Table of Contents

State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 23-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

January 5, 2024

Kathleen E. Walsh, Secretary
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

Re: Massachusetts State Plan Amendment (SPA) 23-0022

Dear Secretary Walsh:

Enclosed please find a corrected approval package for your Massachusetts State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0022 (MMDL No. MA.0807.R00.15). This SPA is to update the CarePlus Alternative Benefit Plan (ABP) to revise the prior authorization requirements for home health nursing, home health aide services, and home health therapy services, and remove the scope limitations on home health aide services. This amendment was originally approved on June 21, 2023. The approval package sent to Massachusetts included the following error:

- The June 21, 2023, MA 23-0022 SPA approval package contained the incorrect ABP3 pages.

The enclosed corrected package contains the original signed letter, CMS-179, and the corrected ABP3 SPA pages.

If you have any questions, please contact Marie DiMartino 617-565-9157, or via email at Marie.DiMartino@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

June 21, 2023

VIA E-MAIL
Kathleen E. Walsh, Secretary
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

Re: Massachusetts State Plan Amendment (SPA) 23-0022

Dear Secretary Walsh:

For your records, this is an approved copy of Massachusetts's Alternative Benefit Plan (ABP) State Plan Amendment (SPA) MA 23-0022. This ABP amendment submitted through the Medicaid Model Data Lab (MMDL No. MA.0807.R00.15) on March 30, 2023, meets all federal statutory and regulatory requirements for establishing an ABP.

The state submitted this SPA to update the CarePlus Alternative Benefit Plan (ABP) to revise the prior authorization requirements for home health nursing, home health aide services, and home health therapy services, and remove the scope limitations on home health aide services. This SPA was approved June 21, 2023, with an effective date of January 1, 2023.

Enclosed are copies of the Summary page and approved Alternative Benefit Plan pages for incorporation into the Massachusetts State Plan.

If you have questions concerning this letter, please contact Marie DiMartino, Division of Program Operations (South Branch) at (617) 565-9157 or via e-mail at Marie.DiMartino@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: **Massachusetts**

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MA-23-0022

Proposed Effective Date

01/01/2023 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Section 1937 of the Social Security Act

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2023	$ 0.00
Second Year	2024	$ 0.00

Subject of Amendment

An amendment to the Medicaid State Plan to update the CarePlus Alternative Benefit Plan (ABP) State Plan to add and update certain home health services.

Governor's Office Review

- ○ **Governor's office reported no comment**
- ○ **Comments of Governor's office received**

  Describe:

- ○ **No reply received within 45 days of submittal**
- ◉ **Other, as specified**

  Describe:

  Not required under 42 CFR 430.12(b)(2)(i)

Signature of State Agency Official

Submitted By:	**Alison Kirchgasser**
Last Revision Date:	**Mar 30, 2023**
Submit Date:	**Mar 30, 2023**

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: MassHealth CarePlus

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). No

Targeting Criteria (select all that apply):

- [ ] Income Standard.
- [ ] Disease/Condition/Diagnosis/Disorder.
- [ ] Other.

Other Targeting Criteria (Describe):

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

No

These assurances must be made by the state/territory if the Adult eligibility group is included in the ABP Population.

☑ The state/territory shall enroll all participants in the "Individuals at or below 133% FPL Age 19 through 64" (section 1902(a)(10)(A)(i)(VIII)) eligibility group in the Alternative Benefit Plan specified in this state plan amendment, except as follows: A beneficiary in the eligibility group at section 1902(a)(10)(A)(i)(VIII) who is determined to meet one of the exemption criteria at 45 CFR 440.315 will receive a choice of a benefit package that is either an Alternative Benefit Plan that includes Essential Health Benefits and is subject to all 1937 requirements or an Alternative Benefit Plan that is the state/territory's approved Medicaid state plan not subject to 1937 requirements. The state/territory's approved Medicaid state plan includes all approved state plan programs based on any state plan authority, and approved 1915(c) waivers, if the state has amended them to include the eligibility group at section 1902(a)(10)(A)(i)(VIII).

☑ The state/territory must have a process in place to identify individuals that meet the exemption criteria and the state/territory must comply with requirements related to providing the option of enrollment in an Alternative Benefit Plan defined using section 1937 requirements, or an Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan that is not subject to section 1937 requirements.

☑ Once an individual is identified, the state/territory assures it will effectively inform the individual of the following:

a) Enrollment in the specified Alternative Benefit Plan is voluntary;

b) The individual may disenroll from the Alternative Benefit Plan defined subject to section 1937 requirements at any time and instead receive an Alternative Benefit Plan defined as the approved state/territory Medicaid state plan that is not subject to section 1937 requirements; and

c) What the process is for transferring to the state plan-based Alternative Benefit Plan.

☑ The state/territory assures it will inform the individual of:

a) The benefits available as Alternative Benefit Plan coverage defined using section 1937 requirements as compared to Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan and not subject to section 1937 requirements; and

b) The costs of the different benefit packages and a comparison of how the Alternative Benefit Plan subject to 1937 requirements differs from the Alternative Benefit Plan defined as the approved Medicaid state/territory plan benefits.

How will the state/territory inform individuals about their options for enrollment? (Check all that apply)

☒ Letter

☐ Email

☒ Other

Alternative Benefit Plan

Describe:

Individuals who are categorically eligible for Medicaid including those who are children, pregnant, a parent of a child under age 19, or are disabled are automatically enrolled in MassHealth Standard. Those CarePlus ABP members who later receive a state or SSI-related disability determination would become categorically eligible for Medicaid and are automatically transferred to MassHealth Standard.

