

**MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

**Preamble**

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

**MODEL APPLICATION TEMPLATE FOR  
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:

**Massachusetts**  
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

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(Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Wendy E. Warring	Position/Title: Commissioner, Division of Medical Assistance
Name: Tricia Spellman	Position/Title: Chief Financial Officer, DMA
Name: Beth Waldman	Position/Title: Director, Demonstration & SCHIP Program

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 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) 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 any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Effective Date:

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Approval Date:

09/19/02

**Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements (Section 2101)**

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) (42 CFR 457.70):

1.1.1  Obtaining coverage that meets the requirements for a separate child health program (Section 2103); **OR**

1.1.2.  Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**

1.1.3.  A combination of both of the above.

1.2  Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

The Division assures that no expenditures for child health assistance will be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS.

1.3  Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

The Division assures its compliance with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 C FR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: October 1, 1997  
Implementation date: August 24, 199  
Plan Amendment – Adjustments to cost sharing  
Effective date: March 1, 2003  
Implementation: March 1, 2003

**Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination** (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Table 2a displays the distribution of children by insurance status based on the Current Population Survey (CPS) data made available by the U.S. Bureau of the Census. The CPS is an annual national survey providing data on health insurance coverage, income, employment status, demographic characteristics and other family and individual characteristics. The CPS is considered the most reliable source of estimates of the uninsured population at the state level. To enhance the statistical reliability of demographic estimates contained in this data, the Division completed an analysis using a merged database comprising survey samples from the March, 1993 supplement and the March, 1994 supplement. In this analysis, the 1993-1994 data is considered a proxy for estimating the current distribution of Massachusetts children based on income, age and health insurance status.

Although more recent data from the March 1995 supplement is available, it is not comparable to the 1993 and 1994 data for purposes of this analysis because survey questions were changed. The March 1996 supplement contains a Massachusetts sample too small in aggregate to provide statistically reliable estimates.

Data has been manipulated by the Massachusetts Institute of Social and Economic Research at the University of Massachusetts in Amherst.

Table 2b displays the distribution of insured children by type of health care coverage.

Table 2a.

**Health Insurance Status of Children in Massachusetts by Age and Income Level  
(1)**

**Uninsured Children**

<u>Federal Poverty Level</u>	<u>Age 0 - 6</u>	<u>Age 7 - 12</u>	<u>Age 13 - 17</u>	<u>Age 18 (2)</u>	<u>Total</u>
0% - 100% FPL	12,738	10,215	9,581	2,072	34,607
101% - 133% FPL	7,985	1,840	5,710	828	16,362
134% - 150% FPL	3,149	266	2,600	353	6,369
151% - 200% FPL	2,338	6,623	9,506	1,410	19,876
201% - 400% FPL	15,016	10,868	15,380	3,544	44,808
401% + FPL	14,055	2,941	4,432	2,607	24,035
<b>Total</b>	<b>55,281</b>	<b>32,753</b>	<b>47,210</b>	<b>10,814</b>	<b>146,058</b>

**Insured Children**

<u>Federal Poverty Level</u>	<u>Age 0 - 6</u>	<u>Age 7 - 12</u>	<u>Age 13 - 17</u>	<u>Age 18</u>	<u>Total</u>
0% - 100% FPL	92,244	69,043	38,390	4,005	203,682
101% - 133% FPL	32,829	27,732	23,640	1,948	86,150
134% - 150% FPL	14,899	9,679	10,841	1,072	36,490
151% - 200% FPL	39,240	29,630	21,585	2,832	93,287
201% - 400% FPL	194,427	161,942	135,331	17,751	509,451
401% + FPL	178,375	151,055	122,694	32,066	484,189
<b>Total</b>	<b>552,013</b>	<b>449,080</b>	<b>352,482</b>	<b>59,674</b>	<b>1,413,249</b>

(1) Based on 1995, 1996, and 1997 Merged Current Population Survey (CPS) data.

(2) Estimated based on CPS and Census data.

Table 2b

**Coverage of Insured Children in Massachusetts by Age and Income  
(1)**

**Insured Children**

<u>Federal Poverty Level</u>	<u>Age 0 - 6</u>	<u>Age 7 - 12</u>	<u>Age 13 - 17</u>	<u>Age 18 (2)</u>	<u>Total</u>
0% - 100% FPL	92,244	69,043	38,390	4,005	203,682
101% - 133% FPL	32,829	27,732	23,640	1,948	86,150
134% - 150% FPL	14,899	9,679	10,841	1,072	36,490
151% - 200% FPL	39,240	29,630	21,585	2,832	93,287
201% - 400% FPL	194,427	161,942	135,331	17,751	509,451
401% + FPL	<u>178,375</u>	<u>151,055</u>	<u>122,694</u>	<u>32,066</u>	<u>484,189</u>
<b>Total</b>	<b>552,013</b>	<b>449,080</b>	<b>352,482</b>	<b>59,674</b>	<b>1,413,249</b>

**Children Covered by Employer Related Group Health Insurance**

<u>Federal Poverty Level</u>	<u>Age 0 - 6</u>	<u>Age 7 - 12</u>	<u>Age 13 - 17</u>	<u>Age 18</u>	<u>Total</u>
0% - 100% FPL	7,408	13,282	9,544	873	31,107
101% - 133% FPL	16,258	11,201	8,891	745	37,095
134% - 150% FPL	8,847	6,181	8,612	652	24,291
151% - 200% FPL	19,349	14,747	13,678	1,863	49,638
201% - 400% FPL	157,962	129,847	111,084	14,844	413,737
401% + FPL	<u>162,714</u>	<u>139,641</u>	<u>107,194</u>	<u>29,539</u>	<u>439,088</u>
<b>Total</b>	<b>372,539</b>	<b>314,899</b>	<b>259,003</b>	<b>48,516</b>	<b>994,957</b>

**Children Covered by Other Health Insurance (3)**

<u>Federal Poverty Level</u>	<u>Age 0 - 6</u>	<u>Age 7 - 12</u>	<u>Age 13 - 17</u>	<u>Age 18</u>	<u>Total</u>
0% - 100% FPL	84,835	55,761	28,846	3,132	172,575
101% - 133% FPL	16,571	16,531	14,749	1,203	49,054
134% - 150% FPL	6,052	3,497	2,230	420	12,199
151% - 200% FPL	19,891	14,883	7,907	969	43,649
201% - 400% FPL	36,465	32,095	24,247	2,907	95,714
401% + FPL	<u>15,661</u>	<u>11,414</u>	<u>15,500</u>	<u>2,526</u>	<u>45,101</u>
<b>Total</b>	<b>179,475</b>	<b>134,180</b>	<b>93,479</b>	<b>11,158</b>	<b>418,292</b>

(1) Based on 1995, 1996, and 1997 Merged Current Population Survey data.

(2) Estimated based on CPS and Census data.

(3) Includes Medicaid, Medicare, CHAMPUS, and Other Insurance.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR 457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Massachusetts has many efforts currently underway to identify and enroll eligible children in either MassHealth or the Children's Medical Security Plan (CMSP). These efforts are described below.

**MassHealth**

MassHealth is administered by the Massachusetts Division of Medical Assistance (the Division), which is the state's Title XIX agency. The Division enrolls children in MassHealth through one of its four MassHealth Enrollment Centers (MECs), or through one of the community-based mini-grant sites, including school systems and community-based organizations. Applications for MassHealth may either be mailed in or phoned in. Pregnant applicants may also receive assistance with their MassHealth application from one of six regionally-based Healthy Start outreach workers (see below for a more detailed description of the Healthy Start program). Infants born to mothers enrolled in MassHealth Standard are guaranteed MassHealth eligibility for the first 12 months of life.

**Children's Medical Security Plan (CMSP)**

CMSP is administered by the Massachusetts Department of Public Health (the Department), which is the state's Title V agency. The Department enrolls children in CMSP through a toll-free number operated by the state's contracted administrator for CMSP, or through one of six regionally-based outreach workers employed by the Department. Applications may be made either by mail or by phone.

The Division and the Department have created a single point of access for the two programs. There is a streamlined, single application for both MassHealth and CMSP. An application is reviewed first for MassHealth eligibility. If the child is determined ineligible for MassHealth, then the application is forwarded to CMSP.

Although each agency has designated sites for accepting applications for MassHealth and CMSP, there are several other programs operated by each of the agencies that also evaluate families for potential eligibility for MassHealth and CMSP. These programs include:

- **Early Intervention Programs:** Early Intervention Programs (EIPs), certified by the Department of Public Health, offer developmental services to both insured and uninsured children. EIPs are reimbursed by the Department of Public Health for services delivered to uninsured children. EIP staff provide information about CMSP and MassHealth to families with uninsured children.
- **School-Based Health Centers:** Thirty-one school-based health centers in the Commonwealth are funded by the Department of Public Health to offer comprehensive primary care services to children and adolescents who are students at the schools served by the centers. The sites are able to bill MassHealth, CMSP and other insurers for services delivered, and also provide services to uninsured children. Additionally, these 31 sites are required to provide information about CMSP and MassHealth to children who indicate they are uninsured.
- **Community-Based Primary Care:** Forty-nine community-based primary care sites are funded by the Department of Public Health to offer supportive services to ease access to medical primary care. These services, which include social services, nutrition and health education, outreach, case management and transportation, are available to both insured and uninsured children. Medical services provided to uninsured children are billed to the Commonwealth's uncompensated care pool. Additionally, these 49 primary care sites are required to provide information about CMSP and MassHealth to children who are uninsured.
- **The Supplemental Nutrition Program for Women, Infants and Children (WIC):** WIC sites are operated under the auspices of the Department of Public Health. The program provides nutritious food to supplement the regular diet of pregnant women, infants and children under age five who meet federal and state income and adjunct eligibility requirements. Women and children under five years old qualify if the combined family income is at or below 185% FPL. WIC staff encourage uninsured pregnant women and parents and guardians of uninsured children to apply for MassHealth. Staff also refer uninsured clients with higher levels of income to CMSP.
- **Disproportionate Share Hospitals:** These hospitals are MassHealth providers that serve a disproportionate share of low income and uninsured people. The hospitals are entitled to apply to the Commonwealth's free care pool for payment for health care services delivered to uninsured patients. In addition, staff at these hospitals are able to assist uninsured patients in applying for CMSP and MassHealth benefits.

- **Healthy Start:** The Healthy Start program, operated by the Department of Public Health, serves two roles. First, multicultural staff screen uninsured pregnant women for MassHealth eligibility. For women who appear to meet the eligibility requirement for MassHealth, program staff assist the woman in filing an application for MassHealth, as well as facilitating the woman's access to MassHealth Prenatal (the Division's benefit package providing presumptive eligibility for prenatal care services for pregnant women who appear to be MassHealth eligible). Additionally, the staff follow up with the woman to ensure that she has in fact accessed prenatal care services in a timely manner. The MassHealth application submitted by the Healthy Start staff includes an application for any uninsured children in the woman's family. If a woman appears to be ineligible for MassHealth benefits, the Healthy Start Program will pay claims for prenatal care services delivered to these women by medical care providers who are authorized Healthy Start billers.
- **Case Management Program for Children with Special Health Care Needs:** The Department of Public Health employs regionally-based case managers who offer case management services to children with special health care needs and their families. These case managers often assist families with MassHealth or CMSP applications, if the child is uninsured. Case managers also provide other social services that may increase access to medical primary care services, including identification of providers with experience in treating children with special health care needs and assisting the family with accessing transportation or other necessary services.
- **FirstSteps and Healthy Families Home Visiting Programs:** Under these home-visiting programs operated by the Department of Public Health, community-based providers perform home visiting services for high-risk pregnant women, and first-time teen mothers. Home visitors perform many activities, including assisting the pregnant women or mothers in accessing health insurance through either CMSP or MassHealth, as well as facilitating the child's access to primary medical care services.
- **The Municipal Medicaid Program:** The Division contracts with Massachusetts municipalities to provide direct health care services to special education students and to assist with administration of the Medicaid program in general. One of the activities that is included in the administration is identification of potential MassHealth eligibles, and referral of those eligibles to MassHealth. In addition, under the Municipal Medicaid program, school health personnel are working to improve the number of MassHealth enrolled children and adolescents who receive primary and preventive health care services in accordance with the requirements of the EPSDT Medical Protocol

and Periodicity Schedule, and working to increase the coordination between school health personnel and the MassHealth managed care system. Finally, the Division and the Department have been working very closely together to use the network of public and private schools within the Commonwealth to provide outreach to uninsured students and their families to encourage their enrollment in CMSP and MassHealth. A more detailed description of these outreach activities can be found in Section 5.

- 2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

### **Insurance Partnerships**

The Commonwealth's Division of Medical Assistance continues to form public/private partnerships with Massachusetts employers through its premium assistance programs.

The Division encourages employer-sponsored coverage for low-income employees and their families through a combination of the SCHIP program and its 1115 Waiver. The Division provides premium assistance payments on behalf of eligible children with family income at or below 200% FPL. In addition, under the 1115 Waiver, the Division provides premium assistance to eligible adults who work for a qualified small employer and makes an incentive payment to the small employer.

### **Outreach Partnerships**

The Division enlists the support of community-based organizations, social service agencies, schools and advocacy organizations to inform community residents of available health insurance programs; identify uninsured individuals, families, and children; assist with the enrollment process; and support the promotion of educational strategies developed to help members utilize their health care services. This process includes the distribution of mini-grants (\$10,000 - \$15,000) to 84 community-based organizations to assist in enrollment of "hard-to reach" uninsured individuals and families and support post enrollment educational strategies.

- 2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)*

**(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

The Division of Medical Assistance will assess children's eligibility for both Title XIX and Title XXI programs. The Division is the Commonwealth's Title XIX agency and has been charged with expanding its health programs to cover Title XXI populations. Eligibility for MassHealth Title XIX and MassHealth Title XXI will be determined simultaneously. The Medical Benefit Request (MBR) is used to assess eligibility for all MassHealth programs (TXIX and TXXI), as well as the Children's Medical Security Plan. Sufficient information is collected on the MBR to assess if the applicant is eligible for any MassHealth coverage type (e.g. MassHealth Standard, CommonHealth or Family Assistance). The MBR information is data entered into the Division's eligibility system (MA-21) to invoke an eligibility determination. MA-21 is designed to assign the most comprehensive coverage type to the eligible applicant. See Section 4.4.1 for a more detailed description of the eligibility process.

If a child with family income between 150% and 200% of the FPL appears to have access to health insurance through an employer, the Division will conduct a health insurance investigation to determine if the insurance meets Division standards and is cost effective. If there is access to qualified health insurance coverage, the children will be eligible for premium assistance towards the cost of their employer sponsored insurance.

The MBRs of children who are ineligible for MassHealth are forwarded to CMSP.

Division notices include information regarding the WIC program if a family member is pregnant or under age five. Ineligible pregnant woman are notified of the Healthy Start program.

**Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.**

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

The Division will use Title XXI funds to deliver child health assistance through the following MassHealth coverage types: MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, and MassHealth Prenatal. Coverage types are described below.

- **MassHealth Standard**

Delivery system options: managed care organization (MCO) or primary care clinician (PCC) plus behavioral health program (BHP). Standard members who have other insurance and those who have not yet enrolled in a managed care plan may obtain services from any MassHealth provider on a fee-for-service basis.

