Commonwealth of Massachusetts

State Plan Under Title XIX of the Social Security Act

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Medical Assistance Program
State: Massachusetts

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State Plan under Title XIX of the Social Security Act
State: Massachusetts

Citation

42 CFR 430.10

As a condition for receipt of Federal funds under Title XIX of the Social Security Act the

Massachusetts Executive Office of Health and Human Services
(Single State Agency)

submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of Titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Citation

SECTION 1: SINGLE STATE AGENCY ORGANIZATION

1.1 Designation and Authority

42 CFR 431.10
AT-79-29

(a) The Massachusetts Executive Office of Health and Human Services is the single State agency designated to administer or supervise the administration of the Medicaid program under Title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph.)

Attachment 1.1-A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

Citation 1.1 Designation and Authority (cont.)

Sec. 1902 (a) of the Act

(b) The state agency that administered or supervised the administration of the plan approved under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

☐ Yes. The state agency so designated is

_____

_____

This agency has a separate plan covering that portion of the State Plan under Title XIX for which it is responsible.

☒ Not applicable. The entire plan under Title XIX is administered or supervised by the state agency named in paragraph 1.1 (a).

Citation — 1.1 Designation and Authority (cont.)

Intergovernmental Cooperation Act of 1968

(c) Waivers of the single state agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

☒ Yes. **Attachment 1.1-B** describes these waivers and the approved alternative organizational arrangements.

☐ Not applicable. Waivers are no longer in effect.

☐ Not applicable. No waivers have ever been granted.

Citation 1.1 Designation and Authority (cont.)

42 CFR 431.10
AT-79-29

(d) ☐ The agency named in paragraph 1.1 (a) has responsibility for all determinations of eligibility for Medicaid under this plan.

☒ Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in **Attachment 2.2-A**. There is a written agreement between the agency named in paragraph 1.1 (a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

Citation

1.1 Designation and Authority (cont.)

42 CFR 431.10
AT-79-29

(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under Title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

Citation 1.2 Organization for Administration

42 CFR 431.11
AT-79-29

(a) **Attachment 1.2-A** contains a description of the organization and functions of the Medicaid agency and an organization chart of the agency.

(b) Within the state agency, the Division of Medical Assistance (DMA) has been designated as the medical assistance unit. **Attachment 1.2-B** contains a description of the medical assistance unit and an organization chart on the unit.

(c) **Attachment 1.2-C** contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) Eligibility determinations are made both by DMA staff and by state or local staff of an agency other than the agency named in paragraph 1.1 (a). **Attachment 1.2-D** contains a description of the staff designated to make such determinations and the functions they will perform.

☐ Not applicable. Only staff of the agency named in paragraph 1.1 (a) make such determinations.

Citation	1.3	Statewide Operation
42 CFR 431.50 (b) AT-79-29		The plan is in operation on a statewide basis in accordance with all of 42 CFR 431.50.

☒ The plan is state administered.

☐ The plan is administered by the political subdivisions of the state and is mandatory on them.

1.4 Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(l) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

While MassHealth has a long history of interaction with the two federally recognized tribes in the state (Mashpee Wampanoag Tribe and Wampanoag Tribe of Gay Head (Aquinnah)), the Commonwealth is now establishing quarterly meetings with the tribes, both in-person and by conference call, with email contact as needed between meetings. These quarterly meetings will serve as a formal mechanism to seek advice from and provide information to the tribes regarding State Plan Amendments, waiver proposals and the other program changes listed above that would impact tribe members.

The consultation process used for the development and submission of this State Plan Amendment is described below.

Mashpee Wampanoag Tribe: The MassHealth Director of Outreach and Education sent an email on 7/28/10 to the tribe's Health Director, MassHealth Insurance Coordinator and Outreach and Enrollment Specialist, suggesting a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Health Director, the Health and Human Services Liaison to the Tribal Council, the MassHealth Insurance Coordinator, and the Outreach and Enrollment Specialist, sent an email to the MassHealth Director of Outreach and Education on 8/2/10 confirming that the tribe agrees with this approach.

Wampanoag Tribe of Gay Head (Aquinnah): During a conference call on 9/15/10 with the Chairwoman and the Acting Health Director of the tribe, the MassHealth Director of Outreach and Education and the Member Education Clinical Coordinator suggested a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Chairwoman and the Acting Health Director confirmed on the call that they agreed with this approach.

During quarterly consultation calls on January 19, 2011, the representatives from the Mashpee Wampanoag Tribe, the Wampanoag Tribe of Gay Head (Aquinnah) and the Indian Health Programs confirmed that they considered any State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects to have a direct effect on Tribal members. The Commonwealth will therefore seek advice and feedback from the Tribes and Indian Health Program on all such changes to be submitted to CMS.

Native American Lifelines of Boston: During a conference call on 10/27/11 with the Acting Site Director, the MassHealth Director of Outreach and Education suggested a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Acting Site Director confirmed on the call that he agreed with this approach.

During quarterly consultation calls on January 19, 2011, the representatives from the Mashpee Wampanoag Tribe, the Wampanoag Tribe of Gay Head (Aquinnah) and the Indian Health Programs confirmed that the Commonwealth will raise issues identified as having a direct effect on the Tribes in the quarterly consultation calls or via email at least a month in advance of submission to CMS; and when notice is provided in calls or via email, the Tribes will have at least two weeks to respond with advice to the Commonwealth. For major initiatives the Commonwealth will notify the Tribes early in the process of development through the stakeholder processes associated with each initiative. These

stakeholder processes ask stakeholders, including the Tribes, to give us their advice and feedback on the initiatives.

During the call on October 27, 2011 with Native American Lifelines of Boston, the Acting Site Director indicated he agreed with the approach and timeframes for consultation as described above.

Citation 1.5 Pediatric Immunization Program

1928 of the Act

1. The state has implemented a program for the distribution of pediatric vaccines to program-registered providers for the immunization of federally vaccine-eligible children in accordance with section 1928 as indicated below.

   a. The state program will provide each vaccine-eligible child with medically appropriate vaccines according to the schedule developed by the Advisory Committee on Immunization Practices and without charge for the vaccines.

   b. The state will outreach and encourage a variety of providers to participate in the program and to administer vaccines in multiple settings, e.g., private health care providers, providers that receive funds under Title V of the Indian Health Care Improvement Act, health programs or facilities operated by Indian tribes, and maintain a list of program-registered providers.

   c. With respect to any population of vaccine-eligible children a substantial portion of whose parents have limited ability to speak the English language, the state will identify program-registered providers who are able to communicate with this vaccine-eligible population in the language and cultural context which is most appropriate.

   d. The state will instruct program-registered providers to determine eligibility in accordance with section 1928 (b) and (h) of the Social Security Act.

   e. The state will assure that no program-registered provider will charge more for the administration of the vaccine than the regional maximum established by the Secretary. The state will inform program-registered providers of the maximum fee for the administration of vaccines.

   f. The state will assure that no vaccine-eligible child is denied vaccines because of an inability to pay an administration fee.

   g. Except as authorized under Section 1915 (b) of the Social Security Act or as permitted by the Secretary to prevent fraud or abuse, the state will not impose any additional qualifications or conditions, in addition to those indicated above, in order for a provider to qualify as a program-registered provider.

Citation 1.5 Pediatric Immunization Program (cont.)

1928 of the Act

2. The state has not modified or repealed any immunization law in effect as of May 1, 1993 to reduce the amount of health insurance coverage of pediatric vaccines.

3. The state Medicaid agency has coordinated with the state public health agency in the completion of this preprint page.

4. The state agency with overall responsibility for the implementation and enforcement of the provisions of section 1928 is:

☐ State Medicaid Agency

☒ State Public Health Agency

_____

Susan M. Lett, M.D., M.P.H.
Medical Director
Division of Epidemiology and Immunization
Bureau of Communicable Disease Control
Massachusetts Department of Public Health

State Plan Under Title XIX of the Social Security Act
State: Massachusetts

CERTIFICATION

I certify that the Massachusetts Executive Office of Health and Human Services is the single state agency responsible for administering the State Medicaid Plan. The legal authority under which the agency administers the plan on a statewide basis and makes rules and regulations that it follows in administering the Plan is section 16 of chapter 6A of the Massachusetts General Laws as amended by Section 15 of Chapter 26 of the Acts of 2003.

Dated: 9/10/03

Tom Reilly
Attorney General

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Waivers under the Intergovernmental Cooperation Act of 1968

Waiver #1.[1]

a. Waiver was granted on June 19th, 1973.
(date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to Fraudulent Claims Commission, and the resources and/or services of such agency to be utilized in administration of the plan are described below:

See attached letters
1) June 25, 1972 to Secretary Richardson, HEW and
Reply of June 19th, 1973

[1] (Information on any additional waivers, which have been granted, is contained in attached sheets.)

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Waivers under the Intergovernmental Cooperation Act of 1968

c. The methods for coordinating responsibilities among the several agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

See attached letters

1) June 25, 1972 to Secretary Richardson, HEW and
2) Reply of June 19th, 1973

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE DEPARTMENT
STATE HOUSE, BOSTON 02133

(6/25/72)

Dear Elliot:

As you know, Public Welfare in Massachusetts is one of the most controversial programs we administer. Its costs and problems, especially since the state takeover, are known to all of us, and they continue to be the source of great public concern.

The Department of Public Welfare has taken many steps to streamline procedures and revise its administrative structure to develop an efficient welfare administration. Even with these sound administrative steps more was felt necessary.

In order to assure the success of these administrative changes, to provide effective weapons to prevent and detect actual and potential fraud and to restore confidence in the integrity of the Department, legislative action was taken. Chapter 943, Acts of 1971 was enacted and signed into law. The Chapter is entitled "An Act establishing a Fraudulent Claims Commission and a Bureau of Welfare Auditing within the Executive Office for Administration and Finance and Abolishing the Fraudulent Claims Board of the Department of Public Welfare."

This letter is a request for a waiver of the Single State Agency provision as it applies to the Administration of the Public Assistance programs and the program of Medical Assistance, Titles I, IV, IV A, XIV and XIX, in the Commonwealth of Massachusetts. The request is made under the provisions of section 204 of the Intergovernmental Cooperation Act of 1968 (82 Stat. 1101) and in accordance with Circular No. A 102 dated October 19, 1971 and issued by the Office of Management and Budget, George P. Shultz, Director.

Chapter 943, Acts of 1971 was enacted and is now law. This Act established a Fraudulent Claims Commission. It is the opinion of all in authority that the provisions of this Act impose the administration of grants in aid to the Commonwealth, enable us to achieve the fullest cooperation and coordination of activities in Government and establish coordinated intergovernmental policy and administration of Federal Assistance programs.

Enclosed herewith is a brief in support of this request, which presents:

1. An adequate showing that the provisions of the Single State Agency requirement prevent the establishment of the most effective and efficient organizational arrangements within the State government and

2. The objectives of the Federal statutes authorizing the grant in aid programs will not be endangered by the use of mandated State structure.

I hope after viewing this material we may receive a favorable reply at your earliest convenience.

With best wishes.

Sincerely,

Frank Sargent

The Honorable Elliot L. Richardson
Secretary
Department of Health, Education and Welfare
Washington, D.C. 20201

VIA TELECOPIER TO MR. ED SIENICKI, SRS

June 19, 1973

Honorable Francis W. Sargent
Governor of Massachusetts
Boston, Massachusetts 02133

Dear Governor Sargent:

This is in further response to your letter of June 22, 1972 requesting a waiver of the single State agency requirement pursuant to Section 204 of the Intergovernmental Cooperation Act.

You had requested a waiver of the single State agency provision as it applies to the administration of the Public Assistance programs and the program of Medical Assistance, Titles I, IV, XIV, and XIX, in the Commonwealth of Massachusetts. The provisions of this waiver would allow the implementation of chapter 943 of the Acts of 1971 of the Massachusetts General Court establishing a Fraudulent Claims Commission and a Bureau of Welfare Auditing within the Executive Office for Administration and Finance, and abolishing the Fraudulent Claims Board in the Department of Public Welfare.

After examining the provisions of the law establishing the Fraudulent Claims Commission and the "Fraud Identification and Referral Procedures", I have determined that you have made an adequate showing that the single State agency requirement prevents the establishment of the most effective and efficient organizational arrangements in the State in this area. It is understood that if the State deems it essential to the efficiency of this organizational arrangement, the Fraudulent Claims Commission, as the single State agency responsible for the investigation and documentation of fraud within the State, shall have access to all records within the Department regarding the administration of public assistance. In addition, it is understood that the Fraudulent Claims Commission rather than the Department of Public Welfare has the power to decide whether a case should or should not be investigated for fraud. I have further determined that the objectives of the Public Assistance and Medical Assistance Programs, Titles I, IV, XIV, and XIX will not be endangered by the implementation of Chapter 943 of the Acts of 1971 of the Massachusetts General Court.

The waiver of the single State agency requirement requested in your letter of June 22 in reference to the establishment and functioning of the Fraudulent Claims Commission is hereby granted.

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The SRS Regional Office will continue to assist you in anyway possible to assure the adequate implementation of your programs and objectives.

Sincerely,

Secretary

Bcc: Regional Director, Region I
Regional Commissioner, Region I
W. Page
C. Botts
Bureau Commissioner, APA
Bureau Commissioner, MSA
J. Cohen
D. Lewis
Bea Moore
Reading

Page 2 – Governor Sargent

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Secretary

Bcc: Regional Director, Region I
Regional Commissioner, Region I
W. Page
C. Botts
Bureau Commissioner, APA
Bureau Commissioner, MSA
J. Cohen
D. Lewis
Bea Moore
Reading

State Plan Under Title XIX Of The Social Security Act
State: Massachusetts

Massachusetts Executive Office of Health and Human Services

Description of the Organization and Functions of the Single State Agency and an Organization Chart

The Executive Office of Health and Human Services (EOHHS) is the single state Medicaid agency responsible for administering the Title XIX program. EOHHS is headed by the Secretary of Health and Human Services, who is appointed by the Governor and serves as the executive and administrative head of all agencies, offices, departments and divisions within EOHHS, authorized to exercise general charge and supervision over the administration of each agency. Also within EOHHS and subject to its authority are the Commonwealth's health and human services agencies, which are organized under offices or departments within EOHHS as follows: (1) the Department of Elder Affairs, (2) the Office of Health Services, (3) the Office of Children, Youth and Family Services, (4) the Office of Disabilities and Community Services, and (5) the Department of Veterans' Services. EOHHS also includes the Managed Care Oversight Board and the Health Facilities Appeals Board.

The Secretary is vested with the authority to administer the Medicaid program, through any of the agencies within EOHHS.[1] Within EOHHS are all key offices and administrative personnel, including the Office of Medicaid, which serves as the medical assistance unit required by 42 CFR 431.11, and is headed by the Medicaid Director who along with other appropriate personnel participates in the development, analysis, and evaluation of the Medicaid program. In addition, the Undersecretary of EOHHS, who reports directly to the Secretary, oversees the Chief Financial Officer, the Director of MassHealth Operations, the Chief Administrative Officer, and the Director of Human Resources. The General Counsel and Chief Information Officer are also within the EOHHS, reporting directly to the Secretary. In addition to the Office of Medicaid and MassHealth Operations, the following EOHHS agencies, under the Secretary's direction, have Medicaid-related responsibilities: the Department of Elder Affairs, the Office of Disabilities and Community Services, and the Office of Health Services.

Prior to July 1, 2003, the Division of Medical Assistance (DMA) was designated by the legislature as the single state agency. Effective July 1, 2003, pursuant to Mass. Gen. Laws, c. 6A, § 16, as amended by Section 15 of Chapter 26 of the Acts of 2003, the Massachusetts legislature designated EOHHS as the single state agency.[2] It also amended Mass Gen. Laws. c. 118E (the state Medicaid operational statute) to provide in Section 1 to provide that EOHHS "shall be the single state agency responsible for the administration of programs of medical assistance and medical benefits established [under that chapter]…."

[1] In Massachusetts the health plans provided by the state Medicaid program are called MassHealth.

[2] M.G.L.c.6A, §16, as amended by St.2003, c.26, §15. The legislative change was one component of a comprehensive reorganization of EOHHS, the details of which are reflected in this attachment. The reorganization of EOHHS was proposed by the Governor to improve the efficiency and effectiveness of the executive office in providing services to Massachusetts's residents, including MassHealth members. The Division of Medical Assistance within EOHHS is grouped with other health agencies within the Office of Health Services.

I. The Secretary of EOHHS

The Secretary of EOHHS plans, organizes, staffs, directs, and controls the Medical Assistance (Medicaid) program, through the agencies described above, to provide high quality, necessary medical care to financially and medically needy individuals in the Commonwealth of Massachusetts in the most cost-effective manner, and has the authority to adopt rules and regulations for the administration of the Medicaid program, as well as the operations and administration of all EOHHS agencies. The Secretary directs the development and implementation of Medicaid cost reduction strategies to meet the challenge of the escalating cost of medical care. The Secretary also oversees MassHealth's extensive managed care program.

The Secretary of Elder Affairs, the Assistant Secretary for the Office of Disabilities and Community Services, the Assistant Secretary for the Office of Health Services, and the Medicaid Director report directly to the Secretary. Also reporting to the Secretary is the Undersecretary of the Executive Office of Health and Human Services, who is responsible for managing certain administrative, financial, and operational aspects of the Medicaid program. Following is a description of the Medicaid-related responsibilities of the units and personnel who report directly to the Secretary.

II. The Medicaid Director

The Medicaid Director, reporting to and under the direction of the EOHHS Secretary, manages the Office of Medicaid.[3] The Office of Medicaid is the medical assistance unit required by 42 CFR 431.11 within EOHHS, the single state Medicaid agency. The Medicaid Director has primary oversight for the MassHealth program. Acting under the authority of the Secretary of EOHHS, the Medicaid Director is responsible for coordinating the overall administration and support of the MassHealth program across all EOHHS agencies, including the Office of the Undersecretary of EOHHS, Elder Affairs, the Office of Disabilities and Community Services, and the Office of Health Services. Staff reporting directly to the Medicaid Director manages waiver implementation and administration, Medicaid reimbursement and purchasing policies, and the Office of Clinical Affairs.[4]

[3] For additional staffing and functional detail of the Office of Medicaid, see **Attachment 1.2-B.**
[4] For additional staffing and functional detail of the Office of Clinical Affairs, see **Attachment 1.2-C.**

III. The Undersecretary of the Executive Office of Health and Human Services

The Undersecretary has responsibility for the administration and operation of the EOHHS. Directly reporting to the Undersecretary are the Chief Financial Officer, the Director of MassHealth Operations, the Chief Administrative Officer, and the Human Resources Director.

A. Chief Financial Officer

The Chief Financial Officer is responsible for the management and oversight of the budget, revenue, and accounting functions for EOHHS.

B. Chief Administrative Officer

The Chief Administrative Officer is responsible for managing the administrative needs of EOHHS, including, as pertains to Medicaid, facilities management, internal control and audit, contracts, including transportation contracts, and cultural competency initiatives.

C. MassHealth Chief Operating Officer

The MassHealth Chief Operating Officer has responsibility for Medicaid member services, claims operations, provider relations, and other Medicaid-related operational needs of the Secretariat. The COO is responsible for overseeing member services and eligibility operations, claims and provider operations, internal control and external audit, project management, hearings, security and privacy, and program evaluation including study and sampling activities in fulfillment of the federal Medicaid Eligibility Quality Control requirements.

D. Human Resources Director

The Human Resources Director is responsible for all personnel-related functions pertaining to EOHHS, including staffing, payroll administration, labor relations and professional development.

IV. The Secretary of Elder Affairs

The Secretary of Elder Affairs is responsible, under the direction of the EOHHS Secretary, for administering the Medicaid program with regard to non-acute services provided to eligible persons over 65. In the administration of these responsibilities, the Secretary of Elder Affairs works closely with the Assistant Secretary of Disabilities and Community Services.

V. The Assistant Secretary of Disabilities and Community Services

The Assistant Secretary of Disabilities and Community Services is responsible, under the direction of the EOHHS Secretary, for leading the policy direction of MassHealth long-term care services for the disabled, particularly policy affecting benefits and services provided in home-based and community-based settings. Working with the Secretary of Elder Affairs, the Director of Long Term Care and other EOHHS agencies, the Assistant Secretary guides the coordination of a comprehensive system of community-based long-term care for the disabled.

VI. The Assistant Secretary for the Office of Health Services

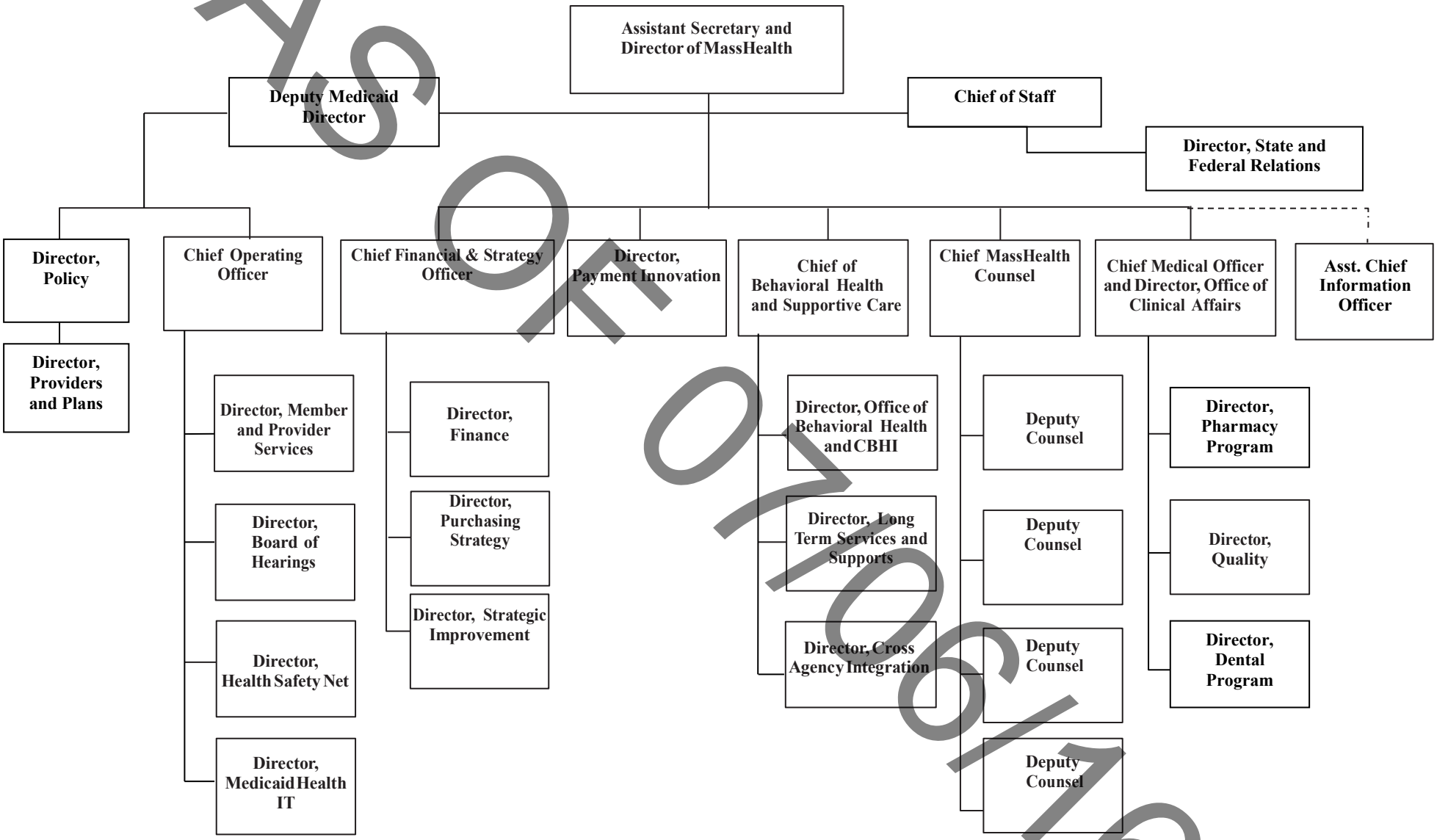
The Assistant Secretary for the Office of Health Services is responsible, under the direction of the EOHHS Secretary, for administering the Medicaid program with regard to all acute and ambulatory care. Reporting directly to the Assistant Secretary is the Commissioner of Mental Health and the Director for Acute and Ambulatory Care. The Director and her staff are primarily responsible for the development, management, and evaluation of a comprehensive system of acute and ambulatory services that provide improved health care for Medicaid clients and an improved health care system through the Primary Care Clinician Plan (PCC), the Managed Care Organization (MCO) program, fee-for-service hospital and ambulatory programs, and other initiatives to provide increased access to and availability of preventive and primary. The Commissioner of Mental Health is responsible for the Behavioral Health program. Reporting to the Commissioner is the Deputy Commissioner for Mental Health who manages the Behavioral Health Program.

VII. Other EOHHS Staff

Also reporting directly to the Secretary of EOHHS is a **Chief Information Officer and the General Counsel.** The **Chief Information Officer** is responsible for all functions related to the management information needs of the Secretariat. That responsibility extends to Medicaid-related needs, including management information reporting and analysis, systems maintenance for claims payment and provider support systems, and managing both the Medicaid Management Information System (MMIS) and office automation services.

The **General Counsel** provides legal advice to the Secretary and his staff on all legal issues relating to the administration of his responsibilities, including the administration of the Medicaid program. Legal staff provides Medicaid expertise to support the Medicaid program report to the General Counsel through the senior legal managers for that unit. The General Counsel acts as the EOHHS liaison to the Governor's Chief Legal Counsel and to the Attorney General.