Adults 19-64 years old who are only eligible for an ABP and are 19-20 years old, or have voluntarily disclosed on their application that they meet the targeting criteria for our MassHealth Standard ABP, including those who have breast or cervical cancer; or are HIV positive; and those who are referred eligible from the Department of Mental Health because they are receiving services or are on a waiting list to receive such services are automatically enrolled in the MassHealth Standard ABP.

For all other eligible CarePlus ABP members, medically frail self-identification instructions are included in MassHealth CarePlus eligibility notices, which are sent out at initial enrollment and whenever a member is re-determined eligible. These instructions are also in the MassHealth member handbook and the CarePlus enrollment guide. These instructions also include a high-level overview of the differences in benefits between MassHealth Standard ABP and CarePlus ABP; these instructions also specify that there are no cost-sharing differences between the two plans.

Provide a copy of the letter, email text or other communication text that will be used to inform individuals about their options for enrollment.

An attachment is submitted.

When did/will the state/territory inform the individuals?

Self-identification instructions are included in MassHealth CarePlus eligibility notices, which are sent out at initial enrollment and whenever a member is re-determined eligible. These instructions are also in the MassHealth Member Booklet and the MassHealth CarePlus enrollment guide.

Please describe the state/territory's process for allowing individuals in the Section 1902(a)(10)(A)(i)(VIII) eligibility group who meet exemption criteria to disenroll from the Alternative Benefit Plan defined using section 1937 requirements and enroll in the Alternative Benefit Plan defined as the state/territory's approved Medicaid state plan.

CarePlus ABP members who wish to identify as medically frail are instructed to contact the MassHealth Enrollment Center (MEC) to receive choice counseling. MEC staff are trained to accept any member's self-attestation of his or her medically frail status and are able to process transfer requests for medically frail members.

If a CarePlus ABP member identifies as medically frail, staff at the MEC will explain the differences in benefits and managed care options in MassHealth Standard ABP. They will also explain that there are no differences in cost sharing between the two health plans. Medically frail members may, at their option, remain in CarePlus ABP or choose to be enrolled in the MassHealth Standard ABP.

If a medically frail CarePlus ABP member chooses to move to the MassHealth Standard ABP, MEC staff process that request by assigning the member to the appropriate aid category. This triggers the MassHealth system to send out a new eligibility notice and a MassHealth Standard managed care enrollment guide. Members transferred to MassHealth Standard ABP receive benefits as described in MassHealth Standard ABP 8.

☑ The state/territory assures it will document in the exempt individual's eligibility file that the individual:

a) Was informed in accordance with this section prior to enrollment;

b) Was given ample time to arrive at an informed choice; and

c) Chose to enroll in Alternative Benefit Plan coverage subject to section 1937 requirements or defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Alternative Benefit Plan

Where will the information be documented? (Check all that apply)

- [x] In the eligibility system.
- [ ] In the hard copy of the case record.
- [ ] Other

What documentation will be maintained in the eligibility file? (Check all that apply)

- [ ] Copy of correspondence sent to the individual.
- [ ] Signed documentation from the individual consenting to enrollment in the Alternative Benefit Plan.
- [x] Other

Describe:

Medically frail members choosing to remain in CarePlus will have a flag associated with their file in the MassHealth eligibility system. Medically frail members who choose to move to MassHealth Standard ABP will be placed in a special MassHealth Standard ABP Medically Frail aid category. All other exempt individuals will be moved to the MassHealth aid category that is related to their eligibility group.

- [x] The state/territory assures that it will maintain data that tracks the total number of individuals who have voluntarily enrolled in either Alternative Benefit Plan coverage subject to section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, which is not subject to section 1937 requirements.

Other information related to benefit package selection assurances for exempt participants (optional):

PRA Disclosure Statement

V.20130807

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Enrollment Assurances - Mandatory Participants — ABP2c

These assurances must be made by the state/territory if enrollment is mandatory for any of the target populations or sub-populations.

When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchmark or Benchmark-Equivalent Plan) that could have exempt individuals, prior to enrollment:

☑ The state/territory assures it will appropriately identify any individuals in the eligibility groups that are exempt from mandatory enrollment in an Alternative Benefit Plan or individuals who meet the exemption criteria and are given a choice of Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan, not subject to section 1937 requirements.

How will the state/territory identify these individuals? (Check all that apply)

☒ Review of eligibility criteria (e.g., age, disorder/diagnosis/condition)

Describe:

Individuals who are categorically eligible for Medicaid including those who are children, pregnant, a parent of a child under age 19, or are disabled are automatically enrolled in MassHealth Standard. Those CarePlus ABP members who later receive a state or SSI-related disability determination would become categorically eligible for Medicaid and are automatically transferred to MassHealth Standard.

Adults 19-64 years old who are only eligible for an ABP and are 19-20 years old, or have voluntarily disclosed on their application that they meet the targeting criteria for our MassHealth Standard ABP, including those who have breast or cervical cancer; or are HIV positive; and those who are referred eligible from the Department of Mental Health because they are receiving services or are on a waiting list to receive such services are automatically enrolled in the MassHealth Standard ABP.

☒ Self-identification

Describe:

CarePlus members may self-identify as exempt at any time after their MassHealth CarePlus eligibility determination. EOHHS has adopted the federal definition of individuals who are medically frail or otherwise have special medical needs as found at 42 CFR 440.315(f). MassHealth accepts CarePlus members' self-attestation of their medically frail status.