- **MassHealth CommonHealth**

Delivery system options: Generally CommonHealth members may obtain services on a fee-for-service basis. Uninsured CommonHealth members may, at their option, participate in the Division's managed care network.

- **MassHealth Family Assistance**

(A) Premium Assistance

Delivery system options: Not applicable.

(B) Purchase of Medical Benefits

Delivery system options: Generally, managed care (MCO or PCC plus BHP). Family Assistance members who have not yet enrolled in a managed care plan may obtain services from any MassHealth provider on a fee for service basis and behavioral health services through the Behavioral Health Plan. MassHealth Family Assistance members who are eligible to receive covered services through other state agencies under agreement with the Division, may obtain services on a fee for service basis as

well.

- **MassHealth Prenatal**

Delivery system options: fee-for-service.

## **METHODS OF DELIVERING INSURANCE PRODUCT AND SERVICES**

MassHealth members receive services through the following:

### **1. Primary Care Clinician (PCC) Plan Provider Network**

The PCC plan is a primary care case management program administered by the Division. In the PCC Plan, members enroll with a primary care clinician (PCC), who provides most primary and preventive care. There are currently approximately 1200 PCC practices in the PCC Plan network, including individual physicians, group practices, community health center, independent nurse practitioners, and hospital outpatient departments. The Division monitors the performance of providers in the network, including developing and implementing quality improvement.

### **2. Managed Care Organization (MCO) Provider Network**

The Division currently contracts with MCOs that provide comprehensive health coverage to MassHealth Standard members and Family Assistance members as well as to uninsured CommonHealth members who opt to participate in the MCO Network. The network of MassHealth MCOs reflects industry trends towards mixed models, a combination of staff, network, and IPA. MCOs are available to MassHealth members throughout the state, although not all contracting MCOs are statewide. MassHealth members enrolled in MCOs choose a primary care provider (PCP) from among an MCO's list of participating providers. These MCO participating providers must assure equal access to MassHealth member (i.e., PCPs may not be closed to MassHealth members if they are open to commercial MCO members).

### **3. Fee for Service**

Members may receive certain services on a fee-for-service basis. Rates for these services are established either through contacts with the Division or through regulations promulgated by the Massachusetts Division of Health Care Finance and Policy (DHCFP). Any provider meeting the eligibility criteria set forth in the Division's program regulations and provider agreements may participate in the Division's program.

#### **4. Behavioral Health Program (BHP)**

The BHP is a managed behavioral health care program which offers a comprehensive provider network including a broad spectrum of mental health and substance abuse providers who provide a full continuum of mental health and substance abuse services to eligible members. Covered mental health benefits are described in section 6. Members enrolled either in the PCC Network or in an MCO are automatically enrolled in the BHP: there are no pre-enrollment assessments required. In addition, eligible members are only disenrolled if they become ineligible for managed care or enroll in an MCO which contracts with the Division to provide behavioral health services for that enrollee's coverage type.

The Division contracts with a vendor to administer and manage its BHP.

##### BPH Linkage With the PCC Plan

- The BHP vendor is required to facilitate communication and coordination of care with primary care clinicians and to establish annual BHP – PCC linkage improvement goals.

#### **5. School Based Health Centers (SBHC)**

School health clinics (hereinafter referred to as School-Based Health Centers, or SBHCs) have linkage to primary care providers in the PCC Plan. Some MCOs also have contractual agreements with School Based Health Centers (SBHC) to pay the SBHC for care delivered to members enrolled in the MCO.

SBHCs are operated as satellite sites of existing MassHealth providers. If the provider that operates the SBHC is a PCC, then the qualified SBHC site can act as an arm of that PCC, and treat those students who are enrolled with the operating provider as their PCC. SBHCs use the provider number of the existing MassHealth provider of which they are a satellite. If the provider is an MCO, the MCOs pay the SBHC from the MCO capitation paid by the Division. Where SBHCs do not have their own provider agreements, they cannot claim payment from the Division directly.

The Division has sought to educate PCCs about the availability of SBHC sites for primary care delivery to school-aged members. The Division has facilitated agreements between PCCs and SBHCs in selected areas to encourage them to create written agreements regarding care for adolescents served by both providers. The Division has also been working directly with SBHCs to improve their ability to coordinate with primary care providers.

**6. Municipal Medicaid**

Municipal Medicaid providers have linkage to PCPs in both the PCC and MCO Plans. Special education-related services are paid for by either the municipality or the child's insurer, including MassHealth. These services are reimbursed on a fee-for-service basis.

**7. Family Planning**

PCC members are guaranteed confidentiality and unrestricted access to Family Planning services by being able to obtain these services from any participating provider without consulting their PCC or obtaining the Division's prior approval. MassHealth members enrolled in an MCO may access Family Planning services provided by the MCO. However, such MCO enrollees may also receive Family Planning services from any Family Planning provider without consulting their PCP or MCO and are not required to obtain prior approval from the Division. For Family Planning services provided by MassHealth providers not participating in the MCO network, the Division reimburses the provider on a fee-for-service basis.

**PAYMENT MECHANISMS**

**1. PCC Payment Mechanisms**

Fee For Service

The Division currently reimburses both PCCs and non-PCCs on a fee-for-service basis.

Enhancement

The Division pays PCCs an enhancement for most office and home visits when they see one of their members. An enhanced fee is not paid for referrals. The Division also pays PCCs an enhancement for providing EPSDT services according to the periodicity schedule. These additional payments compensate PCCs for the case management functions they perform.

Prospective Interim Payment (PIP)

A prospective interim payment (PIP) is also available to PCCs. The PIP is an optional monthly cash advance for PCCs. The payment is made at the beginning of each month and is equal to twenty-five percent (25%) of the Division's average monthly payment to the PCC for services to the PCCs Plan members in the previous quarter. Reconciliations occur using subsequent claims submissions.

## 2. **MCO Payment Mechanisms**

### Capitation Payments

The Division pays the MCOs a monthly capitation rate on a per-member per-month basis, based on a member's rating category. Capitation rates are developed commensurate with the risk facing an MCO. Rating categories therefore, are distinguished either by differences in expected utilization of services between groups of MassHealth members or differences in the covered services for which the MCOs are capitated. In addition, the Division offers the MCOs the option to purchase stop loss insurance coverage for persons with disabilities and provides risk-sharing for persons who meet the special criteria of Rating Category III (AIDS) and Rating Category IV (Severely Disabled).

The Division has developed a reconciliation process to reconcile estimated capitation payments with actual enrollment volume.

## 3. **BHP Payment Mechanisms**

### Capitation and Risk Sharing Arrangements

The Division pays the vendor a monthly capitation rate on a per member per month a basis for the two existing rating categories: (1) disabled, including SSI; and (2) families and children, including the AFDC population.

The Division has established risk banks that ensure that neither the BHP vendor nor the Division bear the full risk or retain all of the savings for service expenditures. The Division performs various reconciliations on a monthly, semi-annual and annual basis to monitor whether actual service expenditures exceed or are less than monthly capitation payments. The BHP vendor's gain or loss is calculated annually.

### Termination of the BHP Contract

To ensure continued access to care for members and payment to providers in the event that the BHP vendor contract is terminated and/or the vendor is insolvent, the Division would either attempt to secure a new vendor or until such time, ensure that members receive their care through fee-for-service providers.

The Division requires the BHP vendor to provide the following, which shall be used to ensure payment to providers for services rendered to members and payment of administrative costs to manage the program:

- promissory note which guarantees to pay claims to providers for services in the event of the vendor's insolvency;
- a promissory note which guarantees payment to the Division to be used to offset administrative costs in the event of the vendor's insolvency; and
- any combination of the following, approved by the Division: (a) performance bond, (b) irrevocable letter of credit, or (c) a cash reserve maintained in an escrow account in an amount equal to the estimated monthly enrollment in the contract times the applicable Capitation Rate times 1.5.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

- **Primary Care Clinician (PCC) Plan Provider Network**

A PCC Plan Provider must sign the Division's PCC Agreement and meet the requirements specified in the Agreement. The requirements include, but are not limited to: informing members about service availability, referral processes, grievance procedures, after-hour call-in systems, and procedures for appointments, emergencies and urgent care; providing 24-hour/7day/week telephone coverage system with physician back-up; making necessary referrals, and monitoring all Medicaid-covered services which require a referral; and ensuring that care is provided in accordance with acceptable medical practices and professional standards.

The Primary Care Clinician is responsible for authorizing most specialty services. Members can access any MassHealth provider for specialty services however, some services require that members first obtain authorization from their PCC.

The PCC must provide primary care as appropriate, and maintain an adequate appointment system that ensures prompt access to medical care.

**PCC Network Management**

The PCC Plan Network Management Services (NMS) is a clinically focused management system that monitors, measures, and analyzes health care delivery by PCCs. The major goal of Network Management Services is to improve health care delivery systems that promote improved member health outcomes.

The NMS program assists PCCs and the Division by: measuring, monitoring and

promoting improvements in health care delivery and outcomes; conducting visits to PCC practices; producing data reports; and assisting PCCs in understanding their utilization statistics. The NMS program also conducts periodic regional information meetings with PCCs, and performs provider-relations, information, and referral activities through the PCC Plan Hotline.

NMS site visits focus primarily on PCCs with large practices. Regional Network managers make site visits to these PCCs to review the Profile Reports, discuss how the measures reflect on the PCC practice, and help formulate improvement plans to address opportunities for improvement.

The PCC Plan Hotline is toll free and staffed by PCC Plan Hotline Provider Service Representatives. Providers may call the PCC Plan Hotline for information regarding the PCC Plan or MassHealth.

- **Managed Care Organization (MCO) Provider Network**

MCO Qualifications and Responsibilities

The Division's MCO contract details the MCOs' qualifications and responsibilities. The Division's decision to contract with an MCO is largely based on that organization's ability to meet Division-defined contract requirements concerning:

- Access, member services and utilization;
- Quality;
- Behavioral health; and
- Financial stability

These requirements define what the MCOs must provide to MassHealth members enrolled in their plan, and are the cornerstone of all contract management activities. The Division's contract requirements for MCOs are designed to:

- Be consistent with generally accepted standards;
- Address the specific needs of the MassHealth population;
- Address all significant aspects of the performance of MCOs;
- Be set at best practice level and be improvement-oriented; and
- Be specific and measurable so that data from measures can be used by the Division and the MCO to identify opportunities for improving performance.

Coordination of Services

MassHealth members enrolled in MCOs may receive the same covered services as

MassHealth members in the PCC Plan. However, there are differences in how services are obtained.

For each member enrolled in an MCO, the Division pays the MCO a monthly capitation to provide most, but not all, MassHealth services. MCOs are responsible for providing behavioral health services to MassHealth members enrolled in MCOs. MassHealth members enrolled in an MCO may obtain non-capitated MassHealth services from any MassHealth provider. Contracted MCOs are responsible for coordination of such non-capitated services. This coordination includes informing members of the availability of non-capitated services and the processes for accessing those services.

#### School Based Health Centers (SBHC)

The Division's MCO contracts contain language requiring MCOs to coordinate with SBHCs to improve the quality of, and access to, health care services at SBHCs. The MCOs have undertaken, and will continue, several activities to meet this goal.

The following are examples of these activities: Representatives from DPH's SBHC Program attend MCO meetings. At the meetings, participants address MCO-SBHC linkage issues. MCOs work with SBHCs located in their service area(s), to improve their individual relationships. Each MCO has identified a single contact person for the SBHC to call. Finally, the MCOs and SBHCs are currently investigating other ways to communicate with each other regarding children being seen by both providers.

#### MCO Contract Management

The Division maintains a quality-focused, collaborative management approach with its contracted MCOs, an approach that emphasizes continuous quality improvement in several components of service delivery, including clinical care, customer service and administration.

Each MCO's contract management requirements include, but are not limited to, 1) compliance with the contract and with all applicable state and federal laws and regulations, 2) designating a representative to act as a liaison with the Division, and 3) participation in and successful completion of performance evaluation activities related to the continuous quality improvement model of contract management utilized by the Division. The Division oversees compliance by the MCOs using a continuous quality improvement model.

MCO contracts substantially comply with the waiver terms and conditions related to access effective 7/1/97. This means that the MCOs with which the Commonwealth contracts will satisfy the majority of the waiver terms and conditions by meeting the purchasing specifications mandated in the MCO contracts. Overall, the requirements

detailed in the MCO contracts satisfy the intent and purpose of the waiver terms and conditions.

• **Behavioral Health Program Provider Responsibilities**

The vendor must develop policies and procedures for the provider network. These policies are subject to review and approval by the Division and at a minimum must address:

- Timeliness for rendering services;
- Service authorization requests;
- Frequency of reviews;
- Continued stay/continued care clinical criteria; and
- Required reporting formats.

Through its contracted provider network, the vendor is responsible for providing all medically necessary care, 24 hours a day with the most clinically appropriate provider and at the most clinically appropriate level of care.

The vendor must ensure that members have access to all covered services utilizing the following standards:

- inpatient services – within 15 miles or 30 minutes travel time, whichever requires less travel time;
- all other covered services – within 20 miles or no more than 30 minutes travel time, whichever requires less travel time.

In addition, the Division requires that members' access to service is consistent with the degree of urgency as set forth below:

- Emergency services must be provided immediately;
- Urgent care must be provided within 48 hours; and
- Non-urgent care must be provided within ten (10) working days.

The Division also required the vendor to develop a protocol to ensure linkage between primary care providers and BH providers. The vendor and the Division's PCC Plan collaborated to issue a communication protocol to facilitate coordination and integration in the physical and behavioral health treatment of members.

**BHP Coordination of Care with Commonwealth Agencies**

BHP members receive their acute mental health and substance abuse services through the BHP vendor and its subcontracted provider network. Non-acute mental health, substance

abuse and other services, such as long-term hospitalization, residential services, vocational training, and other continuing care services are not covered by MassHealth. However, BHP Plan members who meet the eligibility requirements established by the following Commonwealth agencies can receive many of these non-acute care services from these agencies:

- Department of Education (DOE) and Local Education Authorities (LEAs);
- Department of Mental Health (DMH);
- Department of Mental Retardation (DMR);
- Department of Public Health's Bureau of Substance Abuse Services (BSAS);
- Department of Social Services (DSS);
- Department of Youth Services (DYS); and
- Massachusetts Commission for the Deaf and Hard of Hearing.

To ensure coordination of care for members eligible to receive services under the BHP and a Commonwealth state agency, the BHP vendor is required to establish relationships and meet regularly with the above-listed state agencies, subject to review and approval by the Division. In addition, the BHP vendor is required to implement and maintain a plan of ongoing communication with designated state agency staff to address members' service planning, admissions, discharge plans, utilization, and coordination of services between the acute care system managed by the vendor and the non-acute care systems managed by the state agencies.

Under an agreement with DMH, the Division purchases services on behalf of DMH for DMH clients requiring mental health emergency services, program services, or acute inpatient mental health services.

