Table of Contents

State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 23-0022

This file contains the following documents in the order listed:

- 1) Corrected Approval Letter
- 2) Originally signed Approval Letter
- 3) Summary Form (with 179-like data)
- 4) Corrected Approved SPA Page(s)



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,

James G. Scott, Director Division of Program Operations

Enclosures



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:

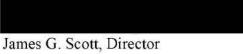
For your records, this is an approved copy of Massachusetts's Alternative Benefit Plan (ABP) State Plan Amendment (SPA) MA 23-0022. This ABP amendment submitted through the Medicaid Model Data Lab (MMDL No. MA.0807.R00.15) on March 30, 2023, meets all federal statutory and regulatory requirements for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



Division of Program Operations

Enclosures

Amount

Medicaid Alternative Benefit Plan: Summary Page (CMS 179)

State/Territory name: Transmittal Number:

Massachusetts

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 Y	ear	
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

11

11



_	OM	B Control Number: 09381148
Attachment 3.1-L-	OM	B Expiration date: 10/31/2014
Alternative Benefit Plan Populations		ABP1
Identify and define the population that will part	icipate in the Alternative Benefit Plan.	
Alternative Benefit Plan Population Name:	MassHealth CarePlus	
Identify eligibility groups that are included in the targeting criteria used to further define the popu	e Alternative Benefit Plan's population, and which may con lation.	tain individuals that meet any
Eligibility Groups Included in the Alternative B	enefit Plan Population:	
	Eligibility Group:	Enrollment is mandatory or voluntary?
+ Adult Group		Mandatory X
Enrollment is available for all individuals in the	ese eligibility group(s).	
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 inc		
Any other information the state/territory wishes	to provide about the population (optional)	
L]
valid OMB control number. The valid OMB co this information collection is estimated to average resources, gather the data needed, and complete	<u>PRA Disclosure Statement</u> 995, no persons are required to respond to a collection of inf ntrol number for this information collection is 0938-1148. T ge 5 hours per response, including the time to review instruc and review the information collection. If you have commen g this form, please write to: CMS, 7500 Security Boulevard, and 21244-1850.	The time required to complete tions, search existing data ts concerning the accuracy of



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

ABP2a

Attachment 3.1-L-

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

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.

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)

X	Letter
1	Lotter

🗌 Email

X Other



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.



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

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



	OMB Control Number: 09381148
Attachment 3.1-L-	OMB Expiration date: 10/31/2014
Enrollment Assurances - Mandatory Participants	ABP2c
These assurances must be made by the state/territory if enrollment is mandatory for any	y of the target populations or sub-populations.
When mandatorily enrolling eligibility groups in an Alternative Benefit Plan (Benchma exempt individuals, prior to enrollment:	ark or Benchmark-Equivalent Plan) that could have
The state/territory assures it will appropriately identify any individuals in the eligib enrollment in an Alternative Benefit Plan or individuals who meet the exemption or Plan coverage defined using section 1937 requirements or Alternative Benefit Plan Medicaid state plan, not subject to section 1937 requirements.	riteria and are given a choice of Alternative Benefit
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 a age 19, or are disabled are automatically enrolled in MassHealth Standard. The state or SSI-related disability determination would become categorically eligible to MassHealth Standard.	hose CarePlus ABP members who later receive a
Adults 19-64 years old who are only eligible for an ABP and are 19-20 years application that they meet the targeting criteria for our MassHealth Standard cancer; or are HIV positive; and those who are referred eligible from the Dep receiving services or are on a waiting list to receive such services are automa	ABP, including those who have breast or cervical artment of Mental Health because they are
Self-identification	
Describe:	
CarePlus members may self-identify as exempt at any time after their MassH has adopted the federal definition of individuals who are medically frail or ot CFR 440.315(f). MassHealth accepts CarePlus members' self-attestation of the	herwise have special medical needs as found at 42
Self-identification instructions are included in the MassHealth CarePlus eligi enrollment and whenever a member is re-determined eligible. These instructi and the MassHealth CarePlus enrollment guide, which MassHealth provides members who wish to identify as medically frail are instructed to contact Ma will provide medically frail members with choice counseling.	ons are also in the MassHealth member booklet to help members choose a health plan. CarePlus
Other	
The state/territory must inform the individual they are exempt or meet the exemption all requirements related to voluntary enrollment or, for beneficiaries in the "Individ eligibility group, optional enrollment in Alternative Benefit Plan coverage defined Benefit Plan coverage defined as the state/territory's approved Medicaid state plan.	luals at or below 133% FPL Age 19 through 64" using section 1937 requirements or Alternative