Self-identification instructions are included in the MassHealth CarePlus eligibility notices, which are sent out at initial enrollment and whenever a member is re-determined eligible. These instructions are also in the MassHealth member booklet and the MassHealth CarePlus enrollment guide, which MassHealth provides to help members choose a health plan. CarePlus members who wish to identify as medically frail are instructed to contact MassHealth. MassHealth Enrollment Centers (MECs) will provide medically frail members with choice counseling.

☐ Other

☑ The state/territory must inform the individual they are exempt or meet the exemption criteria and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Alternative Benefit Plan

☑ The state/territory assures that for individuals who have become exempt from enrollment in an Alternative Benefit Plan, the state/territory must inform the individual they are now exempt and the state/territory must comply with all requirements related to voluntary enrollment or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

How will the state/territory identify if an individual becomes exempt? (Check all that apply)

- ☐ Review of claims data
- ☒ Self-identification
- ☐ Review at the time of eligibility redetermination
- ☐ Provider identification
- ☒ Change in eligibility group
- ☐ Other

How frequently will the state/territory review the Alternative Benefit Plan population to determine if individuals are exempt from mandatory enrollment or meet the exemption criteria?

- ○ Monthly
- ○ Quarterly
- ○ Annually
- ◉ Ad hoc basis
- ○ Other

☑ The state/territory assures that it will promptly process all requests made by exempt individuals for disenrollment from the Alternative Benefit Plan and has in place a process that ensures exempt individuals have access to all standard state/territory plan services or, for beneficiaries in the "Individuals at or below 133% FPL Age 19 through 64" eligibility group, optional enrollment in Alternative Benefit Plan coverage defined using section 1937 requirements, or Alternative Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.

Describe the process for processing requests made by exempt individuals to be disenrolled from the Alternative Benefit Plan:

CarePlus ABP members who wish to identify as medically frail are instructed to contact the MassHealth Enrollment Center (MEC) to receive choice counseling. MEC staff are trained to accept any member's self-attestation of his or her medically frail status and are able to process transfer requests for medically frail members.

MEC staff have received training from MEC leadership, weekly training updates, and resources on how to provide choice counseling to medically frail members. MEC staff are also able to process eligibility changes for members meeting other exemptions. MEC staff are instructed to accept member's self-attested medically frail status.

If a CarePlus ABP member identifies as medically frail, staff at the MEC will explain the differences in benefits and managed care options in MassHealth Standard ABP. They will also explain that there are no differences in cost sharing between the two health plans. Medically frail members may, at their option, remain in CarePlus ABP or choose to be enrolled in the MassHealth Standard ABP.

If a medically frail CarePlus ABP member chooses to move to the MassHealth Standard ABP, MEC staff process that request by assigning the member to the appropriate aid category. This triggers the MassHealth system to send out a new eligibility notice and a MassHealth Standard managed care enrollment guide. Members transferred to MassHealth Standard ABP receive benefits as described

in MassHealth Standard ABP 8.

Other Information Related to Enrollment Assurance for Mandatory Participants (optional):

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1- L

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: MassHealth CarePlus

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ○ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ◉ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Benefits in the MassHealth CarePlus Alternative Benefit Plan (ABP) are the same as offered in the Massachusetts Medicaid State Plan with the following exceptions:
1) Benefits targeted for individuals under 21 years of age, including EPSDT, are not included because CarePlus eligibility will be limited to individuals 21 years of age or older. These services would have been found in Essential Health Benefit 10: Pediatric services; and
2) Long term services and supports are generally not available in the CarePlus ABP, including:
- under EHB 1: Ambulatory Patient Services,

Alternative Benefit Plan

- there is no Nursing Facility Services for 21 or Older: Custodial Care benefit in the CarePlus ABP, which would have been listed under Other 1937 Benefits;
- there are no Adult Day Health, Adult Foster Care, Group Adult Foster Care, or Day Habilitation services in the CarePlus ABP.
- there are no Personal Care, Intermediate Care Facility, or Private Duty Nursing services in the CarePlus ABP, which would have been listed under Other 1937 Benefits.

Selection of Base Benchmark Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ◉ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Plan name: 2014 Government Employee Health Association, Inc.

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

The state assures: 1) that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5 and 2) unless otherwise indicated, the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan.

PRA Disclosure Statement

V.20130801

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Alternative Benefit Plan Cost-Sharing	ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

2014 Government Employee Health Association, Inc. Benefit Plan (GEHA)

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

Alternative Benefit Plan

☑ Essential Health Benefit 1: Ambulatory patient services Collapse All ☐

Benefit Provided:
Outpatient Hospital Service

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For those members receiving benefits fee for service (FFS), certain specific services are covered with prior authorization (PA); for example, physical and occupational therapy services provided by an outpatient hospital require PA after 20 visits in a 12-month period. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided:
Hospice Care

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Those members receiving benefits fee for service (FFS) must receive certification of terminal illness and elect hospice benefits.

Benefit Provided:
OLP: Audiologists' Services

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Benefit Title: "Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: Audiologists' Services."

For those members receiving benefits fee for service (FFS), certain high-cost and replacement hearing aids are covered with prior authorization (PA). For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided:

OLP: Chiropractors' Services

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

20 visits/treatments per calendar year

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Benefit Title: "Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: Chiropractors' Services."

For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided:

Physicians' Services

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Benefit Title: "Physicians' services whether furnished in the office, the patient's home, a

hospital, a nursing facility or elsewhere."

For those members receiving benefits fee for service (FFS), certain specific services are covered with prior authorization (PA); for example, reconstructive surgery and non-emergency out-of-state services provided by a physician who practices beyond 50 miles of the state border. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided: Diagnostic Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For those members receiving benefits fee for service (FFS), certain specific services, such as Breast MRI, are covered with prior authorization (PA). For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided: Screening Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For those members receiving benefits through managed care entities, utilization management may apply.