If the Division determines that the BHP vendor is failing to coordinate services with state agencies, the Division may use, without limitation, the following mechanisms to ensure contract compliance:

- corrective action plans;
- development of improvement goals; and
- development of Continuous Quality Improvement projects;

#### BHP Vendor's Administration of Diversionary Services

The BHP vendor is required to maintain a network of diversionary services that meet the access standards and to arrange, coordinate, and oversee the provision of medically necessary diversionary services. Diversionary services are provided as alternatives to inpatient mental health services in more community-based, less structured environments. Diversionary services include crisis stabilization, observation and holding beds, partial hospitalization, and psychiatric day treatment. The provision of these services are

arranged for by the vendor's clinical staff who receive requests for hospitalization and then make a clinical decision to locate and authorize alternative or "diversionary" services for members, as appropriate.

The Division monitors the BHP vendor's compliance for the administration of diversionary services through the following mechanisms:

- The BHP vendor is required to submit utilization and expenditure reports to the Division for all diversionary services provided during the reporting period; these reports must be submitted monthly, quarterly, semiannually, and annually. The Division analyzes and monitors these reports to determine if the utilization of diversionary services is clinically appropriate;
- The Division requires the BHP vendor to submit provider profiles on a semiannual basis;
- On a regular basis, the Division reviews patterns of care, monitors case manager activities, and randomly audits vendor records to monitor and ensure the appropriate use of diversionary services;
- On a regular basis, the Division requires the vendor to conduct provider site visits to review randomly selected medical records and participate in case conferences;
- The Division's BHP staff regularly join vendor staff supervision meetings and clinical management department meetings to monitor compliance with the administration of diversionary services; and
- The Division and DMH review and approve the vendor's medical necessity criteria, level of care determination criteria, and provider policies and procedures, along with the vendor's compliance with the administration of these items.

If the Division determines that the vendor is not in compliance with the administration of diversionary services, the Division will require the BHP vendor to implement a corrective action plan that has been reviewed and approved by the Division. The Division will then closely monitor the vendor's compliance with the approved corrective action plan.

#### BHP Network Management

The Division requires the vendor to conduct Network Management functions. Network management includes:

- development, maintenance, and management of the BHP provider network; and

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- BHP provider contracting, and provider education.

Specifically, the Network Management service administered by the vendor and monitored by the Division includes the following:

- A system for provider profiling and benchmarking;
- A system for the vendor and provider to identify and establish improvement goals and Periodic measurements to track the provider's progress or lack of progress towards improvement goals;
- Monitor the annual turnover of outpatient providers (e.g., therapists, psychiatrists) and use this information to establish improvement goals for the providers for future periods;
- Corrective action plans for the year, methods to be employed to monitor corrective action plans, implementation, and progress;
- A plan, subject to Division approval, for taking appropriate management action with providers who performance is determined to be unacceptable by the vendor's network management department; and
- A plan, subject to Division approval, to terminate or take other appropriate management action with providers who may be insolvent or otherwise financially unsound.

**Section 4. Eligibility Standards and Methodology.** (Section 2102(b))

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.**

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

4.1.1.  Geographic area served by the Plan:

MassHealth is available statewide.

4.1.2.  Age:

Title XXI MassHealth is available to children under the age of 19 through one of the following four (4) coverage types:

- MassHealth Standard (a.k.a. Medicaid);
- MassHealth CommonHealth for disabled children who are not eligible for Standard;
- MassHealth Family Assistance through direct coverage for uninsured children who are not eligible for Standard or CommonHealth; or through premium assistance for children who have access to and enroll in, private health insurance; and
- MassHealth Prenatal for pregnant women.

Eligibility for a coverage type is determined by: the income of the family group; the presence of a disability or pregnancy; and, the availability of health insurance.

4.1.3.  Income:

Title XXI MassHealth is available to children under age 19 whose family group's gross income is no more than 200% of the federal poverty level and who are not eligible for Medicaid under title XIX. For specific income guidelines see Attachment 4.1.

In the determination of eligibility for MassHealth, the gross income of all family group members is counted and compared to an income standard based on the family group size.

A Family includes natural, step, or adoptive parents who reside with their child(ren) under age 19, and any of their children, or whose child(ren) are absent from home to attend school; or siblings under age 19, and any of their children, who reside together when no parent(s) are present. A family includes both parents when they are mutually responsible for one or more children who reside with them.

Family may also include a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family

#### Countability of Income

Eligibility is based on the family group's gross countable earned and unearned income and countable rental income, as defined in (A) and (B), (C) below. Income that is not counted in the eligibility determination is defined in (D), below.

#### (A) Gross Earned Income

This is the total amount of compensation received from work or services performed before any income deduction.

Gross earned income for the self-employed is the total amount of business income listed or allowable on a U.S. Tax Return.

For persons who are seasonally employed, annual gross income is divided by 12 to obtain a monthly gross income with the following exception. If the person experiences a disabling illness or accident during or after the seasonal employment period which prevents the person's continued or future employment, only current available income shall be considered in the eligibility determination.

#### (B) Gross Unearned Income

This is income that does not directly result from the individual's own labor. The total amount of unearned income before any deductions is countable. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, and interest and dividend income.

#### (C) Rental income

Rental income is the total amount of gross income, received from a tenant or boarder, less any allowable deductions listed on an applicant's or member's U.S. Tax Return.

#### (D) Non-Countable Income

The following types of income are non-countable in the determination of eligibility:

- Income received by a TAFDC, EAEDC, or SSI recipient;
- Sheltered workshop earnings;
- The portion of Federal veterans benefits identified as aid and attendance benefits, unreimbursed medical expenses, housebound benefits, or enhanced benefits;
- Income-in-kind;
- Temporary income from U.S. Census Bureau related to Census 2000 activities, or federal unemployment benefits related to the termination of that temporary income.
- Roomer and boarder income; and
- Any other income excluded as provided by federal laws other than the Social Security Act (see 42 C.F.R. Part 416, Appendix to Subpart K).

#### Verification of Income

Verification of gross monthly income is mandatory. In lieu of any of the specific sources and verifications listed below, any other evidence of the applicant's or member's earned or unearned income is acceptable.

#### Earned Income

The following are required to verify earned income:

- Two recent pay stubs;
- A signed statement from the employer; or
- Most recent U.S. Tax Return.

#### Unearned Income

The following are required to verify unearned income:

- Copy of a recent check or stub showing gross income from the source; or
- Statement from the income source, where matching is not available.

Rental Income

The following are required to verify rental income

- Most recent U.S. Tax return

Transfer of Income

All family group members are required to avail themselves of all potential income. If the Division determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received. If the Division is unable to determine the amount of available income, the family group will remain ineligible until such information is made available.

Calculation of Financial Eligibility

The financial eligibility for various MassHealth coverage types is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage. The monthly income standards are determined according to annual FPL standards published by the Federal Register using the following formula:

- Divide the annual federal poverty income standard as it appears in the Federal Register by 12;
- Multiply the un-rounded monthly income standard by the applicable FPL standard (e.g. 133%); and
- Round up to the next whole dollar to arrive at the monthly income standards.

The Division will adjust these standards in April of each calendar year.

Cost of Living Adjustment (COLA) Protections

Members whose income increases each January as the result of a cost of living adjustment shall remain eligible until the subsequent FPL adjustment.

4.1.4.  Resources (including any standards relating to spend downs and disposition of resources):

4.1.5.  Residency (so long as residency requirement is not based on length of time in state):

As a condition of eligibility an applicant or member must:

- Live in the Commonwealth, with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address; or
- Live in the Commonwealth at the time of application having entered the Commonwealth with a job commitment, whether or not currently employed, (also applicable to migrant or seasonal workers.)

Examples of applicants or members who generally do not meet the residency requirement for MassHealth are:

- Students under age 19 whose parents reside out of state; and
- Individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts.

4.1.6.  Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Children under age 19 may establish eligibility for MassHealth CommonHealth under Title XXI provided they:

- Are uninsured;
- Are ineligible for MassHealth Standard;
- Have family group gross income that is less than or equal to 200% of the federal poverty level; and
- Are permanently and totally disabled as defined below

Permanent and Total Disability

Children meeting the following requirements shall be considered permanently and totally disabled.

(A) For 18 Year Old Children

- (1) The child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:
  - (a) can be expected to result in death; or
  - (b) has lasted or can be expected to last for a continuous period of not less than 12 months.

(2) For purposes of this definition, an 18 year old shall be determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(B) For Children Under 18

The child has any medically determinable physical or mental impairment of comparable severity to that which is required of an 18 year old, or is unable to engage in age-appropriate activities. For purposes of this definition, an individual under the age of 18 shall be determined to be disabled only if the child's physical or mental impairments are of such severity that the child is unable to engage in age-appropriate activities.

Verification of Disability

Disability shall be verified by one of the following:

- certification of legal blindness from MCB; or
- a determination of disability by the Social Security Administration; or
- a determination of disability by the Division's Disability Determination Unit (DDU).

4.1.7.  Access to or coverage under other health coverage:

Other Health Coverage

A child shall be considered insured and, as a result, ineligible for Title XXI MassHealth if he or she is:

- a member of a family that is eligible for health benefits through a state health benefits plan based on a family member's employment with a public agency in the state;
- eligible for Mass Health Standard and has family group gross income that is less than the standards described in **Attachment 4-1**; or
- covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

Access to Health Insurance

A child has access to health insurance, for the purpose of determining eligibility for Title XXI MassHealth, where the prospective member, the parent, spouse or legal guardian has access to group health insurance that includes the member, through an employer, the employer contributes at least 50% of the premium cost, and the insurance meets a basic benefit level as defined by the Division.

The Division will require a Title XXI MassHealth child who has access to health insurance to enroll in the employer sponsored insurance plan if:

- the child is ineligible for MassHealth Standard or CommonHealth;
- the family group gross income is between 150 % and 200% FPL; and
- the Division has determined it is cost effective to purchase the insurance.

The Division will provide premium assistance toward the child's private health insurance premium payment through a benefit under MassHealth Family Assistance.

4.1.8.  Duration of eligibility:

A pregnant woman who has been determined eligible for MassHealth Standard shall continue to be eligible for the duration of her pregnancy and the two calendar months following the month in which her pregnancy ends, regardless of any subsequent changes in family group income. No other children will receive a durational guarantee of eligibility. They will be subject to a periodic review of eligibility.

4.1.9.  Other standards (identify and describe):

All MassHealth members must meet the requirements described in this section.

Social Security Number (SSN) Requirements

As a condition of eligibility for any MassHealth coverage type, applicants and members must furnish a SSN. Applicants who do not have a SSN will be notified of their obligation to apply for one.

The Division shall verify each applicant's SSN by a computer match with the Social Security Administration.

Right to Know Uses of Social Security Numbers

All household members will be given written notice in a booklet

accompanying their MassHealth Benefit Request of the following:

- the reason the SSNs are requested;
- the computer-matching with SSNs in other personal data files within the Division, other government agencies, and elsewhere; and
- that failure to provide the SSN of any person receiving or applying for benefits may result in denial or termination of his or her benefits.

Assignment of Rights to Medical Support and Third Party Payments

Every legally able applicant or member must assign to the Division his or her own rights to medical support and third party payments for medical services provided under MassHealth as well as the rights of those for whom he or she can legally assign medical support and third party payments.

The applicant or member must provide the Division with information to help pursue any medical support and source of third party payment, including support available from the absent parent, who is legally obligated to pay for care and services for the applicant/member and/or for person(s) on whose behalf benefits are requested unless he or she can show good cause not to provide this information.

Refusing to comply with the requirements of this section will exclude the applicant or member from receipt of MassHealth benefits unless the applicant or member is a pregnant woman who is eligible for Mass Health Standard.

Good Cause for Non-cooperation

Good cause for non-cooperation is present if at least one of the following circumstances exists regarding the child of the applicant or member:

- the child was conceived as a result of incest or forcible rape;
- legal proceedings for adoption are pending before a court;
- a public agency or licensed facility is assisting in resolving the issue of adoption and discussions have not lasted longer than three months; or
- cooperation would result in serious harm or emotional impairment to the child or relative with whom the child resides or to the applicant or member.

Assignment for Third Party Recoveries

As a condition of eligibility, an applicant or member must inform the Division when a household member is involved in an accident, or suffers from an illness or injury which has or may result in a lawsuit or insurance claim. The applicant or member must:

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- file a claim for compensation;
- assign to the Division the right to recover an amount equal to the MassHealth benefits provided from either the member or the third party; and
- provide information about the third party claim and cooperate with the Division's Post Payment Recovery Unit unless the Division determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the applicant or member.

Citizenship and Immigration Requirements

In determining eligibility for Title XXI MassHealth, a child must be a citizen or a qualified alien, as defined in section 431 of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), as amended. In addition, immigrants who are subject to the terms of section 403 of PRWORA are not eligible to apply for coverage for five years after the date they become a qualified alien.

Verifications of Immigration Status

For aliens, a determination of eligibility will be made once the application is complete except for documentation of immigration status. Aliens who have not submitted documentation of immigration status within sixty days of the date of the eligibility determination, or whose verification cannot be confirmed by the U.S. Immigration and Naturalization Service, shall subsequently be ineligible.

TITLE XXI MassHealth Specific Eligibility Requirements by Coverage Type

In addition to other requirements described in Section 4, a child must meet the specific Title XXI eligibility requirements of each coverage type. The requirements for MassHealth CommonHealth are described in Section 4.1.6.

Eligibility requirements for MassHealth Standard, Family Assistance (direct coverage and premium assistance), and Prenatal follow:

(A) MassHealth Standard

MassHealth Standard is available to uninsured children under the age of 19 subject to the following requirements:

Children under One

A child under one is eligible if the gross income of the family group is greater than 185% FPL and less than or equal to 200% FPL.

A MassHealth Standard eligible child who is receiving inpatient hospital services on the date of his or her first birthday shall remain eligible until the end of the stay for which the inpatient services are furnished.

Children Aged One through Eighteen

Children aged one through eighteen are eligible for MassHealth Standard if the gross income of the family group meets the income standards described in Attachment 4-2. If the individual is pregnant, the unborn child or children are counted as if born and living with the mother in determining family group size.

Presumptive Eligibility for Standard

An uninsured child whose self-declared family group income meets the financial requirements of MassHealth Standard shall be determined presumptively eligible in accordance with the requirements described at Section 4.3.

Health Insurance Premium Program (HIPP)

MassHealth Standard members may receive premium assistance toward the employee's full share of the cost of employer-sponsored health insurance through the HIPP program. Additionally, the Division will cover any MassHealth covered services not covered by the member's private health insurance or on a fee-for-service basis.

(B) MassHealth Family Assistance – Direct Coverage

Direct coverage under MassHealth Family Assistance is available to uninsured children aged one through eighteen provided:

- the gross income of the family group is greater than 150% but less than or equal to 200% FPL
- the child is ineligible for MassHealth Standard and MassHealth CommonHealth; and
- the child is not insured and does not have access to health insurance, as defined in Section 4.1.7.

If the individual is pregnant, the unborn child or children are counted as if born and living with the mother in determining family group size.

Time Limited MassHealth Family Assistance

A child may receive MassHealth Family Assistance benefits on a fee for service basis for a maximum of 60 days if a member of his or her family group has declared he or she has access to employer sponsored health insurance benefits. During this 60-day period, the Division shall determine if the insurance meets HIPAA and basic benefit level requirements. If the insurance meets these requirements, the Division will subsequently require the child to be enrolled in the employer sponsored health insurance plan and a premium assistance amount will be established as described below.