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?
O Monthly
O 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



Attachment 3.	1- L-		OMB Control Nun OMB Expiration o	
		efit Package or Benchmark-Equiva	97	ABP3
Select one of th	he following:			
C The st	tate/territory is amend	ling one existing benefit package for the popu	ulation defined in Section 1.	
• The st	tate/territory is creatin	ng a single new benefit package for the popul	ation defined in Section 1.	
Name	e of benefit package:	MassHealth CarePlus		
Selection of th	e Section 1937 Cove	erage Option		
	6	tion 1937 Coverage option the following type his Alternative Benefit Plan (check one):	e of Benchmark Benefit Package or Bench	mark-
• Benchn	nark Benefit Package			
() Benchn	nark-Equivalent Ben	efit Package.		
The st	tate/territory will pro-	vide the following Benchmark Benefit Packaş	ge (check one that applies):	
0	The Standard Blue Program (FEHBP	e Cross/Blue Shield Preferred Provider Option).	n offered through the Federal Employee H	lealth Benefit
0) State employee co	overage that is offered and generally available	e to state employees (State Employee Cove	erage):
0	A commercial HM HMO):	10 with the largest insured commercial, non-	Medicaid enrollment in the state/territory	(Commercial
	Secretary-Approv	ed Coverage.		
	• The state/terr	itory offers benefits based on the approved sta	ate plan.	
		itory offers an array of benefits from the secti ges, or the approved state plan, or from a corr		chmark plan
	C The state	/territory offers the benefits provided in the a	pproved state plan.	
	C Benefits	include all those provided in the approved sta	ate plan plus additional benefits.	
	C Benefits	are the same as provided in the approved state	e 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.	
	C The state	/territory offers a partial list of benefits provi	ded in the approved state plan plus addition	onal benefits.
	Please briefly ide	entify the benefits, the source of benefits and	any limitations:	
	Medicaid State P 1) Benefits target eligibility will be Essential Health 2) Long term ser	IassHealth CarePlus Alternative Benefit Plan Plan with the following exceptions: ted for individuals under 21 years of age, incl e limited to individuals 21 years of age or olde Benefit 10: Pediatric services; and vices and supports are generally not available 1: Ambulatory Patient Services,	luding EPSDT, are not included because C er. These services would have been found	CarePlus



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 Bas	se Benchmark Plan
	ry must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or ivalent Package.
The Base Bench	mark Plan is the same as the Section 1937 Coverage option. No
Indicate wh	ich Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:
C La	rgest plan by enrollment of the three largest small group insurance products in the state's small group market.
C An	y of the largest three state employee health benefit plans by enrollment.
An	y of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
C La	rgest insured commercial non-Medicaid HMO.
Pla	an name: 2014 Government Employee Health Association, Inc.
Other Informati	ion Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):
unless otherwis	es: 1) that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5 and 2) e indicated, the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services e currently approved 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.20130801



_	OMB Control Number: 09381148
Attachment 3.1-L-	OMB Expiration date: 10/31/2014
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 cost sharing must comply with Section 1916 of the Social Security Act.	t otherwise described in the state plan. Any such
The Alternative Benefit Plan for individuals with income over 100% FPL includes cost Attachment 4.18-A.	-sharing other than that described in 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



_	OMB Control Number: 09381148
Attachment 3.1-L-	OMB Expiration date: 10/31/2014
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 Approved."	than Secretary-Approved. Otherwise, enter "Secretary-
Secretary-Approved	