Benefit Provided: Pediatric or Family Nurse Practitioners' Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For those members receiving benefits fee for service (FFS), the same prior authorization requirements as those summarized under Physicians' Services apply. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided:
Home Health: Part-time Nursing Services

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Other

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
State Plan Title: "Home health services: Intermittent or part time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area."

For those members receiving benefits fee for service (FFS), nursing visits are covered with authorization in excess of limitations; for example, after 30 nursing visits in a calendar year. These 30 nursing visits within a calendar year are any combination of nursing services. This PA threshold resets every January 1st of the calendar year. After the threshold for PA is exceeded services must be provided through the PA unless they have a qualified break in service. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided:
Clinic Services

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See Below

Duration Limit:
None

Scope Limit:
Covered within the limitations outlined below.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For those members receiving benefits fee for service (FFS), (1) MassHealth covers clinic services provided by the following: Designated Emergency Mental Health Providers, Freestanding Ambulatory Surgery Centers, Family Planning Clinics, Sterilization Clinics, Radiation Oncology Centers, Renal Dialysis Clinics, Rehabilitation Centers, Speech and Hearing Centers, Mental Health Centers, Substance Use Disorder Treatment Clinics, Limited Services Clinics, and Urgent Care Clinics; (2) MassHealth applies NCCI edits to providers of clinic services who bill using those codes; (3) Prior authorization is required for out of state FASC services when the FASC is located more than 50 miles from the Massachusetts border; (4) family planning clinics may be paid for a maximum of one HIV pre-test and one HIV post-test counseling visit per member per test per day, and a maximum of four HIV pre-test and four HIV post-test counseling visits per calendar year; (5) MassHealth covers medication assisted treatment for opioid dependency at opioid treatment service centers, in accordance with applicable clinical standards.

For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided: FQHC Services and Other Amb. Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Benefit Title: "Federally qualified health center (FQHC) services and other ambulatory services."

For those members receiving benefits fee for service (FFS), services provided at FQHCs are subject to the same prior authorization requirements summarized in this ABP. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided: Rural Health Clinic Services

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Benefit Title: "Rural Health Clinic Services and other ambulatory services furnished by a rural health clinic."

For those members receiving benefits fee for service (FFS), services provided at RHCs are subject to the same prior authorization requirements summarized in this ABP. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided: Family Planning Services and Supplies

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Title: "Family planning services and supplies for individuals of child-bearing age."

For those members receiving benefits fee for service (FFS), the same prior authorization requirements as those summarized under Physicians' Services apply. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Benefit Provided: Home Health: Aide Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Other

Duration Limit: None

Scope Limit: Other

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Title: "Home health services: Home health aide services provided by a home health agency." Prior authorization is required after 240 home health aide units in a calendar year. Prior authorization is required whenever services provided exceed 20 occupational-therapy, 20 physical-therapy, 35 speech-language therapy visits in a calendar year. Additionally, prior authorization is required when the member

requires home health aide services in addition to therapy services. For those members receiving benefits through managed care entities, other utilization management may apply.

Add

Alternative Benefit Plan

☑ Essential Health Benefit 2: Emergency services — Collapse All ☐

Benefit Provided: Emergency Hospital Services

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Covered without limitations.

Benefit Provided: Transportation – Emergent

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

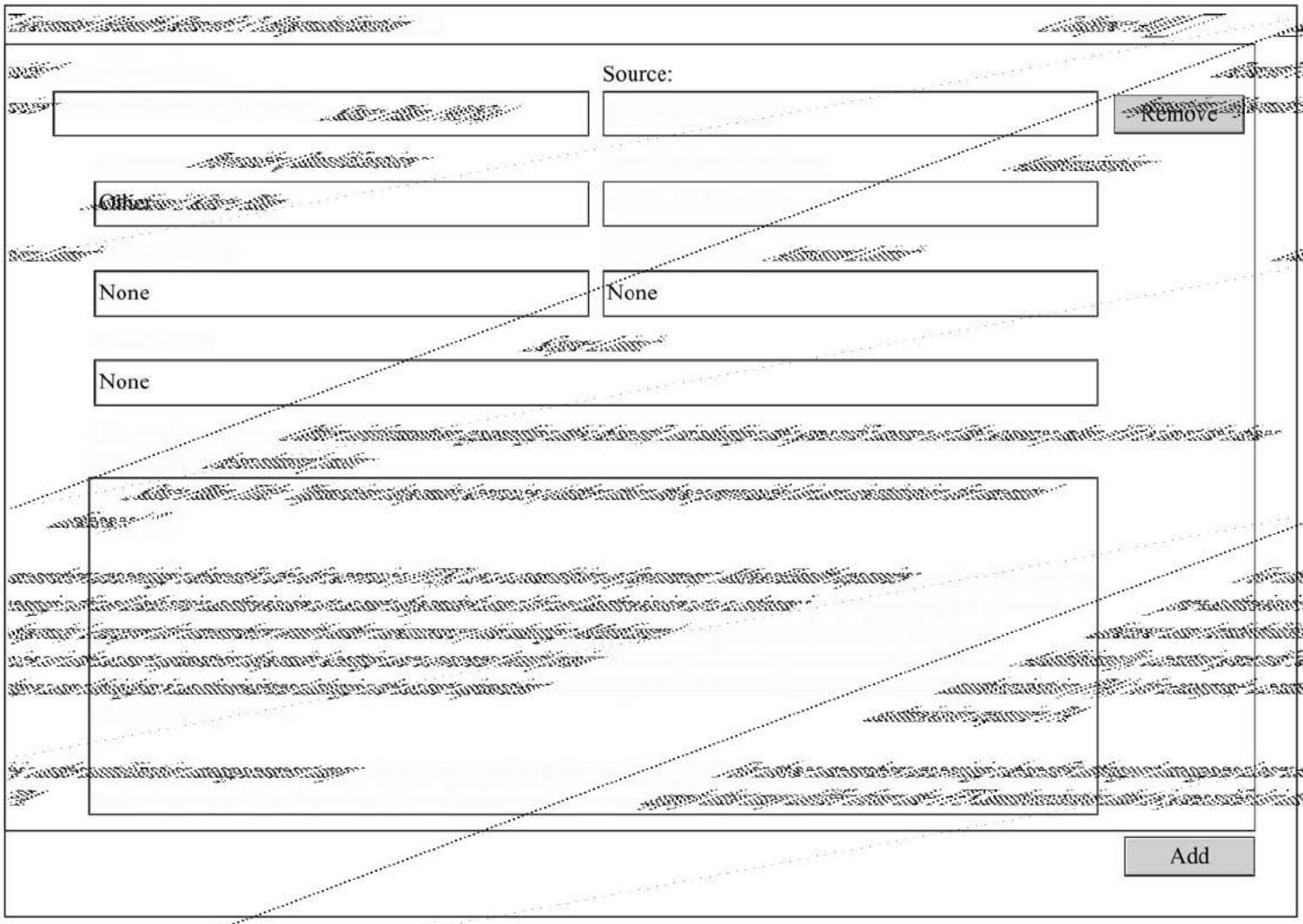
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Covered without limitations.