MassHealth Leadership Team



State Plan Under Title XIX Of The Social Security Act
State: Massachusetts

Massachusetts Executive Office of Health and Human Services
Office of Medicaid

Description of the Organization and Functions of the Medical Assistance Unit and an Organization Chart

The Office of Medicaid is the medical assistance unit required by 42 CFR 431.11 within the Executive Office of Health and Human Services (EOHHS), the single state Medicaid agency. The Director of the Office is the Medicaid and SCHIP Director and has primary oversight for the Medicaid program. Reporting directly to the Secretary of Health and Human Services, and acting under his authority, the Office is responsible for coordinating the overall administration and support of the Medicaid program across all EOHHS agencies, including primarily the Department of Elder Affairs, the Office of Disabilities and Community Services, the Office of Health Services, and the Office of Children, Youth and Families.[1]

Prior to July 1, 2003, the Division of Medical Assistance (DMA) was designated as both the single state agency and the medical assistance unit. Effective July 1, 2003, pursuant to Mass. Gen. Laws c. 6A, § 16, as amended by Section 15 of Chapter 26 of the Acts of 2003, the Massachusetts legislature designated EOHHS as the single state agency.[2]

To ensure that the Medicaid program continues to function efficiently and effectively under the reorganized secretariat, the Office maintains strong ties and communications with EOHHS staff throughout the Secretariat.

Federal regulations require that the medical assistance unit be "staffed with a program director and other appropriate personnel who participate in the development, analysis and evaluation of the Medicaid program." 42 CFR Section 431.11(b). Accordingly, the Office of Medicaid is staffed and functionally organized as follows:

I. The Medicaid Director

The Medicaid Director reports to the Secretary of Health and Human Services, chief executive officer of the single state agency for Medicaid. The Medicaid Director under Secretary's direction manages the Office of Medicaid. The Medicaid Director has primary oversight for the Medicaid program. Staff reporting directly to the Medicaid Director manage waiver implementation and administration, Medicaid reimbursement and purchasing policies, as well as the Medical Director, who manages the Office of Clinical Affairs.[3] The functions of the Office of Medicaid are set out below.

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[1] For a full description of the organization and function of EOHHS and these agencies, see **Attachment 1.2-A**.

[2] That legislative change was one component of a comprehensive reorganization of EOHHS, the details of which are reflected in this attachment. The reorganization of EOHHS was proposed by the Governor to improve the efficiency and effectiveness of the executive office in providing services to Massachusetts residents, including Medicaid recipients.

[3] For additional staffing and functional detail of the Office of Clinical Affairs, see **Attachment 1.2-C**.

II. Functions of the Office of Medicaid

The Office of Medicaid, consistent with federal requirements, has responsibility for the development, evaluation and analysis for the medical assistance program and SCHIP, acting on behalf of the Secretary of Health and Human Services, as follows:

A. Development

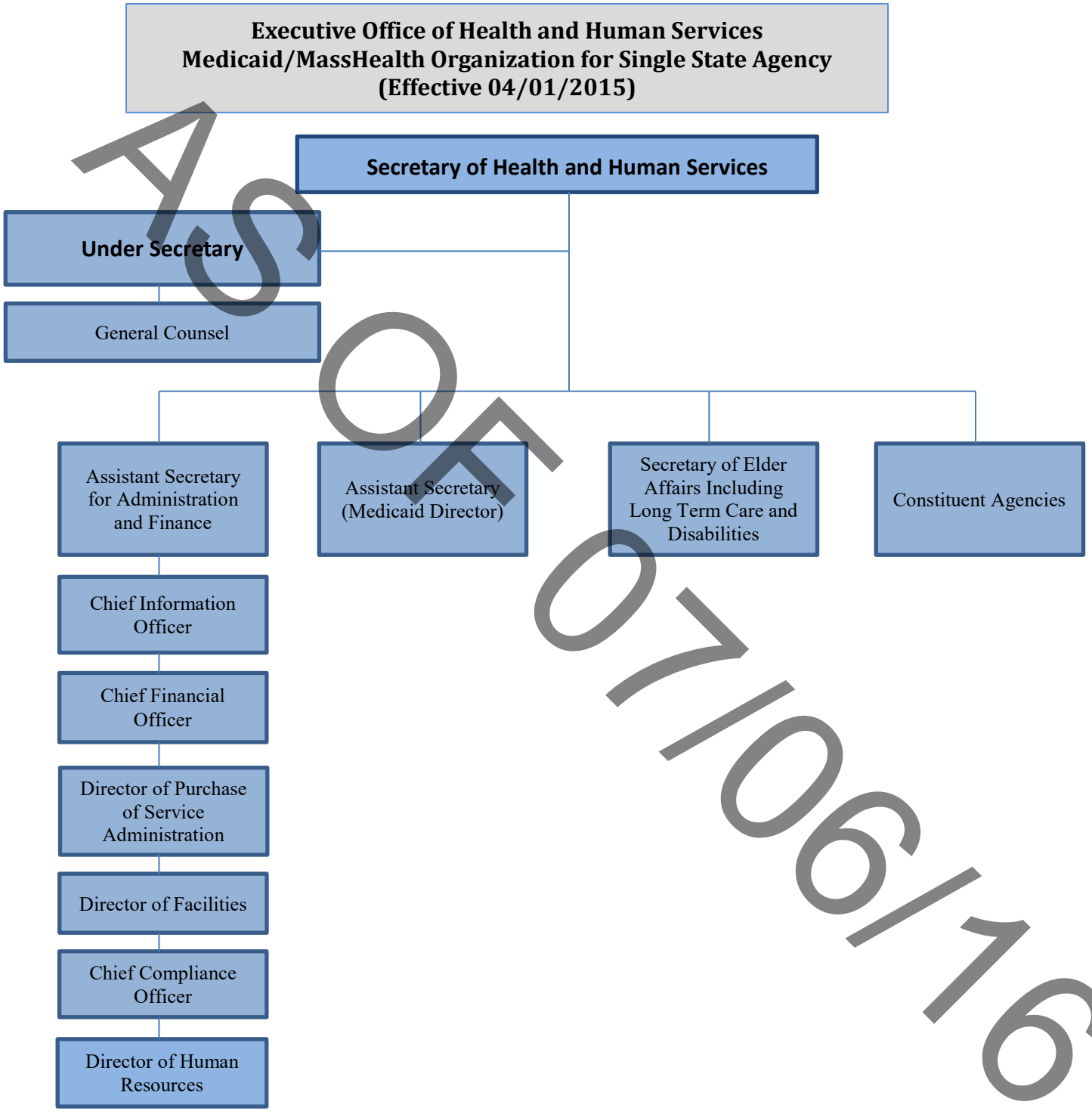
- Oversee the Medicaid program, including administration of the Title XIX state plan, Section 1115 Demonstration Project, Title XXI SCHIP plan, and Home and Community-Based Services waivers;
- Manage the drafting and filing of State Plan Amendments;
- Lead the design of and request for new waivers for the Medicaid program;
- Coordinate Medicaid policy strategy and development, in conjunction with Elder Affairs, the Offices of Disabilities and Community Services, Health Services;
- Integrate EOHHS responses to surveys and/or investigations of the Medicaid program by other states, interest or advocacy groups, Congressional committees, the Office of the Inspector General, and the General Accounting Office;
- Analyze federal Medicaid-related policy activities, including proposals being considered by Congress and national policy groups, and identify Medicaid policy changes in other states;
- Serve along with the Secretary of Health and Human Services as the primary point of contact with the state legislature on Medicaid policy issues, constituent affairs, and legislation;
- Convene the Medical Care Advisory Committee (MCAC) required by 42 CFR Section 431.12;
- Provide staff as project leaders or coordinators on complex projects that affect entire or a major component of the Medicaid program;
- Manage within EOHHS the promulgation of regulations for Title XIX or XXI eligibility, payments, rates, billing, service coverage, and provider participation policies;
- Develops and integrate Medicaid eligibility and health plan enrollment policy, working closely with eligibility policy implementation staff in the Office of the Undersecretary; and
- Maintain relationships with key federal contacts to help ensure that the Medicaid program operates within the framework of federal rules, regulations, and reporting requirements.

B. Evaluation

- Provide MassHealth program evaluation support and knowledge management by identifying key areas to evaluate and designing evaluation approaches;
- Coordinate and support evaluations of current and new Medicaid programs, including the annual reports required under 1115 Waivers and the SCHIP program; and
- Maintain a library of external reports and evaluations of Medicaid programs and ensure that key staff in EOHHS receives information in relevant reports.

C. Analysis

- Support Medicaid in purchasing high quality health services in a manner that promotes program goals, maximizes efficiency, and supports leveraging available federal and third-party funding;
- Conduct economic analysis on various purchasing and reimbursement policies and present policies and options to program staff for consideration;
- Monitor the academic literature and the purchasing methods of other states and payers to identify best practices and innovative approaches to purchasing health care services;
- Analyze Medicaid claims data, cost reports, and other industry data to support rate-making activities; and
- Coordinate with EOHHS and its agencies the process of Medicaid budget forecasting and the implementation and analysis of Medicaid purchasing strategies.


Executive Office of Health and Human Services
Medicaid/MassHealth Organization for Single State Agency
(Effective 04/01/2015)
Secretary of Health and Human Services
Under Secretary
General Counsel
Assistant Secretary for Administration and Finance
Assistant Secretary (Medicaid Director)
Secretary of Elder Affairs Including Long Term Care and Disabilities
Constituent Agencies
Chief Information Officer
Chief Financial Officer
Director of Purchase of Service Administration
Director of Facilities
Chief Compliance Officer
Director of Human Resources

State Plan Under Title XIX of the Social Security Act
State: Massachusetts

Description of the Kinds and Numbers of Professional Medical Personnel and Supporting Staff Used in the Administration of the State Plan and their Responsibilities

I. Office of Clinical Affairs

The Office of Clinical Affairs (OCA) within the Office of Medicaid is responsible for establishing a proactive system of clinical accountability that assures the purchase and provision of clinically effective, high quality, and cost efficient health care for MassHealth members. The Medical Director serves as the leader/manager of OCA. This individual ensures the development and implementation of clinical policies, standards, and practices affecting the Medicaid health care community. The Medical Director must be a physician licensed by the Board of Registration in Medicine. The clinical staff and functions of the Office of Clinical Affairs are described in detail below.

A. Clinical Oversight and Consultation

In addition to the Medical Director, there are four part-time Associate Medical Directors who are physicians licensed by the Massachusetts Board of Medicine. They aid the Medical Director by recommending, developing, and implementing, as necessary, health policies and programs within the agency. They provide clinical support and supervision to the Prior Approval unit and other OCA units as well as consultation services to the Medicaid program within EOHHS. The medical specialty areas of these physicians should include pediatrics, psychiatry, general medicine, and obstetrics/gynecology, reflecting the majority of patients within MassHealth and supporting their healthcare requests and needs.

B. Managing Projects

A unit within OCA manages its projects, as well as other projects that require the participation of OCA are completed in a timely manner and meet professional standards.

C. Pharmacy

The Director of Pharmacy, who is a pharmacist with a PharmD, manages the pharmacy unit. S/he is responsible for the day-to-day management of the pharmacy program as well as development and consultation on pharmacy policy. The Director manages the Pharmacy on Line Processing System (POPS), oversees the Drug Utilization Review Program (DUR), and serves as an expert consultant in all areas pertaining to pharmacy. Staff under the direction of the Director of Pharmacy are responsible for educational interventions directed towards providers, including "academic detailing" to physicians and coordinating with the DUR program and others on the design and implementation of such programs.

The pharmacy program has a Clinical Pharmacist with specialty education and training in evidence-based medical practice as it relates to drugs. This person assists with the design of the pharmacy benefit to help ensure clinical appropriateness and assists with guideline development to monitor drug utilization.

The POPS Program and Contract Manager is responsible for the direct and proximal management of the contract between the state and the pharmacy fiscal agent. S/he oversees day-to-day interface issues and monitors performance for contract compliance.

The program is assisted by a Project Manager, assigned and dedicated to the Pharmacy program by the Clinical Projects function in the Office of Clinical Affairs. The pharmacy program also has an administrative assistant.

D. Prior Approval (for Non-Pharmacy Services)

In certain instances EOHHS will not process a claim unless the Provider has obtained Prior Authorization (PA) to furnish the medical service for which payment is requested. The purpose of the Prior Authorization process is to determine medical necessity and medical appropriateness of a given service. Prior Authorization determines only the medical necessity of the authorized service and does not establish or waive any other pre-requisites for payment.

Only certain types of services within a category may require Prior Authorization. A consultant who has education and experience in the service area being requested reviews the Prior Authorization requests. These clinical reviewers include dentists, physicians, nurses, therapists - requests for dental services are reviewed by dentists, requests for physical therapy services are reviewed by physical therapists and so on. The Prior Authorization unit is managed by the Director of Prior Authorization.

E. Utilization Management

The Utilization Management and Program Integrity Unit is managed by the Director of Utilization Management, a Registered Nurse with a BSN and MBA. She is responsible for Provider Compliance across all Provider types as well as the development and consultation on Utilization policy. The Director oversees the program compliance for Institutional Providers (Acute and Chronic/Rehabilitation Hospitals) and Non-Institutional Providers (all other provider types with Medicaid contracts), Program Integrity activities as well as acting as an expert consultant in all areas pertaining to Provider Compliance. The Unit has 3 Program Managers who oversee a staff of 12 clinical and non-clinical personnel. There is also a Registered Nurse responsible for Special Projects audits that require considerable case development. The Unit is also responsible for recoveries for all provider types as well as serving as the Division liaison to the Medicaid Fraud Control Unit at the Attorney General's office.

II. Office of Health Services

Within the Executive Office of Health and Human Services' Office of Health Services, the Acute and Ambulatory Care Unit staff provides clinical support, as summarized below.

A. Primary Provider Network

The Primary Provider Network staff oversees program and reimbursement policy for the Acute Hospital, Physician and Community Health Center programs. The Physician Program is responsible for pricing and approving certain physician claims. Two RNs, one full-time and one a part-time consultant, review and price these claims. Clinical program staff also review new Healthcare Common Procedure Coding System (HCPCS) codes. The Manager of the Physician Program is also an RN who is able to use clinical skills in supervising the above-mentioned staff, as well as in advising the Director for Acute and Ambulatory Care and others about certain policies with clinical implications. The Manager of the Physician Program also sits on a number of Division workgroups where her clinical input is needed.

B. Primary Care Clinician Plan

The Primary Care Clinician (PCC) Plan clinical staff includes 6 nurses, 4 in the Quality Management Unit and 2 in the Preventive Health Services Unit.

These nurses perform the following functions:

- Provide clinical expertise and guidance in development of PCC Profile Reports;
- Develop materials designed to support PCCs in providing better care to members;
- Act as clinical project coordinators for Quality Improvement Projects;
- Support the MCO Program in the development of MCO Quality goals, and participate in evaluating MCO performance in reaching those goals;
- Coordinate with other state agencies to ensure that our policies and activities are supportive of each other's goals;
- Manage the EPSDT program; and
- Serve as clinical experts on matters related to the immunization program.

DESCRIPTION OF STAFF DESIGNATED TO MAKE ELIGIBILITY DETERMINATIONS AND THE FUNCTIONS THEY PERFORM

Department of Public Welfare eligibility workers located within a statewide network of local offices make eligibility determinations for community (non-institutional) Medicaid cases and perform all eligibility-related activities including representing DMA at hearings involving eligibility-related issues. This activity will continue under Interagency Service Agreement (ISA) during a one-year transitional period only.

DMA eligibility workers located within regional long term care offices make eligibility determinations for all institutionalized cases and perform all eligibility-related activities for these cases.

INTERAGENCY SERVICE AGREEMENT

BETWEEN

THE DEPARTMENT OF PUBLIC WELFARE

AND

THE DIVISION OF MEDICAL ASSISTANCE

I. Transfer of Certain Personnel, Functions and Resources

To reorganize the Department of Public Welfare (DPW) pursuant to legislation designated as H.5090 (hereafter H.5090), the Commissioner of the DPW and the Commissioner of the Division of Medical Assistance (DMA) hereby agree that all equipment, furnishings, personnel, and functions performed by such personnel, for which the Commissioner of DMA (then Deputy Commissioner of DPW) was responsible immediately prior to the effective date of this Interagency Service Agreement (ISA) shall be transferred to DMA upon the signing of this ISA.

II. Transfer of Certain Administrative Authority

All authority for the following functions, as they relate to administration of the medical assistance programs governed by H.5090, shall be transferred to DMA as of the effective date of H.5090: developing and submitting for federal approval any and all amendments to the State Medicaid Plan; adopting, promulgating, amending and rescinding any and all rules, regulations, policies and procedures; entering into contracts; and, issuing special payments, provided that any special payments issued by DPW subsequent to the effective date of H.5090 and prior to the signing of this ISA shall constitute authorized payments.

III. Transfer of Remaining Personnel, Functions and Resources

DPW shall transfer to DMA all responsibilities, functions, personnel, and resources not transferred under Paragraphs I and II of this ISA, in accordance with the provisions of Sections 34 through 40 of H.5090 and Paragraph IV of this ISA.

IV. Written Agreements for Transfer During Transition Period

In accordance with Section 40 of H.5090, there shall be a transition period extending until one year from the effective date of H.5090. The transfer, during this transition period,

of all responsibilities, functions, personnel, or resources pursuant to Paragraph III of this ISA shall be effective only upon the written agreement, through amendment(s) to this ISA, of the Commissioner of DPW and the Commissioner of DMA, or as otherwise determined by the Secretary of the Executive Office of Health and Human Services.

V. Maintenance of Effort

Except as provided in Paragraphs I and II of this ISA, all powers and duties vested in DPW or any board, council or official of DPW and powers and duties vested in DMA under H.5090 shall be exercised by DPW during the transition period until such time as the transfer to DMA of such power or duty shall be effective pursuant to Paragraph IV of this ISA.

Bruce M. Bullen
Commissioner
Division of Medical Assistance

Joseph Ballantyne
Commissioner
Department of Public Welfare

Executed this 30th day of July, 1993.

JK-7/29/93

TN 93-14 approved 4/27/94 eff. 7/1/93

Citation

42 CFR 435.10 and Subpart J

2.1 Application, Determination of Eligibility, and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J, for processing applications, determining eligibility, and furnishing Medicaid.

Citation 2.1 Application, Determination of Eligibility, and Furnishing Medicaid (cont.)

42 CFR 435.914
1902 (a) (34) of the Act

(b) (1) Except as provided in items 2.1 (b) (2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in **Attachment 2.6-A**.

1902 (e) (8) and 1905 (a) of the Act

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902 (a) (10) (E) (i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. **Attachment 2.6-A** specifies the requirements for determination of eligibility for this group.

1902 (a) (47) and 1920 of the Act ☒

(3) Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. **Attachment 2.6-A** specifies the requirements for determination of eligibility for this group.

42 CFR 434.20

(c) The Medicaid agency elects to enter into a risk contract with an HMO that is:

☒ Qualified under title XIII of the Public Health Services Act or is provisionally qualified as an HMO pursuant to section 1930 (m) (3) of the Social Security Act.

☒ Not Federally qualified, but meets the requirements of 42 CFR 434.20 (c) and is defined in **Attachment 2.1-A**.

☐ Not applicable.

Citation 2.1 Application, Determination of Eligibility, and Furnishing Medicaid (cont.)

1902 (a) (52) of the Act

(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902 (a) (10) (A) (i) (IV), (a) (10) (A) (i) (VI), (a) (10) (A) (i) (VII), and (a) (10) (A) (ii) (IX) at locations other than those used by the Title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.

Citation(s)

1902 (e) (13) of the Act

2.1 Application, Determination of Eligibility and Furnishing Medicaid

☒ (e) Express Lane Option. The Medicaid State agency elects the option to rely on the finding from an Express Lane agency when determining whether a child satisfies one or more components of Medicaid eligibility. The Medicaid State agency agrees to meet all of the Federal statutory and regulatory requirements for this option. This authority may not apply to eligibility determinations made before February 4, 2009, or after September 30, 2027.

(1) The Express Lane Option is applied to:

☐ Initial determinations ☒ Redeterminations

☐ Both

(2) A child is defined as younger than age:

☐ 19 ☐ 20 ☒21

(3) The following public agencies are approved by the Medicaid State agency as Express Lane agencies:

The Massachusetts Department of Transitional Assistance in the administration of the Supplemental Nutrition Assistance Program (SNAP).

Citation(s) **2.1 Application, Determination of Eligibility and Furnishing Medicaid** (continued)

(4) The following component/components of Medicaid eligibility are determined under the Express Lane option. Also, specify any differences in budget unit, deeming, income exclusions, income disregards, or other methodology between Medicaid eligibility determinations for such children and the determination under the Express lane option.

The MassHealth agency uses the Express Lane option for annual redeterminations only. All members eligible for this process have completed an initial application and have been approved for both Medicaid and SNAP. The MassHealth agency will identify children eligible for both Medicaid and SNAP through a data match. The SNAP eligibility decision will verify residency and serve as a proxy for income. Medicaid benefits will be renewed based on the child's eligibility for SNAP. Parents and legal caretaker relatives who are part of the same family group as these children will be included in this process and will also have their coverage renewed if they are eligible for SNAP, pursuant to Section 1115 Demonstration authority.

SNAP households have a certification period that does not exceed 12 months, except that the certification period may be up to 36 months if all adult household members are elderly or disabled. Unless the household is certified for 36 months, the Department of Transitional Assistance must contact the household halfway into the certification period to determine continued eligibility. In most cases, recertification requires that the household submit a certification form, be interviewed, and provide requested verification in accordance with timeliness standards.

The following summarizes differences in methodology between Medicaid and SNAP:

Budget Unit:
For Medicaid

- The MassHealth agency uses Modified Adjusted Gross Income (MAGI) household composition subject to its state plan and 1115 demonstration waiver in determining eligibility.

For SNAP- the household consists of

(1) the individual;
(2) the individual's spouse if living with him or her;
(3) the individual's natural, adopted, and stepchildren younger than 22 years old if living with him or her;
(4) any child under 18 over whom the individual exercises care and control; and
(5) a group of individuals living together who purchase food and prepare meals together.

Income Limit:
For Medicaid- MAGI household income at or below 150% of the federal poverty level (FPL) for children to age 21, except infants. Infants aged 0 to 1 are eligible to at or below 200% FPL but will be included in the Express Lane process only to at or below 150% FPL.

For SNAP- Gross income at or below 200% FPL for most households (see 106 CMR 365.180 for exceptions). Households that contain an elderly or senior member do not have a gross income limit.

Income Disregards:
For Medicaid-

- The MassHealth agency uses Modified Adjusted Gross income subject to its state plan and 1115 demonstration waiver in determining eligibility, including all authorized income disregards and exclusions.

For SNAP-

- Income disregards are used to determine benefit level, not eligibility, for all SNAP households included in this process except for those with an elderly or disabled member and gross household income above 200% FPL.
- For households with an elderly or disabled member and gross income above 200% FPL, a 100% net income threshold must be met by using the following disregards:
    - Standard disregard determined according to household size;
    - Earned income deduction equal to 20% of gross monthly earned income;
    - Excess medical deduction for unreimbursed medical expenses in excess of $35 a month for households with elderly or disabled members;
    - Amount of actual dependent care expenses;
    - Legally obligated child support payments;
    - If homeless, shelter/utility deduction of $143 per month;
    - If not homeless, shelter expenses and utility costs in excess of 50% of the households income after all other deductions are allowed, up to a capped amount unless the household has an elderly/disabled member.

Income Exclusions:
For Medicaid- The MassHealth agency uses Modified Adjusted Gross Income (MAGI) subject to its state plan and 1115 demonstration waiver in determining eligibility, including all authorized income disregards and exclusions.

For SNAP-

- In-kind income and cash contributions;
- Vendor payments (money payment not payable directly to the household);
- Infrequent irregular incomes not in excess of $30 per recipient per quarter;
- Educational loans, grants, and scholarships;
- Other loans including loans from private individuals and commercial institutions;
- Reimbursements for past or future expenses that do not exceed actual expenses and do not represent a gain or benefit to the household;
- Monies received and used for the care and maintenance of a third party beneficiary who is not a household member;
- Earnings of elementary or secondary school students;

- Nonrecurring lump sum payments;
- Cost of producing self-employment income;
- Income excluded by law;
- Income of nonhousehold members, except when nonhousehold member has been disqualified per certain regulations;
- Payments made to SNAP/ET participants for education and/or training-related expenses;
- Income of SSI recipients necessary for fulfilment of PASS;
- Legally obligated child support payments.

(5) Check off and describe the option used to satisfy the Screen and Enroll requirement before a child may be enrolled under title XXI.

☐ (a) Screening threshold established by the Medicaid agency as:

☒ (i) percentage of the Federal poverty level which exceeds the highest Medicaid income threshold applicable to a child by a minimum of 30 percentage points: 180% FPL ; or

☐ (ii) percentage of the FPL (describes how this reflects the value of any differences between income methodologies of Medicaid and the Express Lane agency:):or

☐ (b) Temporary enrollment pending screen and enroll:

Citation(s)

2.1 Application, Determination of Eligibility and Furnishing Medicaid (continued)

☐ (c) State's regular screen and enroll process for CHIP.

☐ (6) Check off if the State elects the option for automatic enrollment without a Medicaid application, based on data obtained from other sources and with the child's or family's affirmative consent to the child's Medicaid enrollments.

☐ (7) Check off if the State elects the option to rely on a finding from an Express Lane agency that includes gross income or adjusted gross income shown by State income tax records or returns.

Citation

2.2 Coverage and Conditions of Eligibility

42 CFR 435.10

Medicaid is available to the groups specified in **Attachment 2.2-A**.

☐ Mandatory categorically needy and other required special groups only.

☐ Mandatory categorically other needy, other required special groups, and the medically needy, but no other optional groups.

☐ Mandatory categorically needy, other required special groups, and specified optional groups.

☒ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in **Attachment 2.6-A**.

All applicable requirements of 42 CFR Part 435 and sections 1902 (a) (10) (A) (i) (IV), (V), and (VI); 1902 (a) (10) (A) (ii) (XI); 1902 (a) (10) (E); 1902 (l) and (m); 1905 (p), (q) and (s); 1920; and 1925 of the Act are met.

Citation	2.3	Residence
435.10 and 435.403, and 1902 (b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)		Medicaid is furnished to eligible individuals who are residents of the state under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it at a fixed address.

Superseded by TN-013-018 MMDL

Citation	2.4	Blindness
42 CFR 435.530 (b) 42 CFR 435.531 AT-78-90 AT-79-29		All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in **Attachment 2.2-A**.