Presumptive Eligibility for MassHealth Family Assistance

An uninsured child whose self-declared family group income is greater than 150% FPL and less than or equal to 200% FPL shall be determined presumptively eligible in accordance with the requirements at Section 4.3.

MassHealth Family Assistance Premiums

MassHealth Family Assistance members may be assessed a monthly (health insurance) premium. The premiums are \$12 per child per month with a family maximum of \$36 per month.

MassHealth Family Assistance members shall be responsible for monthly premium payments beginning with the calendar month following the date of their eligibility determination.

MassHealth Family Assistance members, who self-identify as members of a federally recognized American Indian tribe or who are Alaskan Natives will not be charged a monthly premium.

MassHealth Family Assistance members who are determined eligible for

another coverage type shall cease to be responsible for the premium payment to the Division as of the calendar month in which the coverage type changes.

Members who are assessed a revised premium payment, as the result of a reported change, shall be responsible for the new monthly premium payment beginning with the calendar month following the reported change.

#### Delinquent Premium Payments

Any portion of a premium payment that is not made within sixty calendar days of the billing date will result in termination of coverage after advance notice. Another coverage period will not begin unless the Division collects all premiums that the Division determines to be outstanding.

Once terminated for non-payment of a premium:

- if payment is made in full within thirty (30) calendar days of the date of the termination, coverage shall begin retroactive to the date of termination, if otherwise eligible; or
- if payment is made in full later than thirty (30) calendar days of the date of the termination, coverage shall begin retroactive to the date of the premium payment, if otherwise eligible.

#### Voluntary Withdrawal

In case of a member's voluntary withdrawal, coverage shall continue, and the member shall be responsible for payment of premiums through the end of the calendar month of withdrawal.

#### Change in Premium Calculation

The premium amount is recalculated when the Division is informed of changes in income, or family group size. The premiums may also be recalculated when an adjustment is made to the premium schedule.

#### (C) Family Assistance/Premium Assistance

Premium Assistance under MassHealth Family Assistance is available to children aged one through eighteen provided:

- the gross income of the family group is greater than 150% but less than or equal to 200% FPL
- the child is ineligible for MassHealth Standard and MassHealth CommonHealth
- the child has access to employer-sponsored health insurance where the employer contributes at least 50% of the premium cost, the insurance

- meets the basic benefit level and
- it is cost effective to the Division to provide premium assistance.

In order to determine whether an employer–sponsored health plan meets the Basic Benefit Level, the Commonwealth reviews a copy of the summary of benefits and/or a copy of the policy from either the employee or employer. A Family Assistance coordinator compares the plan to the Division's basic benefit requirements to ensure that the plan includes all state mandated benefits.

The Division makes monthly premium assistance payments on behalf of a child toward the cost of the employer-sponsored health insurance. The premium assistance payment is calculated by using the following information:

- the total health insurance premium
- the employer share of the health insurance premium; and
- the DMA calculated member share of the health insurance premium (if applicable). The member share is \$12 per child with a maximum of \$36 per family. Alaska Natives and American Indians who are members of federally recognized tribes will not have a calculated member share.

This information will be collected on the MBR. To verify the information, a DMA representative will contact the applicant's employer to collect the required data. Once the information is collected and verified, the Division will calculate a premium assistance payment amount.

#### 1. Estimated Premium Assistance Amount

The estimated premium assistance amount equals the total health insurance premium minus the employer share of the premium minus the DMA calculated member share of the premium. For example, if the total monthly health insurance premium is \$500 and the employer is contributing 70% to the cost of the health insurance premium, then the current employee share is \$150 per month. If the family's income is above 150% FPL, then DMA will calculate a member share of the premium based on the number of eligible children in the family (\$12 per child, with a \$36 maximum). If the DMA calculated member share is \$24 (2 children X \$12), then the DMA estimated premium assistance amount would be \$126 per month.

#### 2. Cost Effectiveness Test

The estimated premium assistance amount will then be compared to the cost of covering eligible individuals under direct coverage.

The estimated premium assistance amount will be compared to the

cost of covering the children in the family on MassHealth Family Assistance. Therefore, if a family with two children and one parent applies for coverage, the estimated premium assistance amount would be compared to covering two members on the Division's MCO program, or \$300 per month ( $\$150 \text{ pmpm}^1 \times 2 \text{ children}$ ).

### 3. Actual Premium Assistance Amount

Once the estimated premium assistance amount has been compared to the cost of covering eligible individuals on MassHealth Family Assistance, the Division will calculate an actual premium assistance amount.

- a) If the estimated premium assistance amount is less than the cost effective amount (as defined in #2 above), then the Division will set the actual premium assistance amount at the estimated premium assistance amount.
- b) If the estimated premium assistance amount is higher than the cost effective amount (as defined in #2 above), then the Division will set the actual premium assistance amount at the cost effective amount. If it is determined that the remainder of the health insurance premium is greater than 5% of the family's gross income, then the family will be given the choice of enrolling their children in the applicable direct coverage program.

Premium assistance payments are made directly each month on behalf of the children to the parent/policyholder or, if the parent works for a qualified small employer that participates in the Division's Insurance Partnership program, the payments may be made on behalf of the children to either the employer or the health insurance carrier. The qualified employer must reduce the member's payroll deduction for health insurance by the amount of the premium assistance payment.

In addition to premium assistance payments, the Division will pay copays, coinsurance, and deductibles for children eligible for premium assistance provided:

- (1) the copay, coinsurance or deductible was incurred as the result of a well-baby/well-child care visit; or
- (2) the policyholder's annualized share of the employer-sponsored health insurance premiums, combined with copays, coinsurance,

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<sup>1</sup> For demonstration purposes only, represents the average MCO pmpm.

and deductibles incurred and paid by members, exceeds five percent of the family group's gross income in a 12-month period beginning with the date of eligibility for premium assistance.

Members receive an initial notice at the time of eligibility explaining the Division's policy on payment of copays, coinsurance and deductibles. Providers may bill the Division directly or members may seek reimbursement from the Division. The Division has developed a C.A.R.E. kit for families to use in this process. (See Attachment 4.2)

(D) MassHealth Prenatal

MassHealth Prenatal is available to uninsured pregnant women under the age of 19 whose self-declared income is greater than 185% FPL and less than or equal to 200% FPL. The unborn child or children are counted as if born and living with the mother in determining family group size.

- 4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))
- 4.2.1.  These standards do not discriminate on the basis of diagnosis.
  - 4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
  - 4.2.3.  These standards do not deny eligibility based on a child having a pre-existing medical condition.
- 4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

REQUEST FOR MASSHEALTH

To become an applicant, a person must file a Medical Benefit Request (MBR) at a MassHealth Enrollment Center (MEC), or outreach site. The Division may request additional information, if necessary, to determine eligibility for MassHealth.

The request is considered complete on the date all required information with the exception of documentation of immigration status is received. When it is complete, it shall activate the Division's eligibility process of determining the appropriate coverage type providing the most comprehensive medical benefits.

The Division shall request all corroborative information necessary to determine eligibility generally within five (5) business days of receipt of the MBR. The applicant must provide such information within sixty (60) calendar days of the information

request.

If necessary information is received within the sixty-(60) calendar day period, the MBR is considered complete; if not received within the sixty-(60) calendar day period, the Division shall deactivate the MBR.

#### Reactivating the Medical Benefit Request

If all required information is submitted to the Division subsequent to the sixty (60) calendar day period, the Division shall reactivate the MBR as of the date the information is submitted. A new MBR must be submitted if all required information is not received within one (1) year of receipt of the previous MBR.

#### Presumptive Eligibility Process

A child may be determined presumptively eligible for Standard or Family Assistance through a presumptive eligibility process based on the household's self declaration of gross income on the Medical Benefit Request (MBR). A child may only be presumptively eligible for Family Assistance if he or she has no health insurance coverage.

Department of Public Health (DPH) staff will assist applicants, either telephonically or on-site, in completing the Medical Benefit Request (MBR). If DPH determines that the family group income of the child is at or below 200% of FPL, the signed MBR is submitted to DMA and presumptive eligibility is established. Children whose income exceeds MassHealth standards are provided coverage under the Children's Medical Security Plan (CMSP)

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until the Division makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days of the begin date, the MBR will be deactivated in accordance with Section 2.2.1.1 and presumptive eligibility will end. A child may receive presumptive eligibility only once in a twelve-month period.

### DATA MATCHING AND VERIFICATION

#### Process for Data Matching

The Division initiates matches with other agencies, health insurance carriers, and employers when an MBR is received. These agencies and matches include but are not limited to the following: The Department of Employment and Training (DET), Bureau of Vital Statistics, Veteran's Services, Department of Revenue (DOR), Bureau of Special Investigations (BSI), Internal Revenue Service (IRS), Social Security Administration (SSA), Alien Verification Information System, Department of Youth Services (DYS), Department of Social Services (DSS), Department of Correction (DOC) and the

Department of Transitional Assistance (DTA).

#### Process for Agency Data Matches

Where possible, the Division's eligibility system attempts data verification through automated matching with other DMA systems (e.g., MMIS) and external agencies. Initial matching is performed during the MBR screening when the system, based on data entry of the request, checks DMA databases and MMIS, to confirm eligibility status and retrieve existing information.

The system also prepares and generates matching requests to other agencies for customer information that has not yet been verified, or is out of date or missing. These matching requests are generated automatically and do not require worker intervention. For applicants, a match is triggered at the time the MBR is received. For on-going cases, a match is triggered when a member reports changes to certain types of information or a report occurs when new employment is reported to DOR by the employer.

As soon as the worker has entered (and reviewed) new household members' names, dates-of-birth, and SSNs, the system will automatically trigger a request for SSN verification and SSA unearned income information. This information will be processed and returned that same night, for review the following morning by the worker.

The SSN verification processing will identify additional SSNs held by the member, as well as identify a transposition or minor data entry error in the original data entry of the SSN. Following SSN verification, 'Alerts' may be posted to a person's record to indicate an inconsistency.

#### Data to Match and Verify

Using a gross income test has eliminated the need to verify a host of work-related expenses while elimination of the asset test has obviated the need for the applicant to produce a more complex set of verifications. Verification only of the following (through either the customer or automated matching) is a prerequisite for eligibility determination:

- Income (for all except MassHealth Prenatal, and for presumptive eligibility determinations for MassHealth Standard and MassHealth Family Assistance, and for those without income);
- Disability (for CommonHealth);
- TPL (from accident or injury);
- SSN;
- Citizenship and immigration status; and
- Access to, and availability of, health insurance.

#### Matching Agencies

The Division works with the following agencies to verify eligibility information.

- DET  
DMA processes matches with DET for unemployment information. Recipients of unemployment insurance are identified for income matching purposes, and for determining eligibility for Basic. These individuals are paid by DET for up to thirty (30) weeks following job loss, providing the recipient is unemployment insurance eligible.
- DOR  
Provides information on employment status (new hires), and quarterly wages. New hires are reported by employers within fourteen (14) calendar days of their start date. This data will be used to determine eligibility for MassHealth, and to generate an inquiry by the Division to the member regarding their employment status and availability of health insurance.  
  
The wage reporting system provides the wages an individual receives on a quarterly basis from employers. If discrepancies regarding wages are noted between the Division's data and DOR's data regarding an individual, an inquiry will also be generated to the member.
- INS  
The Alien Status Verification Index (ASVI) provides alien information. This database verifies alien immigration status, containing data for over 50 million aliens.
- SSA  
SSA provides a variety of data. Social Security income and insurance (Medicare) data is provided on a regular basis through the BENDX matching system. Social Security numbers are verified by SSA through the NUMIDENT match. SSI income is provided through the SDX match. Finally, Medicare Buy-in data is also transmitted through HCFA to SSA. These data matches are considered to provide primary verification of social security and SSI income, and will update the individual's income directly and generate an eligibility determination.

#### Eligibility Review

The Division shall review eligibility with respect to circumstances that may change. The Division will update the file based on information received as the result of such review. Eligibility may be reviewed:

- As a result of a member's reported change in circumstances;
- By external matching with other agencies and health insurance carriers; and
- Where matching is not available, through a written update of the member's circumstances on a prescribed form.

If the member fails to provide a written update within thirty (30) calendar days of the request, MassHealth coverage may be terminated.

When there are no changes in the member's circumstances, eligibility shall be redetermined at least once annually.

## MEMBER ENROLLMENT

### Introduction

The Massachusetts Division of Medical Assistance (DMA) uses an enrollment Broker (EB) to educate and enroll all managed care eligible MassHealth members in a health plan. Health Benefit Advisors (HBAs) are employees of the EB. An HBA's major responsibilities include: educating potential members or their representatives about managed care plans, enrolling managed care eligible MassHealth members into a health care plan, providing customer service to the entire MassHealth population, and administering the Division's non-emergency transportation program for all eligible MassHealth members.

MassHealth members who are not eligible for managed care (e.g., persons with other insurance) do not need to enroll in a health plan because they will receive their care on a fee-for-service basis. Premium Assistance members will access services covered under an employer-sponsored plan according to the terms of those plans.

The Division has established processes for, and provided training to other state agencies in order to facilitate the enrollment into MassHealth of uninsured members serviced by these agencies. Referral and reporting processes have been established between the Division and the Department of Public Health, the Department of Employment and Training, the Department of Transitional Assistance and the Commission for the Blind. In addition, all health care agencies and the Office of Refugees and Immigrants have received presentations on health care reform customized to meet the needs of their consumers. All agencies have been or will be provided with MBRs in large quantities.

### MassHealth Standard/MassHealth Family Assistance Members

All MassHealth Standard/MassHealth Family Assistance members eligible to participate in managed care must enroll with either a Division contracted Managed Care Organization (MCO) or in the Primary Care Clinician (PCC) plan. During any period a managed care eligible Standard member is not enrolled in a managed care plan, such member will receive Mental Health and Substance Abuse (BEHAVIORAL HEALTH PROGRAM) services from any MassHealth provider.

Currently, the Division has no lock-in policy and members can transfer to another healthcare plan in their service area at any time.

### Description of Enrollment Process

HBAs enroll MassHealth managed care eligible members into a health plan under either the PCC plan or an MCO according to the Division's policies, procedures, instructions and timeframes.

The EB tracks and manages all systems activities necessary to enroll all managed care-eligible members. These activities include, but are not limited to, tracking those members who have received enrollment and outreach materials and ensuring timely mailing of appropriate outreach materials.

#### Receipt of Member Data

The EB receives data regarding managed care eligible members from MMIS. Eligibility workers at Division determine MassHealth eligibility. The system then identifies members who meet managed care eligibility criteria and transmits this data to the EB for enrollment into a health plan.

The EB begins all enrollment and outreach mailing activities for Standard members within five (5) business days after receipt of member data from the Division.

#### Outreach Process

The EB must mail enrollment and outreach materials to all Standard and Family Assistance members who become eligible for managed care. Distribution or mailing must occur no later than five (5) business days after the EB receives from the Division member enrollment data including: the members' names, addresses, Recipient identification (RID) numbers, categories of assistance, and case head RIDS and names.