Add

Alternative Benefit Plan



Alternative Benefit Plan

Source:

Remove

Other

None

None

None

Source:

Remove

Other

None

None

None

Source:

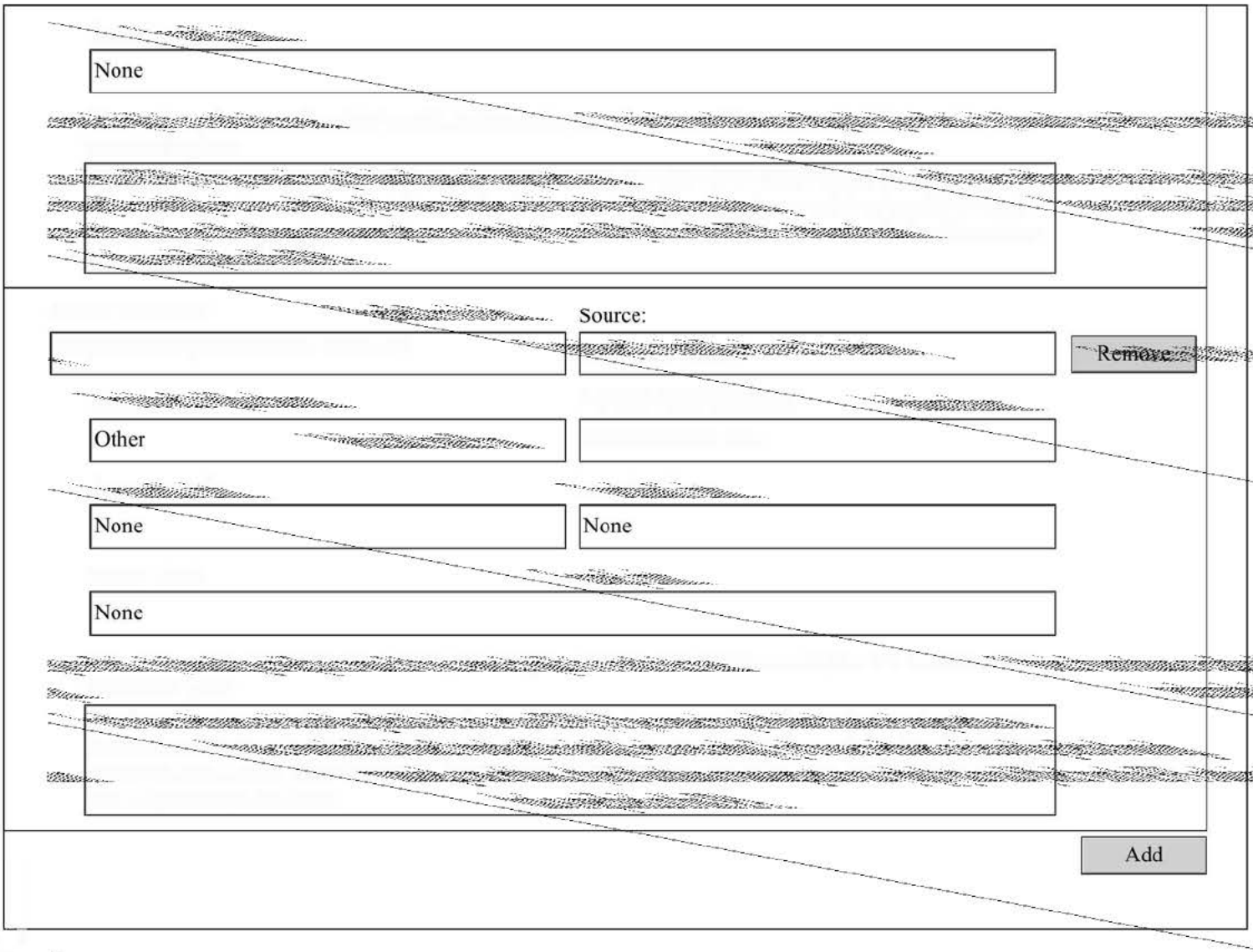
Remove

Other

None

None

Alternative Benefit Plan



Alternative Benefit Plan

Source:

Remove

Other

None

None

None

Source:

Remove

Other

None

None

Source:

Remove

Other

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

For those members receiving benefits fee for service (FFS), the same prior authorization requirements as those summarized under Physicians' Services, Outpatient Hospital Services, and Inpatient Hospital Services apply. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA. All CarePlus managed care contractors provide certification of compliance with MHPAEA. Inpatient services are not provided in an IMD.