Citation	2.5	Disability
42 CFR 435.121, 435.540 (b), 435.541		All of the requirements of 42 CFR 435.540 and 435.541 are met. The state uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of **Attachment 2.2-A** of this plan.

Citation (s) 2.6 Financial Eligibility

42 CFR 435.10 and Subparts G & H
1902 (a) (10) (A) (i) (III), (IV), (V), (VI), and (VII)
1902 (a) (10) (A) (ii) (IX), 1902 (a) (10) (A) (ii) (X), 1902 (a) (10) (c),
1902 (f), 1902 (l) and (m),
1905 (p) and (s),
1902 (r) (2),
and 1920

The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in **Attachment 2.6-A**.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Citation	2.7 Medicaid Furnished Out of State
431.52 and 1902 (b) of the Act, P.L. 99-272 (Section 9529)	Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the state while the individual is in another state, to the same extent that Medicaid is furnished to residents in the state.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Definition of an HMO that is not Federally Qualified

The Massachusetts Department of Public Welfare also enters into risk contracts with the following types of health maintenance organizations:

(1) health maintenance organizations that are licensed by the Massachusetts Division of Insurance, which defines "health maintenance organization" in Chapter 176G of the Massachusetts General Laws as "a company organized under the laws of the commonwealth, or organized under the laws of another state and qualified to do business in the commonwealth, which

(a) provides or arranges for the provision of health services to voluntarily enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum; and

(b) demonstrates to the satisfaction of the commissioner proof of its capability to provide its members protection against loss of prepaid fees or unavailability of covered health services resulting from its insolvency or bankruptcy or from other financial impairment of its obligations to its members"; and

(2) other public or private organizations organized under state law that

(a) are organized primarily for the purpose of providing health care services;

(b) make the services provided to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO; and

(c) make provision, satisfactory to the Department of Public Welfare, against the risk of insolvency, and assure that Medicaid enrollees will not be liable for the organization's debts if the organization does become insolvent.

Citation(s)

Group Covered and Agencies Responsible for Eligibility Determination

The following groups are covered under this plan.

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups**

42 CFR 435.110

1. Recipients of AFDC

The approved State AFDC plan includes:

☒ Families with an unemployed parent for the mandatory 6-month period and an optional extension of 6 months. (12 months per calendar year – see A.3)

☒ Pregnant women with no other eligible children.

☒ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of **Attachment 2.6-A**.

42 CFR 435.115

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered and Agencies Responsible for Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

2. Deemed Recipients of AFDC

1902 (a) (10) (A) (i) (I) of the Act

b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC is there were no work supplementation program, in accordance with section 482 (e) (6) of the Act.

402 (a) (22) (A) the Act

c. Individuals whose AFDC payments are reduced to zero by reason of of recovery of overpayment of AFDC funds.

406 (h) and 1902 (a) (10) (A) (i) (I) of the Act

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of Section 406 (h) of the Act.

1902 (a) of the Act

e. Individuals deemed to be receiving AFDC who meet the requirements of Section 473 (b) (1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

A.2.b and A.2.c superseded by TN-013-024 MMDL

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered and Agencies Responsible for Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

407 (b), 1902 (a) (10) (A) (i) and 1905 (m) (l) of the Act

3. Qualified Family Members

Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed.

☒ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.

1902 (a) (52) and 1925 of Act

4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve the months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

A.3. superseded by TN-013-024 MMDL

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered and Agencies Responsible for Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

   a. Families denied AFDC solely because of income and resources deemed to be available from –

      (1) stepparents who are not legally liable for support of stepchildren under a state law of general applicability;

      (2) grandparents;

      (3) legal guardians; and

      (4) individual alien sponsors (who are not spouses of the individual or the individual's parent);

   b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

   c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

Superseded by TN-013-024

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered and Agencies Responsible for Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

☒ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this state's August 1972 plan).

☒ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; state did or does not cover this service.

1902 (a) (10) (A) (i) (III) and 1905 (n) of the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who --

(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered and Agencies Responsible for Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the state had an AFDC-unemployed parents program; or

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the state's approved AFDC plan.

1902 (a) (10) (A) (i) (III) and 1905 (n) of the

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

☒ Children born after 10/01/81 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the state's approved AFDC plan.

Superseded by TN-013-024 MMDL

Citation(s)

Group Covered and Agencies Responsible for Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1902 (a) (10) (A) (i) (IV) and 1902 (l) (l) (A) and (B) of the Act

8. Pregnant woman and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in Section 1902 (a) (10) (A) (i) (IV) and 1902 (l) (1) (A) and (B) of the Act. The income level for this group is specified in **Supplement 1 to Attachment 2.6-A**.

☒ The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State Plan, state legislation, or state appropriations as of December 19, 1989.

9. Children:

1902 (a) (10) (A) (i) (VI) 1902 (l) (l) (c) of the Act

a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

1902 (a) (10) (A) (i) and 1902 (l) (1) (D) of the Act

b. born after September 30, 1983, who have attained 6 years of age (VII) but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in **Supplement 1 to Attachment 2.6A.**

Citation(s)

Group Covered and Agencies Responsible for Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1902 (e) (5) of the Act

10. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902 (e) (6) the Act

11. A pregnant woman who would otherwise lose eligibility because of an of of increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

Citation(s) **Group Covered and Agencies Responsible for Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1902 (e) (4) of the Act

12. A child born to a woman who is eligible for and receiving Medicaid on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.

42 CFR 435.120

13. Aged, Blind, and Disabled Individuals Receiving Cash Assistance

☒ a. Individuals receiving SSI.

This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under Section 1619 (a) of the Act or considered to be receiving SSI under Section 1619 (b) of the Act.

☒ Aged

☒ Blind

☒ Disabled

Citation(s) **Group Covered and Agencies Responsible for Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

435.121

13. ☐ b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619 (a) of the Act or who meet the requirements for SSI status under section 1619 (b) (1) of the Act and who met the state's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619 (a) or met the requirements under Section 1619 (b) (1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619 (a) eligibility standard or the requirements of Section 1619 (b) of the Act.)

1619 (b) (1) of the Act

☐ Aged

☐ Blind

☐ Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in **Attachment 2.6-A**).

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1902 (a) (10) (A) (i) (II) and 1905 (q) of the Act

14. Qualified severely impaired blind and disabled individuals under age 65, who –

a. For the month preceding the first month of eligibility under the requirements of Section 1905 (q) (2) of the Act, received SSI, a State supplemental payment under Section 1616 of the Act or under Section 212 of P.L. 93-66 or benefits under Section 1619 (a) of the Act and were eligible for Medicaid; or

b. For the month of June 1987, were considered to be receiving SSI under Section 1619 (b) of the Act and were eligible for Medicaid. These individuals must –

(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;

(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;

(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under Section 1611 (b) of the Act;

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

☐ Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1619 (b) (3) of the Act

☐ The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435. 121. Individuals who qualify for benefits under Section 1619 (a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under Section 1619 (b) (1) of the Act and who met the state's more restrictive requirements in the month before the month they qualified for SSI under Section 1619 (a) or met the requirements of Section 1619 (b) (1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under Section 1619 (a) of the Act or meet the SSI requirements under Section 1619 (b) (1) of the Act.

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1634 (c) of the Act

15. Except in states that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who —

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under Section 202 (d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

☐ c. The State applies more restrictive eligibility requirements than those under SSI, and part of all the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

☐ d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

42 CFR 435.122

16. Except in states that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional state supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

42 CFR 435.130

17. Individuals receiving mandatory state supplements.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the state's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

☒ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

☒ Aged ☒ Blind

☒ Disabled

☐ Not Applicable. In December 1973, the essential spouse was not eligible for Medicaid.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

42 CFR 435.132

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they —

    a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and

    b. Remain institutionalized; and

    c. Continue to need institutional care.

42 CFR 435.133

20. Blind and disabled individuals who —

    a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and

    b. Were eligible for Medicaid in December 1973 as blind or disabled; and

    c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

42 CFR 435.134

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L.92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

☒ Includes persons who would have been eligible for cash assistance But had not applied in August 1972 (this group was included in this state's August 1972 plan).

☒ Includes persons who would have been eligible for cash assistance August, 1972 if not in a medical institution or intermediate care facility (this group was included in this state's August 1972 plan).

☐ Not applicable with respect to intermediate care facilities; the state. did or does not cover this service.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

42 CFR 435.135

22. Individuals who —

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under Section 215 (i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

☐ Not applicable with respect to individuals receiving only SSP because the state either does not make such payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the state applies more restrictive eligibility requirements than those under SSI.

☐ The state applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by Section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under Section 1634 (b) of the Act.

☐ Not applicable with respect to individuals receiving only SSP because the state either does not make these payments or does not provide Medicaid to SSP-only recipients.

☐ The state applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

* Agency that determines eligibility for coverage.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

A. **Mandatory Coverage – Categorically Needy and Other Required Special Groups** (cont.)

1634 (d) of the Act

24. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for purposes of title XIX, to be SSI beneficiaries under Section 1634 (d) of the Act.

☐ Not applicable with respect to individuals receiving only SSP because the state either does not make these payments or does not provide Medicaid to SSP-only recipients.

☐ Not applicable because the state applies more restrictive eligibility than those under SSI and the state chooses SSI/SSP ineligibility or subsequent cost-of-living increases.

☐ The state applies more restrictive eligibility requirements than those under SSI and part of all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

* Agency that determines eligibility for coverage.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Group Covered and Agencies Responsible For Eligibility Determinations

Citation(s)

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (cont.)

1902 (a) (10) (E) (i) and 1905 (p) of the Act

25. Qualified Medicare beneficiaries —

a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under Section 1818A of the Act);

b. Whose income does not exceed 100 percent of the Federal poverty level; and

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical assistance for this group is limited to Medicare cost sharing as defined in item 3.2 of this plan.)

1902 (a) (10) (E) (ii), 1905 (s) and 1905 (p) (3) (A) (i) of the Act

26. Qualified Disabled and Working Individuals —

a. Who are entitled to hospital insurance benefits under Medicare Part A under Section 1818A of the Act;

b. Whose income does not exceed 200 percent of the Federal poverty level;

c. Whose resources do not exceed two times the SSI resource limit; and

d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

(Medical assistance for this group is limited to Medicare Part A premiums under Section 1818A of the Act.)

* Agency that determines eligibility for coverage.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Group Covered and Agencies Responsible For Eligibility Determinations

Citation(s)

A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (cont.)

1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act

27. Specified low-income Medicare beneficiaries —

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under Section 1818A of the Act);

b. Whose income is greater than100 percent but less than 120 percent of the Federal poverty level; and

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(Medical assistance for this group is limited to Medicare Part B premiums under Section 1839 of the Act)

1902 (a) (10) (E) (iv) and 1905 (p) (3) (A) (ii) and 1860D-14(a) (3) (D) of the Act

28. Qualifying Individuals —

a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level; and

c. whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.210 (a) (10) (A) (ii)and 1905 (a) of the Act

☒ 1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional state supplement as 1902 specified in 42 CFR 435.230, but who do not receive cash assistance.

☐ The plan covers all individuals as described above

☒ The plan covers only the following group or groups of individuals:

- ☒ Aged
- ☒ Blind
- ☒ Disabled
- ☒ Caretaker relatives
- ☒ Pregnant women
- ☒ Children under age of 21*

42 CFR 435.211

☒ 2. Individuals who would be eligible for AFDC, SSI or an optional state supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

* Effective 12/1/91, applies only to children under the age of 18.

B.1 for caretaker relatives, pregnant women and children superseded by TN-013-024 MMDL

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.212
1902 (e) (2)

☐ 3. The state deems as eligible those individuals who become otherwise and ineligible for Medicaid while enrolled in an HMO qualified under title XIII of the Public Health Service Act or while enrolled in an entity described in sections 1903 (m) (2) (B) (iii), (E), or (G) or 1903 (m) (6) of the Act, but who have been enrolled in the HMO or entity for less than the minimum enrollment period listed below. The HMO or entity must have a risk contract as specified in 42 CFR 434.20 (a). Coverage under this section is limited to HMO services and family planning services described in Section 1905 (a) (4) (C) of the Act.

The minimum enrollment period is _____(not to exceed six months).

The state measures the minimum enrollment period from:

☐ The date beginning the period of enrollment in the HMO or other entity, without any intervening disenrollment, regardless of Medicaid eligibility.

☐ The date beginning the period of enrollment in the HMO as a Medicaid patient (including periods when payment is made under this section) with any intervening disenrollment.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

☐ The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

42 CFR 435.217

☒ 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the state's Section 1915 (c) waiver under which this group(s) is covered. In the event an existing 1915 (c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

☒ PACE Enrollees

* Agency that determines eligibility for coverage.

Citation(s)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1902 (a) (10) (A) (ii) VII) of the Act

☒ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in Section 1905 (o) of the act.

☐ The state covers all individuals as described above.

☒ The state covers only the following group or groups of individuals:

☒ Aged
☒ Blind
☒ Disabled
☒ Individuals under the age of—
  ☒ 21*
  ☐ 20
  ☐ 19
  ☐ 18
☒ Caretaker relatives
☒ Pregnant women

* Prior to 12/31/13, applies to children under the age of 18.

Citation(s)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.220

☐ 6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a state agency as a service expenditure. The state's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

☐ The state covers all individuals as described above.

1902 (a) (10) (A) (ii) and 1905 (a) of the Act

☐ The state covers only the following group or groups of individuals:

☐ Individuals under the age of —

☐ 21
☐ 20
☐ 19
☐ 18

☐ Caretaker relatives
☐ Pregnant women

42 CFR 435.222
1902 (a) (10)(A) (ii)(I);
1902(a) (10) (A) (ii) (IV) and 1905 (a) (i) of the Act

7. ☒ a. All individuals who are not described in Section 1902 (a) (10) (A) (i) of the Act, who meet the income and resource requirements of the AFDC State Plan, and who are under the age of:

☒ 21*
☐ 20
☐ 19
☐ 18 .

* Prior to 12/31/13, applies to children under age 18

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.222

☐ b. Reasonable classifications of individuals described in (a) above, as follows:

☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

☐ (a) In foster homes (and are under the age of ____).

☐ (b) In private institutions (and are under the age of ____).

☐ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).

☐ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).

☐ (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.

☐ (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of ____).

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

☐ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

☐ (6) Other defined groups (and ages), as specified in Supplement 1 of **Attachment 2.2-A**.

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1902 (a) (10) (A) (ii) (VIII) of the Act

☒ 8. A child for whom there is in effect a state adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the state adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement —

a. Was eligible for Medicaid under the state's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The State covers individuals under the age of —

☒ 21
☐ 20
☐ 19
☒ 18* effective 12/1/91, applies to children under age 18

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.223

☐ 9. Individuals described below who would be eligible for AFDC if coverage under the state's AFDC plan were as broad as allowed under Title IV-A:

1902 (a) (10) (A) (ii) and 1905 (a) of the Act

☐ Individuals under the age of —

- ☐ 21
- ☐ 20
- ☐ 19
- ☐ 18

☐ Caretaker relatives
☐ Pregnant women

* Agency that determines eligibility for coverage.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination**

B. **Optional Groups Other Than the Medically Needy**

42 CFR 345.230 ☒ 10. States use SSI criteria with agreements under Section 1634 of the Act

The following groups of individuals who receive only a state supplementary payment (but no SSI payment) under an approved optional state supplementary payment program that meets the following conditions. The supplement is —

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the state.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

☒ (1) All aged individuals.

☒ (2) All blind individuals.

☒ (3) All disabled individuals.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.230

☒ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☒ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

☒ (6) Disabled individuals in domiciliary facilities or other group living arrangement as defined under SSI.

☐ (7) Individuals receiving a Federally administered optional state supplement that meets the conditions specified in 42 CFR 435.230.

☐ (8) Individuals receiving a state administered optional state supplement that meets the conditions specified in 42 CFR 435.230.

☐ (9) Individuals in additional classifications approved by the Secretary as follows:

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes

☒ No

The standards for optional state supplementary payments are listed in Supplement 6 of **Attachment 2.6-A**.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination**

B. **Optional Groups Other Than the Medically Needy**

42 CFR 435.120
435.121, 435.230
1902 (a) (10)
(A) (ii) (XI)of the Act

☒ 11. Section 1902 (f) states and SSI criteria states without agreements under Section 1616 of the Act

The following groups of individuals who receive a state supplementary payment under an approved optional state supplementary payment program that meets the following conditions. The supplement is —

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

☒ (1) All aged individuals.

☒ (2) All blind individuals.

☒ (3) All disabled individuals.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

- ☐ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI
- ☐ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- ☐ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
- ☐ (7) Individuals receiving federally administered optional state supplement that meets the conditions specified in 42 CFR 435.230.
- ☐ (8) Individuals receiving a state administered optional state supplement that meets the conditions specified in 42 CFR 435.230.
- ☐ (9) Individuals in additional classifications approved by the Secretary as follows:

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

☐ Yes

☐ No

The standards for optional state supplementary payments are listed in Supplement 6 of **Attachment 2.6-A**.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

42 CFR 435.231
1902 (a) (10) (A) (ii) (V) of the Act

☒ 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in **Supplement 1 to Attachment 2.6-A**.

☐ The state covers all individuals as described above.

☒ The state covers only the following groups or groups of individuals:

1902 (a) (10) (A) (ii) and 1905 (a) of the Act

☒ Aged
☒ Blind
☒ Disabled
☒ Individuals under the age of —

☒ 21 *effective 12/1/91, applies to children under age 18
☐ 20
☐ 19
☒ 18
☒ Caretaker relatives
☒ Pregnant women

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1902 (e) (3) of the Act

☒ 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the state has made a determination as required under Section 1902 (e) (3) (B) of the Act.

Supplement 3 to Attachment 2.2-A describes the method that is used to determine the cost effectiveness of caring of this group of disabled children at home.

1902 (a) (10) (A) (ii) (IX) and 1902 (l) of the Act

☐ 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in **Supplement 1 to Attachment 2.6-A** for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in **Supplement 2 to Attachment 2.6-A**:

a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and

b. Infants under one year of age.

B.14 superseded by TN 013-024 MMDL

Item 15 page is reserved for future use.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1902 (a) (10) (A) (ii) (X) and 1902 (m) (1) and (3) of the Act

☒ 16. Individuals —

a. Who are 65 years age or older or are disabled, as determined under Section 1614 (a) (3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in **Supplement 1 to Attachment 2.6-A** for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the state's more restrictive financial criteria; or under the state's medically needy program as specified in **Attachment 2.6-A**.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1902 (a) (47) and 1920 of the Act

☒ 17. Pregnant women who are determined by a "qualified provider" (as defined in Section 1920 (b) (2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under **Attachment 2.6-A** and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with Section 1920 of the Act.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1906 of the Act

18. Individuals required to enroll in cost-effective employer-based Act group health plans remain eligible for a minimum enrollment period of **six** months.

1902 (a) (10) (F) and 1902 (u) (l) of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the state determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See **Supplement 11 to Attachment 2.6-A**.

Citation(s)

B. **Optional Groups Other Than the Medically Needy** (cont.)

1902(a)(10)(A)(ii)(XVII) ☒ 20. All "Independent foster care adolescents" under 21 years of age (as defined in §1905(w) (1) of the Social Security Act)

and
1905 (w) (l) of the Act

a) Reasonable classification of individuals as follows:

☐1) Individuals under the age of

☐19
☐20

☐2) Individuals to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of Title IV before the date the individuals attained 18 years of age.

☐3) Other (please describe):

_____

b) Financial requirements

1) Income test

☒ There is no income test for this group

☐ The income test for this group is

_____

2) Resource test

☒ There is no resource test for this group

☐ The resource test for this group is

_____

Note:

If there is an income or resource test, then the standards and methodologies used cannot be more restrictive than those used for the State's low-income families with children eligible under section 1931 of the Act as specified in Supplement 12 of Attachment 2.6-A.

Citation(s)

Group Covered And Agencies Responsible For Eligibility Determination (cont.)

C. **Optional Coverage of the Medically Needy**

42 CFR 435.301

This plan includes the medically needy.

☐ No
☒ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902 (e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902 (a) (10) (C) (ii) (I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under Section 1902 (a) (10) (A) (i) of the Act.

Citation(s)

C. **Optional Coverage of the Medically Needy** (cont.)

1902 (e) (4) of the Act

4. Newborn children born on or after October 1, 1984 to a woman who is eligible as medically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible for one year so long as the woman remains or if pregnant would remain eligible and the child is a member of the woman's household.

42 CFR 435.308

5. ☒ a. Financially eligible individuals who are not described in Section C.3. above and who are under the age of —

☒ 21*
☐ 20
☐ 19
☐ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

☐ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

☐ (a) In foster homes (and are under the age of ____).

☐ (b) In private institutions (and are under the age of ____).

* Prior to 12/31/13, applies to children under the age of 18.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

C. **Optional Coverage of the Medically Needy** (cont.)

☐ (c) In addition to the group under b. (1) (a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ____).

☐ (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ____).

☐ (3) Individuals in NFs (who are under the age of ____). NF services are provided under this plan.

☐ (4) In addition to the group under (b) (3), individuals in ICFs/MR (who are under the age of ____).

☐ (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

☐ (6) Other defined groups (and ages), as specified in **Supplement 1 of Attachment 2.2-A**.

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

C. **Optional Coverage of the Medically Needy** (cont.)

42 CFR 435.310	☒	6.	Caretaker relatives.
42 CFR 435.320 and 435.330	☒	7.	Aged individuals.
42 CFR 435.322 and 435.330	☒	8.	Blind individuals.
42 CFR 435.324 and 435.330	☒	9.	Disabled individuals.
42 CFR 435.326	☐	10.	Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
435.340		11.	Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

* Agency that determines eligibility for coverage

Citation(s) **Group Covered And Agencies Responsible For Eligibility Determination** (cont.)

C. **Optional Coverage of the Medically Needy** (cont.)

1906 of the Act

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of six months.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Coverage and Eligibility

Requirements Relating to Determining Eligibility for Medicare Prescription Drug Low-Income Subsidies

Agency	Citation(s)	Group Covered
	1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.

Reasonable Classifications of Individuals under the Age of 21, 20, 19, and 18

(not applicable)

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home

For each applicant to the Kaileigh Mulligan Home Care for Disabled Children Program, the state estimates and compares expenditures for the child's care if Medicaid was to be the only payor in the institution or in the child's place of residence. The state must determine that the estimated cost of care that would be expened for medical assistance for the child for care outside an institution is not greater than the estimated amount that would otherwise be expanded for medical assistance for the child within an appropriate institution. Each eligible child is reviewed annually in the same manner.

I. **Estimating Institutional Costs**

The Department has identified the medical institutions in Massachusetts in which severely disabled children would otherwise reside if home-based care were not available. These institutions can be categorized by the level of medical care provided as either acute hospital, chronic hospital or pediatric nursing care facility.

(A) Acute Hospital – Date was retrieved from the primary hospitals statewide in which Medicaid-eligible children might reside on a long-term basis. Patient claims were reviewed for a fiscal year with the following characteristics: (a) birth to 18 years of age; (b) length of stay 30 days or more; (c) specific diagnostic codes common to severe disabling conditions; and (d) no other health insurance coverage present.

Calculation:

Total of all expenditures associated with hospitalization - total number of inpatient days billed

= average amount spent per diem for each patient (inflated to next fiscal year)

(B) Chronic Hospital – Data was retrieved from all chronic hospitals statewide for all patients for a fiscal year.

Calculation:

Total of all expenditures (per diem + ancillaries) - total number of days billed

= average amount spent per diem for each patient (inflated to next fiscal year)

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children at Home (cont.)

(C) Pediatric Nursing Care Facility – Per diem rates were retrieved from the four pediatric nursing facilities statewide reflecting patients with the most complex nursing care needs for a fiscal year.

Calculation:

Total of 4 per diem rates - Number of pediatric facilities (i.e. 4)

= average amount spent per diem for each patient (inflated to next fiscal year)

II. **Estimating Medical Care Outside an Institution**

The Department is able to identify medical care needs for each program applicant through information received in the program application and medical records.

(A) Specific services such as nursing (total hours), physician and/or therapy visits are identified. Estimated frequency of units to be used for each service and estimated costs associated with usage are recorded.

(B) Need for medical equipment (items an average cost of $100 or more per month) is identified and average costs are assigned to each item listed.

(C) Average aggregate costs are assigned to general categories of pharmacy and medical supplies for each applicant at either the acute or chronic hospital, or pediatric nursing home levels of care. (Costs are based on the average usage of such specific items for children at each level of care as estimated over a fiscal year and then inflated in new fiscal years.)

(D) All estimates of costs for services, equipment, and pharmacy items to be used by the applicant are totaled.

III. **Comparing Costs**

Estimated non-institutional costs for each applicant are compared to the estimated costs in the appropriate institution. Each applicant's medical care costs must be less in the non-institutional setting than the estimated costs in the appropriate institution.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Citation(s)

A. **General Conditions of Eligibility**

Each individual covered under the plan:

42 CFR Part 435, Subpart G

1. is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.

42 CFR Part 435, Subpart F

2. meets the applicable non-financial eligibility conditions.

a. For the categorically needy:

(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.

(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.

1902 (l) of the Act

(iii) For financially eligible pregnant women, infants, or children covered under sections 1902 (a) (10) (A) (i) (IV), 1902 (a) (10) (A) (i) (VI), 1902 (a) (10) (A) (i) (VII), and 1902 (a) (10) (A) (ii) (IX) of the Act, meets the non-financial criteria of section 1902 (l) of the Act.

1902 (m) of the Act

(iv) For financially eligible aged and disabled individuals covered under section 1902 (a) (10) (A) (ii) (X) of the Act, meets the non-financial criteria of section 1902 (m) of the Act.

A.2.a(i) and (iii) superseded by TN 013-024 MMDL

Citation(s)

A. General Conditions of Eligibility (cont.)

b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.

1905 (p) of the Act

c. For financially eligible qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act, meets the non-financial criteria of section 1905 (p) of the Act.

1905 (s) of the Act

d. For financially eligible qualified disabled and working individuals covered under section 1902 (a) (10) (E) (ii) of the Act, meets the non-financial criteria of section 1905 (s).