The member has fourteen (14) calendar days to choose a health plan or the Division will assign the member to a managed care plan.

#### Enrollment Package

The member receives an enrollment package inviting him or her to choose a health plan. The enrollment package includes information on how to enroll in a health plan, inserts that explain the various health plan options and enrollment form, a description of the member's legal rights, a self-addressed stamped envelope, and a notice translated into several different languages advising the member to have the information translated immediately.

The enrollment package materials indicate that the member has fourteen (14) calendar days to choose a health plan or the Division will choose one for the member.

Members may call either an EB or the plan directly for assistance in selecting a primary care physician. For members who are assigned to an MCO, the MCO will contact the member directly to assist them in selecting a PCP.

The EB also must mail enrollment materials to managed care-eligible members on request.

### Assignment

Members who do not choose a health plan within the fourteen (14) calendar day time limit will be assigned to a health plan. The term "assign" when used in this document refers to enrollment activities involving members who have not made an affirmative choice of a health plan.

### Activities Associated with Non-Responding Members and Timeframes

Standard or Family Assistance members who have not responded to the enrollment and outreach materials within fourteen (14) calendar days will be assigned to a managed care plan either systematically or manually. Manual assignments occur when computer assignment is not possible.

### Algorithm

The assignment methodology takes into account the geographic location of the MCO and PCC plan providers relative to the member's residence and the Division assigns members based on the rate at which a given health plan is selected in a given service area, compared to each of the other available plans.

The following methodology is used to make assignments among the PCC Plan and each of the MCO Plans available for assignment.

### The Division:

a) Periodically calculates the ratio for each of the Division's member enrollment areas, for each MCO in the member enrollment area which is not frozen for assignment, of the number of newly eligible members who picked that MCO compared to the number of newly eligible members in that member enrollment area who picked another MCO not available for assignment or the PCC Plan. Members, who had selected MCOs that are not available for assignment, will not be a part of the equation. This ratio is called the "Choice Factor".

b) Every month, randomly assigns all members eligible for assignment that month to plans (including the PCC Plan), in the same proportions as the choice factor for each, as calculated above. For example:

- The PCC Plan and MCOs A and B are all in one member enrollment area. Both MCOs are available for assignments. It has been determined that over the past six (6) months that there were 80 members who made voluntary choices. They made the following choices:
  - 40 picked PCCP(50.0%)

## Model Application Template for the State Children's Health Insurance Program

- 30 picked MCO-A(37.5%)
- 10 picked MCO-B(12.5%)

Assignments would be made as follows:

- Randomly, 50% will be assigned to the PCC Plan, 37.5% to MCO-A, and 12.5% to MCO-B.

c) Gives MCOs a choice factor of 10% one-month after expanding into a new service area. This will remain in effect until the next semi-annual adjustment.

d) Adjusts assignment ratios based on semi-annual evaluations of individual MCO quality of care and goal performance.

The assignment algorithm applies only to Standard, Family Assistance, and Basic members who are not disabled. The Division does not assign these groups to MCOs but assigns them to a PCC based on disabling condition, provider experience, and geographic location.

### Manual Assignments

Manual assignments are done by EBs and occur when the system is unable to make a zip code, city/town or service area match between the member and an available health plan. The EB receives a printout of members who need to be assigned on a monthly basis. Manual assignment, like automatic assignments, are made based on geography and voluntary selection rates.

Additionally, any member who loses and then within 1 year regains managed care eligibility may be automatically re-enrolled with the health plan with which the member was most recently enrolled.

### Transfer Policy

The Division does not have a lock-in policy. Members who either choose or are assigned to a health plan may transfer to another available health plan in their geographic service area at any time for any reason. The transfer process begins when the member calls the Customer Service Center toll free number and requests a transfer. An EB helps the member identify a new health plan in his or her service area.

### Member-Initiated Transfers

The member-initiated transfer process for members begins when the member calls the Customer Service Center toll free number and requests a transfer. An EB helps the member identify a new health plan in his or her service area. The transfer is processed by the EB within twenty-four (24) hours.

### Division-Initiated Transfers

If a health plan terminates its agreement with the Division, the Division initiates the transfer of the existing members. EBs contacts the members to select a new health plan in their service area.

#### Provider-Requested Transfers

Provider-requested disenrollments begin with a written request sent by the provider to the Division. The written request is reviewed for complete information and compared against the Plan's criteria for member disenrollment. If the provider is able to demonstrate by written request that the member exhibited a pattern of disruptive or non-compliant behavior, the member may be transferred to another PCC or health plan.

#### Transfers To Another Health Plan

A member can transfer from one health plan to another available health plan at any time. The only restrictions are that: (1) the health plan must be in the members' geographic service area; (2) the members' request must meet the time and distance guidelines or (3) the member must request and receive approval for an out-of-area transfer using the process for an out-of-area enrollment.

#### PCC Disenrollment from the PCC Plan or PCP Voluntary Termination from an MCO Plan

If a PCC chooses to terminate from the PCC Plan, the Division requests that the PCC submit written notice to the Division at least thirty (30) days prior to the date of the intended termination. The Division sends a letter and enrollment package and asks the member to choose another health plan. The member is instructed to call the Customer Service Center toll free number for assistance in enrolling with a new managed care plan.

If a PCP chooses to terminate from an MCO, the MCO will facilitate informing the member of the termination and will help the member choose another PCP within the MCO. If the member would like to choose a PCP in another MCO plan or a PCC in the PCC Plan, the member is instructed to contact the Customer Service Center toll free number for assistance.

#### MASSHEALTH CUSTOMER SERVICE CENTER

The Division's Enrollment Broker (EB) operates a toll-free customer service center for all MassHealth members. The customer service center is located at 55 Summer Street, 6<sup>th</sup> Floor, Boston, MA, 02111. The toll-free telephone number is 1-800-841-2900. The toll-free number is an enhanced telephone system with TTY transmission and reception capability and an automatic call distribution system. The EB is required to handle 95% of all incoming calls in three rings or fewer. Additionally, the EB must operate this call center between the hours of 8 a.m. and 5 p.m. EST, Monday through Friday, with the exception of all Federal and designated Massachusetts State holidays.

The EB is required to have a sufficient number of multi-lingual HBAs to respond to all MassHealth- related calls, letters and occasional walk-in encounters. In addition, the EB must:

- Train all EB staff assigned to the MassHealth toll-free phone number to adequately and appropriately respond to questions relating to any MassHealth benefit package inquiries;
- Assist members eligible for Standard, Basic, or Family Assistance benefits in the resolution of problems relating to the accessibility of health care services, including but not limited to identifying transportation service issues, language barriers, and handicap accessibility issues;
- Respond to and make best efforts to resolve MassHealth-related inquiries and complaints by members, prospective members, people assisting members or acting on their behalf, including members' family members, other state agencies, advocates or private agency providers;
- Facilitate the resolution of non-clinical service disputes between MassHealth members participating in managed care and their providers;
- Establish procedures, subject to the Division's approval, by which to determine when Division intervention or assistance should be sought and how it should be obtained;
- Maintain standard referral form(s) and procedures for each instance in which the EB determines that Division assistance is required to adequately, appropriately, and correctly resolve or respond to any member-identified issue;
- Ensure call-backs to members within twenty-four (24) hours of receipt, including, but not limited to, after-hour messages received via after-hour voice mail messaging; and
- Ensure that all non-English speaking callers are provided translation services, e.g., EB staff answering telephone calls must speak the caller's language, or must be able to access interpreter services without disrupting the call by contacting other EBs or utilizing the AT&T Language Line service or similar telephone translation service.

4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

- 4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A) and 2110(b)(2) (B)); (42CFR 457.310(b), 42CFR 457.350(a)(1) and 457.80(c)(3))

The following section describes the process used to determine eligibility for the most comprehensive MassHealth coverage type for which the applicant is eligible.

Initially, eligibility information is collected on the Medical Benefit Request (MBR) form. Sufficient information is collected to assess if the applicant is eligible for any MassHealth coverage type. This information is then entered into the Division's computerized MA21 eligibility system, which then invokes the Decision Trees to establish the most comprehensive coverage for which the individual is eligible.

The decision trees are used by the eligibility system to identify the benefits or programs for which a person is eligible based on his or her personal characteristics and circumstances. All charts assume that the individual meets the Massachusetts residency requirement.

All of the data collected from the MBR is stored on MA21 and when a subsequent change to the member's circumstances is reported, the Decision Tree process is again invoked to assess the impact of that change.

The change event may result in a change to a different coverage type, a change in MassHealth Family Assistance premium, a change in the premium assistance amount, a loss of eligibility, or no change. This process is performed automatically by MA21 without worker intervention, and the member is automatically notified of any change in eligibility status or coverage type. In making these determinations, MA21 will also update MMIS with the correct category of assistance, which in turn, dictates the funding source (Title XXI vs. Title XIX).

Children are not eligible for Title XXI MassHealth if they are: (1) an inmate of a public institution as defined at 42 CFR 435.1009; or (2) a patient in an institution for medical diseases as defined 42.CFR 435.1009, at the time of initial application or any redetermination of eligibility.

- 4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

Once an eligibility determination is made by the MA-21 system, MMIS is automatically updated to reflect the coverage type for which the child is eligible.

Since the Division offers a variety of programs to Massachusetts' residents, MA-21 updates MMIS not only by coverage type but by funding source as well. A unique category of assistance is then assigned to ensure the accuracy of both coverage type and funding source.

These categories will also trigger a referral to the Division's enrollment broker, whenever the child is required to enroll with a primary care clinician or MCO.

- 4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

As described above in Section 4.4.1 and 4.4.2, the Division uses an automated eligibility system to place children in the richest benefit category for which they are eligible. A child who is eligible for Medicaid will automatically be placed in a Title XIX aid category.

- 4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

- 4.4.4.1.  Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The Division's premium assistance program, which is based on the combined authority of the Division's 1115 Waiver Insurance Partnership Program and Title XXI, will prevent families from dropping their private health insurance coverage. The Division covers children with family incomes at or below 200% of the Federal Poverty Level (FPL) regardless of insurance status at the time of application. Thus, there will be no financial incentive for families to drop private coverage to enroll in MassHealth. To discourage families from dropping their private coverage prior to applying for MassHealth, the Division emphasizes in its marketing and outreach materials the availability of premium assistance benefits for insured families. Additionally, when the family applies for MassHealth benefits, the Division uses the information included on the Medical Benefit Request (MBR) to complete an intensive health insurance investigation. This investigation includes matching the applicant's data against the Division's health insurance carrier database. This database includes

subscriber lists representing approximately 90% of the health insurance market in the Commonwealth. The investigation also includes contact with the applicant's employer to determine whether employer-sponsored health insurance is available. The information provided by the employer includes: the total health insurance premium; the current employer contribution towards the premium; and the summary of benefits included in the plan. Through the health insurance investigation, the Division will be able to ensure that all applicants who have private health insurance and all applicants with access to employer-sponsored health insurance participate in private coverage.

Through these mechanisms the Division ensures that:

- Families with employer-sponsored coverage will be covered through premium assistance under the Division's 1115 Waiver Insurance Partnership Program.
- Families without private coverage, but with access to employer coverage, will be covered through premium assistance under Title XXI.
- Families without private coverage, and without access to employer coverage, will be covered through MassHealth direct coverage.

The Division continuously monitors the effectiveness of the programs. The Division monitors members who apply without insurance to determine: how many of those members are required to enroll in employer-sponsored health insurance; how many had no access to employer-sponsored health insurance; and how many had access to employer-sponsored health insurance but were enrolled in direct coverage because the employer-sponsored health insurance did not meet the minimum requirements.

The Commonwealth measures the overall changes in the employer-sponsored insurance market through employer surveys. Through this mechanism, the Division is able to monitor changes both in the overall ESI market and within the large and small group markets. These employer statistics may be used to determine whether changes in the MassHealth Family Assistance Population are due to specific employer benefit changes or larger trends in the Commonwealth.

The Maternal and Child Health Policy Research Center found, through its survey of employers nationwide, that the employers

who would be most likely to drop coverage levels or consider dropping coverage are small employers (See Maternal and Child Health Policy Research Center: Fact Sheet #3, *The Potential for Crowd Out due to CHIP: Results From a Survey of 450 Employers*. March 1998). The Division believes that its Insurance Partnership Program (IP) will dissuade small businesses from dropping or reducing the health insurance coverage. The IP provides incentive payments to small employers who provide health insurance benefits to low income employees. If the Division finds through its monitoring that small employers have changed health benefits adversely to take advantage of MassHealth, the Division will evaluate those changes and will implement corrective action plans, as necessary.

Through all of these mechanisms, the Division will identify whether crowd out is occurring in the Family Assistance population. If the Division finds a significant level of crowd out either through employee or employer behavioral changes, it will evaluate the impact and make appropriate modifications to its programs.

- 4.4.4.2.  Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.
- 4.4.4.3.  Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.
- 4.4.4.4.  If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

If a child is uninsured at the time of application and has access to employer-sponsored insurance, the child may receive premium assistance. There is no waiting period.

The minimum employer contribution.

The minimum employer contribution is 50% of the total

cost of the health insurance premium.

The cost-effectiveness determination.

The cost effectiveness determination, as described in full detail earlier in Section 4, ensures that the premium assistance payment would not be greater than the amount it would cost for the Division to provide services to the member through the direct coverage option.

- 4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

The Division of Medical Assistance does not discriminate on the basis of ethnicity when determining eligibility for MassHealth programs. Alaska Native and American Indians who are members of a federally recognized tribe are not required to pay premiums.

Generally, the MassHealth outreach "net" covers the four corners of the state, and should capture any AI/AN. Our MBRs and member handbooks, which are used in our outreach efforts, specifically address AI/AN. The Division has had a Taunton MEC outreach worker that makes regular trips out to the hospital on Martha's Vineyard, which is the primary health care provider for the Wampanoags of Aquinnah and other islanders. In addition, Duke's County Health Commission was given a mini-grant to do general outreach, which would have included the AI/AN population on Martha's Vineyard.

**Section 5. Outreach (Section 2102(c))**

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

The Division will accomplish outreaching, providing information, and assisting with program enrollment, using these procedures:

1. Enlist the support of community-based organizations, social service agencies, schools, and advocacy organizations to inform community residents of available health insurance programs; identify uninsured children; assist with the enrollment process; and support the promotion of educational strategies developed to help members utilize their health care services.
  - a) Award \$10,000 - \$15,000 Mini Grants to 84 community-based organizations to assist in enrollment of "hard-to-reach" uninsured individuals and families and support post enrollment education strategies. The Division and Department of Public Health (DPH) will continue to collaborate on the issuance and monitoring of a joint RFR.
  - b) Perform targeted enrollment and member education campaigns for specific communities or vulnerable populations, such as immigrants and homeless populations, that have high numbers of "hard-to-reach" uninsured residents. The Division will make regional outreach coordinators available at each of its four (4) MassHealth Enrollment Centers (MECs) to provide outreach, enrollment, and member education training to community-based organizations in these specified areas.
  - c) Conduct school-based outreach campaigns to distribute informational materials explaining the availability of health insurance to families of children attending public, private, and parochial schools and daycare centers and to work with school nurses and/or other school staff to facilitate the enrollment of uninsured children in the appropriate health insurance program. Special emphasis will be placed on pre-school through first grade settings to reach this statistically-higher uninsured group. The Division and DPH will coordinate all activities related to this initiative.
  - d) Create and distribute promotional materials to community-based agencies and school settings. Offer training and informational sessions at community sites,

statewide, at least once per contracted year.