Add

Alternative Benefit Plan

■ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☐ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The Commonwealth of Massachusetts's ABP prescription drug benefit is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

Source:

Remove

None

Source:

Remove

None

Source:

Remove

None

Source:

Remove

Other

None

None

None

home."

Alternative Benefit Plan

Source:

Remove

Other

None

None

None

Source:

Remove

Other

None

None

Source:

Remove

Alternative Benefit Plan

Authorization:	Provider Qualifications:
Authorization required in excess of limitation	Medicaid State Plan
Amount Limit:	**Duration Limit:**
See below	None

Scope Limit:

Diversional and recreational therapies are not covered.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

State Plan Title: "Home health services: Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility."

For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Add

Alternative Benefit Plan

☑ Essential Health Benefit 8: Laboratory services — Collapse All ☐

Benefit Provided:
Other Laboratory and X-ray Services

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
For those members receiving benefits fee for service (FFS), certain specific services are covered with prior authorization (PA); for example, BRCA genetic testing. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Add

Alternative Benefit Plan

Source:

Remove

Other

None

None

None

Source:

Remove

None

None

Add

Alternative Benefit Plan

Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
Other

Provider Qualifications:
Other

Amount Limit:
Other

Duration Limit:
Other

Scope Limit:
Not a provided benefit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
This benefit plan is for individuals age 21-64 and will not include any EPSDT or pediatric service benefits.

Add

Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

Source:

Remove

Source:

Remove

Source:

Remove

Source:

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Alternative Benefit Plan

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Alternative Benefit Plan

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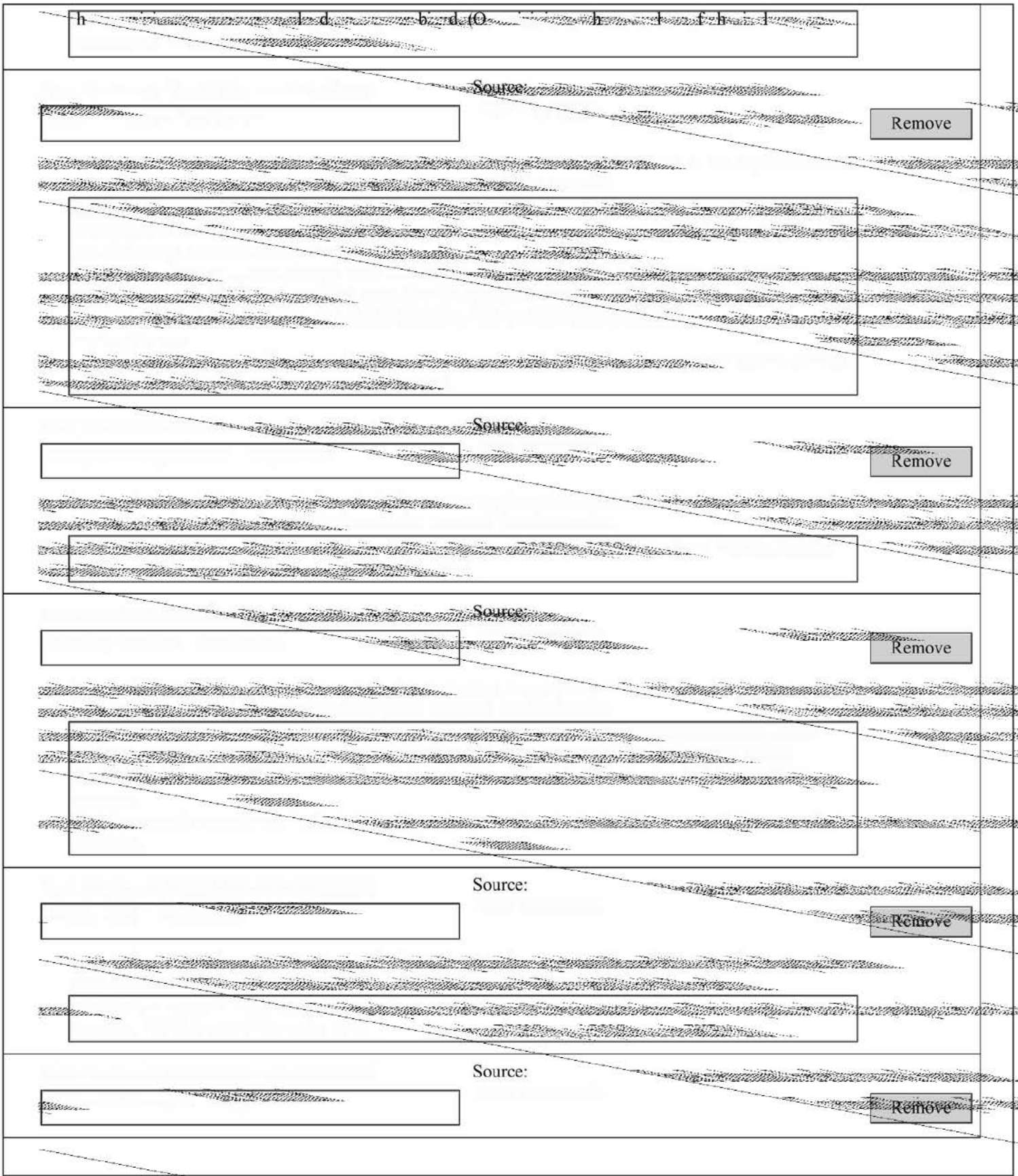
Alternative Benefit Plan



