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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 24-0019

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

December 19, 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) 24-0019

Dear Secretary Walsh:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0019. This amendment proposes to update cost sharing requirements.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations Sections 1916 and 1916A of the Social Security Act, and 42 CFR 447.50-447.57. This letter informs you that Massachusetts's Medicaid SPA TN 24-0019 was approved on December 19, 2024, effective April 1, 2024.

Enclosed are copies of the Summary Page (CMS-179) and approved SPA pages to be incorporated into the Massachusetts State Plan.

If you have any questions, please contact Kia Carter-Anderson at (404) 562-7431 or via email at kia.carter-anderson@cms.hhs.gov.

Sincerely,

[redacted]

Ruth A. Hughes, Acting Director
Division of Program Operations

Enclosures

cc: Alison Kirchgasser
Kaela Konefal

Medicaid Premiums and Cost Sharing: Summary Page (CMS 179)

State/Territory name: **Massachusetts**

Transmittal Number:

Enter the Transmittal Number (TN), including dashes, in the format SS-YY-NNNN or SS-YY-NNNN-xxxx (with xxxx being optional to specific SPA types), where SS = 2-character state abbreviation, YY = last 2 digits of submission year, NNNN = 4-digit number with leading zeros, and xxxx = OPTIONAL, 1-to 4-character alpha/numeric suffix.

MA-24-0019

Proposed Effective Date

04/01/2024 *(mm/dd/yyyy)*

Federal Statute/Regulation Citation

Sections 1916 and 1916A of the Social Security Act, and 42 CFR 447.50-447.57

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2024	$ 898000.00
Second Year	2025	$ 1792000.00

Subject of Amendment

An amendment to the state's Medicaid State Plan to eliminate copayments.

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:	**Dec 16, 2024**
Submit Date:	**Jun 28, 2024**

Medicaid Premiums and Cost Sharing

State Name: Massachusetts

OMB Control Number: 09381148

Transmittal Number: MA - 24 - 0019

Cost Sharing Requirements	G1
1916 1916A 42 CFR 447.50 through 447.57 (excluding 447.55)	
The state charges cost sharing (deductibles, co-insurance or co-payments) to individuals covered under Medicaid.	No

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 09381148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather 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 C42605, Baltimore, Maryland 212441850.

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Medicaid Premiums and Cost Sharing

State Name: Massachusetts

OMB Control Number: 09381148

Transmittal Number: MA - 24 - 0019

Cost Sharing Limitations — G3

42 CFR 447.56
1916
1916A

☑ The state administers cost sharing in accordance with the limitations described at 42 CFR 447.56, and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act, as follows:

Exemptions

Groups of Individuals - Mandatory Exemptions

The state may not impose cost sharing upon the following groups of individuals:

- ■ Individuals ages 1 and older, and under age 18 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118).
- ■ Infants under age 1 eligible under the Infants and Children under Age 18 eligibility group (42 CFR 435.118), whose income does not exceed the higher of:
  - ■ 133% FPL; and
  - ■ If applicable, the percent FPL described in section 1902(l)(2)(A)(iv) of the Act, up to 185 percent.
- ■ Disabled or blind individuals under age 18 eligible for the following eligibility groups:
  - ■ SSI Beneficiaries (42 CFR 435.120).
  - ■ Blind and Disabled Individuals in 209(b) States (42 CFR 435.121).
  - ■ Individuals Receiving Mandatory State Supplements (42 CFR 435.130).
- ■ Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age.
- ■ Disabled children eligible for Medicaid under the Family Opportunity Act (1902(a)(10)(A)(ii)(XIX) and 1902(cc) of the Act).
- ■ Pregnant women, during pregnancy and through the postpartum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends, except for cost sharing for services specified in the state plan as not pregnancy-related.
- ■ Any individual whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- ■ An individual receiving hospice care, as defined in section 1905(o) of the Act.
- ■ Indians who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services.
- ■ Individuals who are receiving Medicaid because of the state's election to extend coverage to the Certain Individuals Needing Treatment for Breast or Cervical Cancer eligibility group (42 CFR 435.213).

Groups of Individuals - Optional Exemptions

The state may elect to exempt the following groups of individuals from cost sharing:

The state elects to exempt individuals under age 19, 20 or 21, or any reasonable category of individuals 18 years of age or over. **Yes**

Indicate below the age of the exemption:

- ○ Under age 19
- ○ Under age 20
- ○ Under age 21
- ◉ Other reasonable category

Description:

Copays are eliminated, effective 4/1/24.

The state elects to exempt individuals whose medical assistance for services furnished in a home and community-based setting is reduced by amounts reflecting available income other than required for personal needs. **No**

Services - Mandatory Exemptions

The state may not impose cost sharing for the following services:

- ☑ Emergency services as defined at section 1932(b)(2) of the Act and 42 CFR 438.114(a).
- ☑ Family planning services and supplies described in section 1905(a)(4)(C) of the Act, including contraceptives and pharmaceuticals for which the state claims or could claim federal match at the enhanced rate under section 1903(a)(5) of the Act for family planning services and supplies.
- ☑ Preventive services, at a minimum the services specified at 42 CFR 457.520, provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics.
- ☑ Pregnancy-related services, including those defined at 42 CFR 440.210(a)(2) and 440.250(p), and counseling and drugs for cessation of tobacco use. All services provided to pregnant women will be considered pregnancy-related, except those services specificially identified in the state plan as not being related to pregnancy.
- ☑ Provider-preventable services as defined in 42 CFR 447.26(b).