2. Collaborate with primary care providers (including family practice, adult medicine, and pediatric and adolescent health providers) in targeted communities and/or among populations that have high numbers of uninsured residents to furnish information about the availability of free or low-cost health insurance for children.
  - a) Coordinate Division outreach efforts with the Massachusetts Hospital Association and with the Massachusetts League of Community Health Centers.
  - b) Provide outreach assistance at community health centers, hospital outpatient clinics, WIC sites, Early Intervention Programs, home visiting programs and school based health centers, as requested.
  - c) Notify school nurses upon changes in eligibility guidelines and/or enrollment procedures.
  - d) Share informational articles describing recent health program expansions in provider and professional association publications.
  - e) Make informational presentations at conferences, workshops, and trainings attended by health care providers.
3. The Division will initiate and coordinate activities with other State agencies to provide information about health coverage to uninsured children and facilitate program enrollment, where appropriate.
  - a) Enrolling eligible Healthy Start enrollees in MassHealth.
  - b) Cross-training of staff at Department of Social Services (DSS), Department of Transitional Assistance (DTA), Department of Mental Health (DMH), Division of Insurance (DOI), Department of Youth Services (DYS), Department of Revenue (DOR), Office of Refugees and Immigrants (ORI), Department of Employment and Training (DET), Department of Mental Retardation (DMR), Department of Public Health (DPH), Children's Trust Fund (CSE), etc. who deliver direct-services to individuals, families and children.
4. The Division will develop a multi-media enrollment campaign for targeted underserved populations and promote member information on how to access MassHealth benefits.
  - a) Use a media consultant to assist with the design and implementation of a media

campaign for non-English speaking populations.

- b) Produce Public Service Announcements (PSAs) for distribution to local ethnic television and radio stations.
- c) Solicit free media coverage through newspapers, television, radio, billboards and transit authorities, or make purchase of media coverage when appropriate.
- d) Maintain ongoing communication with print media outlets (daily newspapers, weekly community newspapers, and magazines) in targeted communities, regarding outreach activities.

**Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

6.1. The state elects to provide the following forms of coverage to children:  
(Check all that apply.) (42CFR 457.410(a))

- 6.1.1.  Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)
  - 6.1.1.1.  FEHBP-equivalent coverage; (Section 2103(b)(1))  
(If checked, attach copy of the plan.)
  - 6.1.1.2.  State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
  - 6.1.1.3.  HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

This applies only to Direct Coverage programs, not Premium Assistance. See Section 6.1.4 below.

- 6.1.2.  Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430)  
Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431. **See instructions.**
- 6.1.3.  Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) [Only applicable to New York; Florida; Pennsylvania]  
Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the

actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

- 6.1.4.  Secretary-Approved Coverage. (Section 2103(a)(4)) (42 CFR 457.450)
- 6.1.4.1.  Coverage the same as Medicaid State plan
- 6.1.4.2.  Comprehensive coverage for children under a Medicaid Section 1115 demonstration project
- The Basic Benefit Level, as approved by the Secretary under the Massachusetts 1115 Demonstration Project, for premium assistance toward employer-sponsored health insurance.
- 6.1.4.3.  Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population
- 6.1.4.4.  Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5.  Coverage that is the same as defined by existing comprehensive state-based coverage
- 6.1.4.6.  Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7.  Other (Describe)

- 6.2. The state elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

### **COVERED SERVICES FOR MASSHEALTH STANDARD**

Title XXI MassHealth eligibles who receive MassHealth Standard receive services which the Commonwealth provides under the State's Medicaid Plan. Certain services listed below are covered only following prior authorization based on a finding of medical necessity.

- 6.2.1.  Inpatient services (Section 2110(a)(1))  
All acute inpatient hospital services such as daily physician intervention, surgery, obstetrics, radiology, laboratory and other diagnostic and treatment procedures.

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- 6.2.2.  Outpatient services (Section 2110(a)(2))  
Acute outpatient services includes emergent and urgent care, clinic visits, and outpatient surgical, and related diagnostic and medical services.
- 6.2.3.  Physician services (Section 2110(a)(3))  
Physician services (primary and specialty) include all medical, radiological, laboratory, anesthesia and surgical
- 6.2.4.  Surgical services (Section 2110(a)(4))  
Surgical services include services provided in section 6.2.1, 6.2.2, and 6.2.3
- 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))  
Clinical services include services provided in section 6.2.2 and 6.2.3
- 6.2.6.  Prescription drugs (Section 2110(a)(6))  
Legend drugs that are approved by the U.S. Food and Drug Administration
- 6.2.7.  Over-the-counter medications (Section 2110(a)(7))  
Non-legend drugs that are approved by the U.S. Food and Drug Administration
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))  
All laboratory services necessary for the diagnosis, treatment, and prevention of disease, and maintenance of health of MassHealth members.  
All x-rays, including portable x-rays and magnetic resonance imagery (MRI), and radiological services.
- 6.2.9.  Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))  
All prenatal and family planning medical services, family planning counseling services, follow-up-care, outreach and community education.
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental

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- 6.2.12.  hospital and including community-based services (Section 2110(a)(11))  
Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))  
Durable medical equipment, orthotic and prosthetic devices, hearing aids, and eyeglasses are covered when medically necessary and according to the requirements described in the Provider Regulations.
- 6.2.13.  Disposable medical supplies (Section 2110(a)(13))
- 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14))  
Includes personal care services and home health nursing services such as skilled nursing and home health aide services.
- 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15))  
Includes nurse practitioner services, nurse midwife services, and private duty nursing care.
- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.  Dental services (Section 2110(a)(17))  
Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20.  Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))  
Includes individual treatment, comprehensive evaluation, and group therapy.
- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative,

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remedial, therapeutic, or rehabilitative services. (See instructions)  
(Section 2110(a)(24))

Includes inpatient and outpatient rehabilitation and chronic disease hospital services, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services

- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26))  
Includes emergency and non-emergency ambulance.
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))  
Medically necessary transportation by taxi, or chair car to a MassHealth provider for a MassHealth covered service.
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))  
Adult Day Health services  
Chapter 766: home assessment and participation in team meetings  
Chiropractic services  
Institutional Care

**COVERED SERVICES FOR MASSHEALTH FAMILY ASSISTANCE/DIRECT COVERAGE**

MassHealth Family Assistance covered services received through direct coverage, are equivalent to the MassHealth Standard covered services with the following exceptions: non-emergency transportation, long term community based services, personal care services, day habilitation, and adult day health services are not covered. Long Term care is limited to 100 days. Certain services listed below are covered only following prior authorization based on medical necessity.

- 6.2.1.  Inpatient services (Section 2110(a)(1))  
All acute inpatient hospital services such as daily physician intervention, surgery, obstetrics, radiology, laboratory and other diagnostic and treatment procedures.
- 6.2.2.  Outpatient services (Section 2110(a)(2))  
Acute outpatient services includes outpatient surgical, and related diagnostic and medical services.
- 6.2.3.  Physician services (Section 2110(a)(3))

Physician services (primary and specialty) include all medical, radiological, laboratory, anesthesia and surgical.

- 6.2.4.  Surgical services (Section 2110(a)(4))  
Surgical services include services provided in section 6.2.1, 6.2.2, and 6.2.3
- 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))  
Clinical services include services provided in section 6.2.2 and 6.2.3
- 6.2.6.  Prescription drugs (Section 2110(a)(6))  
Legend drugs that are approved by the U.S. Food and Drug Administration
- 6.2.7.  Over-the-counter medications (Section 2110(a)(7))  
Non-legend drugs that are approved by the U.S. Food and Drug Administration.
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))  
All laboratory services necessary for the diagnosis, treatment, and prevention of disease, and maintenance of health of MassHealth members. All x-rays, including portable x-rays and magnetic resonance imagery (MRI), and radiological services.
- 6.2.9.  Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))  
All Prenatal care and family planning medical services, family planning counseling services, follow-up-care, outreach and community education.
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12.  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))  
Durable medical equipment, orthotic and prosthetic devices, hearing aids,

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and eyeglasses are covered when medically necessary and according to the requirements described in the Provider Regulations.

- 6.2.13.  Disposable medical supplies (Section 2110(a)(13))
- 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14))  
Home health nursing services such as skilled nursing and home health aide services.
- 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15))  
Includes nurse practitioner services, nurse midwife services.
- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.  Dental services (Section 2110(a)(17))  
Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20.  Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))  
Includes individual treatment, comprehensive evaluation, and group therapy.
- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))  
Inpatient chronic or rehabilitation limited to 100 days, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services.

- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26))  
Emergency ambulance only.
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))  
Chapter 766: home assessment and participation in team meetings  
Chiropractic services.

### **COVERED SERVICES FOR MASSHEALTH COMMONHEALTH**

MassHealth CommonHealth covered services are equivalent to MassHealth Standard covered services with the following exception: out of state services are covered for emergencies only. Certain services listed below are covered only following prior authorization based on a funding of medical necessity.

- 6.2.1.  Inpatient services (Section 2110(a)(1))  
All acute inpatient hospital services such as daily physician intervention, surgery, obstetrics, radiology, laboratory and other diagnostic and treatment procedures.
- 6.2.2.  Outpatient services (Section 2110(a)(2))  
Acute outpatient services includes emergent and urgent care, clinic visits, and outpatient surgical, and related diagnostic and medical services.
- 6.2.3.  Physician services (Section 2110(a)(3))  
Physician services (primary and specialty) include all medical, radiological, laboratory, anesthesia and surgical
- 6.2.4.  Surgical services (Section 2110(a)(4))  
Surgical services include services provided in section 6.2.1, 6.2.2, and 6.2.3
- 6.2.5.  Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))  
Clinical services include services provided in section 6.2.2 and 6.2.3
- 6.2.6.  Prescription drugs (Section 2110(a)(6))  
Legend drugs that are approved by the U.S. Food and Drug

Administration

- 6.2.7.  Over-the-counter medications (Section 2110(a)(7))  
Non-legend drugs that are approved by the U.S. Food and Drug Administration
- 6.2.8.  Laboratory and radiological services (Section 2110(a)(8))  
All laboratory services necessary for the diagnosis, treatment, and prevention of disease, and maintenance of health of MassHealth members.  
All x-rays, including portable x-rays and magnetic resonance imagery (MRI), and radiological services.
- 6.2.9.  Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))  
All Prenatal care and Family Planning medical services, Family Planning counseling services, follow-up-care, outreach and community education.
- 6.2.10.  Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11.  Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12.  Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))  
Durable medical equipment, othotic and prosthetic devices, hearing aids, eyeglasses are covered when medically necessary and according to the requirements described in the Provider Regulations.
- 6.2.13.  Disposable medical supplies (Section 2110(a)(13))
- 6.2.14.  Home and community-based health care services (See instructions) (Section 2110(a)(14))  
Includes personal care services and home health nursing services such as skilled nursing and home health aide services.
- 6.2.15.  Nursing care services (See instructions) (Section 2110(a)(15))  
Includes nurse practitioner services, nurse midwife services, and private duty nursing care.

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- 6.2.16.  Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17.  Dental services (Section 2110(a)(17))  
Preventive and basic services, emergency dental care and oral surgery, and orthodontic services.
- 6.2.18.  Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- 6.2.19.  Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20.  Case management services (Section 2110(a)(20))
- 6.2.21.  Care coordination services (Section 2110(a)(21))
- 6.2.22.  Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))  
Includes individual treatment, comprehensive evaluation, and group therapy.
- 6.2.23.  Hospice care (Section 2110(a)(23))
- 6.2.24.  Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))  
Includes inpatient and outpatient rehabilitation and chronic disease hospital services, early intervention services, oxygen and respiratory therapy services, podiatry services, vision care services
- 6.2.25.  Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26.  Medical transportation (Section 2110(a)(26))  
Includes emergency and non-emergency ambulance.
- 6.2.27.  Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))  
Medically necessary transportation by taxi, or chair car to a MassHealth provider for a MassHealth covered service.
- 6.2.28.  Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

Adult Day Health services  
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6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1.  The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

6.3.2.  The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1.  **Cost Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a

community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act.

**Describe the community-based delivery system.** (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2.  **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

## Section 7. Quality and Appropriateness of Care

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

- The Division of Medical Assistance is committed to total quality management (TQM) and applies TQM principles to all its activities, including its quality assurance and monitoring. The QA activities specific to each of the MassHealth components are described below.

The Division's MCO contract details the MCOs' qualifications and responsibilities. The Division's decision to contract with an MCO is largely based on that organization's ability to meet Division-defined contract requirements concerning:

- Access, member services and utilization;
- Quality;
- Behavioral health; and
- Financial stability

These requirements define what the MCOs must provide to MassHealth members enrolled in their plan, and are the cornerstone of all contract management activities. The Division's Purchasing Specifications for MCOs are designed to:

- Be consistent with generally accepted standards (e.g. NCQA);
- Address the specific needs of the MassHealth population;
- Address all significant aspects of the performance of MCOs;
- Be set at best practice level and be improvement-oriented; and
- Be specific and measurable so that data from measures can be used by the Division and the MCO to identify opportunities for improving performance.

Will the state utilize any of the following tools to assure quality?  
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1.  Quality standards  
The Division currently coordinates quality assurance efforts through the following types of activities:
- The Commissioner and Executive staff lead an agency-wide goal setting process to develop improvement goals focused on the special

needs of the plan members and the agency. Program-specific goals are then developed to address the agency-side improvement goals;

- All contractors, including managed care plans and providers, are required to engage in quality improvement and monitoring activities;
- Each benefit plan (i.e., MCO Program, PCC Plan, Behavioral Health Plan) has quality management staff responsible for developing, implementing and monitoring quality-based initiatives to improve health care outcomes. The staff coordinates activities to help ensure consistency in quality measurement across the Division and identify and adopt quality improvement initiatives. In addition, the Division's Medical Director provides direction on all clinically-related quality initiatives;
- Division Project Management meetings are held regularly to identify and coordinate priority initiatives and allocate agency resources to these efforts;
- Regular meetings with sister agencies are conducted to develop interagency quality improvement projects in areas such as clinical practice and to share information; and
- The Division is currently conducting an agency-wide cultural competency education program to improve the Division's provision of services to members with special cultural and linguistic needs.

7.1.2.  Performance measurement

**MCO Program**

Each MCO must participate in regular (semi-annual) contract status meetings with the Division. The primary purpose of these meetings is to review each MCO's progress toward the achievement of annual improvement goals. For purposes of these meetings, the MCO provides the Division with a written update, detailing progress toward meeting both MCO specific and standard Improvement Goals. The Division evaluates MCO performance on each goal and then produces an overall performance score for each MCO. The performance scores are used to make "quality of care adjustments" to the Division's assignment algorithm. Performance scores for all contracted MCOs are ranked, and higher scoring MCOs are more likely to receive positive adjustments in capitation rates and enrollment volume.