Essential Health Benefit 1: Ambulatory patie	nt services	Collapse All
Benefit Provided:	Source:	
Outpatient Hospital Service	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
benchmark plan: For those members receiving benefits fe authorization (PA); for example, physics hospital require PA after 20 visits in a 1	including the specific name of the source plan if it is not the b e for service (FFS), certain specific services are covered with al and occupational therapy services provided by an outpatient 2-month period. For those members receiving benefits through nanagement may apply that may differ from the FFS authoriza	prior
Benefit Provided:	Source:	
Hospice Care	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
benchmark plan:	including the specific name of the source plan if it is not the b or service (FFS) must receive certification of terminal illness a	
Benefit Provided:	Source:	
OLP: Audiologists' Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Other Amount Limit:	Medicaid State Plan Duration Limit:	



		ومعادية والمعالية وا
benchmark plan:	g the specific name of the source plan if it is not the base	
	her type of remedial care recognized under state law, be of their practice as defined by state law: Audiologists'	
	ice (FFS), certain high-cost and replacement hearing aids se members receiving benefits through managed care that may differ from the FFS authorization that is	
enefit Provided:	Source:	
LP: Chiropractors' Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Authorization required in excess of limitation	Medicaid State Plan	
Amount Limit:	Duration Limit:	
20 visits/treatments per calendar year	None	
Scope Limit:		
None		
	the specific name of the source plan if it is not the base	
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services."	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' naged care entities, other utilization management may	
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' naged care entities, other utilization management may	
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' naged care entities, other utilization management may that is specified in this SPA.	Remove
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' naged care entities, other utilization management may that is specified in this SPA.	Remove
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t enefit Provided: hysicians' Services	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' naged care entities, other utilization management may that is specified in this SPA. Source: State Plan 1905(a)	Remove
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t enefit Provided: hysicians' Services Authorization:	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' maged care entities, other utilization management may that is specified in this SPA. Source: State Plan 1905(a) Provider Qualifications:	Remove
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t enefit Provided: hysicians' Services Authorization: Other	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' naged care entities, other utilization management may that is specified in this SPA. Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan	Remove
benchmark plan: State Plan Benefit Title: "Medical care and any oth furnished by licensed practitioners within the scop Services." For those members receiving benefits through man apply that may differ from the FFS authorization t enefit Provided: hysicians' Services Authorization: Other Amount Limit:	her type of remedial care recognized under state law, be of their practice as defined by state law: Chiropractors' maged care entities, other utilization management may that is specified in this SPA. Source: State Plan 1905(a) Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
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hospital, a nursing facility or elsewhere."			2
authorization (PA); for example, reconstructive su by a physician who practices beyond 50 miles of t through managed care entities, other utilization ma	ce (FFS), certain specific services are covered with prior rgery and non-emergency out-of-state services provided he state border. For those members receiving benefits anagement may apply that may differ from the FFS		
authorization that is specified in this SPA.			
Benefit Provided:	Source:		
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Authorization:	Provider Qualifications:		
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Other information regarding this benefit, including benchmark plan:	the specific name of the source plan if it is not the base		
entities, other utilization management may apply t specified in this SPA.	Source:		2
Screening Services	State Plan 1905(a)	Remove	
	Provider Qualifications:		
Authorization:	Medicaid State Plan	1	
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Pediatric or Family Nurse Practitioners' Services	State Plan 1905(a)	Remove	
Authorization:	Provider Qualifications:		
Other	Medicaid State Plan]	
TN: MA 23-0022 Appr	oval Date: 06/21/2023	مى بىلىچىنىڭ ئېشىرىن	-
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those summarized under Physicians' Serv	for service (FFS), the same prior authorization requirements a ices apply. For those members receiving benefits through anagement may apply that may differ from the FFS authorizat	
enefit Provided:	Source:	
lome Health: Part-time Nursing Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
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health agency or by a registered nurse wh For those members receiving benefits fee excess of limitations; for example, after 3 a calendar year are any combination of m calendar year. After the threshold for PA have a qualified break in service. For those	ntermittent or part time nursing services provided by a home en no home health agency exists in the area." for service (FFS), nursing visits are covered with authorizatio 0 nursing visits in a calendar year. These 30 nursing visits wit arsing services. This PA threshold resets every January 1st of is exceeded services must be provided through the PA unless see members receiving benefits through managed care entities, that may differ from the FFS authorization that is specified in	hin the they
enefit Provided:	Source:	
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Authorization:	Provider Qualifications:	
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Covered within the limitations outlined l	below.	
TN: MA 23-0022	Approval Date: 06/21/2023	and a second sec
Supersedes TN: 22-0010	Effective Date: 01/01/2023	