Alternative Benefit Plan

Source:

Remove

Source:

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Alternative Benefit Plan

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Source:

Remove

Add

Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered — Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:

Christian Science Facilities

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

GEHA Benefit Name: Care provided at Christian Science Facilities and by Christian Science Practitioners MassHealth does not cover this provider type; however, all the medically necessary services they provide are covered in this ABP through various categories including Physicians' Services and Outpatient Hospital Services under EHB 1.

Add

Alternative Benefit Plan

Source:

Package

Remove

Other

None

None

None

Other:

Source:

Package

Remove

Other

None

None

None

Other:

Source:

Package

Remove

Other

None

None

Scope Limit:

Treatment for congenital dyslexia by this provider type is excluded.

Other:

State Plan Benefit Title: "Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: Optometrists' services."

Those members receiving benefits fee for service (FFS) are limited to one comprehensive eye examination within a 24-month period; additional services are provided when medically necessary. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:

Eyeglasses

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See below for scope limits

Other:

State Plan Benefit Title: "Prescribed drugs, dentures, and prosthetic devices and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist: Eyeglasses."
Exclusions consist of absorptive lenses of greater than 25% absorption, prisms obtained by decentration; contact lenses for extended wear use; invisible bifocals; and Welsh 4-drop lenses.
For those members receiving benefits fee for service (FFS), certain specific services are covered with prior authorization (PA); for example, certain high-index lenses, special needs glasses, and glass lenses. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:

Dental

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Covered with the limitations outlined below.

Other:

Coverage for dental services is limited to the following: diagnostic services including oral evaluation

(comprehensive and periodic) and radiographs; preventive services including prophylaxis; emergency care visits; certain restorative services (all fillings); certain prosthodontic services (full and partial dentures including repairs);extractions; anesthesia; treatment of complications related to surgery; certain oral surgery such as biopsies and soft-tissue surgery; and certain periodontal services, including gingivectomies, gingivoplasties, and periodontal scaling and root planing. In addition, there are limited exceptions that allow for topical fluoride when documented as medically necessary.

For those members receiving benefits fee for service (FFS), certain specific services are covered with prior authorization (PA); for example, removal of impacted teeth (completely bony). For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:
Transportation – Non-emergent

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Non-emergency transportation is covered to the same extent as under the approved Medicaid state plan for transportation.
For those members receiving benefits fee for service (FFS), all forms of transportation except public transportation require prior authorization from the MassHealth agency. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:
Targeted Case Management Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
State Plan Title: Case Management Services. FFS members seeking TCM are subject to the eligibility criteria described in the State Plan in Supplement 1 to Attachment 3.1-A.
- Case Management for Medicaid Recipients Age 18 and Older who are Diagnosed with AIDS and Living in a staffed, congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program which require that a

person be HIV positive, and in which no more than three mentally and/or physically impaired individuals share a single bedroom and bathroom.
- Case Management for Individuals eligible for Medical Assistance and for services provided, purchased, or arranged by the Department of Mental Retardation, not including individuals who reside in ICFs/MR.
- Case Management for Individuals with Mental Illness as Determined by the Department of Mental Health (DMH).
- Case Management for Individuals under age 21 with Serious Emotional Disturbance (SED).
- Case Management for Children Committed to the Department of Youth Services.

Other 1937 Benefit Provided:
OLP: Podiatrist

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See below

Duration Limit:
None

Scope Limit:
Other than routine foot care services

Other:
State Plan Title: "Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law: Podiatrist." The following limits are hard limits for members aged 21 and older: Office visits are limited to one initial visit; one limited visit per 30 day period; one extended visit per 30 day period; and one follow up visit per week. Out of office visits are limited to one visit in a 30 day period in a long-term-care facility or the member's home and two visits in a 30 day period in a hospital setting. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:
OLP: Other Practitioners' Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
State Plan Title: "Medical care and any other type of remedial care provided by licensed practitioners, furnished by such practitioners within the scope of their practice as defined by state law: Other Licensed Practitioners' services (OLP)". OLP services not listed elsewhere include hearing instrument specialist services, public health dental hygienist services, and acupuncturist services. Hearing instrument specialist services are limited to the practice of fitting and dispensing of hearing aids which means measurement of human hearing solely for the purpose of making selections, adaptations or sales of hearing aids intended to

compensate for impaired hearing. Acupuncturist services are limited to the practice of providing medically necessary acupuncture for treatment of pain and as a substance use disorder treatment. For those members receiving benefits fee for service (FFS), certain specific services are covered with prior authorization (PA); for example, certain high-cost hearing aids. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:
Extended Services for Pregnant Women

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
For those members receiving benefits fee for service (FFS), qualified providers are subject to the same prior authorization requirements summarized in this ABP, including Physicians' Services and Outpatient Hospital Services. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Other 1937 Benefit Provided:
OLP: Midlevel Practitioners' Services

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See Below

Other:
State Plan Title: "Medical care and any other type of remedial care provided by licensed practitioners furnished by licensed practitioners within the scope of their practice as defined by state law: Midlevel Practitioners' Services". This includes services of certain midlevel practitioners (e.g., clinical nurse specialists, psychiatric clinical nurse specialists, certified registered nurse anesthetists and certified nurse practitioners) not listed elsewhere. Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered. Limits on covered services can be exceeded when medically necessary, with prior authorization. For those members receiving benefits through managed care entities, other utilization management may apply that may differ from the FFS authorization that is specified in this SPA.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Medication Assisted Treatment (MAT)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Confirming coverage for the mandatory MAT benefit for drugs and biological products and related counseling services and behavioral therapy under the SUPPORT Act under EHB 5: Mental Health and Substance Use Disorder services including behavioral health treatment and EHB 6: Prescription Drugs.