Enforceability of Exemptions

The procedures for implementing and enforcing the exemptions from cost sharing contained in 42 CFR 447.56 are (check all that apply):

- ☑ To identify that American Indians/Alaskan Natives (AI/AN) are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services in accordance with 42 CFR 447.56(a)(l)(x), the state uses the following procedures:
  - ☐ The state accepts self-attestation
  - ☐ The state runs periodic claims reviews

☐ The state obtains an Active or Previous User Letter or other Indian Health Services (IHS) document

☐ The Eligibility and Enrollment and MMIS systems flag exempt recipients

☒ Other procedure

Description:

Copays are eliminated effective 4/1/24. MassHealth still charges premiums to members as outlined in the State Plan and in the Commonwealth's 1115 Demonstration Waiver Attachment C.

Additional description of procedures used is provided below (optional):

☐ To identify all other individuals exempt from cost sharing, the state uses the following procedures (check all that apply):

☐ The MMIS system flags recipients who are exempt

☐ The Eligibility and Enrollment System flags recipients who are exempt

☐ The Medicaid card indicates if beneficiary is exempt

☐ The Eligibility Verification System notifies providers when a beneficiary is exempt

☒ Other procedure

Description:

Copays are eliminated effective 4/1/24. MassHealth still charges premiums to members as outlined in the State Plan and in the Commonwealth's 1115 Demonstration Waiver Attachment C.

Additional description of procedures used is provided below (optional):

Copays are eliminated effective 4/1/24. MassHealth still charges premiums to members as outlined in the State Plan and in the Commonwealth's 1115 Demonstration Waiver Attachment C.

Payments to Providers

☐ The state reduces the payment it makes to a provider by the amount of a beneficiary's cost sharing obligation, regardless of whether the provider has collected the payment or waived the cost sharing, except as provided under 42 CFR 447.56(c).

Payments to Managed Care Organizations

The state contracts with one or more managed care organizations to deliver services under Medicaid. Yes

☐ The state calculates its payments to managed care organizations to include cost sharing established under the state plan for beneficiaries not exempt from cost sharing, regardless of whether the organization imposes the cost sharing on its recipient members or the cost sharing is collected.

Aggregate Limits

☑ Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household do not exceed an aggregate limit of 5 percent of the family's income applied on a quarterly or monthly basis.

■ The percentage of family income used for the aggregate limit is:

- (●) 5%
- ( ) 4%
- ( ) 3%
- ( ) 2%
- ( ) 1%
- ( ) Other: [ ] %

■ The state calculates family income for the purpose of the aggregate limit on the following basis:

- ( ) Quarterly
- (●) Monthly

The state has a process to track each family's incurred premiums and cost sharing through a mechanism that does not rely on beneficiary documentation. **Yes**

■ Describe the mechanism by which the state tracks each family's incurred premiums and cost sharing (check all that apply):

- ☒ As claims are submitted for dates of services within the family's current monthly or quarterly cap period, the state applies the incurred cost sharing for that service to the family's aggregate limit. Once the family reaches the aggregate limit, based on incurred cost sharing and any applicable premiums, the state notifies the family and providers that the family has reached their aggregate limit for the current monthly or quarterly cap period, and are no longer subject to premiums or cost sharing.
- ☐ Managed care organization(s) track each family's incurred cost sharing, as follows:
- ☐ Other process:

■ Describe how the state informs beneficiaries and providers of the beneficiaries' aggregate family limit and notifies beneficiaries and providers when a beneficiary has incurred premiums and cost sharing up to the aggregate family limit and individual family members are no longer subject to premiums or cost sharing for the remainder of the family's current monthly or quarterly cap period:

Beneficiaries are sent a notice indicating their monthly cap and subsequent notices anytime they experience a modification to that cap resulting from a change in circumstance. This information can also be accessed through a self-service voice response system.

The state has a documented appeals process for families that believe they have incurred premiums or cost sharing over the aggregate limit for the current monthly or quarterly cap period. **Yes**

Describe the appeals process used:

All members are informed of their right to appeal in monthly cap notices. Through this process members may

request a standard fair hearing through our Board of Hearings to remedy concerns they have exceeded the monthly cap.

Members may also contact MassHealth customer service to report overpayments. Through this process, a member may initiate an internal review and reconciliation of overpayments. Our customer service vendor will work with MassHealth Eligibility and Claims Operations to review eligibility case facts and incurred cost sharing. If we identify an overpayment, we will issue a reimbursement to the provider where the overpayment occurred if member is fee-for-service. If the member is enrolled in a managed care entity, the managed care plan will handle the reimbursement. This customer service process is not intended to replace the fair hearing process, but instead seeks to provide members with an informal way to resolve errors or report a change that may impact their cap. Members will still have the option to pursue a fair hearing regardless of whether they use this customer service process.

☒ Describe the process used to reimburse beneficiaries and/or providers if the family is identified as paying over the aggregate limit for the month/quarter:

The state implemented a process by which beneficiary and providers can contact the agency for administrative review of cost sharing claims. If determined a cost sharing was erroneously deducted from a provider claim, the state will administratively reprocess the claim and the provider will be responsible for returning copayments collected in error to the beneficiary.

☒ Describe the process for beneficiaries to request a reassessment of their family aggregate limit if they have a change in circumstances or if they are being terminated for failure to pay a premium:

Beneficiaries will have their family aggregate limit assessed and individual limit adjusted if needed on a monthly basis. Additionally, beneficiaries may contact the state at any time during the month to request their family aggregate limit be reassessed. The state will also have the ability to turn off cost sharing at the individual level at any time.

The state imposes additional aggregate limits, consistent with 42 CFR 447.56(f)(5). No

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