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.

enefit Provided:	Source:	
QHC Services and Other Amb. Services	State Plan 1905(a)	Remove
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ssential Health Benefit 2: Emergency servic	es	Collapse All
Benefit Provided:	Source:	
Emergency Hospital Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
None	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
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benchmark plan: Covered without limitations.		
Benefit Provided:	Source:	
Transportation – Emergent	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
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Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
Limit on days supply	Yes	State licensed
Limit on number of prescriptions	<u>.</u>	
Limit on brand drugs		
Other coverage limits		
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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 cover	ered.	
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 th	herapy, occupational therapy, or speech pathology and new or medical rehabilitation facility."	
State Plan Title: "Home health services: Physical th audiology services provided by a home health ager	ncy or medical rehabilitation facility."	
State Plan Title: "Home health services: Physical th audiology services provided by a home health ager For those members receiving benefits through man	ncy or medical rehabilitation facility."	Add



Benefit Provided:	Source:	
Other Laboratory and X-ray Services	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		_
None		
Other information regarding this benefit, in benchmark plan:	ncluding the specific name of the source plan if it is not the base	
	for service (FFS), certain specific services are covered with prior enetic testing. For those members receiving benefits through	
managed care entities, other utilization ma that is specified in this SPA.	nagement may apply that may differ from the FFS authorization	



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Benefit Provided:	Source:	
Medicaid State Plan EPSDT Benefits	State Plan 1905(a)	Remove
Authorization:	Provider Qualifications:	
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Amount Limit:	Duration Limit:	
Other	Other	
Scope Limit:		
Not a provided benefit.		
Other information regarding this benefit, ind benchmark plan:	cluding the specific name of the source plan if it is not the base	
This benefit plan is for individuals age 21-6	4 and will not include any EPSDT or pediatric service benefits.	
		Add



Other Covered Benefits from Base Benchmark

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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 the GEHA Benefit Name: Care provided at Christian Scie MassHealth does not cover this provider type; howev are covered in this ABP through various categories in Services under EHB 1.	ence Facilities and by Christian Science Practitioners er, all the medically necessary services they provide	
		Add



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	Package	Remove
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Supersedes TN. 22-0010	Effective Date: 01/01/2023	