Citation(s)	Condition or Requirement

42 CFR 435.406 3. Is residing in the United States (U.S.), and--

a. Is a citizen or national of the United States;

b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;

c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;

e. Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.
☒ State covers all authorized QAs.
☐ State does not cover authorized QAs.

f. State elects CHIPRA option to provide full Medicaid coverage to otherwise eligible pregnant women or children as specified below who are aliens lawfully residing in the United States; including the following:

(1) A "Qualified alien" otherwise subject to the 5-year waiting period per section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
(2) A citizen of a Compact of Free Association State (i.e., Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau) who has been admitted to the U.S. as a non-immigrant and is permitted by the Department of Homeland Security to reside permanently or indefinitely in the U.S.;
(3) An individual described in 8 CFR section 103.12(a)(4) who does not have a permanent residence in the country of their nationality and is in a status that permits the individual to remain in the U.S. for an indefinite period of time, pending adjustment of status. These individuals include:
   (a) An individual currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
   (b) An individual currently under Temporary Protected Status pursuant to section 244 of the INA;
   (c) A family Unity beneficiary pursuant to section 301 of Public Law 101-649 as amended by, as well as pursuant to, section 1504 of Public Law 106-554;

(d) An individual currently under Deferred Enforced Departure pursuant to a decision made by the President; and

(e) An individual who is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status; and

(4) An individual in non-immigrant classifications under the INA who is permitted to remain in the U.S. for an indefinite period, including the following as specified in section 101(a)(15) of the INA:

- A parent or child of an individual with special immigrant status under section 101(a)(27) of the INA, as permitted under section 101(a)(15)(N) of the INA;
- A Fiancé of a citizen, as permitted under section 101(a)(15)(K) of the INA;
- A religious worker under section 101(a)(15)(R);
- An individual assisting the Department of Justice in a criminal investigation, as permitted under section 101(a)(15)(S) of the INA;
- A battered alien under section 101(a)(15)(U) (see also section 431 as amended by PRWORA); and
- An individual with a petition pending for 3 years or more, as permitted under section 101(a)(15)(V) of the INA.

☒ Elected for pregnant women
☒ Elected for children under age 19

g. ☒ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

Item 3 Superseded by TN-013-028 MMDL

Citation(s)

A. General Conditions of Eligibility (cont.)

d. Is an alien granted lawful temporary resident status under section 210 of the Immigration and Nationality Act not within the scope of c. above (coverage must be restricted to certain emergency services during the five-year period beginning on the date the alien was granted such status); or

e. Is an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (coverage must be restricted to certain emergency services).

42 CFR 435.403
1902 (b) of the Act

4. Is a resident of the state, regardless of whether or not the individual maintains the residence permanently or maintains it at a fixed address.

☐ State has interstate residency agreement with the following states:

☐ State has open agreement(s).

☐ Not applicable; no residency requirement.

Item 3d and 3e superseded by TN-013-028 MMDL

Item 4 Superseded by TN-013-018 MMDL

Citation(s) **A. General Conditions of Eligibility** (cont.)

42 CFR 435.1008

5. a. Is not a inmate of a public institution. Public institutions do not include medical institutions, intermediate care facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.

42 CFR 435.1008
1905 (a) of the Act

b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.

☐ Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.

42 CFR 433.145
the 1912 of the Act

6. Is required, as a condition of eligibility, to assign his or her own rights, or rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

Citation(s)

A. General Conditions of Eligibility (cont.)

An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself of herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902 (l) (l) (A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

☐ Assignment of rights is automatic because of State law.

42 CFR 435.910

7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

Citation(s)

A. General Conditions of Eligibility (cont.)

1902 (c) (2)

8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902 (a) (10) (A) (i) (IV) and 1902 (a) (10) (A) (ii) (IX) of the Act.

1902 (e) (10) (A) and (B) of the Act

9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402 (a) (43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

Citation(s)

A. General Conditions of Eligibility (cont.)

1906 of the Act

10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

Citation(s)

B. Post-Eligibility Treatment of Institutionalized Individuals' Incomes

1. The following items are not considered in the post-eligibility process:

1902 (o) of the Act

a. SSI and SSP benefits paid under §1611 (e) (l) (E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.

Bondi v Sullivan (SSI)

b. Austrian Reparation Payments (pension (reparation) payments made under §500-506 of the Austrian General Social Insurance Act). Applies only if state follows SSI program rules with respect to the payments.

1902 (r) (l) of the Act

c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).

105/206 of P.L. 100-383

d. Japanese and Aleutian Restitution Payments.

1. (a) of P.L. 103-286

e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).

10405 of 101-239

f. Payments from the Agent Orange Settlement Fund or any other P.L. fund established pursuant to the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)

6 (h) (2) of P.L. 101-426

g. Radiation Exposure Compensation.

12005 of P.L. 103-66

h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

Citation(s)

B. Post-Eligibility Treatment of Institutionalized Individual's Incomes (cont.)

1924 of the Act
435.725
435.733
435.832

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than $30 for individuals and $60 for couples for all institutionalized persons.

a. Aged, blind, disabled:

Individuals $60.00
Couples $120.00

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met

b. AFDC related:

Children $60.00
Adults $60.00

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit that determines that a criterion is met.

c. Individual under age 21 covered in the State Plan as specified in item B.7. of **Attachment 2.2-A**:

$60.00.

Citation(s)

B. Post-Eligibility Treatment of Institutionalized Individual's Incomes (cont.)

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater needs; describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in section 1924 (d) (2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in section 1924 (d) (3) (C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

☒ The poverty level component is calculated using the applicable percentage (set out section 1924 (d) (3) (B) of the Act) of the official poverty level.

☐ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____% of the official poverty level (still subject to maximum maintenance needs standard).

☐ The maintenance needs standard for all community spouses is set at the maximum permitted by section 1924 (d) (3) (C).

Except that, when applicable, the state will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Citation(s) **B. Post-Eligibility Treatment of Institutionalized Individual's Incomes** (cont.)

In determining any excess shelter allowance, utility expenses are calculated using:

☒ the standard utility allowance under section 5 (e) of the Food Stamp Act of 1977; or

☐ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

☒ one-third of the amount by which the poverty level component (calculated under section 1924 (d) (3) (A) (i) of the Act, using the applicable percentage specified in section 1924 (d) (3) (B)) exceeds the dependent family member's monthly income.

☐ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under section 1924 (d) (1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, coinsurance charges, or copayments.

(ii) Necessary medical or remedial cares recognized under state law but not covered under the State Plan*. (Reasonable limits on amounts are described in **Supplement 3 to Attachment 2.6-A**).

* These expenses include, but are not limited to guardianship services and related expenses that are essential to access or consent to medical treatment. See decision of Massachusetts' highest court in Rudow v. Commissioner, Division of Medical Assistance, 202 N.E.2d 339 (Mass. 1999).

Citation(s)

B. Post-Eligibility Treatment of Institutionalized Individual's Incomes (cont.)

435.725
435.733
435.832

4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:

a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:

☐ AFDC level; or
☐ Medically needy level:

(check one)

☐ AFDC levels in Supplement 1
☒ Medically needy level in Supplement 1
☐ Other: $_____

b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse) are incurred by and for the institutionalized individual or institutionalized couple and are not subject to the payment by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under state law but not covered under the State Plan. (Reasonable limits on amount are described in **Supplement 3 to Attachment 2.6-A**)

435.725
from 435.733
435.832

5. At the option of the state, as specified below, the following is deducted any remaining monthly income of an institutionalized individual or an institutionalized couple:

A monthly amount for the maintenance of the home of the individual or couple for not longer than six months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:

☐ No
☒ Yes (the applicable amount is shown on page 5a.)

Citation(s) **B. Post-Eligibility Treatment of Institutionalized Individuals' Incomes** (cont.)

☒* Amount for maintenance of home is:
$(100% of the federal-poverty-level for a single person)

☐ Amount for maintenance of home is the actual maintenance costs not to exceed $____.

☐ Amount for maintenance of home is deductible when countable income is determined under section 1924 (d) (1) of the Act only if the individual's home and the community spouse's home are different.

☒ Amount for maintenance of home is not deductible when countable income is determined under section 1924 (d) (l) of the Act.

* A deduction for maintenance of a home is allowed when a physician certifies in writing that a single individual, with no eligible dependents in the home, is likely to return home within six months from the month of admission. This income deduction terminates at the end of the sixth month following the month of admission regardless of the prognosis to return home at that time. The amount to be deducted shall be the federal-poverty-level income standard for one person.

Citation(s)

C. Financial Eligibility

42 CFR 435.711
435.721, 435.831

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902 (f) of the Act, or more liberal methods under section 1902 (r) (2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients in a non-section 1902 (f) state and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

Supplement 1 to Attachment 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the federal income poverty level—pregnant women and infants or children covered under sections 1902 (a) (10) (A) (i) (IV), 1902 (a) (10) (A) (i) (VI), 1902 (a) (10) (A) (i) (VII), and 1902 (a) (10) (A) (ii) (IX) of the Act and aged and disabled individuals covered under section 1902 (a) (10) (A) (ii) (X) of the Act—and for mandatory groups of qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act.

Language related to categorically needy AFDC recipients, pregnant women, infants and children superseded by TN 013-024 MMDL

Citation(s)

C. Financial Eligibility (cont.)

☒ Supplement 2 to Attachment 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

☐ Supplement 7 to Attachment 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.

☐ Supplement 4 to Attachment 2.6-A specifies the methods for determining income eligibility used by states that have more restrictive methods than SSI, permitted under section 1902 (f) of the Act.

☐ Supplement 5 to Attachment 2.6-A specifies the methods for determining resource eligibility used by states that have more restrictive methods than SSI, permitted under section 1902 (f) of the Act.

☒ Supplement 8a to Attachment 2.6-A specifies the methods for determining income eligibility used by states that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.

☒ Supplement 8b to Attachment 2.6-A specifies the methods for determining resource eligibility used by states that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.

Citation(s)

C. Financial Eligibility (cont.)

1902 (r) (2) of the Act

1. **Methods of Determining Income**

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable income for AFDC-related individuals, the following methods are used:

☐ (a) the methods under the state's approved AFDC plan only; or

☒ (b) the methods under the state's approved AFDC plan and/or any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

1902 (e) (6) the Act

(3) Agency continues to treat women eligible under the provisions of sections 1902 (a) (10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

1.a.(1) and (2) superseded by TN 013-024 MMDL

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Citation(s) **C. Financial Eligibility** (cont.)

42 CFR 435.721
435.831, and
1902 (m) (l) (B) (m) (4)
and 1902 (r) (2)
of the Act

b. Aged individuals. In determining countable income for aged individuals including aged individuals with incomes up to the federal poverty level described in section 1902 (m) (l) of the Act, the following methods are used:

☐ The methods of the SSI program only.

☒ The methods of the SSI program and/or any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

Citation(s) **C. Financial Eligibility** (cont.)

☐ For individuals other than optional state supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902 (f) of the Act, as specified in **Supplement 4 to Attachment 2.6-A**; and any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

☒ For institutional couples, the methods specified under section 1611 (e) (5) of the Act.

☐ For optional state supplement recipients under section 435.230, income methods more liberal than SSI, as specified in **Supplement 4 to Attachment 2.6-A**.

☐ For optional state supplement recipients in section 1902 (f) states and SSI criteria states without section 1616 or 1634 agreements —

- ☐ SSI methods only.
- ☐ SSI methods and/or any more liberal methods than SSI described in **Supplement 8a to Attachment 2.6-A**.
- ☐ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in **Supplement 4 to Attachment 2.6-A** and more liberal method are described in **Supplement 8a to Attachment 2.6-A**.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

Citation(s)

C. Financial Eligibility (cont.)

42 CFR 435.721 and 435.831
1902 (m) (l) (B), (m) (4), and 1902 (r) (2) of the Act

c. Blind Individuals. In determining countable income for blind individuals, the following methods are used:

☐ The methods of the SSI program only.

☒ SSI methods and/or any more liberal methods described in **Supplement 8a to Attachment 2.6-A**

☐ For individuals other than optional state supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902 (f) of the Act, as specified in **Supplement 4 to Attachment 2.6-A**, any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

☒ For institutional couples, the methods specified under section 1611 (e) (5) of the Act.

☐ For optional state supplement recipients under §435.230, income methods more liberal than SSI, as specified in **Supplement 4 to Attachment 2.6-A**.

☐ For optional state supplement recipients in section 1902 (f) states and SSI criteria states without section 1616 or 1634 agreements--

☐ SSI methods only.

☐ SSI methods and/or any more liberal methods than SSI described in **Supplement 8a to Attachment 2.6-A**.

☐ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in **Supplement 4 to Attachment 2.6-A** and more liberal methods are described in **Supplement 8a to Attachment 2.6-A**.

Citation(s)

C. Financial Eligibility (cont.)

In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

42 CFR 435.721, and 435.831
1902 (m) (l) (B) (m) (4), and 1902 (r) (2) of the Act

d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the federal poverty level described in section 1902 (m) of the Act the following methods are used:

☐ The methods of the SSI program.

☒ SSI methods and/or any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

☒ For institutional couples: the methods specified under section 1611 (e) (5) of the Act.

☐ For optional state supplement recipients under section 435.230: income methods more liberal than SSI, as specified in **Supplement 4 to Attachment 2.6-A**.

☐ For individuals other than optional state supplement recipients (except aged and disabled individuals described in section 1902 (m) (l), of the Act): more restrictive methods than SSI, applied under the provisions of section 1902 (f) of the Act, as specified in **Supplement 4 to Attachment 2.6-A**; and any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

Citation(s)

C. Financial Eligibility (cont.)

☐ For optional state supplement recipients in section 1902 (f) states and SSI criteria states without section 1616 or 1634 agreements—

☐ SSI methods only.

☐ SSI methods and/or any more liberal methods than SSI described in **Supplement 8a to Attachment 2.6-A**.

☐ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902 (m) (l) of the Act. More restrictive methods are described in **Supplement 4 to Attachment 2.6-A** and more liberal methods are specified in **Supplement 8a to Attachment 2.6-A**.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

Citation(s)

C. Financial Eligibility (cont.)

1902 (l) (3) (E) and 1902 (r) (2) of the Act

e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902 (a) (10) (A) (i) (IV), (VI), and (VIII), and 1902 (a) (10) (A) (ii) (IX) of the Act —

(1) The following methods are used in determining countable income:

☐ The methods of the state's approved AFDC plan.

☐ The methods of the approved title IV-E plan.

☒ The methods of the approved AFDC State Plan and/or any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

☐ The methods of the approved Title IV-E plan and/or any more liberal methods described in **Supplement 8a to Attachment 2.6-A**.

Citation(s) **C. Financial Eligibility** (cont.)

(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

1902 (e) (6) of the Act

(3) The agency continues to treat women eligible under provisions of sections 1902 (a) (10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

1905 (p) (l), 1902 (m) (4), and 1902 (r) (2) of the Act

f. Qualified Medicare Beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act, the following methods are used:

☐ The methods of the SSI program only.

☒ SSI methods and/or any more liberal methods than SSI described in **Supplement 8a to Attachment 2.6-A**.

☒ For institutional couples, the methods specified under section 1611 (e) (5) of the Act.

C.1.e (2) superseded by TN 013-024 MMDL

Citation(s) **C. Financial Eligibility** (cont.)

If an individual receives a Title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a Title II COLA is not counted as income during a "transition period" beginning with January, when the Title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual federal poverty level.

For individuals with Title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving Title II income, the revised poverty levels are effective no later than the date of publication.

1905 (s) of the Act

g. (1) Qualified disabled and working individuals.

In determining countable income for qualified disabled and working individuals covered under 1902 (a) (10) (E) (ii) of the Act, the methods of the SSI program are used.

1905 (p) of

(2) Specified low-income Medicare beneficiaries.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902 (a) (10) (E) (iii) of the Act, the same method as in f. is used.

Citation(s)

C. Financial Eligibility (cont.)

1902 (u) of the Act

h. COBRA Continuation Beneficiaries

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

☒ The disregards of the SSI program;

☐ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

NOTE: For COBRA continuation beneficiaries specified at 1902 (u) (4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612 (b) (4) (B) (ii).

Citation(s)

C. Financial Eligibility (cont.)

1902 (k) of the Act

2. Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902 (k) (2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

☐ The agency does not count the funds in a trust as described above in any instance where the state determines that it would work an undue hardship. **Supplement 10 of Attachment 2.6-A** specifies what constitutes an undue hardship.

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

3. Medically needy income levels (MNILs) are based on family size.

Supplement 1 to Attachment 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902 (f) of the Act, **Supplement 1** so indicates.

Citation(s)

C. Financial Eligibility (cont.)

42 CFR 435.732, 435.831

4. Handling of Excess Income – Spend-down for the Medically Needy in All States and the Categorically Needy in 1902 (f) States only

a. Medically Needy

(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either six or one month(s) (not to exceed six months) to determine the amount of excess countable income applicable to the cost of medical care and services.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

(a) Health insurance premiums, deductibles, and coinsurance charges.

(b) Expenses for necessary medical and remedial care not included in the plan.

(c) Expenses for necessary medical and remedial care included in the plan.

☐ Reasonable limits on amounts of expenses deducted from income under a. (2) (a) and (b) above are listed below.

1902 (a) (17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a state or local government.

Citation(s)

C. Financial Eligibility (cont.)

1903 (f) (2) of the Act

a. Medically Needy (continued)

☐ (3) If countable income exceeds the MNIL standard, the agency deducts spend-down payments made to the state by the individual.

Citation(s)

C. Financial Eligibility (cont.)

42 CFR 435.732

b. Categorically Needy – Section 1902 (f) States

The agency applies the following policy under the provisions of section 1902 (f) of the Act. The following amounts are deducted from income to determine the individual's countable income:

(1) Any SSI benefit received.

(2) Any state supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a state supplement 1902 (a) (10) (A) (ii) (XI) or the Act.

(3) Increases in OASDI that are deducted under sections 435.134 and 435.135 for individuals specified in that section, in the manner elected by the state under that section.

(4) Other deductions from income described in this State Plan at **Attachment 2.6-A, Supplement 4.**

(5) Incurred expenses for necessary medical and remedial services recognized under state law.

1902 (a) (17) of the Act, P.L. 100-203

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a state or local government.

Citation(s)

C. Financial Eligibility (cont.)

4.b. Categorically Needy – Section 1902 (f) States (continued)

1903 (f) (2) of of the Act

☐ (6) Spend down payments made to the State by the individual.

NOTE: FFP will be reduced to the extent a state is paid a spenddown payment by the individual.

Citation(s)

C. Financial Eligibility (cont.)

5. Methods For Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the state's approved AFDC plan; and

☒ (b) The methods under the state's approved AFDC plan and/or any more liberal methods described in **Supplement 8b to Attachment 2.6-A.**

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation(s)

C. Financial Eligibility (cont.)

5. Methods For Determining Resources (cont.)

1902 (a) (10) (A), 1902 (a) (10) (C), 1902 (m) (l) (B) and (C), and 1902 of the Act

b. Aged individuals. For aged individuals covered under section 1902 (a) (10) (A) (ii) (X) of the Act, the agency used the following methods for treatment of resources:

☐ The methods of the SSI program.

☒ SSI methods and/or any more liberal methods described in **Supplement 8b to Attachment 2.6-A**.

☐ Methods that are more restrictive (except for individuals described in section 1902 (m) (l) of the Act) and/or more liberal than those of the SSI program. **Supplement 5 to Attachment 2.6-A** describes the more restrictive methods and **Supplement 8b to Attachment 2.6-A** specifies the more liberal methods.

Citation(s)

C. Financial Eligibility (cont.)

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

c. Blind individuals. For blind individuals, the agency uses the following methods for treatment of resources:

☐ The methods of the SSI program.

☒ SSI methods and/or any more liberal methods described in **Supplement 8b to Attachment 2.6-A.**

☐ Methods that are more restrictive and/or more liberal than those of the SSI program. **Supplement 5 to Attachment 2.6-A** describe the more restrictive methods and **Supplement 8b to Attachment 2.6-A** describe the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation(s) **C. Financial Eligibility** (cont.)

1902 (a) (10) (A), 1902 (a) (10) (C), 1902 (m) (l) (B) and (C), and 1902 (r) (2) of the Act

d. Disabled individuals, including individuals covered under section 1902 (a) (10) (A) (ii) (X) of the Act. The agency uses the following:

☐ The methods of the SSI program.

☒ SSI methods and/or any more liberal methods described in **Supplement 8b to Attachment 2.6-A**.

☐ Methods that are more restrictive (except for individuals described in section 1902 (m) (l) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in **Supplement 5 to Attachment 2.6-A** and more liberal methods are specified in **Supplement 8b to Attachment 2.6-A**.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

1902 (l) (3) and 1902 (r) (2) of the Act

e. Poverty level pregnant women covered under sections 1902 (a) (10) (A) (i) (IV) and 1902 (a) (10) (A) (ii) (IX) (A) of the Act.

The agency uses the following methods in the treatment of resources.

☐ The methods o f the SSI program only.

☐ The methods of the SSI program and/or any more liberal methods described in **Supplement 5a or Supplement 8b to Attachment 2.6-A**.

C.5.e superseded by TN 013-024 MMDL

Citation(s) **C. Financial Eligibility** (cont.)

☐ Methods that are more liberal than those of SSI. The more liberal methods are specified in **Supplement 5a or Supplement 8b to Attachment 2.6-A**.

☒ Not applicable. The agency does not consider resources in determining eligibility.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

1902 (l) (3) and 1902 (r) (2) of the Act

f. Poverty level infants covered under section 1902 (a) (10) (A) (i) (IV) of the Act.

The agency uses the following methods for the treatment of resources:

☐ The methods of the state's approved AFDC plan.

☐ Methods more liberal than those in the state's approved AFDC plan (but not more restrictive), in accordance with section 1902 (l) (3) (C) of the Act, as specified in **Supplement 5a of Attachment 2.6-A**.

1902 (l) (3) (C)

☐ Methods more liberal than those in the state's approved AFDC plan (but no more restrictive), in accordance with section 1902 (l) (3) (C) of the Act, as specified in **Supplement 5a or Supplement 8b to Attachment 2.6-A**.

1902 (r) (2) of the Act

☒ Not applicable. The agency does not consider resources in determining eligibility.

Citation(s)

C. Financial Eligibility (cont.)

1902 (l) (3) and 1902 (r) (2) of the Act

g. 1. Poverty level children covered under section 1902 (a) (10) (A) (i) (VI) of the Act.

The agency uses the following methods for the treatment of resources:

☐ The methods of the state's approved AFDC plan.

1902 (l) (3) (C) of the Act

☐ Methods more liberal than those in the state's approved AFDC plan (but not more restrictive), in accordance with section 1902 (l) (3) (C) of the Act, as specified in **Supplement 5a of Attachment 2.6-A**.

1902 (r) (2) of the Act

☐ Methods more liberal than those in the state's approved AFDC plan (but not more restrictive), as described in **Supplement 8b to Attachment 2.6-A**.

☒ Not applicable. The agency does not consider resources in determining eligibility.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation(s) **C. Financial Eligibility** (cont.)

1902 (l) (3) and 1902 (r) (2) of the Act

g. 2. Poverty level children under section 1902 (a) (10) (A) (i) (VII) of the Act.

The agency uses the following methods for the treatment of resources:

☐ The methods of the state's approved AFDC plan.

1902 (l) (3) (C) of the Act

☐ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as specified in **Supplement 5a of Attachment 2.6-A**.

1902 (r) (2) of the Act

☒ Methods more liberal than those in the state's approved AFDC plan (but not more restrictive), as described in **Supplement 8b to Attachment 2.6-A**.

☐ Not applicable. The agency does not consider resources in determining eligibility.

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation(s)

C. Financial Eligibility (cont.)

1905 (p) (1) (C) and (D) and 1902 (r) (2) of the Act

5. h. For Qualified Medicare beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act the agency uses the following methods for treatment of resources:

☐ The methods of the SSI program only.

☒ The methods of the SSI program and/or more liberal methods as described in **Supplement 8b to Attachment 2.6-A.**

1905 (s) of the Act

i. For qualified disabled and working individuals covered under section 1902 (a) (10) (E) (ii) of the Act, the agency uses SSI program methods for the treatment of resources.

1902 (u) of the Act

j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:

☒ The methods of the SSI program only.

☐ More restrictive methods applied under section 1902 (f) of the Act as described in **Supplement 5 to Attachment 2.6-A**.

Citation(s) **C. Financial Eligibility** (cont.)

1902 (a) (10) (E) (iii) of the Act

k. Specified low-income Medicare beneficiaries covered under section 1902 (a) (10) (E) (iii) of the Act--

The agency uses the same method as in C.5.h. of **Attachment 2.6-A**.

6. Resource Standard – Categorically Needy

a. 1902 (f) states (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

☐ Same as SSI resource standards.

☐ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902 (f) states (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to Attachment 2.6-A specifies for 1902 (f) states the categorically needy resource level for all covered categorically needy groups.

Citation(s) **C. Financial Eligibility** (cont.)

1902 (l) (3) (A), (B) and (C) of the Act

c. For pregnant women and infants covered under the provisions of section 1902 (a) (10) (A) (i) (IV) and 1902 (a) (10) (A) (ii) (IX) of the Act, the agency applies a resource standard.

☐ Yes. **Supplement 2 to Attachment 2.6-A** specifies the standard, which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the state's approved AFDC plan.

☒ No. The agency does not apply a resource standard to these individuals.

1902 (l) (3) (A) and (C) of the Act

d. For children covered under the provisions of section 1902 (a) (10) (A) (i) (VI) of the Act, the agency applies a resource standard.

☐ Yes. **Supplement 2 to Attachment 2.6-A** specifies the standard, which is no more restrictive than the standard applied in the state's approved AFDC plan.

☒ No. The agency does not apply a resource standard to these individuals.

Superseded by TN 013-024 MMDL

Citation(s)

C. Financial Eligibility (cont.)

1902 (m) (l) (C), and (m) (2) (B) of the Act

e. For aged and disabled individuals described in section 1902 (m) (l) of the Act who are covered under section 1902 (A) (10) (A) (ii) (X) of the Act, the resource standard is:

☒ Same as SSI resource standards.

