2016**

16. RETURN TO:

Daniel J. Cohen
State Plan Coordinator
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 06/17/2016

18. DATE APPROVED: 11/18/2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 06/01/2016

20. SIGNATURE OF REGIONAL OFFICIAL:

/s/

21. TYPED NAME: Richard R. McGreal

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

23. REMARKS:

CMS and MA agreed by email to pen & ink change to Box #8 to remove reference to page 1b

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

1. Cost Effectiveness based on Expenditure Projection

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

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

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

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

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

2. Cost Effectiveness based on Actual Expenditures or Client Diagnosis

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

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

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

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

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

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

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

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

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

Authority to provide premium assistance for student health insurance plan through the individual market will sunset on December 31, 2017 if the State does not obtain a freedom of choice (FOC) waiver prior to that date.

Citation 3.2 (2) Coordination of Medicaid with Medicare with Other Insurance

1906 of the Act

(c) Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations

The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State Plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans and cost-effective student health insurance coverage offered in the individual market.

When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State Plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22 (h).

1902 (a) (10) (F) of the Act

(d) ☒ The Medicaid agency pays premiums for individuals described in item 19 of **Attachment 2.2-A**.