	his provider type is excluded.	
Other:		
	and any other type of remedial care recognized under state law, in the scope of their practice as defined by state law: Optometrists'	
within a 24-month period; additional se	for service (FFS) are limited to one comprehensive eye examination rvices are provided when medically necessary. For those members re entities, other utilization management may apply that may differ fied in this SPA.	
Other 1937 Benefit Provided:	Source:	
Eyeglasses	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
See below for scope limits		
	ugs, dentures, and prosthetic devices and eyeglasses prescribed by a	
State Plan Benefit Title: "Prescribed dru physician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; in For those members receiving benefits for authorization (PA); for example, certain	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; invisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply	
State Plan Benefit Title: "Prescribed druphysician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; in For those members receiving benefits for authorization (PA); for example, certain those members receiving benefits through that may differ from the FFS authorization that may differ from the FFS authorization the transformation of the transformation that may differ from the FFS authorization the transformation that may differ from the FFS authorization the transformation that may differ from the FFS authorization the transformation that may differ from the transformation transformation the transformation the transformation transformation the transformation transformation the transformation transfo	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; invisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply	
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State Plan Benefit Title: "Prescribed druphysician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; in For those members receiving benefits for authorization (PA); for example, certain those members receiving benefits through that may differ from the FFS authorizate. Dther 1937 Benefit Provided: Dental Authorization:	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; invisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply ion that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
State Plan Benefit Title: "Prescribed dru physician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; in For those members receiving benefits fa authorization (PA); for example, certain those members receiving benefits throu that may differ from the FFS authorizat Other 1937 Benefit Provided: Dental	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; nvisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior n high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply ion that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
State Plan Benefit Title: "Prescribed druphysician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; in For those members receiving benefits for authorization (PA); for example, certain those members receiving benefits through that may differ from the FFS authorizate. Dther 1937 Benefit Provided: Dental Authorization:	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; invisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply ion that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
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State Plan Benefit Title: "Prescribed druphysician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; ir For those members receiving benefits fa authorization (PA); for example, certain those members receiving benefits throuthat may differ from the FFS authorizate. Dther 1937 Benefit Provided: Dental Authorization: Other Amount Limit:	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; ivisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply ion that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
State Plan Benefit Title: "Prescribed druphysician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; ir For those members receiving benefits for authorization (PA); for example, certain those members receiving benefits throuthat may differ from the FFS authorizate. Dther 1937 Benefit Provided: Dental Authorization: Other Amount Limit: None	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; invisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply ion that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove
State Plan Benefit Title: "Prescribed druphysician skilled in diseases of the eye Exclusions consist of absorptive lenses contact lenses for extended wear use; ir For those members receiving benefits frauthorization (PA); for example, certain those members receiving benefits throuthat may differ from the FFS authorizate. Dental Authorization: Other Amount Limit: None Scope Limit:	or by an optometrist: Eyeglasses." of greater than 25% absorption, prisms obtained by decentration; invisible bifocals; and Welsh 4-drop lenses. ee for service (FFS), certain specific services are covered with prior in high-index lenses, special needs glasses, and glass lenses. For gh managed care entities, other utilization management may apply ion that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None	Remove



visits; certain restorative services (all fillings) including repairs);extractions; anesthesia; trea such as biopsies and soft-tissue surgery; and o gingivoplasties, and periodontal scaling and r allow for topical fluoride when documented a For those members receiving benefits fee for authorization (PA); for example, removal of i	service (FFS), certain specific services are covered with prior impacted teeth (completely bony). For those members ties, other utilization management may apply that may differ	
Other 1937 Benefit Provided:	Source:	8 <u></u>
Transportation – Non-emergent	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		8
transportation require prior authorization from	service (FFS), all forms of transportation except public n the MassHealth agency. For those members receiving utilization management may apply that may differ from the A.	
Other 1937 Benefit Provided:	Source:	
Targeted Case Management Services	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	,
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		s
criteria described in the State Plan in Supplem - Case Management for Medicaid Recipients in a staffed, congregate residential program w	FFS members seeking TCM are subject to the eligibility nent 1 to Attachment 3.1-A. Age 18 and Older who are Diagnosed with AIDS and Living which meets the Department of Public Health (DPH) funding portive Residential Services program which require that a	
TN: MA 23-0022	Approval Date: 06/21/2023	(

Effective Date: 01/01/2023



person be HIV positive, and in which no more than th	ree mentally and/or physically impaired individuals	
share a single bedroom and bathroom.	al Assistance and for services provided, purchased, or	
arranged by the Department of Mental Retardation, no		
	ss as Determined by the Department of Mental Health	
(DMH).	, ,	
- Case Management for Individuals under age 21 with		
- Case Management for Children Committed to the De	epartment of Youth Services.	
Other 1937 Benefit Provided:	Source:	12
OLP: Podiatrist	Section 1937 Coverage Option Benchmark Benefit	
	Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
See below	None	
Scope Limit:		
Other than routine foot care services		
Other:		
	remedial care recognized under state law, furnished by	6
licensed practitioners within the scope of their practic		
limits are hard limits for members aged 21 and older:		
limited visit per 30 day period; one extended visit per		
of office visits are limited to one visit in a 30 day peri-		
and two visits in a 30 day period in a hospital setting.		
managed care entities, other utilization management n	nay apply that may differ from the FFS authorization	
that is specified in this SPA.		1
Other 1937 Benefit Provided:	Source:	
OLP: Other Practitioners' Services	Section 1937 Coverage Option Benchmark Benefit Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	f.
		s
Amount Limit:	Duration Limit:	6
None	None	c
Scope Limit:		
None		
Other:		
State Plan Title: "Medical care and any other type of r	remedial care provided by licensed practitioners,	
furnished by such practitioners within the scope of the		
Practitioners' services (OLP)". OLP services not listed		
services, public health dental hygienist services, and a		
services are limited to the practice of fitting and dispe		
human hearing solely for the purpose of making selec	tions, adaptations or sales of hearing aids intended to	
TN: MA 23-0022 Approval	Date: 06/21/2023	