☐ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the state covers the medically needy).

Supplement 2 to Attachment 2.6-A specifies the resource levels for these individuals.

Citation(s)

C. Financial Eligibility (cont.)

7. Resource Standard – Medically Needy

a. Resource standards are based on family size.

1902 (a) (10) (C) (i) of the Act

b. A single standard is employed in determining resource eligibility for all groups.

c. In 1902 (f) states, the resource standards are more restrictive than in 7.b. above for--

- ☐ Aged
- ☐ Blind
- ☐ Disabled

Supplement 2 to Attachment 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., **Supplement 2 to Attachment 2.6-A** so indicates.

1902(a)(10)(E) 1905(p)(1)(D), 1905(p)(1)(D) And 1860-D-14(a)(3)(D) of the Act

8. Resource Standard – Qualified Medicare Beneficiaries ,Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals

For Qualified Medicare Beneficiaries covered under section 1902 (a) (10) (E) (i) of the Act, Specified Low Income Medicare beneficiaries covered under section 1902 (a) (10) (E) (iii) of the Act, and Qualifying Individuals covered under 1902(a) (10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.

1902(a)(10)(E)(ii),1905(s) And 1860D-14(a)(3)(D) Of the Act

9. Resource Standard – Qualified Disabled and Working Individuals

For qualified disabled and working individuals covered under section 1902 (a) (10) (E) (ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource standard.

Citation(s)

C. Financial Eligibility (cont.)

1902 (u) of the Act

10. For COBRA continuation beneficiaries, the resource standard is:

☒ Twice the SSI resource standard for an individual.

☐ More restrictive standard as applied under section 1902 (f) of the Act as described in **Supplement 8 to Attachment 2.6-A**.

Citation(s)

C. Financial Eligibility (cont.)

1902 (u) of the Act

10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

☒ This state has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.

Citation(s)

C. Financial Eligibility (cont.)

42 CFR 435.914

11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

☐ Aged, blind, disabled.

☐ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

☒ Aged, blind, disabled.

☒ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

☒ Aged, blind, disabled.

☒ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if they following individuals would have been eligible at any time during that month, had they applied.

☐ Aged, blind, disabled.

☐ AFDC-related.

Citation(s)

C. Financial Eligibility (cont.)

1920 (b) (1) of the Act

☒ (3) For a presumptive eligibility for pregnant women only.

Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in **Attachment 2.6-A** of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the state agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.

1902 (e) (8) and 1905 (a) of the Act

☒ b. For qualified Medicare beneficiaries defined in section 1905 (p) (1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905 (p) (1). The eligibility determination is valid for--

☐ 12 months

☒ 6 months

☐ ___ months (no less than 6 months and no more than 12 months)

C.11.a (3) superseded by TN 013-024 MMDL

C.11.b. superseded by TN 019-026 MACPRO

Citation(s) **C. Financial Eligibility** (cont.)

1902 (a) (18)
1902 (f) of
the Act

12. Pre-OBRA 93 Transfer of Resources – Categorically and Medically Needy, and Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals

The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value affects eligibility for certain services as detailed in **Supplement 9 to Attachment 2.6-A**.

1917 (c)

13. Transfer of Assets – All Eligibility Groups

The agency complies with the provisions of section 1917 (c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.

Disposal of assets at less than fair market value affects eligibility for certain services as detailed in **Supplement 9(a) to Attachment 2.6-A**, except in instances where the agency determines that the transfer rules would work an undue hardship.

1917 (d)

14. Treatment of Trusts – All Eligibility Groups

The agency complies with the provisions of section 1917 (d) of the Act, as amended by OBRA 93, with regard to trusts.

- ☐ The agency uses more restrictive methodologies under section 1902 (f) of the Act, and applies those methodologies in dealing with trusts;
- ☐ The agency meets the requirements in section 1917 (d) (f) (B) of the Act for use of Miller trusts.

The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in **Supplement 10 to Attachment 2.6-A**.

Citation(s)

C. Financial Eligibility (cont.)

1924 of the Act

15. The agency complies with the provisions of section 1924 with respect to income and resource eligibility and posteligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

☐ the maximum standard permitted by law;

☑ the minimum standard permitted by law; or

$___ a standard that is an amount between the minimum and the maximum

A. Mandatory Categorically Needy

1. **AFDC-related groups** other than poverty level pregnant women and infants:

FAMILY SIZE	MONTHLY PAYMENT STANDARDS
1.	$ 392.00
2.	$ 486.00
3.	$ 579.00
4.	$ 668.00
5.	$ 760.00
6.	$ 854.00
7.	$ 946.00
8.	$ 1,037.00
9.	$ 1,128.00
10.	$ 1,220.00
Each Additional	$ 95.00

2. **Pregnant Women and Infants** under Section 1902 (a) (10)(A) (i) (IV) of the Act: Effective April 1, 1990, based on the following percent of the official Federal income poverty guidelines: **185** percent.

Superseded by TN 013-024 MMDL

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Income Eligibility Levels

A. Mandatory Categorically Needy

3. In accordance with Section 1902 (a)(10)(A)(i)(VI) of the Act and 42 U.S.C. Section 1396a (a)(10)(A)(i)(VI)**: Children who have attained age 1 but have not attained age 6,** whose family income is at or below **133 percent** of the federal poverty level guidelines, as revised annually in the *Federal Register*.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Income Eligibility Levels

4. In accordance with Section 1902 (a)(10)(A)(i)(VII) of the Act and 42 U.S.C. Section 1396a (a)(10)(A)(i)(VII): Children born after September 30, 1983 who have **attained age 6 but have not attained age 19**, in families with incomes at or below **100 percent** the federal poverty level guidelines, as revised annually in the *Federal Register*.

B. Optional Categorically Needy Groups with Incomes Related to Federal Poverty Level

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of **pregnant woman and infants** under the provisions of Sections 1902(a)(1)(A)(ii)(IX) and 1902(1)(2) of the Act are as follows:

Based on **185 percent** of the federal income poverty level (no less than 133 percent and no more than 185 percent).

FAMILY SIZE	MONTHLY INCOME STANDARD *
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
Each Additional	

Not Applicable

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See 07-005 Approval Letter

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Income Eligibility Levels

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State Plan under Title XIX of the Social Security Act
State: Massachusetts
Income Eligibility Levels

C. Income Eligibility Level - Mandatory Group of Qualified Disabled and Working Individuals (cont.)

1. Aged and Disabled Individuals

In accordance with Section 1902(m)(4) of the Act and 42 U.S.C.§1392a(m)(4): **Aged or disabled individuals** who have income at or below **100 percent** of the Federal poverty guidelines, as revised annually in the Federal Register.

For persons receiving Title II benefits:

- Any amount attributable to the most recent increase in the monthly insurance benefit, as a result of title II COLA is not counted as income during the transition period. The transition period begins in January, when the title II benefits for December are received and ends on the last day of the month following the month of publication of the revised annual Federal poverty level guidelines

- The revised poverty level guidelines are effective on the first day of the month following the end of the transition period

For persons not receiving title II benefits:

- The revised poverty level guidelines are effective no later that the beginning of the month following the date of publication.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Income Eligibility Levels

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State Plan under Title XIX of the Social Security Act
State: Massachusetts
Income Eligibility Levels

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Income Eligibility Levels (cont.)

D. **Medically Needy**

☒ Applicable to all groups. ☐ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for 12 months ☐ urban only ☒ urban & rural	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1]	Net income level for persons living in rural areas for ___ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1]
1	$ 6,264	$ 0	$ N/A	$ N/A
2	$ 7,800	$ 0	$	$
3	$ 9,300	$ 0	$	$
4	$ 10,692	$ 0	$	$
For each additional person add:	$	$	$	$

[1] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

Income Eligibility Levels (cont.)

D. **Medically Needy** (cont.)

(1)	(2)	(3)	(4)	(5)
Family Size	Net income level protected for maintenance for 12 months ☐ urban only ☐ urban & rural	Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1]	Net income level for persons living in rural areas for ___ months	Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1]
5	$ 12,192	$ 0	$ N/A	$ N/A
6	$ 13,692	$ 0	$	$
7	$ 15,192	$ 0	$	$
8	$ 16,596	$ 0	$	$
9	$ 18,096	$ 0	$	$
10	$ 19,956	$ 0	$	$
For each additional person add:	$ 1,596	$[2]	$	$

[1] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

[2] Column 2 exceeds 435.1007 limits by variable amounts beginning with family size of 11.

Resource Levels

A. **Categorically Needy Groups with Incomes Related to Federal Poverty Level**

1. **Pregnant Women**

a. **Mandatory Groups**

☐ Same as SSI resources levels.

☒ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	N/A
2	No resource level applied to pregnant women

b. **Optional Groups**

☐ Same as SSI resources levels.

☐ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	_____
2	_____

Resource Levels (cont.)

2. **Infants**

a. **Mandatory Group of Infants**

☐ Same as resource levels in the state's approved AFDC plan.

☒ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____

- No resource level applied, regardless of family size.

Superseded by TN 013-024 MMDL

Resource Levels (cont.)

b. **Optional Group of Infant N/A**

☐ Same as resource levels in the state's approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____

Resource Levels (cont.)

3. **Children**

a. **Mandatory Group of Children under Section 1902 (a) (10) (i) (VI) of the Act**. (Children who have attained age 1 but have not attained age 6.)

☐ Same as resource levels in the state's approved AFDC plan.

☒ * Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____
7	_____
8	_____
9	_____
10	_____

* No resource level applies

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Resource Levels (cont.)

b. **Mandatory Group of Children under Section 1902 (a) (10) (i) (VII) of the Act**. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

☐ Same as resource levels in the state's approved AFDC plan.

☒ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	$2,000
2	$3,000
3	$3,100
4	$3,200
5	$3,300
6	$3,400
7	$3,500
8	$3,600
9	$3,700
10	$3,800

Superseded by TN 013-024 MMDL

Resource Levels (cont.)

4. **Aged and Disabled Individuals**

☒ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	_____
2	_____
3	_____
4	_____
5	_____

☐ Same as medically needy resource levels (applicable only if state has a medically needy program)

Resource Levels (cont.)

b. **Medically Needy**

Applicable to all groups —

☐ Except those specified below under the provisions of section 1902 (f) of the Act.

Family Size	Resource Level
1	$2,000
2	$3,000
3	$3,100
4	$3,200
5	$3,300
6	$3,400
7	$3,500
8	$3,600
9	$3,700
10	$3,800
For each additional person	$100

Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid

Guardianship Fees and Related Expenses.

The Division allows deductions from a member's income for guardianship fees and related expenses when a guardian is essential to enable an incompetent applicant or member to gain access to or consent to medical treatment, as provided below.

(a) Expenses Related to the Appointment of a Guardian

(i) The Division allows a deduction for fees and expenses related to the appointment of a guardian if the guardian's appointment is made for the purpose of:

1. assisting an incompetent applicant to gain access to medical treatment through MassHealth; or

2. consenting to medical treatment on behalf of a MassHealth member.

(ii) The Division allows a deduction for reasonable costs, including attorney fees, as approved by the probate court, not to exceed $500 for the appointment, except as provided in (a) (iii).

(iii) The Division may allow a deduction, as approved by the probate court, of up to $750 for the appointment when the medical issues before the court are more complex. An example of such complexities includes providing evidence of the need for anti-psychotic medications.

(iv) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(b) Guardianship Services Related to the Application Process

(i) The Division allows a deduction for fees for guardianship services related to the MassHealth application process when the guardian has been appointed by the probate court to assist an incompetent person with the MassHealth application when the securing of MassHealth benefits is essential for the member to gain access to medical treatment.

(ii) The Division allows a deduction for reasonable costs related to the MassHealth application process, as approved by the probate court, not to exceed $500. In cases where an administrative hearing is held, the total deduction may not exceed $750 for the cost related to the application process and hearing.

(iii) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(c) Guardianship Services Related to the Re-determination Process

Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid (cont.)

(i) The Division allows a deduction for fees for guardianship services related to the MassHealth redetermination process when the guardian has been appointed by the probate court to assist an incompetent person with securing continued access to medical treatment.

(ii) The Division allows a deduction for reasonable costs related to the MassHealth redetermination process, as approved by the probate court, not to exceed $250. In cases where an administrative hearing is held, the total deduction may not exceed $375 for the costs related to the redetermination process and hearing.

(iii) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(d) Monthly Guardianship Services

(i) The Division allows a deduction for monthly fees for a guardian to the extent the guardian's services are essential to consent to medical treatment on behalf of the member.

(ii) The Division allows a deduction, as approved by the probate court, for up to 24 hours per year at a maximum of $50 per hour for guardianship services.

(iii) The Division allows the deduction only if the guardianship services provided include the attendance and participation of the guardian in quarterly care meetings held by the nursing facility where the member lives.

(iv) The Division allows this deduction only if each year the guardian submits to the Division a copy of the affidavit that describes the guardianship services provided to the member.

(v) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(e) Expenses Incurred by the Guardian in Connection with Monthly Guardianship Services

(i) The Division allows a deduction up to, but not exceeding, the member's monthly patient-paid amount for filing and court fees incurred by the guardian in connection with monthly guardianship services that are essential to consent to medical treatment for the member.

(ii) If monthly guardianship services are provided, these expenses are included in the affidavit of services required under (d) (iv).

(iii) The deduction is made from the member's monthly patient-paid amount in the month following receipt of the affidavit of services.

(f) Hardship

(i) If exceptional circumstances exist that make the deductions allowed for guardianship expenses insufficient to cover the expenses required for a guardian to provide essential guardianship services needed to gain access to or consent to medical treatment, the guardian, on behalf of the member, may appeal to the Board of Hearings for an increased deduction.

Reasonable Limits on Amounts for Necessary Medicaid or Remedial Care Not Covered under Medicaid (cont.)

(ii) A hearing officer may allow for an increased deduction for guardianship expenses only in circumstances where the issues surrounding the member's need to gain access to or consent to medical treatment are extraordinary.

(iii) Extraordinary circumstances may exist when:

(1) there is a need for a guardian to consistently spend more than 24 hours per year providing guardianship services to appropriately consent to medical treatment needed by the member; or

(2) the circumstances of a MassHealth member cause the guardian appointment or application process to be particularly complex and significantly more costly than the deduction allowed in (a) or (b).

(g) Guardianship Services and Expenses that are not Deductible

The following fees and costs are not allowed as a deduction.

(i) Amounts that are also used to reduce a member's assets.

(ii) Amounts that are also used to meet a deductible or any other deduction allowed under Division regulations.

(iii) Expenses related to the appointment of a guardian for an applicant when the appointment is made more than six months before submission of a MassHealth application.

(iv) Expenses related to the appointment of a guardian for an applicant or member when the applicant or member does not request a deduction for the appointment within six months of the date of application or date of appointment, whichever is later.

(v) Expenses, fees, or costs for expenses that are not essential to obtain medical treatment for the ward including financial management, except when the management is necessary to accurately complete a MassHealth application or redetermination form.

(vi) Expenses, fees, or costs for transportation or travel time.

(vii) Attorney fees, except when payment of the fees is required for the appointment of the guardian.

(viii) Fees for guardianship services provided by a parent, spouse, sibling, or child, even if appointed by the probate court. However, the Division allows a deduction for guardianship expenses in accordance with (a) and (e).

Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid

Reasonable and necessary medical and remedial care expenses recognized under State law that are not covered by Medicaid or payable by a third party which are incurred in the three month period prior to the month of application may be allowable deductions. Expenses incurred prior to this three month period are not allowable deductions.

For medically necessary services and items not covered by the Medicaid State Plan, the actual paid amount will be used as the deduction, subject to the following limit: the highest of a payment/fee recognized by Medicaid, Medicare, or any commercial payers in the Commonwealth.

No deduction shall be allowed for medical and remedial care expenses that were incurred as a result of the imposition of a transfer of resources penalty.

Section 1902 (f) Methodologies for Treatment of Income That Differ from Those of the SSI Program

(Section 1902 (f) more restrictive methods and criteria and state supplement criteria in SSI criteria states without Section 1634 agreements and in Section 1902 (f) states. Use to reflect more liberal methods only if you limit to state supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of Section 1902 (r) (2) of the Act. Use Supplement 8a for Section 1902 (r) (2) methods.)

More restrictive methods of treating resources than those of the SSI Program - Section 1902 (f) States only

Methodologies for Treatment of Resources for Individuals with Incomes up to a Percentage of the Federal Poverty Levels

(Do not complete if you are electing more liberal methods under the authority of Section 1902 (r) (2) of the Act instead of the authority specific to federal poverty levels. Use Supplement 8b for Section 1902 (r) (2) methods.)

For pregnant women and children described in 1902 (a) (10) (i) (IV) and (VI), the agency does not consider resources in determining eligibility.

PAYMENT CATEGORY	ADMINISTERED BY		INCOME LEVEL				INCOME DISREGARD
(1)	(2)		(3)		(4)		(5)
Reasonable Classification	Federal	State	Gross		Net		
AGED	**INDIVIDUAL**		**INDIVIDUAL**	**COUPLE**	**INDIVIDUAL**	**COUPLE**	**DISREGARD**
Full Cost of Living Expenses	674.00	128.82	1690.64	2510.44	802.82	1212.72	First $20 unearned income. If no unearned income, or less than $20.00 this is deducted from earned income. First $65 earned income and ½ remaining earned income
Shared Living Expenses	674.00	39.26	1511.52	2510.44	713.26	1212.72	
Household of Another	449.34	104.36	1192.40	1864.60	553.70	889.80	
Rest Home	674.00	293.00	20.19	---------	976.00	---------	
Nursing Facility	30.00	42.80	230.60	376.20	72.80	145.60	
Assisted Living	674.00	454.00	2341.00	3469.00	1128.00	1692.00	
DISABLED	**INDIVIDUAL**		**INDIVIDUAL**	**COUPLE**	**INDIVIDUAL**	**COUPLE**	
Full Cost of Living Expenses	674.00	114.39	1661.78	2467.12	788.39	1191.06	
Shared Living Expenses	674.00	30.40	1493.80	2467.12	704.40	1191.06	
Household of Another	449.34	87.58	1158.84	1821.36	536.92	868.18	
Rest Home	674.00	293.00	2019.00	------	967.00	------	
Nursing Facility	30.00	42.80	230.60	376.20	72.80	145.60	
Assisted Living	637.00	454.00	2341.00	3469.00	1128.00	1692.00	
BLIND	**INDIVIDUAL**		**INDIVIDUAL**	**COUPLE**	**INDIVIDUAL**	**COUPLE**	
Full Cost of Living Expenses	674.00	149.74	1732.48	3379.96	823.74	1647.48	
Shared Living Expenses	674.00	149.74	1732.48	3379.96	823.74	1647.48	
Household of Another	449.34	374.40	1732.48	3379.96	823.74	1647.48	
Rest Home	674.00	149.74	1732.48	--------	823.74	-------	
Nursing Facility	30.00	42.80	230.60	376.20	72.80	145.60	
Assisted Living	674.00	454.00	2341.00	3469.00	1128.00	1692.00	

For Title XIX purposes, the limit is subject to the 300% cap, or $ 2022.00

Income Levels for 1902 (f) States – Categorically Needy
Who Are Covered under Requirements More Restrictive Than SSI

Resource Standards for 1902 (f) States – Categorically Needy

More Liberal Methods of Treating Income under Section 1902 (r) (2) of the Act

☐ Section 1902 (f) State ☒ Non-Section 1902 (f) State

See SPA 89-05 for 1902 (r) (2) submittal

For medically needy aged, disregard unearned monthly income equal to the monthly cost of authorized PCA services up to an amount equal to $20 less than the difference between the medically needy income standard and 133% FPL.

For all non-MAGI population under the state plan, disregard state veteran annuity payments under Section 6b of Chapter 115 of Massachusetts General Law.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Less Restrictive Methods of Treating Income under Section 1902 (r) (2) of the Act

For children who have attained one year of age but have not attained 6 years of age eligible at 133 percent of the Federal poverty level (FPL) under §1902(a)(10)(A)(i)(VI) and 1902(I)(I)(C)of the Social Security Act (the Act):

Disregard income between 133 percent and 150 percent of the FPL for the family size involved as revised annually in the Federal Register.

For children born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age eligible at 100 percent of the FPL under §1902(a)(10)(A)(i)(VII) and 1902(I)(I)(D)of the Act:

Disregard income between 100 percent and 150 percent of the FPL for the family size involved as revised annually in the Federal Register.

For optional reasonable classifications of children under age 21 covered under 42 CFR 435.222, §1902(a)(10)(A)(ii)(I), and §1902(a)(10)(A)(ii)(IV):

Disregard income between the state's AFDC payment standard as of 7/16/1996 (as specified on Supplement 1 to Attachment 2.6-A page 1) and 150 percent of the FPL using gross income for the family size involved as revised annually in the Federal Register

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Less Restrictive Methods of Treating Income under Section 1902 (r) (2) of the Act

☒ All wages paid by the U.S. Census Bureau for temporary employment related to decennial census activities are excluded. All federal unemployment benefits paid following the termination of U.S. Census Bureau employment related to decennial census activities are also excluded.

The exclusions apply to individuals in the following groups:

- Poverty level pregnant women and infants at §1902(a)(10)(A)(i)(IV) and described at § 1902(l)(1)(A) or (l)(1)(B), poverty level children who have attained one year of age but have not attained 6 years of age at 1902(a)(10)(A)(i)(VI) and described at 1902(l)(1)(C), and poverty level children who have attained age 6 but have not attained age 19 at §1902(a)(10)(A)(i)(VII) and described at §1902(l)(1)(D).
- 1902(a)(10)(A)(ii)(I), those who meet the income requirements for supplemental security income as described at 1905(a)(iii) aged, (a)(vii) blind, or disabled.
- 1902(a)(10)(A)(ii)(X), those described at 1902(m)(1) (poverty level group of aged and disabled)
- 1902(a)(10)(C)(i)(III), parents, children and disabled individuals described at § 1905 (a)(i) (children under the age of 18), 1905(a)(ii) (caretaker relatives), 1905(a)(iii) (individuals age 65 and older), 1905 (a)(vii)(blind or disabled individuals).

More Liberal Methods of Treating Resources under Section 1902 (r) (2) of the Act

☐ Section 1902 (f) State ☒ Non-Section 1902 (f) State
See SPA 89-05 for 1902 (r) (2)

Disregard all assets for all AFDC related individuals in the following groups:

A. Categorically Needy and Other Required Special Groups

1902 (a) (10) (A) (i) (III)

B. Optional Groups Other Than the Medically Needy

1902 (a) (10) (A) (ii) (I)
1902 (a) (10) (A) (ii) (V)
1902 (a) (10) (A) (ii) (VII)
1902 (a) (10) (A) (ii) (VIII)

C. Optional Coverage of the Medically Needy

1902 (a) (10) (C) (i) (III)

For all non-MAGI population under the state plan, disregard state veteran annuity payments under Section 6b of Chapter 115 of Massachusetts General Law.

Categorically needy children and pregnant women superseded by TN 013-024 MMDL

Transfer of Resources

1902 (f) and 1917 the Act

The agency provides for the denial of eligibility by reason of disposal of resources of for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in Section 1613 (c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. ☐ The agency uses a procedure, which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value are described as follows:

Transfer of Resources (cont.)

b. ☒ The period of ineligibility is less than 24 months, as specified below:

The number of months that result when the total value of the assets transferred is divided by the average monthly cost of care in Massachusetts.

c. ☒ The agency has provisions for waiver of denial of eligibility in any instance where the state determines that a denial would work an undue hardship.

Transfer of Resources (cont.)

2. Transfer of the home of an individual who is an inpatient in a medical institution.

☒ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under Section 1917 (c) (2) (B) (i).

a. Subject to the exceptions in Section 1917 of the Act, an individual is ineligible for 30 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 30 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

Transfer of Resources (cont.)

☐ b. Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

The number of months that result when the total value of the assets transferred is divided by the average monthly costs of care in Massachusetts.

Transfer of Resources (cont.)

No individual is ineligible by reason of item A.2 if—

(i) a satisfactory showing is made to the agency (in accordance with any regulations of the secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) title to the home was transferred to the individual's spouse or child who is under age 21, or (for states eligible to participate in the state program under Title XVI of the Social Security Act) is blind or permanently and totally disabled or (for states not eligible to participate in the state program under Title XVI of the Social Security Act) is blind or disabled as defined in Section 1614 of the Act;

(iii) a satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

(iv) the agency determines that denial of eligibility would work an undue hardship.

Transfer of Resources (cont.)

3. 1902 (f) States

☐ Under the provisions of Section 1902 (f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under Section 1917 (c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedure for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

Transfer of Resources (cont.)

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Transfer of Assets

1917 (c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

☒ payments based on a level of care in a nursing facility;

☒ payments based on a nursing facility level of care in a medical institution; and

☒ home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

☐ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905 (a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

home health services (section 1905 (a) (7));

home and community care for functionally disabled and elderly adults (section 1905 (a) (22)); and

personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905 (a) (24).

☐ The following other long-term care services for which medical assistance is otherwise under the agency plan:

Transfer of Assets (cont.)

3. Penalty Date – The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

   ☒ the first day of the month in which the asset was transferred;

   ☐ the first day of the month following the month of transfer.

4. Penalty Period – Institutionalized Individuals – In determining the penalty for an institutionalized individual, the agency uses:

   ☒ the average monthly cost to a private patient of nursing facility services in the Commonwealth.

   ☐ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period – Non-institutionalized Individuals – The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

   ☐ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

   ☒ N/A
   Does not impose a penalty period.

Transfer of Assets (cont.)

6. Penalty period for amounts of transfer less than cost of nursing facility care —

   a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

      ☐ does not impose a penalty;

      ☒ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

   b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

      ☐ does not impose a penalty;

      ☒ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap —

   The agency:

   ☒ totals the value of all assets transferred to produce a single penalty period;

   ☐ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap —

   The agency:

   ☒ assigns each transfer its own penalty period;

   ☐ uses the method outlined below:

Transfer of Assets (cont.)