The MCO program conducts an annual external independent review of its contracted MCOs called the "Clinical Topic Review "(CTR). The goal of the CTR is to assess the MCOs in the areas of access and quality of care and to identify potential opportunities for improvement. The CTR topics focus on clinical issues that are of particular concern to MassHealth members as identified through other data sources, including HEDIS and the Member Satisfaction Survey. Data for the CTR is based on medical record reviews.

### **PCC Plan**

The Division conducts PCC Plan quality management and improvement activities by working collaboratively within PCC Plan functional areas and across other Division programs and units. The Division designs and coordinates the implementation of Plan-wide clinical quality improvement and measurement activities aimed at measuring and improving clinical care and member health and satisfaction. Some examples include:

**Asthma Quality Improvement Projects:** these projects focus on improving the delivery of health care and the self-management techniques of persons with asthma in order to achieve improvements in health outcomes, satisfaction, and reductions in emergency department visits and hospitalizations for asthma. Activities include educating clinicians about current asthma treatments and patient self-management, improving process and coordination of care between PCCs, hospitals, and members, and member education. Measures of success include increased prescribing of anti-inflammatory medications, reduction in emergency department visits and hospital admissions for asthma, improvements in member self-management skills, and member satisfaction with asthma care.

**HEDIS:** in collaboration with the MCO Program and the BHP, the PCC Plan collects a subset of measures from the following "domains": Effectiveness of Care, Access/Availability of Care, Use of Services, and Health Plan Descriptive Information. HEDIS results will be used to evaluate contract performance, assess performance against program goals, and identify future clinical priority areas.

### **Behavioral Health Program**

The Division holds weekly and monthly meetings with the vendor. The purpose of the meeting is:

- To evaluate the progress the vendor is making toward meeting its short-term improvement goals; and

- To provide the vendor with direction toward meeting its long term-goals.

The vendor is asked to present supporting documentation prior to these meetings. The vendor is required to review with the Division the details regarding the progress it is making toward meeting contract requirements and all short-term and long-term goals. One example of such documentation is the vendor's Annual Quality Program and Plan Evaluation.

The BHP requires the vendor to conduct annual satisfaction assessments and a variety of tools are implemented to conduct such surveys. The vendor surveys and analyzes the results of the member satisfaction surveys for those who have utilized services. The vendor conducts an annual survey to assess the level of provider satisfaction within their provider network and the vendor hires a consumer-run organization that conducts face-to-face surveys (conducted by consumers who interview consumers currently receiving services) to gain a different perspective of member satisfaction with the services the vendor has provided. The analysis of these three surveys is reported to the Division.

#### 2000-2001 MassHealth Member Survey

2000-2001 MassHealth Member Survey includes 27 additional questions to focus on describing the experience of children with special health care needs. The results of these targeted questions may be used for development of broader initiatives to assess quality of care for children with special health care needs. In addition, two questions regarding counseling for smoking cessation and two questions pertaining to interpreter services have been added to the survey for the first time. Several questions in this survey pertain to behavioral health care.

#### HEDIS

On an annual basis, HEDIS data is collected by the PCC Plan and the MCO Program. The Division endorses a rotation of measures strategy whereby a subset of HEDIS measures is collected by each participating health plan. HEDIS behavioral health measures have been conducted every second year. The data is analyzed and the results used for quality improvements by the Division and the plans. A comprehensive HEDIS MassHealth Report, which includes plan-specific and MassHealth results, is produced each year.

#### Independent External Review

Each year, the Division retains the services of an independent auditing

firm to perform a review of its BHP vendor. The purpose of this review is to obtain a report on the appropriateness of the vendor's controls over the administration of the BHP for the past contract year. The Division agrees to a focused consultant review in the following areas:

1. Internal control and contract compliance
2. Prior year audit findings and corrective action plan;
3. Claims administration;
4. BHP financial reports and capitation rate payment reconciliation statement;
5. Vendor's administrative functions and DSTRA activities;
6. Vendor's contract performance standards; and
7. Provider accounts receivable confirmation

The consultants conduct on-site visits, review vendor's electronic and paper claims, review relevant contracts and other documentation, and interview vendor personnel responsible for the BHP administration. The detailed report and the report specifications are submitted to the Division upon completion of the annual review.

7.1.3.  Information strategies

**MCO Program**

In order to help MCOs meet the standard improvement goals, the Division conducts periodic work groups related to each goal to assist the MCOs in developing strategies to attain the goals. Both Division and MCO representatives participate in these work groups. The work groups maximize both the Division and the MCO resources by providing a mechanism for coordination initiatives across provider networks and other state agencies. (For example: DPH participates in the Child and Adolescent Work Group). These meetings are excellent opportunities to discuss the specific needs of the Medicaid population and for MCOs to share best practices.

**PCC Plan**

The PCC Plan is a member of the MassHealth Medical Directors' Workgroup. The workgroup is made up of Medical Directors of each of the MCOs with which the Division contracts and other health care professionals. The Medical Directors' Workgroup advises and guides the Division and the PCC Plan on clinical and practice management issues that determine the quality of health care received by the PCC Plan members.

The Division currently works with a contractor (the Enrollment Broker) to provide member enrollment and education. In collaboration with the Division, the contractor produces and distributes a quarterly newsletter in English and Spanish for PCC Plan members. The newsletter incorporates easy-to-read principles and covers topics such as key managed care concepts, health education, national health observances, and important health and safety messages.

Targeted member education activities are also conducted by the contractor's community representatives through participation in local health fairs and lobby activities in PCC offices. Member education is supported by the PCC Plan Quarterly Management Improvement Projects for conditions such as diabetes and asthma. The PCC Plan works collaboratively with PCCs to distribute member fact sheets, wallet cards, and related care management support materials to educate members.

#### **Behavioral Health Program**

The Quality council is composed of the Division and the vendor's staff, service providers and consumers. Its purpose is to monitor the vendor's progress in meeting the BHP annual improvement goals and contract requirements as well as to provide feedback to the vendor regarding clinical and service delivery issues. Other council meetings that provide a monitoring and feedback loop include the Behavioral Health Advisory Council (every second month), Family Advisory Council (monthly), and the Consumer Advisory Council (monthly).

#### 7.1.4. Quality improvement strategies

##### **MCO Program**

The Division currently negotiates annual improvement goals and measures with contracted MCOs. The improvement goals are used to evaluate contract performance. The MCO improvement goals are also related to the Division's quality improvement goals and are designed to ensure that the Division achieves these goals for its members. The need for improvement goals is identified from several data sources including:

- Annual MCO data submissions, including HEDIS and Member Satisfaction reporting;
- MCO data collected during the prior year's improvement goal efforts;
- Data from the annual Independent External Review; and
- Findings from the annual external review conducted with each MCO around specific clinical topic areas.

The Division uses this information to identify opportunities to improve

compliance with the requirements in the contract and suggests improvement goals. The Division currently develops two (2) types of improvement goals:

- (1) Standard improvement goals, applicable to all MCOs. These goals reflect a common need for improved performance in a particular area across MCOs. Examples of standard improvement goals for prior years include:
  - Reducing inappropriate emergency room use;
  - Increasing services delivered to children and adolescents (EPSDT and school based health center linkages);
  - Increasing both the penetration and duration of mental health and substance abuse services delivered; and
  - Improving coordination between the Division and the MCO for noncapitated services.
- (2) MCO-specific improvement goals. The Division negotiates the specific goal and measure language with each MCO based on the MCO's individual need for improvement.

#### Division Sponsored Work Groups

In order to help MCOs meet the standard improvement goals, the Division facilitates monthly work groups related to each goal to assist the MCOs in developing strategies to attain the goals. Both Division and MCO representatives participate in these work groups. The work groups maximize both the Division and the MCO resources by providing a mechanism to coordinate initiatives across provider networks and other state agencies. (For example: DPH participates in the Maternal and Child Health Work Group). These meetings are excellent opportunities to discuss the specific needs of the MassHealth population and for MCOs to share best practices.

#### Contract Status Meetings

Each MCO must participate in regular (semi-annual) contract status meetings with the Division. The primary purpose of these meetings is to review MCO progress towards the achievement of annual improvement goals. During this meeting, the MCO provides the Division with a written update, detailing progress toward meeting both MCO specific and standard improvement goals. The Division evaluates MCO performance on each goal annually, the Division produces an overall performance score for each MCO. This score includes the results of both the Quality Improvement goal process and the

Contract Reporting requirement process.

**PCC Program**

The PCC Plan currently sets annual goals to guide the development of its programs and initiatives. The PCC Plan goals focus on continuous improvement with respect to clinical programs and administrative aspects of service delivery and address each of the functional areas involved in quality monitoring and improvement activities (Quality Management, Operations and Provider Communication, Member Education, and Maternal and Child Health). Progress towards goal attainment is measured at regular intervals.

**BH Program**

The Division no longer negotiates annual improvement goals and measures with the vendor. Instead, the various projects and activities which were formerly categorized as "improvement goals" have subsequently become incorporated into the amended contract as "requirements," and any new improvement goals are currently categorized as "performance standards." The focus of these projects and activities is aimed at improving access to care and improving quality of care.

**Fee For Service**

Quality Improvement projects are designed to increase hospital compliance with clinical standards of care. The Division's contractor gathers hospital data through record review and other analytic means in order to assist hospitals to achieve individual goals of improved care. The contractor conduct educational sessions to share information. Outcomes are measured via project-specific clinical indicators gathered primarily from medical record review.

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

The PCC Plan Maternal and Child Health activities currently focus on improvement of primary and preventive health care service delivery for children and adolescents. Current initiatives include member education activities, provider education activities, and coordination with other state agencies involved in the health care of children and adolescents. The Division leads a maternal and child health advisory group comprised of providers, child advocates, and other state agencies to assist in identifying and prioritizing policies and activities to improve

the managed care system for children and adolescents. The group also reviews progress and data related to the identified initiatives. Recent examples of activities include: collaboration with school-based health centers; collaboration with Massachusetts Health Quality Partners (MHQP) to complete a set of pediatric preventive care guidelines that comply with the EPSDT requirements for screening; improved linkages with WIC and Early Intervention, including the latest set of CAHPS 1 questions for the MassHealth Member Survey regarding children's special health care needs and their experience with care, coordinating with a SPRANS grant to enhance the managed care system for children with special health care needs, and reviewing MassHealth HEDIS data and identifying HEDIS measures relevant to maternal and child health.

**7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b)**

The Division requires that members' access to services is consistent with the degree of urgency as set forth below:

- emergency services must be provided immediately;
- urgent care must be provided within 48 hours; and
- non-urgent care must be provided within 10 working days.

The Division currently has contracts with four (4) MCOs. MCOs are available to members throughout most of the state, although not all contracting MCOs are statewide. Similar to the Behavioral Health Program, the Division's MCO contracts detail the MCOs' responsibilities regarding member access to medical care. All the MCOs must meet, through their contractual obligation with the Division, member access requirements that are specified in the MCO contract. (See Attachment 7.1 Provider/Patient Ratios.)

The Division currently has contracts with approximately 1,300 PCC practices, in the PCC Plan network. This network includes about 3000 clinicians in various practice settings; individual physicians, group practices, community health centers, independent nurse practitioners, and hospital outpatient departments. The PCC Plan Provider Agreement also requires that each PCC practice comply with certain access requirements ensuring prompt access to medical care. (See Attachment 7.1 Provider/Patient Ratios.)

**7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR**

457.495(c)

The Division has several methods in place to monitor and assure access to covered services, in addition to what is described above, the Division contracts with a vendor to administer and manage the Behavioral Health Program. The Behavioral Health Program offers a comprehensive provider network that includes a broad spectrum of mental health and substance abuse providers across the full-continuum of care. The vendor is responsible for all provider network management activities. Through its contracted provider network, the vendor is responsible for providing all medically necessary care, 24 hours a day with the most clinically appropriate provider, and at the most clinically appropriate level of care. The vendor must ensure that members have access to all covered services utilizing the following standards:

non-emergency inpatient services - within 60 miles or 45 minutes travel time;  
all other covered services - within 20 miles or 30 minutes travel time.

- 7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or**, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

The Division assures that prior authorization of health services are completed in a timely manner and in accordance with State law. The Division takes into consideration the urgency of care in responding to prior authorization requests.

Members may appeal any service denials to the Division's Board of Hearings.

**Section 8. Cost Sharing and Payment** (Section 2103(e))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.**

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505)

- 8.1.1.  YES  
8.1.2.  NO, skip to question 8.8.

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.

(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums:

If a family's gross income is determined to be above 150% of the poverty level, the family will be required to share in the cost of coverage. This requirement is

waived for pregnant women and newborns eligible for MassHealth Standard. For children covered through MassHealth Family Assistance and disabled children covered through MassHealth CommonHealth, the cost sharing will be a monthly premium payment.

The monthly premium payment for Family Assistance direct coverage members is \$12 per child with a family maximum of \$36 per month. The monthly premium payment for CommonHealth members ranges from \$15 to \$35 based upon the federal poverty level. CommonHealth members whose family group income is over 150% FPL are charged \$15 per month. The monthly premiums increase by \$5 for each additional 10% of the FPL through 200%.

As discussed in Section 4, American Indians and Alaskan Natives are exempt from payment of premiums.

8.2.2. Deductibles:

8.2.3. Coinsurance or copayments:

8.2.4. Other:

- 8.3. Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)(1)(B)) (42CFR 457.505(b))

All of the Division's outreach and enrollment materials will display the eligibility requirements, coverage types and any cost sharing requirements. The member booklet sent to all potential applicants along with the Medical Benefit Request (MBR) displays the cost sharing required for families with gross income between 150% and 200% FPL. Additionally, families who complete an MBR and apply for benefits will be notified in writing of any cost sharing requirements once eligibility is determined.

- 8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

- 8.4.1.  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)
- 8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)
- 8.4.3.  No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

- 8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

No premiums will be charged to families with gross income under 150% FPL. Monthly premiums for Family Assistance (direct coverage) members will be \$12 per child, with a family maximum of \$36 per month. Additionally, there are no co-payments to providers at the point of service. The annualized share of the premium will never equal more than 5 percent of the family groups income.

As required by Title XXI, the Division will cover well childcare in full and set a family cap on the amount of total cost sharing for Title XXI children receiving Premium Assistance. The Division will cover cost sharing for well baby and well childcare services by paying the provider or the family for any well child or well baby care co-payments and/or deductibles. Additionally, the Division will set a family cap on cost sharing at 5% of the family gross income. Once these families have incurred and paid bills on behalf of their children exceeding 5% of the family income, they will cease to be responsible for any additional co-payments or deductibles relative to their children's health care for that eligibility year.

After the eligibility determination is complete, the Division will notify the families of the cost sharing limits for both well child care and expenses exceeding the family cap and the payment procedures. This notice will also include a definition of well childcare services. The 5% cap will be calculated based on the gross family income used for the eligibility determination; any cost sharing in the form of premiums will be deducted from that amount and the family will be notified of the amount of co-payments and deductibles for which they will be responsible.

For example: A family of four with \$29,000 in gross income and two children is determined eligible for MassHealth Family Assistance premium assistance payments. Based on the cost of their health insurance and their employer contribution, they are responsible for \$24 of the health insurance premium each month, or \$288 annually. Five percent of their gross family income is \$1,450. The Division will automatically deduct the \$288 and notify the family that once they incur and pay \$1162 in co-payments or deductibles relative to their children's health care for that eligibility year, any additional out of pocket expenses toward covered services will be paid by the Division.