Effective Date: 01/01/2023



for example, certain high-cost hearing aids. F	and as a substance use disorder treatment. For those members and as a substance use disorder treatment. For those members an specific services are covered with prior authorization (PA); For those members receiving benefits through managed care oply that may differ from the FFS authorization that is	
ther 1937 Benefit Provided:	Source: Section 1937 Coverage Option Benchmark Benefit	
Extended Services for Pregnant Women	Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		
prior authorization requirements summarized Hospital Services. For those members received	service (FFS), qualified providers are subject to the same I in this ABP, including Physicians' Services and Outpatient ing benefits through managed care entities, other utilization the FFS authorization that is specified in this SPA. Source: Section 1937 Coverage Option Benchmark Benefit	Demour
Services	Package	Remove
Authorization:	Provider Qualifications:	
Authorization: Other	Provider Qualifications: Medicaid State Plan	
Other	Medicaid State Plan	
Other Amount Limit:	Medicaid State Plan Duration Limit:	
Other Amount Limit: None	Medicaid State Plan Duration Limit:	
Other Amount Limit: None Scope Limit: See Below Other:	Medicaid State Plan Duration Limit:	



	Source: Section 1937 Coverage Option Benchmark Benefit	
Medication Assisted Treatment (MAT)	Package	Remove
Authorization:	Provider Qualifications:	
Other	Medicaid State Plan	
Amount Limit:	Duration Limit:	
None	None	
Scope Limit:		
None		
Other:		
MAT is provided as defined in the approved state		
September 30, 2025.	for the period beginning October 1, 2020, and ending	9
September 30, 2025. Other 1937 Benefit Provided:	for the period beginning October 1, 2020, and ending Source: Section 1937 Coverage Option Benchmark Benefit	
September 30, 2025. Other 1937 Benefit Provided:	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
September 30, 2025. Other 1937 Benefit Provided:	Source: Section 1937 Coverage Option Benchmark Benefit	Remove
September 30, 2025. Other 1937 Benefit Provided: Routine Patient Costs: Qualifying Clinical Trials	Source: Section 1937 Coverage Option Benchmark Benefit Package	Remove
September 30, 2025. Other 1937 Benefit Provided: Routine Patient Costs: Qualifying Clinical Trials Authorization:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications:	Remove
September 30, 2025. Other 1937 Benefit Provided: Routine Patient Costs: Qualifying Clinical Trials Authorization: Other	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan	Remove
September 30, 2025. Other 1937 Benefit Provided: Routine Patient Costs: Qualifying Clinical Trials Authorization: Other Amount Limit:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
September 30, 2025. Other 1937 Benefit Provided: Routine Patient Costs: Qualifying Clinical Trials Authorization: Other Amount Limit: None	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
September 30, 2025. Other 1937 Benefit Provided: Routine Patient Costs: Qualifying Clinical Trials Authorization: Other Amount Limit: None Scope Limit:	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit:	Remove
September 30, 2025.         Other 1937 Benefit Provided:         Routine Patient Costs: Qualifying Clinical Trials         Authorization:         Other         Amount Limit:         None         Scope Limit:         See Below         Other:         Confirming coverage of routine patient costs in quality	Source: Section 1937 Coverage Option Benchmark Benefit Package Provider Qualifications: Medicaid State Plan Duration Limit: None ualifying clinical trials as required under Section he state plan 3.1A and 3.1B pages under "Coverage of	Remove