9. Penalty periods – transfers by a spouse that results in a penalty period for the individual —

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When a transfer by an individual's spouse results in a period of ineligibility for the individual, and the spouse later becomes institutionalized and applies for medical assistance, the Division will apportion the remaining period of ineligibility equally between the spouses. If both spouses become nursing-facility residents in the same month, the Division will divide the period of ineligibility equally between them. When one spouse is no longer subject to a penalty, any remaining penalty must then be imposed on the remaining nursing-facility-resident spouse.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset —

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

☒ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

☒ For transfers of individual income payments, the agency will impose partial month penalty periods.

☒ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

☐ The agency uses an alternate method to calculate penalty periods, as described below:

Transfer of Assets (cont.)

11. Imposition of a penalty would work an undue hardship – The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determination:

    a. Where the Division has issued a notice of the period of ineligibility due to a disqualifying transfer of resources, the nursing-facility resident may request a hardship waiver.

    b. If the nursing-facility resident feels the imposition of a period of ineligibility would result in undue hardship, the nursing-facility resident must submit a written request for consideration of undue hardship and any supporting documentation to the MassHealth Enrollment Center listed on the notice of the period of ineligibility within 15 days after the date on the notice. Within 30 days after the date of the nursing-facility resident's request, the Division will inform the nursing-facility resident in writing of the undue-hardship decision and of the right to a fair hearing. The Division will extend this 30-day period if the Division requests additional documentation or if extenuating circumstances as determined by the Division require additional time.

    c. The nursing-facility resident may appeal the Division's undue-hardship decision and the imposition of a period of ineligibility by submitting a request for a fair hearing to the Division's Board of Hearings within 30 days after the nursing-facility resident's receipt of the Division's written undue-hardship notice, in accordance with 130 CMR 610.000.

Transfer of Assets (cont.)

d. The nursing-facility resident's request for consideration of undue hardship does not limit his or her right to request a fair hearing for reasons other than undue hardship. The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship.

(1) The Division may waive a period of ineligibility due to a disqualifying transfer of resources if ineligibility would cause the nursing-facility resident undue hardship. The Division may waive the entire period of ineligibility or only a portion when all of the following circumstances exist.

(a) The denial of MassHealth would deprive the nursing-facility resident of medical care such that his or her health or life would be endangered, or the nursing-facility resident would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation.

(b) All appropriate attempts to retrieve the transferred resource have been exhausted, and the recipient of the transfer is unable or unwilling to return the resource or to provide adequate compensation to the nursing-facility resident.

(c) The institution has notified the nursing-facility resident of its intent to initiate a discharge of the resident because the resident has not paid for his or her institutionalization.

(d) There is no less costly noninstitutional alternative available to meet the nursing-facility resident 's needs.

(2) Undue hardship does not exist when imposition of the period of ineligibility would merely inconvenience or restrict the nursing-facility resident without putting the nursing-facility resident at risk of serious deprivation.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006,** the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

Nursing facility services;

Nursing facility level of care provided in a medical institution;

Home and community-based services under a 1915(c) or (d) waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

X The State uses the first day of the month in which the assets were transferred

___ The State uses the first day of the month after the month in which the assets were transferred

or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid:

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period - Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals--
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

___ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care--

   X Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

   X The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

   (a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

   "existing penalty period is divided in half and apportioned evenly between the spouses."

   (b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income—

   When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

   When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

   X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

   X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship--

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Coverage and Eligibility

Trusts

A. The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship. The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship.

1. If the applicant feels the denial or termination of MassHealth would result in undue hardship, the applicant must submit a written request for consideration of undue hardship and any supporting documentation to the MassHealth Enrollment Center listed on the notice of denial within 15 days after the date on the notice. Within 30 days after the date of the applicant's request, the Division will inform applicant in writing of the undue-hardship decision and of the right to a fair hearing. The Division will extend this 30-day period if the Division requests additional documentation or if extenuating circumstances as determined by the Division require additional time.

2. The applicant may appeal the Division's undue-hardship decision by submitting a request for a fair hearing to the Division's Board of Hearings within 30 days after the applicant's receipt of the Division's written undue-hardship notice, in accordance with 130 CMR 610.000.

3. The applicant's request for consideration of undue hardship does not limit his or her right to request a fair hearing for reasons other than undue hardship.

B. The Division may waive or partially waive application of the trust provisions if the following circumstances exist:

1. a. The denial of MassHealth would deprive the applicant of medical care such that his or her health or life would be endangered, or the applicant would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation.

   b. All appropriate attempts to retrieve the transferred resource have been exhausted, and the recipient of the transfer is unable or unwilling to return the resource or to provide adequate compensation to the applicant.

   c. The institution has notified the applicant of its intent to initiate a discharge of the resident because the resident has not paid for his or her institutionalization.

   d. There is no less costly noninstitutional alternative available to meet the applicant's needs.

2. Undue hardship does not exist when imposition of the period of ineligibility would merely inconvenience or restrict the applicant without putting the applicant at risk of serious deprivation.

The maximum value of the exemption for an irrevocable burial trust shall not exceed a reasonable amount, as determined by the Division.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Cost Effectiveness Methodology for COBRA Continuation Beneficiaries

1902 (u) of the Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

☐ The methodology as described in SMM section 3598.

☒ Another cost-effective methodology as described below.

2. The amount of life insurance proceeds that exceeds either $1,5000 or the amount expended by the beneficiary of the policy on the cost of the insured individual's last illness and burial, whichever is less, is countable income.

   This applies only to SSI-related elderly or disabled applicants and recipients.

3. The income of any member of the filing unit who is an AFDC, RRP, GR, Pickle, or SSI recipient is noncountable.

Categorically needy AFDC-related recipients superseded by TN 013-024 MMDL

4. A parent, whether natural or adoptive, has the financial responsibility for the support of his or her unemancipated children under the age of 18. Parents do not have financial responsibility for the support of emancipated children or for the support of children who have reached the age of 18.

   This policy has been in effect since 4/19/83.

5. When the natural or adoptive parent of a child remarries, the assets and income of the stepparent are available to the spouse. The stepparent does not have financial responsibility for the child unless the child is adopted.

6. When spouses reside together, either in the community or in the same room in a long-term-care facility, the assets and income of each spouse are considered mutually available, whether or not actually contributed.

   In the following circumstances, the assets and income of both spouses will not be considered mutually available.

   a. When an applicant or recipient meets all of the following criteria, only the assets and income of the applicant or recipient are considered in determining his or her eligibility for MA. The individual:

      1. must be at least 60 years of age;

      2. must be certified by the Long Term Care Connection to be in need of the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF);

      3. would be institutionalized in an SNF or ICF, unless he or she receives at least one of the following home and community based services administered by the Department of Elder Affairs:

         (a) Case Management Services;

         (b) Homemaker Services;

         (c) Chore Services;

         (d) Social Day Care; and

         (e) Respite Care Services; and

      4. must be otherwise eligible for MA.

   b. When an applicant is receiving hospice care, as described in 106 CMR 507.400, only the assets and income of the applicant or recipient are considered in determining his or her eligibility for MA.

      The policy described in 11. a. has been in effect since August 15, 1985.

      The policy described in 11. b. has been in effect since October 1, 1988.

7. When an SSI-related child under the age of 18 a) who is absent from the parental home and is not expected to return to the parental home by the end of the calendar month of separation or the month immediately following; and b) is an applicant or recipient of Medicaid, the assets and income of the parents are not considered available to the child. For newborns who have never resided with their parents, the date of birth is considered the date of separation.

This policy has been in effect since April 1, 1988.

8. The Home Care for Disabled Children Program allows a child age 18 or under who is severely disabled to remain at home without consideration of parental income and assets provided the child meets the following criteria.

(A) The basis criteria are:

(1) the child's countable assets and income would be within the SSI standard, if he or she were in a medical institution (106 CMR 505.110 (B) and 506.420);

(2) the child is a disabled individual as defined in Title XVI of the Social Security Act;

(3) the state has determined that the child requires a level of care provided in an acute hospital, chronic hospital, or pediatric nursing home as described in 106 CMR 507.200 (B) (C), and (D); (see (B), (C), and (D) below for description of these levels of care);

(4) it is appropriate to provide such care for the individual outside the institution; and

(5) the estimated amount that would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount that would otherwise be expended for medical assistance for the individual within an appropriate institution.

(B) In an acute hospital the child would require the following care:

(1) direct administration of skilled nursing services, seven days a week, 24 hours daily;

(2) daily medical management under the direction and supervision of a physician; and

(3) continued use of medical technology and/or invasive techniques to sustain life, such as ventilation and hyper alimentation; and at least one of the following:

a. assistance in some or all activities of daily living (ADL's); or

b. skilled therapeutic service (occupational therapy, physical therapy, or speech/language therapy) seven days a week.

(C) In a chronic hospital the child would require the following care:

(1) direct administration of skilled nursing services seven days a week; and

(2) weekly medical management under the direction and supervision of a physician; and at least one of the following:

a. skilled therapeutic services five days a week;

b. assistance in some or all ADL's; or

c. continued use of medical technology and/or invasive techniques to sustain life, such as ventilation or hyper alimentation.

(D) To receive treatment in a pediatric nursing home, the child must be non-ambulatory and function at a cognitive level of 12 months or less as indicated by an approved developmental assessment performed by the child's primary care physician or by another professional prescribed by the primary care physician; and requires the following care:

(1) supervision and direct skilled nursing care as provided by a registered nurse, seven days a week; or

(2) daily management and direct skilled nursing services as provided by a registered nurse at least weekly, and substantiated by the delivery of direct daily care by a licensed practical nurse or nurse's aide; and

(3) assistance in all ADL's; and

(4) skilled therapeutic services five days a week, or a combination of different skilled services on different days, but at least one skilled service every day; and

(5) treatment by a physician at least once every 30 days.

This policy has been in effect since 11/1/87.

9. Treatment of Lump Sum Payments.

(A) Definitions

A lump sum payment is a one time only payment that represents either windfall payments such as inheritances or legacies; or the accumulation of recurring income such as retroactive Unemployment Compensation, Railroad Retirement, Federal VA benefits, or Social Security (RSDI).

A retroactive RSDI and/or SSI benefit payment is counted as unearned income in the month received, but does not become a countable asset until the first day of the seventh calendar month after the month of receipt;

Other lump sum payments are counted as unearned income in the calendar month received and as an asset in subsequent months except in the situations specified below:

1. proceeds reserved for the replacement or repair of an asset that is lost, damaged, or stolen and any interest earned on such proceeds subject to the provisions of 106 CMR 505.170 (I);

2. proceeds from the sale of a home used as the principal place of residence subject to the provisions of 106 CMR 505.170 (J);

3. proceeds from the sale of real estate other than a home subject to the provisions of 106 CMR 505.160 (H); or

4. proceeds from the sale of nonexempt vehicles subject to the provisions of 106 CMR 505.160 (G).

(B) Verifications

Verification of a lump sum payment is mandatory and shall be verified when received by one of the following:

a. a benefit or settlement award letter;

b. a retirement fund document indicating the amount of the lump sum payment;

c. a written statement from the agency, company, or institution making the payment; or

d. a copy of the payment document.

10. A retroactive SSI and/or RSDI benefit payment is noncountable as income or assets for six-months after the month of receipt provided the payment is deposited in a separately identifiable account. Any amount of the benefit still retained on the first day of the seventh calendar month after the month of receipt becomes a countable asset.

11. When an institutionalized applicant or recipient has a spouse in the community, the institutionalized individual can reduce his or her countable income by an amount, which may be needed to ensure that the spouse in the community has income at least equal to the "Maintenance Needs Allowance." In determining the amount, if any, of the community spouse's "Maintenance Needs Allowance," the applicable categorically related disregards are allowed against his or her otherwise countable income.

    If the community spouse is neither AFDC-related nor SSI- related, only the following earned income deductions are allowed:

    a. $11, and

    b. any of the following work-related expenses when they are deducted from salary:

        1. Social Security taxes (FICA);

        2. federal and state income taxes;

        3. retirement and employee benefit plans;

        4. health or medical insurance premiums; and

        5. union dues.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Eligibility under Section 1931 of the Act

The state covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State Plan effective July 16, 1996:

- ☒ Pregnant women with no other eligible children.
- ☒ AFDC children age 18 who are full-time students in secondary school or in the equivalent level of vocational or technical training.
- ☐ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.
- ☒ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications.
- ☐ The agency applies lower income standards, which are no lower than the AFDC standards in effect on May 1, 1988, as follows:
- ☐ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:
- ☐ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:
- ☒ The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:
  1. The Division disregards all resources.
  2. The Division disregards all income at or below133% of the federal poverty level for purposes of the 185% gross income test.
  3. To ensure that the 133% gross income test is always less restrictive, the Division will count rental income, when applying the 133% gross income test, by subtracting from the gross rental income any deductions allowed on the US Tax return..
  4. All wages paid by the U.S. Census Bureau for temporary employment related to decennial census activities are excluded. All federal unemployment benefits paid following the termination of U.S. Census Bureau employment related to decennial census activities are also excluded.
- ☒ The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

  Income from temporary U.S. Census Bureau employment was not listed as excluded income in the Title IV-A State Plan in effect on July 16, 1996; therefore, temporary U.S. Census Bureau employment income was countable in determining eligibility for Title IV-A. Federal unemployment benefits paid following the termination of U.S. Census Bureau employment related to census activities was counted in determining eligibility for Title IV-A.

Eligibility under Section 1931 of the Act (cont.)

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

1. The AFDC resource limit in effect on July 16, 1996 was $2,500 per assistance unit.

2. The income test in effect on July 16, 1996 (and still used today by the Department of Transitional Assistance) is a two-part test that gives different results for different assistance units. The first step of the test is the 185% test of financial eligibility. This requires that the assistance unit's gross income not be greater than 185% of the applicable eligibility standard. For example, the income for a family of four may not be greater than $1,235.80 to pass this first test. (Comparatively, 133% of the federal poverty level for a family of four is $1,890.00)

   Next DTA looks to see whether the need standard is met. The need standard, which is based on net income, is, for all family sizes, significantly below 133% gross of the federal poverty level. For example, the greatest income a family of four can have and still meet the need standard is $668.00 per month. (Comparatively, as mentioned above, 133% of the federal poverty level for a family of four is $1,890.00).

☐ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

☐ The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

Superseded by TN-013-024 MMDL

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Conditions and Requirements of Eligibility

Variations from the Basic Personal Needs Allowance

Disclosure Statement for Post-Eligibility Preprint

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 #0938-0673. The time required to complete this information collection is estimated at five hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing 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: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

2. An inaccessible asset is an asset to which the applicant or recipient has no ready access and is not counted when determining eligibility for medical assistance. Inaccessible assets include, but are not limited to, property the ownership of which is the subject of legal proceedings (e.g., probate, divorce suits, etc.); and the cash surrender value of life insurance policies when the policy has been assigned to the issuing company for adjustment. An asset shall also be inaccessible while the applicant's or recipient's medical condition (mental or physical impairment) prevents him or her from taking action directly or through a third party to reduce the excess assets.

3. AFDC-Related

One vehicle per filing unit shall be exempt from having its equity value counted as an asset, provided it is used primarily for transportation purposes. The equity value of all vehicles owned by the filing unit including vehicles that are used primarily for recreational purposes such as snowmobiles, boats, trailers, jeeps, vans and motorcycles shall be countable. The exempt vehicle shall be the one selected by the filing unit.

SSI-Related

a. One vehicle is noncountable regardless of its value if, for the individual or a member of the individual's household:

- it is necessary for employment; or
- it is necessary for the medical treatment of a specific or regular medical problem; or
- it is modified for operation by or transportation of a handicapped person; or
- It is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

b. If no vehicle is excluded under 106 CMR 505.160 (G) (1) a., one automobile is noncountable if its equity value does not exceed $4,500. If the equity value of the automobile exceeds $4,500, the excess is countable toward the applicant or recipient's asset limit.

c. All vehicles other than those described in 106 CMR 505.160 (G) (1) a. or b. are countable assets.

Exemption for SSI-Related Vehicles

In an SSI-related filing unit, the value of nonexempt vehicles is noncountable for three months provided the applicant or recipient signs an agreement with the Department to dispose of the vehicle(s) at fair market value.

An additional three-month extension may be granted if good cause is found for the failure to dispose of the property within the initial three-month period.

4. Burial Funds

Coverage Groups:

1902 (a) (10) (A) (i) (III)
(A) (i) (IV)
(A) (i) (VI)
(A) (i) (VII)
(A) (ii) (I)
(A) (ii) (V)
(A) (ii) (VI)
(A) (ii) (VII)
(A) (ii) (VIII)
(A) (ii) (IX)
(A) (ii) (X)
(C) (i) (III)

1905 (p)

Description: Individuals are allowed to set aside up to $1,500 in funds for burial arrangements (previous policy allowed up to $2,500). However, the amount of such funds is not reduced by the amount of funds set aside in a prepaid irrevocable burial plan as is required by 42 CFR 1231 (b) (5) (ii).

Categorically needy AFDC recipients, pregnant women, infants and children superseded by TN 013-024 MMDL

5. Any burial space for the applicant, recipient, or family member; a separately identifiable amount not to exceed two thousand five hundred dollars ($2,500) for each member of a filing unit, expressly reserved for funeral and burial expenses; the cash surrender value of burial insurance, so called; prepaid irrevocable burial contracts; and irrevocable trust accounts designated for funeral and burial expenses are non-countable resources. Appreciated value or interest earned or accrued and left to accumulate on any such contract or account shall also be noncountable. Use of any of these assets including the interest accrued for other than funeral or burial arrangements of a member of the filing unit shall make the asset available and countable under the appropriate provisions of 106 CMR 505.120 and 505.160.

   The applicant or recipient has the right to establish or change the designation of funds owned by him or her to a separate, identifiable burial account not to exceed $2,500, and it shall be the duty of the Department to inform him or her of the right to establish such a fund.

   If the burial account is in existence at the time of application, it is deemed to be in existence for up to three months prior to application, provided that the account is separately identifiable, clearly designated for burial expenses, and no withdrawals have been made during the period for which retroactive coverage is requested.

   This policy has been in effect since 3/3/83.

6. Former Home of Institutionalized Individuals

Coverage Groups:

1902 (a) (10) (A) (i) (III)
(A) (i) (IV)
(A) (i) (VI)
(A) (i) (VII)
(A) (ii) (I)
(A) (ii) (V)
(A) (ii) (VII)
(A) (ii) (VIII)
(A) (ii) (IX)
(A) (ii) (X)
(C) (i) (III)

1905 (p)

Description: In addition to exemptions allowed at 20 CFR 416.1212 (c) and the undue hardship provision allowed at 20 CFR 416.1245, the former home of an institutionalized individual is exempt when:

- a sibling has an equity interest in the home and was residing there for a period of at least one year immediately before the applicant or recipient's admission to the medical institution;
- a son or daughter was residing in the applicant or recipient's home for a period of at least two years immediately before the date of the applicant's admission to the medical institution, and establishes to the satisfaction of the Department that he or she provided care to the applicant or recipient that permitted the applicant or recipient to reside at home rather than an institution;
- the applicant or recipient owns long-term-care insurance whose coverage meets requirements of 211 CMR 65.00.

Categorically needy AFDC recipients superseded by TN 013-024 MMDL

7. When the natural or adoptive parent of a child remarries, the assets and income of the stepparent are available to the spouse. The stepparent does not have financial responsibility for the child unless the child is adopted.

8. When spouses reside together, either in the community or in the same room in a long-term-care facility, the assets and income of each spouse are considered mutually available, whether or not actually contributed.

   In the following circumstances, the assets and income of both spouses will not be considered mutually available.

   a. When an applicant or recipient meets all of the following criteria, only the assets and income of the applicant or recipients are considered in determining his or her eligibility for MA. The individual:

      1. must be at least 60 years of age;

      2. must be certified by the Long Term Care Connection to be in need of the level of care provided in a skilled nursing facility (SNF) or intermediate care facility (ICF);

      3. would be institutionalized in an SNF or ICF, unless he or she receives at least one of the following home- and community-based services administered by the Department of Elder Affairs:

         (a) Case Management Services;
         (b) Homemaker Services;
         (c) Chore Services;
         (d) Social Day Care; and
         (e) Respite Care Services; and

      4. must be otherwise eligible for MA.

   b. When an applicant is receiving hospice care, as described in 106 CMR 507.400, only the assets and income of the applicant or recipient are considered in determining his or her eligibility for MA.

      The policy described in 11. a. has been in effect since August 15, 1985.

      The policy described in 11. b. has been in effect since October 1, 1988.

9. When an SSI-related child under the age of 18 a) who is absent from the parental home and is not expected to return to the parental home by the end of the calendar month of separation or the month immediately following; and b) is an applicant or recipient of Medicaid, the assets and income of the parents are not considered available to the child. For newborns who have never resided with their parents, the date of birth is considered the date of separation.

   This policy has been in effect since April 1, 1988.

10. The Home Care for Disabled Children Program allows a child age 18 or under who is severely disabled to remain at home without consideration of parental income and assets provided the child meets the following criteria.

(A) The basic criteria are:

(1) the child's countable assets and income would be within the SSI standard, if he or she were in a medical institution (106 CMR 505.110 (B) and 506.420);

(2) the child is a disabled individual as defined in Title XVI of the Social Security Act;

(3) the state has determined that the child requires a level of care provided in an acute hospital, chronic hospital, or pediatric nursing home as described in 106 CMR 507.200 (B), (C), and (D); (see (B), (C), and (D) below for description of these levels of care)

(4) it is appropriate to provide such care for the individual outside the institution;

(5) the estimated amount that would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount that would otherwise be expended for medical assistance for the individual within an appropriate institution.

(B) In an acute hospital the child would require the following care:

(1) direct, administration of skilled nursing services, seven days a week, 24 hours daily;

(2) daily medical management under the direction and supervision of the physician; and

(3) continued use of medical technology and/or invasive techniques to sustain life, such as ventilation and hyperalimentation; and at least one of the following:

a. assistance in some or all activities of daily living (ADL's); or

b. skilled therapeutic service (occupational therapy, physical therapy, or speech/language therapy) seven days a week.

(C) In a chronic hospital the child would require the following care:

(1) direct administration of skilled nursing services seven days a week; and

(2) weekly medical management under the direction and supervision of a physician; and at least one of the following:

a. skilled therapeutic services five days a week;

b. assistance in some or all ADL's; or

c. continued use of medical technology and/or invasive techniques to sustain life, such as ventilation or hyper alimentation.

(D) To receive treatment in a pediatric nursing home, the child must be non-ambulatory and function at a cognitive level of 12 months or less as indicated by an approved developmental assessment performed by the child's primary care physician or by another professional prescribed by the primary care physician; and require the following care:

(1) supervision and direct skilled nursing care as provided by a registered nurse, seven days a week; or

(2) daily management and direct skilled nursing services as provided by a registered nurse at least weekly, and substantiated by the delivery of direct daily care by a licensed practical nurse or nurse's aide; and

(3) assistance in all ADL's; and

(4) skilled therapeutic services five days a week, or a combination of different skilled services on different days, but at least one skilled service every day; and

(5) treatment by a physician at least once every 30 days.

This policy has been in effect since 11/1/87.

11. Treatment of Lump Sum Payments.

(A) Definitions

A lump sum payment is a one time only payment that represents either windfall payments such as inheritances or legacies; or the accumulation of recurring income such as retroactive Unemployment Compensation, Railroad Retirement, Federal VA benefits, or Social Security (RSDI).

A retroactive RSDI and/or SSI benefit payment is counted as unearned income in the month received, but does not become a countable asset until the first day of the seventh calendar month after the month of receipt:

Other lump sum payments are counted as unearned income in the calendar month received and as an asset in subsequent months except in the situations specified below:

1. proceeds reserved for the replacement or repair of an asset that is lost, damaged, or stolen and any interest earned on such proceeds subject to the provisions of 106 CMR 505.170 (I);

2. proceeds from the sale of a home used as the principal place of residence subject to the provisions of 106 CMR 505.170 (J);

3. proceeds from the sale of real estate other than a home subject to the provisions of 106 CMR 505.160 (H);

4. proceeds from the sale of nonexempt vehicles subject to the provisions of 106 CMR 505.160 (G).

(B) Verifications

Verification of a lump sum payment is mandatory and shall be verified when received by one of the following:

(a) a benefit or settlement award letter;

(b) a retirement fund document indicating the amount of the lump sum payment;

(c) a written statement from the agency, company, or institution making the payment; or

(d) a copy of the payment document.

12. A retroactive SSI and/or RSDI benefit payment is noncountable as income or assets for six-months after the month of receipt provided the payment is deposited in a separately identifiable account. Any amount of the benefit still retained on the first day of the seventh calendar month after the month of receipt becomes a countable asset.

13. The home is treated as the principal place of residence and is non-countable for both community and institutionalized applicants and recipients.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

ASSET VERIFICATION SYSTEM

2. System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

__X__ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

___ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

___ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

Massachusetts emailed a solicitation to develop and implement an AVS under a statewide contract to qualified vendors in late December, 2015. We anticipate the AVS will be in place during the first quarter of calendar year 2016.

The vendor selected will implement a system that meets the requirements of Supplement 16 to Attachment 2.6-A page 1.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

DISQUALIFICATIONS FOR LONG-TERM-CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

_____ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

X An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is 750,000.