The Division will make every effort to generate manual payments directly to the providers. Substantial number of providers are already on the state's vendor file. However, if the provider is not included on the state's vendor file, the Division will make the payment to the family and outreach to the provider. The outreach process will assure that the providers are

given the opportunity to become a state vendor. To ensure that members are not required to pay the bill at the point of service the Division will educate the provider community regarding the procedures for payment through bulletins and newsletters.

Consistent with the Division's policies, after the Division notifies the family of the 5% cap it becomes the family's responsibility to track their expenditures and submit appropriate bills for payment. Once the family has incurred and paid out of pocket expenses totaling their family cap, they will be required to submit proof of payment to a DMA representative who will review the submitted bills in a timely manner. The representative will review that the payments were made for the children and for health services covered by the family's policy. Once the review is complete, the family will be notified of the procedures for submitting all future bills to the Division. The family will be able to use this notification as documentation to show the provider. After the family cap has been reached, families will be directed to submit the provider co-payment or deductible bill to the Division for payment. The Division will review the bill and generate a payment to the provider or the member within one to two weeks of receiving the bill.

Whether or not the family has reached their family cap, they will not be responsible for any co-payments or deductibles they incur for well child or well baby care. On average, the co-payments for well child care range from \$5 to \$10 per visit. The family will be directed to submit the well childcare bills to the Division for payment. Once the Division receives the bills for well childcare co-payments, payments will be generated to the provider or the member within one to two weeks.

A copy of the Division's C.A.R.E. Kit is included as attachment 4.2.

- 8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

MassHealth Family Assistance members who self-identify as members of a federally recognized American Indian tribe or who are Alaska Natives will not be charged a monthly premium.

AI/AN who are applying for MassHealth are notified of their exclusion to cost-sharing from information provided in the MBR and member booklet. For AI/AN who are already MassHealth members, a mailing explaining the exclusion from cost-sharing was done to the single federally recognized tribe in Massachusetts, and through some assistance from the tribe, to those members who could be identified as possibly being AI/AN. The cost-sharing exclusion has been implemented through a manual process. Currently, the Division captures the self-declared ethnicity information provided on the MBRs and regularly runs a report identifying potential AI/AN. Then, those individuals are flagged so that they will be excluded from cost sharing through a manual process.

- 8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

A child's coverage under Family Assistance will end if premiums remain unpaid for a 60-day period. The family will receive advance notice of the termination and may appeal the decision. Coverage will be reinstated retroactive to the date of termination if delinquent premiums are paid within 30 days of the termination. If payment is made after the 30-day period, coverage will be reinstated as of the date of the premium payment. However, in order for the Division to insure that there is no gap in coverage, a pay-back plan will be established if the family is interested. The payback plan may be extended for up to 12 months to assist families who have difficulty paying the outstanding balance. The family is not required to submit a new application or submit any other verification to have coverage reinstated.

- 8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. (42CFR 457.570(a))
- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

- 8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

- 8.8.1.  No Federal funds will be used toward state matching requirements. (Section 2105(c)(4)) (42CFR 457.220)
- 8.8.2.  No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. (Section 2105(c)(5) (42CFR 457.224) (Previously 8.4.5)
- 8.8.3.  No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))
- 8.8.4.  Income and resource standards and methodologies for determining

Model Application Template for the State Children's Health Insurance Program

Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

- 8.8.5.  No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)
- 8.8.6.  No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A)) (42CFR 457.475)

**Section 9. Strategic Objectives and Performance Goals and Plan Administration** (Section 2107)

- 9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))
1. Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children.
  2. Expand access to health coverage for low income uninsured children.
  3. Improve the efficiency of the eligibility determination process.
  4. Improve the health status and well being of children enrolled in MassHealth direct coverage programs.
  5. Coordinate with other health care programs -- specifically the state-funded Children's Medical Security Plan (CMSP), to create a seamless system for low-income children in need of health care.
- 9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))
1. Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children.
    - Implement MassHealth Family Assistance in state fiscal year 1998.
  2. Expand access to health coverage for low-income children.
    - Reduce the number of uninsured children in the Commonwealth.
  3. Improve the efficiency of the eligibility determination process.
    - Develop a streamlined eligibility process by eliminating certain verifications.
    - Develop a fully automated eligibility determination system.
  4. Improve the health status and well being of children enrolled in MassHealth direct coverage programs.
    - Improve the delivery of well child care by measuring the number of well child visits and implementing improvement activities as appropriate.
    - Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate
  5. Coordinate with other health care programs, specifically the state funded Children's Medical Security Plan (CMSP) to create a seamless system for low-income children in need of health care.
    - Develop a single application for both MassHealth and the Children's Medical Security Plan
    - Enroll all CMSP members eligible for MassHealth prior to July 1, 1998

- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

As described in section 9.5, an independent annual evaluation of the state plan will be conducted by the University of Massachusetts Medical Center (UMMC).

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- 9.3.1.  The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- 9.3.2.  The reduction in the percentage of uninsured children.
- 9.3.3.  The increase in the percentage of children with a usual source of care.
- 9.3.4.  The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- 9.3.5.  HEDIS Measurement Set relevant to children and adolescents younger than 19.
- 9.3.6.  Other child appropriate measurement set. List or describe the set used.
- 9.3.7.  If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1.  Immunizations
  - 9.3.7.2.  Well childcare
  - 9.3.7.3.  Adolescent well visits
  - 9.3.7.4.  Satisfaction with care
  - 9.3.7.5.  Mental health
  - 9.3.7.6.  Dental care
  - 9.3.7.7.  Other, please list:
- 9.3.8.  Performance measures for special targeted populations.

**1. Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low income children.**

- Implement MassHealth Family Assistance in State Fiscal Year 1998.

The Division will measure the number of applicants with access to employer-sponsored health insurance who enrolled in their employer-sponsored health insurance plan. The Division will also measure the increase in children who are

insured through employer-sponsored health insurance.

**2. Expand access to health coverage for low income uninsured children.**

- Reduce the number of uninsured children in the Commonwealth.

Decrease in the ratio of uninsured to insured children from 2:3 to 1:9.

**3. Improve the efficiency of the eligibility determination process.**

- Develop a streamlined eligibility process by eliminating certain verifications.
- Develop a fully automated eligibility determination system.

Determine 90% of applicants the eligibility status within 15 days receipt of a completed MassHealth Benefit Request (MBR).

**4. Improve the health status and well being of children enrolled in MassHealth direct coverage programs.**

- Improve the delivery of well child care by measuring the number of well child visits and implementing improvement activities as appropriate.
- Improve the immunization rates by measuring the rate of immunization administration and implementing improvement activities as appropriate.

The Division will measure improvements in well child visits rate and immunization status rates through the use of HEDIS data, encounter data and PCC Profile Reports.

**5. Coordinate with other health care programs -- specifically the state funded Children's Medical Security Plan (CMSP), to create a seamless system for low income children in need of health care.**

- Develop single application for both MassHealth and Children's Medical Security Plan.
- Enroll all CMSP members eligible for MassHealth prior to July 1, 1998.

The Division will measure:

- \* the increase in the number of MBR's submitted to the Division.

- \* the completeness and accuracy rate through the number of requests for information forms sent in comparison to the previous fiscal year.
- \* member satisfaction with the MBR through focus groups.

The Division will measure the number of children who were enrolled in CMSP prior to July 1, 1998 to those who enroll with MassHealth after July 1, 1998.

9.4.  The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5.  The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The Division will conduct an annual assessment of the effectiveness of the state plan by measuring the increase in the number of children with employer-sponsored health coverage. The Division will use the Current Population Survey (CPS) to calculate the baseline number of uncovered low income children.

An independent annual evaluation of the state plan will be conducted by the University of Massachusetts Medical Center(UMMC). This evaluation will:

- measure the effectiveness of the state plan according the goals and measurements described in section 9.1, 9.2 and 9.3.
- evaluate the characteristics of the children and families assisted in the state plan. These characteristics include age, family income, health insurance status before and after implementation.
- assess the length of time a member is eligible for the Family Assistance as compared to the length of time the member is enrolled in the plan.
- measure the quality of health coverage for members of MassHealth Family Assistance and MassHealth Standard along with the Division's overall quality assurance program, described in section 7.1.
- collect and evaluate summary information from employer sponsored health insurance plans for those members who receive premium assistance from the Division.
- conduct as part of the Division's 1115 Waiver, employee and employer surveys to assist in evaluating the impact of a Premium Assistance program.

- 9.6.  The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)
- 9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))
- 9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.135)
- 9.8.1.  Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2.  Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3.  Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4.  Section 1132 (relating to periods within which claims must be filed)
- 9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(e)) (42CFR 457.120(a) and (b))

The Division involved the public in the design and implementation of the Title XXI State Plan at various forums. The state legislative process which authorized the basic design and funding for the children's expansion included a public hearing allowing various constituencies to voice their concerns. The Division also conducted a number of meetings throughout the state to obtain feedback on: the proposed benefit packages, the cost sharing proposal, the coordination strategy with the Children's Medical Security Plan, and various outreach activities. These groups included:

- children's health care advocates such as: Health Care For All and Latino organizations;
- health care providers such as: the Massachusetts Medical Society, the Massachusetts Hospital Association, and Primary Care Clinicians (PCCs) at various regional meetings;
- the Division's Child and Adolescent work group (consisting of representatives from: Department of Public Health, Department of Youth Services, Massachusetts Chapter of the Academy of Pediatrics, Alliance for Young Families, Boston Medical Center, Department of Social Services, Mass. Advocacy, Martha Elliot Health Center, Boston Department of Health and Hospitals, Children's League of

Massachusetts, and Children's Hospital);

- school nurses;
- state agencies such as: the Department of Public Health, the Division of Health Care Financing and Policy, the Executive Office of Health and Human Services, and the Executive Office of Administration and Finance; and
- Since implementing the SCHIP program in August 1998, the Division has continued to involve the public in the program. Division staff attend and participate in quarterly meetings of the Health Access Network (HAN) and the Covering Kids and Families group. The Division also holds a quarterly meeting of its Medical Care Advisory Committee to discuss pertinent issues regarding Medicaid and SCHIP. In addition, the Division continues to actively involve the provider community in the MassHealth program. For example, the Division is part of the Massachusetts Health Quality Partners, and meets as needed with the Massachusetts Medical Society and the Massachusetts Hospital Association.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42CFR 457.120(c))

The Division is in regular contact with the Wampanoag Tribe of Aquinnah, the only federally recognized American Indian tribe in the Commonwealth. The Division shares information regarding its policies and provides information and the opportunity to meet and/or comment on any proposed changes to its SCHIP program.

Written and telephone correspondence, as well as face to face meetings have occurred with the Wampanoags of Aquinnah and with the North American Indian Center of Boston (NAICOB). Through these contacts, the tribe is provided an opportunity to comment and provide feedback on program issues.

The tribe has also been invited to participate on various advisory committees. In addition, DMA attends "consultation model" regional meetings that states, CMS, and the local tribes and tribal organizations attend. These meetings have been very beneficial to convey and address current issues and tribal needs.

Also, the Division has a designated staff member in our Member Services Unit who deals with and is responsible for Indian and tribal issues.

There is another Indian organization in Massachusetts – The North American Indian Center of Boston (NAICOB). The Division has contacts with this organization, as it does the Wampanoags of Aquinnah. In addition, the Division has offered to have an outreach worker from the Revere MEC be at the NAICOB offices. NAICOB also has been invited to participate on various advisory

committees. NACIOB has declined both of these offers.

- 9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in §457.65(b) through (d).

In February 2003, MassHealth CommonHealth and MassHealth Family Assistance members received an advance notice telling them of the premium changes. Also in February, members also received individualized notice telling them of any change in their premium amount or member share. The new cost sharing became effective with the members' March bill.

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9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost sharing by enrollees.

Table 9-1 below provides projected SCHIP expenditures for FFY 2002 and 2003. The non-federal share of the funds are all state funds. The state funds are appropriated annually in the Commonwealth's budget and have historically come from a combination of cigarette tax revenue and the Commonwealth's Children's and Senior's Health Care Fund revenue.

Table 9-1	Federal Fiscal Year 2002	Federal Fiscal Year 2003
<b>Benefit Costs</b>		
Insurance payments (premium assistance payments)	\$2,000,000	\$2,150,00
Managed care	\$27,692,308	\$31,436,281
per member/per month rate X # of eligibles		
Fee for Service	\$61,230,769	\$62,002,051
<b>Total Benefit Costs</b>	<b>\$90,923,077</b>	<b>\$ 95,588,332</b>
(Offsetting beneficiary cost sharing payments)	\$1,000,000	\$ 1,584,270
<b>Net Benefit Costs</b>	<b>\$89,923,077</b>	<b>\$94,004,062</b>
<b>Administration Costs</b>		
Personnel		
General administration		
Contractors/Brokers (e.g., enrollment contractors)		
Claims Processing		
Outreach/marketing costs		
Other	\$2,307,692	\$2,589,369
<b>Total Administration Costs</b>	<b>\$2,307,692</b>	<b>\$2,589,369</b>
10% Administrative Cost Ceiling	\$ 8,992,307	\$9,400,406
Federal Share (multiplied by enhanced FMAP rate)	\$ 59,950,000	\$62,785,730
State Share	\$32,280,769	\$33,807,700
<b>TOTAL PROGRAM COSTS</b>	<b>\$93,230,769</b>	<b>\$96,593,431</b>

Protected Sources of non-Federal Plan Expenditures:

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The Children's and Seniors' Health Care Assistance Fund was established by Chapter 203 of the Acts and Resolves of 1997 (see Attachment 1-1 of the Commonwealth's Title XXI State Plan). The Children's and Seniors' Fund is used to fund the children's expansion appropriations and includes the following sources of revenue: cigarette tax revenue, FFP received on prior year expenditures, funds transferred from the General Fund, and premiums collected from families receiving Family Assistance Direct Coverage and the Department of Public Health's Children's Medical Security Plan (CMSP) benefits. The Children's and Seniors' Fund does not include any Uncompensated Care Pool hospital assessments.

As with all collections, the Division will reduce the expenditures by the amount of the premiums by returning to CMS the FFP associated with the premiums for children in Family Assistance Direct Coverage.

**Section 10. Annual Reports and Evaluations (Section 2108)**

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1.  The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2.  The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3.  The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

**Section 11. Program Integrity (Section 2101(a))**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue to Section 12.**

11.1  The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

11.2.1.  42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2.  Section 1124 (relating to disclosure of ownership and related information)

11.2.3.  Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4.  Section 1128A (relating to civil monetary penalties)

11.2.5.  Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6.  Section 1128E (relating to the National health care fraud and abuse data collection program)

**Section 12. Applicant and enrollee protections** (Sections 2101(a))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan.**

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

The Division's review process for eligibility and enrollment matters is consistent with standard Medicaid procedures.

Health Services Matters

12.2 Please describe the review process for **health services matters** that comply with 42 CFR 457.1120.

The Division's review process for health services matters is consistent with standard Medicaid procedures.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

The Division assures that it will offer individuals receiving premium assistance coverage through group health plans that do not meet the requirements of 42 CFR 457.1120 the option of enrolling in direct coverage.