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

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	OMB Control Number: 09381148
Attachment 3.1-L-	OMB Expiration date: 10/31/2014
Benefits Assurances	ABP7
<b>EPSDT Assurances</b> If the target population includes persons under 21, please complete the following assurances re	egarding 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 co- implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug category and class or the same number of prescription drugs in each category and class as	g in each United States Pharmacopeia (USP)
The state/territory assures that procedures are in place to allow a beneficiary to request an prescription drugs when not covered.	d gain access to clinically appropriate
✓ The state/territory assures that when it pays for outpatient prescription drugs covered under requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345 directly contrary to amount, duration and scope of coverage permitted under section 1937	, except for those requirements that are
The state/territory assures that when conducting prior authorization of prescription drugs a complies with prior authorization program requirements in section 1927(d)(5) of the Act.	under an Alternative Benefit Plan, it
Other Benefit Assurances	
The state/territory assures that substituted benefits are actuarially equivalent to the benefit plan, and that the state/territory has actuarial certification for substituted benefits available	
The state/territory assures that individuals will have access to services in Rural Health Cli Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Soc	
The state/territory assures that payment for RHC and FQHC services is made in accordance 1902(bb) of the Social Security Act.	ce with the requirements of section
The state/territory assures that it will comply with the requirement of section 1937(b)(5) of 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as desc. Protection and Affordable Care Act.	
The state/territory assures that it will comply with the mental health and substance use dis 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations use disorder benefits comply with the requirements of section 2705(a) of the Public Health requirements apply to a group health plan.	s applicable to mental health or substance
The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), must 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.



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).

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	OWID Control (Value) - 09501140
Attachment 3.1-L-	OMB Expiration date: 10/31/2014
Service Delivery Systems	ABP8
Provide detail on the type of delivery system(s) the state/territo benchmark-equivalent benefit package, including any variation	ory will use for the Alternative Benefit Plan's benchmark benefit package or n by the participants' geographic area.
Type of service delivery system(s) the state/territory will use for	or 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

OMB Control Number: 09381148



The managed care program is operating under (select one):
C Section 1915(a) voluntary managed care program.
C Section 1915(b) managed care waiver.
C Section 1932(a) mandatory managed care state plan amendment.
• Section 1115 demonstration.
C 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.
The managed care program is operating under (select one):
C Section 1915(a) voluntary managed care program.
C Section 1915(b) managed care waiver.
• Section 1115 demonstration.
C 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



The PCCM delivery system is the same as an already approved PCCM program.	
The recent dentity system is the same as an aready approved receiving ogram.	es
The PCCM program is operating under (select one):	
C Section 1915(b) managed care waiver.	
C Section 1932(a) mandatory managed care state plan amendment.	
• Section 1115 demonstration.	
C 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 that region must enroll either in the PCC Plan or the available CarePlus MCO.	s in
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- service care management models/non-risk, contractual incentives as well as the population served via this delivery system.	-for-
MassHealth CarePlus members may receive benefits Fee-For-Service (FFS) pending enrollment into an available managed of option; as a wrap to primary health insurance; for MassHealth CarePlus benefits that are not covered by the CarePlus MCO (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):	
(optional).	_
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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.



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

ABP9

Yes

Attachment 3.1-L-

#### **Employer Sponsored Insurance and Payment of Premiums**

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.

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.

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:

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	OMB Control Number: 09381148
Attachment 3.1-L-	OMB Expiration date: 10/31/2014
General Assurances	ABP10
Economy and Efficiency of Plans	
The state/territory assures that Alternative Benefit Plan coverage is provided in accorrequirements and other economy and efficiency principles that would otherwise be ap through which the coverage and benefits are obtained.	
Economy and efficiency will be achieved using the same approach as used for Medi	icaid state plan services. Yes
Compliance with the Law	
The state/territory will continue to comply with all other provisions of the Social Sec state/territory plan under this title.	curity Act in the administration of the
✓ The state/territory assures that Alternative Benefit Plan benefits designs shall conform CFR 430.2 and 42 CFR 440.347(e).	m to the non-discrimination requirements at 42
The state/territory assures that all providers of Alternative Benefit Plan benefits shall the Base Benchmark Plan and/or the Medicaid state plan.	l meet the provider qualification requirements of

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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.

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