X This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

X This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*

MASSACHUSETTS

05/05/2014

	Population Group	Net standard as of 12/1/09	Converted standard for FMAP claiming	Same as converted eligibilty standard? (yes, no, or n/a)	Source of information in Column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
onversions for FMAP Claiming Purposes						
1	**Parents/Caretaker Relatives** FPL %	300%	300%	n/a - gross standard	Income conversion plan template for Part 1 MAGI conversions	n/a
2	**Noninstitutionalized Disabled Persons** FPL %	133%	133%‡	n/a	ABD conversion template	n/a
3	**Institutionalized Disabled Persons** SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	**Children Ages 19-20** FPL %	300%	300%	n/a - gross standard	Income conversion plan template for Part 1 MAGI conversions	n/a
5	**Childless Adults** FPL%	300%	300%	n/a - gross standard	Income conversion plan template for Part 1 MAGI conversions	n/a

The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI Conversion Plan

Authorized under the MA 1115 waiver, the MassHealth CommonHealth program covers adults aged 19-64 who are totally and permanently disabled and not eligible for Standard overage but who are employed or not employed and meet a one-time only deductible. There is no income limit for CommoHealth through the 1115 waiver.
/a: Not applicable.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methodology for Identification of Applicable FMAP Rates

Attachment E: Transition Methodologies

In a letter dated March 5, 2014, CMS provided waiver approval under section 1902(e)(14)(A) of the Social Security Act for Massachusetts to enroll individuals previously covered under the MassHealth Section 1115 Demonstration or the Refugee Medical Assistance program into the new adult group without a prior MAGI determination, effective January 1, 2014. Massachusetts used the income and other information already in its eligibility system to identify non-pregnant adults ages 19 to 64 with incomes at or below 133 percent of the federal poverty level (FPL), including a five percent income disregard, who were not enrolled in Medicare and who were not already enrolled in Medicaid coverage as a parent or caretaker relative or on the basis of disability. The Commonwealth enrolled these individuals into coverage for the new adult group seamlessly as of January 1, 2014.

State Plan Under Title XIX of the Social Security Act

State: Massachusetts

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 05/28/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy** Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Childless Adults	Attachment A, Column C, Line 5 of Part 2 of the CMS approved MAGI Conversion Plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

☒ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

☐ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

The state:

☐ Applies existing state data from periods before January 1, 2014.

☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

☐ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☒ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 05/23/2014.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ☒ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☒ Attachment E – Transition Methodologies

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 4 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

SECTION 3: SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration, and Scope of Services

42 CFR Part 440, 1920 (a), 1902 (e), 1905 (a), 1905 (p) 1915, 1920, and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and sections 1902 (a), 1902 (e), 1905 (a), 1905 (p) 1915, 1920, and 1925 of the Act.

(1) Categorically Needy

Services for the categorically needy are described below and in **Attachment 3.1-A**. These services include:

1902 (a) (10) (A) and 1905 (a) of the Act

(i) Each item or service listed in section 1905 (a) (1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or, for EPSDT services, section 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in section 1905 (a) (17) of the Act are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

☐ Not applicable. Nurse-midwives are not authorized to practice in this state.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Citation 3.1 (a) (1) Amount, Duration, and Scope of Services: Categorically Needy (cont.)

1902 (e) (5) of the Act

(iii) Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ (iv) Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.

1902 (a) (10), Clause (VII) of the matter following (E) of the Act

(v) Services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of sections 1902 (a) (10) (A) (i) (IV) and 1902 (a) (10) (A) (ii) (IX) of the Act.

Citation 3.1 (a) (1) Amount, Duration, and Scope of Services: Categorically Needy (cont.)

(vi) Home health services are provided to individuals entitled to nursing facility services as indicated in item 3.1 (b) of this plan.

1902 (e) (7) of the Act

(vii) Inpatient services that are being furnished to infants and children described in section 1902 (1) (1) (B) through (D), or section 1905 (n) (2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

1902 (e) (9) of the Act

☐ (viii) Respiratory care services are provided to ventilator dependent individuals as indicated in item 3.1 (h) of this plan.

1902 (a) (52) and 1925 of the Act

(ix) Services are provided to families eligible under section 1925 of the Act as indicated in item 3.5 of this plan.

1905 (a) (23) and 1929

☐ (x) Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Attachment 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services that may complicate the pregnancy.

PACE State Plan Amendment Pre-Print

Citation	3.1(a)(1)	Amount, Duration, and Scope of Services: Categorically Needy (continued)
1905(a)(26) and 1934 of the Act	☒	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

Attachment 3.1-A identifies the medical and remedial services provided to the categorically needy. Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly populations, this also is not applicable for this program.)

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

3.1 (a) (2) Medically Needy (cont.)

42 CFR Part 440, Subpart B

☒ This State plan covers the medically needy. The services described below and in Attachment 3.1-B are provided

Services for the medically needy include:

1902 (a) (I0) C (iv) of the Act (42 CFR 440.220)

i. If services in an institution for mental disease or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in section 1905 (a) (1) through (5) and I (17) of the Act, or seven of the services listed in sectino1905 (a) (1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A, and in sections 1902, 1095, and 1915 of the Act.

☐ Not applicable with respect to nurse-midwife services under section 1902 (a) (17). Nurse-midwives are not authorized to practice in this State.

1902 (e) (5) of the Act (42 CFR 440.160 and 440.140)

ii. Prenatal care and delivery services for pregnant women.

Citation 3.1 (a) (2) Amount, Duration, and Scope of Services: Medically Needy (cont.)

iii. Pregnancy –related including family planning services, and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant , were eligible for, applied for, and received medical assistance on the day the pregnancy ends.

☒ iv. Services for any medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.

v. Ambulatory services, as defined in **Attachment 3.1-B** for recipients under age 18 and recipients entitled to institutional services.

☐ Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the mentally needy.

vi. Home health services to recipients entitled to nursing facility services as indicated in items 3.1 (b) of this plan.

42 CFR 440.140 ☒
440.150, 440,160
Subpart B,
442.441,
Subpart C ☒
1902 (a) (20)
And (21) of the Act ☒

vii. Services in an institution for mental disease for individuals over age 65.

viii. Services in an intermediate care facility for the mentally retarded.

ix. Inpatient psychiatric services for individuals under age 21.

Citation 3.1 (a) (2) Amount, Duration, and Scope of Services: Medically Needy (cont.)

1902 (e) (9) of Act ☐ (x) Respiratory care services are provided to ventilator-dependent individuals as indicated in item 3.1 (h) of this plan.

1905 (a) (23) and 1929 of the Act ☐ (xi) Home and Community Care for Functionally Disabled and Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

Attachment 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration, and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

PACE State Plan Amendment Pre-Print

Citation		
	3.1(a)(2)	Amount, Duration, and Scope of Services: Medically Needy (continued)
1905(a)(26) and 1934 of the Act	☒	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 3 to Attachment 3.1-A.

Attachment 3.1-B identifies the medical and remedial services provided to the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

Citation 3.1 (a) (4) Amount, Duration, and Scope of Services: Other Required Special Groups: Qualified Medicare Beneficiaries (cont.)

1902 (a) (10)
(E) (iv) (II) 1905 (p) (3)
(A) (iv) (II), 1905 (p) (3)
the Act

(iv) Other Required Special Groups: Qualifying Individuals-2

The portion of the amount of increase to the Medicaid Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902 (a) (10) (E) (iv) (II) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

1925 of the Act

(5) Other Required Special Groups: Families Receiving Extended Medicaid Benefits

Extended Medicaid benefits for families described in section 1925 of the Act are provided as indicated in item 3.5 of this plan.

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

(a) (3) Other Required Special Groups: Qualified Medicare Beneficiaries

1902 (a) (10) (E), (i) and clause (VIII) of the matter following (F), and 1905 (p) (3) of the Act

Medicare cost sharing for qualified Medicare beneficiaries described in section 1905 (p) of the Act is provided only as indicated in item 3.2 of this plan.

(4) (i) Other Required Special Groups: Qualified Disabled and Working Individuals

1902 (a) (10) (E) (ii) and 1905 (a) of the Act

Medicare Part A premiums for qualified disabled and working individuals described in section 1902 (a) (10) (E) (ii) of the Act are provided as indicated in item 3.2 of this plan.

(ii) Other Required Special Groups: Specified Low-Income Medicare Beneficiaries

1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act

Medicare Part B premiums for specified low-income Medicare beneficiaries described in section 1902 (a) (10) (E) (iii) of the Act are provided as indicated in item 3.2 of this plan.

(iii) Other Required Special Groups: Qualifying Individuals-1

1902 (a) (10) (E) (iv) (I) 1905 (p) (3) (A) (ii), and 1933 of the Act

Medicare Part B premiums for qualifying individuals described in 1902 (a) (10) (E) (iv) (I) and subject to 1933 of the Act are provided as indicated in item 3.2 of this plan.

Citation

3.1 (a) Amount, Duration, and Scope of Services (cont.)

Sec. 245A (h) of the Immigration and Nationality Act

(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved state Medicaid plan are provided the services covered under the plan if they:

(A) are aged, blind, or disabled individuals as defined in section 1614 (a) (1) of the Act;

(B) are children under 18 years of age; or

(C) are Cuban or Haitian entrants as defined in section 501 (e) (1) and (2) (A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53 (b), aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1 (a) (6) (i) (A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved state plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Citation 3.1 Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (cont.)

1902 (a) and 1903 (v) of the Act

(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a state supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903 (v) (3) of the Act.

1905 (a) (9) of the Act

(7) Homeless Individuals

Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.

1902 (a) (47) and 1920 of the Act

☒ (8) Presumptively Eligible Pregnant Women

Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State Plan.

42 CFR 441.55
50 FR 43654
1902 (a) (43), 1905 (a) (4) (B), and 1905 (r) of the Act

(9) EPSDT Services

The Medicaid agency meets the requirements of sections 1902 (a) (43), 1905 (a) (4) (B), and 1905 (r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

Citation 3.1 (a) (9) Amount, Duration, and Scope of Services: EPSDT Services (cont.)

42 CFR 441.60

☒ The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.

The Department's Managed Care Unit has in place, through its purchasing specifications and utilization reporting, methods to ensure that continuing care providers have complied with their agreements, including EPSDT requirements.

42 CFR 440.240 and 440.250

(a) (10) Comparability of Services

1902 (a) and 1902 (a) (10), 1902 (a) (52) 3 (v), 1915 (g) and 5 (b) (4) of the Act

Except for those items or services for which sections 1902 (a),1902 (a) (10), 1903 (v), 1915 and 1925 of the Act, 42 CFR 440.250, and section 245A of the Immigration and Nationality Act, permit exceptions:

(i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.

(ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.

(iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.

☒ (iv) Additional coverage for pregnancy-related services and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

Citation

42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT-80-34

3.1 (b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or older.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

☒ Yes.

☐ Not applicable. The State Plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy.

☒ Yes, to all.

☐ Yes, to individuals age 21 or over; SNF services are provided.

☐ Yes, to individuals under age 21; SNF services are provided.

☐ No, SNF services are not provided.

☐ Not applicable; the medically needy are not included under this plan.

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 431.53 (c) (1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in **Attachment 3.1-D**.

42 CFR 483.10 (2) Payment for Nursing Facility Services

The state includes in nursing facility services at least the items and services specified in 42 CFR 483.10 (c) (8) (i).

Citation

3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 440.260
AT-78-90

(d) Methods and Standards to Assure Quality of Services

The standards established and the methods used to assure high quality care are described in **Attachment 3.1-C**.

Citation

3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 441.20
AT-78-90

(e) Family Planning Services

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

Citation 3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 441.30
AT-78-90

(f) (1) Optometric Services

Optometric services (other than those provided under §§435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

☐ Yes.

☐ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

☒ Not applicable. The conditions in the first sentence do not apply.

1903 (i) (1)
of the Act,
P.L. 99-272
(Section 9507)

(2) Organ Transplant Procedures

Organ transplant procedures are provided.

☐ No.

☒ Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at **Attachment 3.1-E.**

Citation

3.1 Amount, Duration, and Scope of Services (cont.)

42 CFR 431.110 (b)
AT-78-90

(g) Participation by Indian Health Service Facilities

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110 (b), on the same basis as other qualified providers.

1902 (e) (9) of the Act.
P.L. 99-509 (Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902 (e) (9) (C) of the Act, are provided under the plan to individuals who:

(1) are medically dependent on a ventilator for life support at least six hours per day;

(2) have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs, or ICFs for the lesser of:

☐ 30 consecutive days;

☐ __ days (the maximum number of inpatient days allowed under the State Plan);

(3) except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF, or ICF for which Medicaid payments would be made;

(4) have adequate social support services to be cared for at home; and

(5) wish to be cared for at home.

☐ Yes. The requirements of section 1902 (e) (9) of the Act are met.

☒ Not applicable. These services are not included in the plan.

Citation

3.2 Coordination of Medicaid with Medicare with Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902 (a) (10) (E) (i) and
1905 (p) (1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and Part B premiums for individuals in the QMB group as defined in Item A.25 of **Attachment 2.2-A**, through the group premium payment arrangement, unless the agency has a Buy-in agreement for such payment, as indicated below.

Buy-in agreement for:

☒ Part A ☒ Part B

☐ The Medicaid agency pays premiums, for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Citation

1902 (a) (10) (E) (ii) and 1905 (a) of the Act

(ii) Qualified Disabled and Working Individual (QDWI)

The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in **Attachment 4.18-E**, for individuals in the QDWI group defined in item A.26 of **Attachment 2.2-A** of this plan.

1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act

(iii) Specified Low-Income Medicare Beneficiary (SLMB)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in item A.27 of **Attachment 2.2-A** of this plan.

1902 (a) (10) (E) (iv) (I) 1905 (p) (3) (A) (ii), and 1933 of the Act

(iv) Qualifying Individual-1 (QI-1)

The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals described in 1902 (a) (10) (E) (iv) (I) and subject to 1933 of the Act.

1902 (a) (10) (E) (iv) (II) 1905 (p) (3) (A) (ii), and 1933 of the Act

(v) Qualifying Individual-2 (QI-2)

The Medicaid agency pays the portion of the amount of increase to the Medicare Part B premium attributable to the Home Health Provision to the individuals described in 1902 (a) (10) (E) (iv) (II) and subject to 1933 of the Act.

Citation

1843 (b) and 1905 (a) of the Act and 42 CFR 431.625

(vi) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

☒ All individuals who are: (a) receiving benefits under titles I, IV-A, X, XIV, or XVI (AABD or SSI); (b) receiving State supplements under title XVI, or (c) within a group listed at 42 CFR 431.625 (d) (2).

☒ Individuals receiving title II or Railroad Retirement benefits.

☒ Medically needy individuals (FFP is not available for this group).

1902 (a) (30) and 1905 (a) of the Act

(2) Other Health Insurance

☐ The Medicaid agency pays insurance premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years of age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).

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

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902 (a) (30), 1902 (n), 1905 (a), and 1916 of the Act

Supplement 1 to **Attachment 4.19-B** describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Sections 1902 (a) (10) (E) (i) and 1905 (p) (3) of the Act

(i) Qualified Medicare Beneficiaries (QMBS)

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902 (a) (10), 1902 (a) (30), and 1905 (a) of the Act

(ii) Other Medicaid Recipients

The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in section 3.2 (a) (1) (iv), payment is made as follows:

42 CFR 431.625

☐ For the entire range of services available under Medicare Part B.

☒ Only for the amount, duration, and scope of services otherwise available under this plan.

1902 (a) (10), 1902 (a) (30), 1905 (a), and1905 (p) of the Act

(iii) Dual Eligible — QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals eligible both as QMBs and categorically or medically needy (subject to any nominal Medicaid copayment).

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

1906 of the Act

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

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

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

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

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

Citation

42 CFR 441.101,
42 CFR 431.620 (c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

☒ Yes. The requirements of 42 CFR Part 441, Subpart C, and 42 CFR 431.620 (c) and (d) are met.

☐ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Citation	3.4 Special Requirements Applicable to Sterilization Procedures
42 CFR 441.252 AT-78-99	All requirements of 42 CFR Part 441, Subpart F are met.

Citation

1902 (a) (52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope of services provided to categorically needy AFDC recipients as described in **Attachment 3.1-A** (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are:

☒ Equal in amount, duration, and scope of services provided to categorically needy AFDC recipients as described in **Attachment 3.1-A** (or may be greater if provided through a caretaker relative employer's health insurance plan).

☐ Equal in amount, duration, and scope of services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

- ☐ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.
- ☐ Medical or remedial care provided by licensed practitioners.
- ☐ Home health services.

Citation 3.5 Families Receiving Extended Medicaid Benefits (cont.)

- ☐ private duty nursing services
- ☐ physical therapy and related services
- ☐ other diagnostic, screening, preventive, and rehabilitation services
- ☐ Inpatient hospital services and nursing facility services for
- ☐ individuals 65 years of age and over in an institution for mental disease
- ☐ Inpatient psychiatric services for individuals under age 21
- ☐ Hospice services
- ☐ Respiratory care services
- ☐ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary

Citation

3.5 Families Receiving Extended Medicaid Benefits (cont.)

(c) ☐ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance:

☐ First six months ☐ Second six months

☐ The agency requires caretakers to enroll in employer's health plans as a condition of eligibility.

☐ First six months ☐ Second six months

(d) ☒ (1) The Medicaid agency provides assistance to families during the second six-month period of extended Medicaid benefits through the following alternative methods.

☐ Enrollment in the family option of an employer's health plan.

☐ Enrollment in the family option of a state employee health plan.

☐ Enrollment in the state health plan for the uninsured.

☒ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Citation 3.5 Families Receiving Extended Medicaid Benefits (cont.)

Supplement 2 to Attachment 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency:

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

☒ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

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Citation

3.9 Reimbursements for Prescribed Drugs

1902 (a) (54)
1903 (i) (10)
1927
P.L. 101-508
(s. 4401)

The state meets all the requirements applicable to reimbursement for prescribed drugs.

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

2. a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4). (Effective 4/1/90, see **Attachment 4.19-B**, 2 A I (90-14).)

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d. Ambulatory services offered by a health center receiving funds under section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

3. Other laboratory and x-ray services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

*Description provided on **Supplement to Attachment 3.1-A**.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

c. Family planning services and supplies for individuals of child-bearing age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d.1 Face-to-face tobacco cessation counseling services for pregnant women provided:

☒ (i) By or under supervision of a physician**;
☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services;** or
☐ (iii) Any other healthcare professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.

** Describe if there are any limits on who can provide these counseling services

All healthcare professionals except physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists and physician assistants must complete a training course to provide tobacco cessation counseling services. Healthcare professionals must be under the supervision of a physician if required under state law.

d.2 Face-to-face tobacco cessation counseling services benefit package for pregnant women

☒ Provided: ☐ No limitations ☒ With limitations**

** Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:
Prior authorization is required for more than a total of 16 group and individual counseling sessions per member per 12 month cycle. Prior authorization is required for more than two intake sessions (quit attempts) per member per 12 month cycle.

*Description provided on **Supplement to Attachment 3.1-A**

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5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Medical and surgical services furnished by a dentist (in accordance with section 1905 (a) (5) (B) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. Podiatrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

*Description provided on **Supplement to Attachment 3.1-A**.

b. Optometrists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Chiropractors' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Other practitioners' services.

☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided.

e. Audiologists' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. Midlevel Practitioner Services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

7. Home health services.

a. Intermittent or part time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*

* Limitations are described in **Supplement to Attachment 3.1-A**.

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d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Limitations are described in **Supplement to Attachment 3.1-A**.

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.
** See Page 3 of **Supplement to Attachment 3.1-A**.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

b. Screening services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Preventive services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d. Rehabilitative services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902 (a) (31) (A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided

18. Hospice care (in accordance with section 1905 (o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

☒ Provided in accordance with section 2302 of the Affordable Care Act

* Description provided on **Supplement to Attachment 3.1-A**.

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, **Supplement 1 to Attachment 3.1-A** (in accordance with Section 1905 (a) (19) or Section 1915 (g) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Special tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

☐ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

☐ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.
* Description provided on **Supplement to Attachment 3.1-A**.

21. Ambulatory prenatal care for pregnant women furnished during a presumption eligibility period by a qualified provider (in accordance with section 1920 of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

22. Respiratory care services (in accordance with section 1902 (e) (9) (A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

23. Pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

24. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

a. Transportation.

☒ Provided: ☐ No limitations ☒ With limitations**
☐ Not provided.

Brokered Transportation

MassHealth provides non-emergency transportation to MassHealth Standard, CommonHealth and CarePlus members through selective broker contracts when no public transportation is available that is suitable to a member's condition within a specified distance from an authorized point of origin and destination. Payment for the non-emergency transportation services arranged through a broker is claimed as medical assistance. Delivery methods consist of ambulatory and non-ambulatory transport, including taxi, livery, ferry, and chair car service, or other methods suitable to the member's condition. MassHealth requires prior authorization to determine the medical necessity of non-emergency transportation provided through the brokerage system. Transportation requests are approved by EOHHS and implemented by the brokers. The state will operate the broker program without regard to freedom of choice of providers (section 1902(a)(23) of the Social Security Act).

The state assures that the six Regional Transit Authorities that serve as transportation brokers were selected by the MassHealth agency pursuant to a competitive procurement conducted consistent with federal requirements, and based on the state's evaluation of the broker's experience, performance, references, resources, qualifications, and cost. Each broker is responsible for arranging with its contracted network of transportation providers to deliver non-emergency transportation to and from medically necessary MassHealth covered services for members in the broker's contractually designated service area.

The state assures that its brokerage contracts are subject to regular auditing and oversight by the state to ensure the quality and timeliness of the transportation services provided, and the adequacy of beneficiary access to medical care and services. In addition, the state requires each broker to undertake extensive oversight activities with respect to its network of transportation providers, and assures that brokers have oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and transport personnel are licensed, qualified, competent and courteous.

The state assures that transportation services will be provided under contracts with brokers who comply with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate). The brokerage contract requires the brokers to comply with 42 CFR § 440.170(a)(4) governing the provision of non-emergency medical transportation, including prohibitions on referrals and conflicts of interest, and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or relationship, as specified in the contracts. Specifically, the brokers are prohibited from directly providing non-emergency medical transportation services, and are prohibited from making a referral or subcontracting to a transportation service provider if the broker has a financial relationship with the transportation provider, as defined at 42 CFR § 411.354(a); or if the broker has an immediate family member, as defined at 42 CFR § 411.351, that has a direct or indirect financial relationship with the transportation provider.

The brokerage contract prohibits the broker from withholding necessary transportation from a MassHealth member for the purpose of financial gain or any other purpose; authorizing transportation that is not the most appropriate and a cost effective means of transportation for that member for the purpose of financial gain or any other purpose; soliciting or accepting any payment or other form of remuneration, including any kickback, rebate, cash, gift, or service in kind from a transportation provider or any other party in order to influence referrals or subcontracting for non-emergency medical transportation provided to a MassHealth member.

Payments under the brokerage contracts are structured to ensure cost-effectiveness. Brokers are required to competitively procure and contract with their network of transportation providers and develop competitive methods of awarding trips and routes to transportation providers. Brokers schedule trips with the lowest cost qualified transportation provider, and the brokers receive reimbursement at cost from the state for their payments to transportation providers.

Brokers are paid a broker-specific average monthly trip cost for each eligible trip. For demand-response trips, the average monthly trip cost is calculated by dividing the broker's total expenditures for demand-response trips by the number of demand-response trips in that month. For program based trips, the average monthly trip cost for each broker is calculated by first determining route-specific average monthly trip rates, and then calculating a combined average trip rate for all routes. To further encourage cost savings, brokers also receive a shared ride incentive payment if they can achieve a target rate of shared ambulatory trips.

A fixed monthly broker management fee paid under the brokerage contract is claimed as an administrative expense. The broker management fee is negotiated between EOHHS and the broker based on the broker's reasonable costs of performing the broker management function, exclusive of direct transportation costs.

The source of the non-federal share of payments for brokered transportation services to MassHealth members is general fund appropriations to the state Medicaid agency.

****** Description of non-brokered transportation is provided on **Attachment 3.1-D**

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided.

c. Care and services provided in Christian Science sanitoria.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided.

d. Nursing facility services for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

f. Critical Access Hospital Services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-A**.

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in **Supplement 2 to Attachment 3.1-A**, and Appendices A-G to **Supplement 2 to Attachment 3.1-A**.

☐ Provided ☒ Not provided.

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Item 26: Personal Care Services

Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☒ Provided:
- ☒ State Approved (Not Physician) Service Plan Allowed
- ☒ Services Outside the Home Also Allowed
- ☒ Limitations Described on Supplement to Attachment 3.1-A

☐ Not provided

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27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in **Supplement 3 to Attachment 3.1-A**.

☒ Election of PACE: by virtue of this submittal, the state elects PACE as an optional State Plan service.

☐ No election of PACE: by virtue of this submittal, the state elects to not add PACE as an optional State Plan service.

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28. Freestanding Birth Center Services

i. Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☐ No limitations ☒ With limitations

☐ None licensed or approved

Please describe any limitations:

Freestanding birth center services are covered for women with low risk pregnancies. Freestanding birth center services include care during pregnancy, labor, delivery, and recovery following delivery, including newborn nursery and post-partum care.

ii. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☐ No limitations ☒ With limitations

☐ Not applicable (There are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

The limitations to the practitioners' services are the same limitations as noted in their respective section of the State Plan.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan: Physicians, and certified nurse midwives.

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

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Item 1: **Inpatient Hospital Services**

1. Utilization Management: As a condition of payment, MassHealth requires preadmission screening for all elective admissions to acute hospitals and for all admissions to a chronic disease and rehabilitation hospital, except for members with other insurance (including Medicare).
2. Prior Authorization: MassHealth requires prior authorization for certain acute inpatient hospital services based on medical necessity, including certain drugs and biologics administered in the acute inpatient hospital setting.

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Item 2.a: **Outpatient Hospital Services**

MassHealth requires prior authorization for certain outpatient hospital services based on medical necessity, including for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period; and for certain drugs and biologics administered in the acute outpatient hospital setting.

DEP/ESPs provide crisis assessment, stabilization, special services and other interventions in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. To qualify as a DEP/ESP, a provider of hospital services must be designated as such by the Commonwealth.

Item 4.a: **Nursing Facilities Services**

If a utilization review team recommends that a recipient in a multi-level long-term-care facility be changed to a lower level of care, the facility is responsible for relocating a recipient to the recommended level of care within the facility. The recipient has the right to appeal the recommendation.

Item 4b: Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found.

In addition to all other medically necessary services covered for individuals under age 21, the following services are covered as Rehabilitation services as defined in 42 USC 1396d (a) (13). These services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual:

a. Mobile Crisis Intervention (Services described in this section are effective July 1, 2009.)

Mobile Crisis Intervention provides a short term service that is mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health (mental health or substance abuse) crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Mobile crisis services may be provided by a single crisis worker or by a team of professionals that are qualified providers who are trained in crisis intervention.