MAT is provided as defined in the approved state plan 3.1A and if applicable, 3.1B pages.

MAT is provided in accordance with 1905(a)(29) for the period beginning October 1, 2020, and ending September 30, 2025.

Other 1937 Benefit Provided:
Routine Patient Costs: Qualifying Clinical Trials

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
See Below

Other:
Confirming coverage of routine patient costs in qualifying clinical trials as required under Section 1905(a)(30). Coverage is provided as defined in the state plan 3.1A and 3.1B pages under "Coverage of Routine Patient Cost in Qualifying Clinical Trials".

Add

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130814

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. No

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.

☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.

Alternative Benefit Plan

☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130917

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☒ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☒ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

As part of implementing its alternative benefit plans, certain MassHealth programs and coverage types under Massachusetts' 1115 Demonstration ended on December 31, 2013 and members enrolled in those programs and coverage types are receiving coverage under a different program or coverage type, including MassHealth CarePlus, as of January 1, 2014. MassHealth's outreach efforts to members include providing written notice to these members explaining that their coverage is changing, that they are receiving the same or richer benefits starting January 1, 2014, and how to select a health plan. Most members affected by this transition are familiar with the MassHealth managed care delivery system. Such members have previously been required to choose between other MassHealth managed care options (such as an MCO or MassHealth's PCC Plan) or, if not currently in MassHealth, have had commercial coverage similar to MassHealth's managed care delivery system. Therefore, requiring CarePlus members to enroll in a MassHealth managed care option is consistent with Massachusetts' goal of providing continuity for individuals who fluctuate between Medicaid and commercial insurance products. MassHealth customer service is prepared to answer questions from any caller about this transition, including questions about selecting a health plan.

MassHealth has also undertaken outreach efforts to stakeholders and providers. Stakeholders and providers have been kept apprised of MassHealth's implementation through Massachusetts' 1115 Demonstration Amendment process, regular stakeholder meetings, the Alternative Benefit Plan public comment period, and the state regulatory process.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: October 1, 2013

Describe program below:

MassHealth contracts with managed care organizations (MCOs) that provide comprehensive health coverage including behavioral health services to CarePlus enrollees. CarePlus members must enroll with a CarePlus MCO, provided there are at least two CarePlus MCOs available in the member's service area; if there are fewer than two available CarePlus MCOs in a particular region, CarePlus members in that region must enroll in the PCC Plan or the available CarePlus MCO unless exempt because MassHealth is providing premium assistance.

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

PIHP: Prepaid Inpatient Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: October 1, 2013

Describe program below:

MassHealth's managed care arrangements include the PCC Plan, a primary care case management (PCCM) program administered by MassHealth. Members enrolled in the PCC Plan receive mental health and substance abuse services through a single Behavioral Health Program (BHP) contractor, which is the PIHP. If there are fewer than two available CarePlus MCOs in a particular region, CarePlus members in that region must enroll in either the PCC Plan or the available CarePlus MCO. If such CarePlus members elect to enroll in the PCC Plan, they will receive mental health and substance abuse services from the PIHP as described above.

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

PCCM: Primary Care Case Management

Alternative Benefit Plan

The PCCM delivery system is the same as an already approved PCCM program. Yes

The PCCM program is operating under (select one):

- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: October 1, 2013

Describe program below:

MassHealth's managed care arrangements include the PCC Plan, a primary care case management (PCCM) program administered by MassHealth. If there are fewer than two available CarePlus MCOs in a particular region, CarePlus members in that region must enroll either in the PCC Plan or the available CarePlus MCO.

Additional Information: #type# (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ◉ Traditional state-managed fee-for-service
- ○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

MassHealth CarePlus members may receive benefits Fee-For-Service (FFS) pending enrollment into an available managed care option; as a wrap to primary health insurance; for MassHealth CarePlus benefits that are not covered by the CarePlus MCO (also referred to as Non-CarePlus MCO Covered Services); or when the member has presumptive or time-limited eligibility.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

V.20130917

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- [ ]

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package. **Yes**

Provide a description of employer sponsored insurance, including the population covered, the amount of premium assistance by population, employer sponsored insurance activities including required contribution, cost-effectiveness test requirements, and benefit information:

The state assures that ESI coverage is established in Section 3.2 and 4.22(h) of the state's approved Medicaid State Plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employer's sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

The state/territory otherwise provides for payment of premiums. **Yes**

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

The state assures that group health insurance coverage is established in Section 3.2 and 4.22(h) of the state's approved Medicaid State Plan. The beneficiary will receive a benefit package that includes a wrap of benefits around the employers sponsored insurance plan that equals the benefit package to which the beneficiary is entitled. The beneficiary will not be responsible for payment of premiums or other cost sharing that exceeds nominal levels as established at 42 CFR part 447 subpart A.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

V.20130917

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130917

Alternative Benefit Plan

OMB Control Number: 09381148
OMB Expiration date: 10/31/2014

Attachment 3.1-L- ☐

Payment Methodology	ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

V.20130917