Mobile Crisis Intervention includes the following activities when performed to resolve the immediate crisis:

- Assessment;
- Crisis counseling including individual and family counseling;
- Clinical consultation and coordination with other health care providers;
- Psychopharmacological management, including availability of on-site prescriber;
- Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support;
- Development of a risk management/safety plan. In cases where the youth does not already have such a plan, Mobile Crisis Intervention creates a risk management/safety plan in concert with the parent(s)/guardian(s)/caregiver(s) and any existing service providers (e.g., ICC, In-Home Therapy Services, outpatient therapist); and
- Referral to other services as needed.

Settings: Mobile Crisis Intervention is provided where the child is located.

Providers: Components of Mobile Crises Crisis Intervention are provided by practitioners, as described below. Practitioners must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers and other clinics.

- **Assessment** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Crisis counseling including individual and family counseling** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is
- **Clinical consultation and coordination with other health care providers** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is

- **Psychopharmacological management** - Psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, board-certified or board-eligible child psychiatrists, psychiatry residents.

- **Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

- **Development of a risk management/safety plan** -LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Referral to other services as needed:** LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, CADACs, CADAC IIs, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

b. In-Home Behavioral Services: (Services described in this section are effective October 1, 2009.)

This service provides for the development of a highly specific behavior plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals in order to treat challenging behaviors that interfere with the youth's successful functioning. An In-Home Behavioral service includes two components: behavior management therapy and behavior management monitoring. It is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff.

1. Behavior management therapy: Behavior management therapy includes activities that are required to develop, implement, monitor and update a behavior plan, including overseeing activities of the behavior management monitor. Behavior management therapy is performed by a licensed clinician who meets the qualifications of a Behavior management therapist as described in the provider qualifications section below.

   Behavior management therapy includes the following:

   - Functional behavioral assessment;
   - Development of a focused behavior plan that identifies specific behavioral and measurable objectives or performance goals and interventions that are designed to diminish, extinguish, or improve specific behaviors related to a youth's behavioral health (mental health or substance abuse) condition(s);
   - Development or revision of a youth's risk management/safety plan to address the specific behavioral needs of the youth;
   - Counseling the parent(s)/guardian(s)/caregiver(s) on how to implement strategies identified in the behavior plan;
   - Working closely with the behavior management monitor to ensure the behavior plans and risk management/safety plan are implemented as developed, and to make any necessary adjustments to the plans;
   - Clinical consultation and coordination with other behavioral health (mental health or substance abuse) care providers; and
   - Referral to other services as needed.

2. Behavior management monitoring. This service includes activities related to the implementation of the behavior plan and a risk management/safety plan as needed. Behavioral management monitoring also includes monitoring the youth's behavior, reinforcing implementation of the behavior plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals.

   Behavioral management monitoring is performed by a paraprofessional who meets the qualifications of a behavior management monitor as described in the definitions section below.

   Behavior management monitoring includes the following:

   - Monitoring the youth's progress on implementation of the goals of the behavior plan developed by the behavior management therapist;
   - Assisting the youth in implementing the goals of the behavior plan developed by the behavioral management therapist;
   - Providing guidance to the parent(s)/guardian(s)/caregiver(s) in implementing the plan; and
   - Working closely with the behavior management therapist to ensure the behavior plans and risk management/safety plan are implemented as developed.

Settings: In-Home Behavioral Services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

Providers The following practitioners may provide any component of behavior management therapy as described above: Developmental-behavioral pediatricians, developmental-behavioral pediatric fellows, LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns and social work interns. Behavior management monitors may provide any component of behavior management monitoring as described above.

Qualified Practitioners of behavior management therapy also must have two years relevant experience providing direct services to youth and families who require behavior management to address behavioral health (mental health or substance abuse) needs; course work and training in conducting functional behavioral assessments, and selecting, implementing and evaluating intervention strategies; supervised experience conducting functional behavioral assessments and designing, implementing, and monitoring behavior analysis programs for clients and other qualifications established by the state. Practitioners must be working under an employment or contractual agreement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth. .

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c. In-Home Therapy Services: (Services described in this section are effective November 1, 2009.)

This service provides for the development of an individualized treatment plan; supervision and coordination of interventions for the purpose of treating the youth's mental health and substance abuse needs. The intervention is designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. This service is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff, offering a combination of medically necessary in home therapy and therapeutic training and support.

1.

In Home Therapy: In-home therapy is a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family. The licensed clinician, in collaboration with the family and youth, develops an individualized treatment plan and, using established psychotherapeutic techniques, and intensive family therapy works with the entire family or a subset of the family to implement focused structural or strategic interventions to advance therapeutic goals. In addition, the clinician assists in identifying and utilizing community resources and develops and maintains natural supports for the youth and parent(s)/guardian(s)/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention. In-Home therapy is performed by a licensed clinician who meets the qualifications of an in-home therapist as described section below.

In-Home Therapy includes the following:

- Assessments;
- Development of an individualized treatment plan by the qualified practitioner in partnership with the youth and parent(s)/guardian(s)/caregiver(s) and, with required consent, in consultation with other providers that is designed to address the youth's mental health or substance abuse condition;
- Ongoing monitoring and modification of the individualized treatment plan as indicated;
- Review/development of a risk management/safety plan;
- Phone and face-to-face consultation with other providers, individuals and entities who may impact the youth's treatment plan;
- Family counseling through which the licensed clinician works with the entire family, or a subset of the family, to advance therapeutic goals; and
- Referral to other services as needed.

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2. Therapeutic training and support is a service provided by an associate-level or bachelor-level paraprofessional working under the supervision of a clinician to support implementation of the in-home therapists treatment plan in order to achieve the goals of the that plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the individualized treatment plan. Phone contact and consultation may be provided as part of the intervention.

   Therapeutic training and support includes the following:

   - Providing guidance to the youth and parent(s)/guardian(s)/caregiver(s) in implementing the treatment plan;
   - Providing skills training for youth and parent(s)/guardian(s)/caregiver(s) in support of the treatment plan goals; and
   - Monitoring the youth's and parent(s)/guardian(s)/caregiver(s) progress on achieving treatment plan goals and communicating regularly with the clinician so that the treatment plan can be modified and necessary.

   Settings: In home therapy services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

   Providers: The following practitioners may provide any component of in-home therapy as described above: In-home therapy services are delivered by the following practitioners: LICSW, LCSW, LMFT, LMHC, Licensed psychologist, Master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinic specialists trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns. The following practitioners may provide any component of therapeutic training and support as described above: Associate-level counselors / paraprofessionals, bachelor-level counselors / paraprofessionals. Practitioners must be working under an employment or contractual arrangement with one of the following outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

d. Therapeutic Mentoring Services: (Services described in this section are effective October 1, 2009.)

Therapeutic mentoring services are structured, one-to-one, strength-based services that are designed to help ameliorate behavioral health (mental health or substance abuse) related conditions which prevent the youth from appropriate social functioning. These services must be delivered according to an individualized treatment plan developed by either an outpatient clinician, an in-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. Progress toward meeting the identified goal(s) must be documented and reported regularly to the provider responsible for the youth's treatment plan.

The therapeutic mentor does not provide social, educational, artistic, athletic, recreational or vocational services.

Settings: Therapeutic mentoring services are provided to youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), school, child care centers and other community settings. .

Providers: Therapeutic mentoring services are delivered by therapeutic mentors. Practitioners must be working under an employment or contractual arrangement with on of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth**.** Providers of therapeutic mentoring utilize therapeutic mentors to provide these services.

e **Family Support and Training:** (Services described in this section are effective July 1, 2009.)

A family support and training partner addresses goals established in an individualized treatment plan in order to resolve or ameliorate the youth's mental health, behavioral and emotional needs through enhancing the capacity of the parent(s)/guardians/caregivers) to implement activities required to meet the goals of the plan. Family support and training is a skill-building support and not a form of therapy or counseling. The individualized treatment plan must be developed by either an outpatient clinician, an In-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. These services include the following when they are relevant to the goals in the youth's individualized care plan:

- providing guidance to parent(s)/guardians(s)/caregiver(s) on navigating systems that support youth with mental health, behavioral and emotional needs, such as working effectively with state agency case managers, school system officials, provider agency staff and clinicians;
- fostering empowerment of parent(s)/guardian(s)/caregiver(s) by offering supportive guidance for parents of youth with mental health needs and encouraging participation in peer/parent support and` self-help groups;
- providing guidance to the parent(s)/guardian(s)/caregiver(s) how to find, access and use formal and informal community-based resources (e.g., after-school programs, food assistance, housing resources, youth-serving systems, etc.); and
- modeling these skills for parent(s)/guardians(s)/caregiver(s).

Family support and training services do not include respite care or child care services.

Settings: Family support and training services are provided in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings.

Providers: Family support and training services are delivered by a family support and training partner. A family support and training partner must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Definitions:

Associate-level counselors/paraprofessional
Associate-level counselors/paraprofessionals must have an associate's degree in a human services field from an accredited academic institution and one (1) year of relevant experience working with families or youth. If the associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Associate-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Bachelor-level counselors/paraprofessional
Bachelor-level counselors/paraprofessionals must have a bachelor's degree in a human services field from an accredited academic institution and one year of relevant experience working with families or youth. If the bachelor's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Bachelor-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Behavior Management Monitor
Behavioral management monitors must have a bachelor's degree in a human services field from an accredited university and one (1) year of relevant experience working with families, children or adolescents who require behavior management, or an associate's degree and a minimum of two (2) years of relevant experience working with families, children or adolescents who require behavior management. Behavior management monitors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Certified Alcoholism/Drug Abuse Counselor (CADAC)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC certification requires a combination of either a Master's degree in a "behavioral science area" and 2,000 hours of supervised experience or a Bachelor's degree in a behavioral science area and 4,000 hours of supervised experience or an Associates' degree in a behavioral science area and 6,000 hours of supervised experience. Certification also requires documentation of having received a minimum of 270 clock hours of continuing education related to the five domains for alcohol and other drug abuse. Consistent with applicable state licensure requirements, certified alcoholism/drug abuse counselors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Certified Alcoholism/Drug Abuse Counselor II (CADAC II)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC II certification requires a master's degree (or higher) from a regionally accredited academic institution in a human services behavioral sciences field with a clinical application (i.e., practicum); 2,000 hours of supervised experience and documentation of completion of 300-hour practicum. Consistent with applicable State licensure requirements, certified alcoholism/drug abuse counselor IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Developmental-Behavioral Pediatrician
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and either board-eligible or board-certified in Developmental-Behavioral Pediatrics

Developmental-Behavioral Pediatric Fellow
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and enrolled in a training program in Developmental-Behavioral Pediatrics accredited by the Accreditation Council for Graduate Medical Education (ACGME). Services provided by the Developmental-Behavioral Pediatric Fellow must be provided in a setting approved for training by the sponsoring training institution, under supervision of a board certified or eligible Developmental-Behavioral Pediatrician, consistent with applicable state licensure requirements.

Family Support and Training Partner
A family support and training worker must have experience as a caregiver of a youth with special needs, preferably youth with behavioral health needs, experience in navigating any of the youth and family-serving systems and teaching family members who are involved with the youth and family serving systems, and either: a bachelor's degree in a human services field from an accredited academic institution, or an associate's degree in a human services field from an accredited academic institution and one (1) year of experience working with children/adolescents/transition-age youth and families, or a high school diploma or General Education Development (GED) and a minimum of two (2) years of experience working with children/adolescents/transition age youth and families. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Family partners are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor I – LADC I
A person licensed by the Department of Public Health to conduct an independent practice of alcohol and drug counseling, and to provide supervision to other alcohol and drug counselors, as defined in 105 CMR 168.000. These requirements include: a master's or doctoral degree in behavioral sciences, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience.

Licensed Alcohol and Drug Counselor II – LADC II
A person licensed by the Department of Public Health to practice alcohol and drug counseling under clinical supervision, as defined in 105 CMR 168.000. These requirements include: a high school diploma or equivalent, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience (4,000 if applicant holds a bachelor's degree). Consistent with applicable state licensure requirements, LADC IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor Assistant – LADC III
A person licensed by the Department of Public Health to provide recovery based services under direct clinical and administrative supervision, as defined in 105 CMR 168.000. These requirements include a high school diploma or equivalent, 2,000 hours of work experience in the alcohol or drug abuse field and a minimum of 50 hours of training in substance abuse counseling. Consistent with applicable state licensure requirements LACD IIIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Independent Clinical Social Worker (LICSW)
A person with a current, valid, unrestricted license to practice as an LICSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education and two years supervised experience.

Licensed Clinical Social Worker (LCSW)
A person with a current, valid, unrestricted license to practice as an LCSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education. Consistent with applicable state licensure requirements, LCSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Worker (LSW)
A person with a current, valid, unrestricted license to practice as an LSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: a bachelor's degree in Social Work from a program accredited by the Council on Social Work Education or a bachelor's degree in any subject and 3500 hours of supervised experience providing social work services. Consistent with applicable state licensure requirements, LSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Work Associate (LSWA)
A person with a current, valid, unrestricted license to practice as an LSWA, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: an associate degree, or at least sixty credit hours of college education, in the fields of social work, psychology, counseling or other similar human services field, from an accredited college or university; or a baccalaureate degree in any field from an accredited college or university; or a minimum of one thousand (1000) hours of education in social work theory and methods in courses or programs approved by the Board of Registration of Social Workers. Consistent with applicable state licensure requirements, LSWAs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Marriage and Family Therapist (LMFT)
A person with a current, valid, unrestricted license to practice as a LMFT, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Mental Health Counselor (LMHC)
A person with a current, valid, unrestricted license to practice as a LMHC, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Psychologist
A person with current, valid, unrestricted license to practice psychology issued by the Massachusetts Board of Registration in Psychology. These requirements include a doctoral degree from a program accredited by the American Psychological Association and two years supervised experience .

Marriage and Family Therapy Intern
The marriage and family therapy intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in marriage and family therapy or a master's in a counseling program that is fully accepted by the Board of Allied Mental Health and Human Services Profession. The marriage and family therapy intern must provide services under the direct supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist consistent with applicable state licensure requirements.

Master's Level Counselor
A person with a master's or doctoral degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university who is supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist.

Mental Health Counselor Intern
The Mental Health Counselor Intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in mental health counseling or a master's in a counseling psychology program that is fully accepted by the Board of Allied Mental Health and Human Services Profession Consistent with applicable state licensure requirements, the Mental Heath Counselor Intern provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Board of Registration in Nursing, a master's degree in the mental health fields and one (1) year of experience delivering mental health services to families and youth. Consistent with applicable state licensure requirements, the Psychiatric Nurse provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse Mental Health Clinical Specialist
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing and current, valid, unrestricted authorization by the Massachusetts Board of Registration in Nursing to practice as a Psychiatric Nurse Mental Health Clinical Specialist.

Psychiatric Nurse Mental Health Clinical Specialist Trainee
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing who is enrolled in a Psychiatric Nurse Mental Health Clinical Specialist training program recognized by the Massachusetts Board of Registration in Nursing. Consistent with applicable state licensure requirements, services provided by the Psychiatric Nurse Mental Health Clinical Specialist trainee are provided under supervision of a Psychiatric Nurse Mental Health Clinical Specialist.

Psychiatric Resident
A person with a current, valid, full or limited license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency training program in either adult psychiatry or child and adolescent psychiatry. Services provided by the Psychiatric intern are provided in a setting approved for residency training by the sponsoring training institution, under supervision of a board certified or eligible child psychiatrist, consistent with applicable state licensure requirements.

Psychiatrist
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine. Psychiatrists treating youth ages 0 to 19 shall be board-certified or board-eligible in child and adolescent psychiatry. Psychiatrists treating youth ages 19 to 21 shall be trained in adult psychiatry.

Psychology Intern
The psychology intern must be admitted to doctoral candidacy in a structured clinical, or counseling, American Psychological Association (APA)-approved doctoral program. Consistent with state licensure requirements, services provided by a psychology intern are provided under the direct supervision of a licensed psychologist.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Pursuant to MGL Chapter 112 §165, applied behavior analysts must be licensed by the Commonwealth of Massachusetts Board of Registration of Allied Mental Health and Human Services Professions. Licensed applied behavior analysts or licensed physicians, psychologists or psychiatrists working under the scope of their practices may bill for applied behavior analyst services provided directly by a licensed assistant applied behavior analysts or a non-licensed para-professional, when the services are performed under the supervision of the licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice and the provided services are within the scope of practice for a licensed applied behavior analyst.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 5: **Physician's Services**

Physician services are provided in accordance with 42 CFR 440.50.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Services that are subject to prior authorization include certain surgery services, including reconstructive surgery and gender reassignment surgery; and certain practitioner-administered drugs. MassHealth covers one application of fluoride varnish every three months for members under 21 years of age without prior authorization; additional applications are covered with medical justification.

See also Supplement to Attachment 3.1-A, p.1, Item 1.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

G. School-Based Services:

School-Based Services (SBS) are services that are listed in a recipient student's Individualized Education Plan (IEP), a section 504 accommodation plan pursuant to 34 C.F.R. § 104.36, an Individualized Health Care Plan, an Individualized Family Service Plan, or are otherwise medically necessary, that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPSDT screen.

Service providers shall be licensed or otherwise qualified under the applicable State practice act or comparable licensing criteria by the State Department of Public Health, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice.

Covered services include: physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR § 440.110; physician services under 42 CFR § 440.50(a); optometry services provided by a qualified professional under 42 CFR § 440.60; respiratory therapy provided by a qualified professional under 42 CFR § 440.60; nursing services coverable under 42 CFR § 440.80 and 42 CFR § 440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse; nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated to individuals who receive appropriate teaching, direction, and supervision from a Registered Nurse or Practical Nurse; fluoride varnish performed by a dental hygienist under 130 CMR § 420.424(b) in accordance with 42 CFR § 440.100; personal care services coverable and performed by individuals qualified under 42 CFR § 440.167; services performed by licensed practitioners within the scope of their practice for individuals with behavioral health (mental health and substance abuse) disorders, as defined under state law, and coverable as medical or other remedial care under 42 CFR § 440.60; diagnostic, screening, preventive, and rehabilitative services covered under 42 CFR § 440.130; medical nutritional services provided by a qualified professional under 42 CFR § 440.60; and sports related or other injury assessment and therapy provided by a qualified professional under 42 CFR § 440.60. Assessments and independent evaluations are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

Item 6: **Licensed Practitioners Services**

Licensed Practitioner Services are provided in accordance with 42 CFR 440.60.

a. **Podiatrists' Services** – Coverage is for podiatry services that are considered medically necessary. Office visits are limited to one initial visit, one limited visit per 30 day period, one extended visit per 30 day period, and one follow up visit per week. Out of office visits are limited to one visit in a 30 day period in a long-term-care facility or the member's home and two visits in a 30 day period in a hospital setting.

b. **Optometrists' Services** –

Members under age 21 are limited to one comprehensive examination within a 12 month period; additional services are provided when medically necessary. . Members aged 21 or older are limited to one comprehensive eye examination within a 24 month period; additional services are provided when medically necessary.

Services that are subject to prior authorization include: fundus photography; non-plastic prosthetic eyes; unlisted services; and vision training.

Exclusions consist of treatment for congenital dyslexia.

c. **Chiropractic Services** – include chiropractic manipulative treatment and radiology services. Services are limited to medically necessary treatment related to a neuromusculoskeletal condition. The MassHealth agency limits payment for chiropractor services for any combination of office visits and chiropractic manipulative treatments. Any office visits or chiropractic manipulative treatments in excess of 20 per member per calendar year are subject to prior authorization.

d. **Other Practitioners' Services** – Other practitioners' services also include psychologists' services, which are limited to psychological testing only; hearing instrument specialist services and public health dental hygienist services. Hearing instrument specialist services are limited to the practice of fitting and dispensing of hearing aids which means the measurement of human hearing solely for the purpose of making selections, adaptations or sales of hearing aids intended to compensate for impaired hearing. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60 month period without prior authorization.

Public health dental hygienist services are limited to services provided in public health settings within the scope of practice governed by the Massachusetts Board of Registration in Dentistry and covered by the MassHealth agency.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 6: **Licensed Practitioners Services (continued)**

f. Midlevel Practitioner Services – Midlevel practitioner services include the services of certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric clinical nurse specialists licensed under state law. The services of all midlevel practitioners are limited to their scope of practice authorized by state law and must be provided in accordance with applicable state licensure and other applicable federal and state requirements.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided

Item 7: **Home Health Services**

c. Medical supplies, equipment, and appliances must be prescribed or ordered by the recipient's physician and must be furnished and claimed directly by appropriate vendors in accordance with the Division's regulations relative to drugs, restorative services, and rehabilitative services. Home health agencies must transmit such prescriptions and orders to vendors who are providers in the Medical Assistance Program.

Item 8: Private Duty Nursing Services

a. Private duty nursing services are provided in accordance with 42 CFR 440.80
b. Private duty nursing services are not provided in a hospital or skilled nursing facility.
c. Private duty nursing services are subject to prior authorization

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

Item 9: **Clinic Services**

Clinic Services are covered with limitations, including those specified in Item 9. MassHealth does not cover experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments, or nonmedical services (e.g., vocational and educational services, research).

Specific clinic services covered by MassHealth include the following:

a. Designated Emergency Mental Health Provider

Designated Emergency Mental Health Providers/Emergency Services Programs (DEP/ESPs) provide crisis assessment, interventions, and stabilization services in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. DEP/ESP services are provided in freestanding facilities. DEP/ESPs operate under the direction of a psychiatrist. To qualify as a DEP/ESP, a provider must be designated as such by the Commonwealth.

(Item 9 Clinic Services, continued)

b. Freestanding Ambulatory Surgery Centers

MassHealth covers the following services in freestanding ambulatory surgery centers (FASCs) - outpatient same-day surgical, diagnostic, and medical services requiring general, local or regional anesthesia, a dedicated operating room, and a postoperative recovery room to patients who require constant medical supervision for a limited amount of time upon completion of the surgery or procedure, and are not expected to require hospitalization or overnight services. FASC services also include anesthesia, laboratory, radiology, drugs, biologicals, equipment, and supplies, related to the provision of the surgery or procedure.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in FASCs when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

FASCs must obtain prior authorization for FASC services provided out of state when the FASC is located more than 50 miles from the Massachusetts border.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

c. Family Planning Clinics

MassHealth covers family planning-related services, including medical examinations, counseling, follow-up health care, laboratory tests, procedures, supplies and drugs, including contraceptive supplies and drugs, provided in a family planning clinic.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in family planning clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

The family planning agency may be paid for a maximum of one HIV pre-test counseling visit and one HIV post-test counseling visit per member per test per day. The MassHealth agency pays for a maximum of four HIV pre-test counseling visits and four HIV post-test counseling visits per calendar year.

(Item 9 Clinic Services, continued)

d. Sterilization Clinics

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) provided in sterilization clinics.

Sterilization is covered in sterilization clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

(Item 9 Clinic Services, continued)

e. Radiation Oncology Centers

MassHealth covers radiation oncology and related services provided in radiation oncology centers, including radiologic procedures, drugs, equipment and supplies, and routine laboratory tests necessary for the diagnosis, detection, and treatment of disease, and for the maintenance of the health of MassHealth members.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9, Clinic Services continued)

f. Renal Dialysis Clinics

MassHealth covers renal dialysis and related services, including supplies, drugs and routine laboratory tests, provided in renal dialysis clinics. MassHealth covers home dialysis training, including self-dialysis (hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis) and continuous ambulatory peritoneal dialysis training only when the MassHealth member attends such training at the clinic site.

(Item 9 Clinic Services, continued)

g. Rehabilitation Centers

MassHealth covers the following services in freestanding rehabilitation centers for individuals requiring physical rehabilitation: rehabilitation evaluations conducted by physicians; and physical, occupational and speech/language therapy visits and evaluations performed by licensed therapists to improve or prevent the worsening of a congenital or acquired condition.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the rehabilitation center to obtain prior authorization for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12-month period. Diversional and recreational therapy are not covered.

(Item 9 Clinic Services, continued)

h. Speech and Hearing Centers

MassHealth covers the following services in a freestanding speech and hearing center: audiological services, and speech, hearing or language services performed by a licensed, certified audiologist or licensed, certified speech therapist.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the speech and hearing center to obtain prior authorization for more than 35 speech and language pathology visits, including group therapy visits, for a member in a 12-month period. Diversional and recreational therapy are not covered.

MassHealth covers up to one individual treatment and one group therapy session per member per day at the speech and hearing center.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

i. Mental Health Centers

MassHealth covers diagnosis and treatment of mental and emotional disorders at mental health centers. Such services include diagnostic services, psychological testing, individual therapy, couple therapy, family therapy, group therapy, medication visit, case consultation, family consultation and psychotherapy for crisis/emergency services.

MassHealth does not cover nonmedical services provided by mental health centers (e.g., vocational, educational, recreational, community, and life-enrichment services) or diagnostic or treatment services provided at a mental health center as an integral part of a planned and comprehensive program (e.g., a residential, day activity, or drop-in program) that is organized to provide primarily non-medical or other nonreimbursable services. Play therapy, as an alternative to strictly verbal expression, is not considered a recreational service and is covered.

MassHealth covers multiple treatment modalities for a member on the same day, except for diagnostics. MassHealth does not cover more than one session of a single type of service provided to an individual member on the same day, except for the provision of psychotherapy for crisis.

Group Therapy is limited to a maximum of 12 members per group.

Psychotherapy for crisis is limited to one initial unit of service and up to three add-on units of service per date of service.

(Item 9 Clinic Services, continued)

j. Substance Use Disorder Treatment Clinics

MassHealth covers individual, group, and family/couple substance abuse rehabilitative counseling, case consultation, and acupuncture detoxification at substance abuse outpatient counseling programs.

MassHealth covers medication assisted treatment for opioid dependency at opioid treatment service centers, in accordance with applicable clinical standards. Prior authorization is required for buprenorphine.

Item 10: **Dental Services**

A. For members under age 21, all medically necessary dental services, including comprehensive and periodic oral evaluations and all dental services needed for maintenance of dental health, restoration of teeth, and relief of pain and infections are covered.

B. For members age 21or over the following dental services are covered:

- diagnostic services including oral evaluation (comprehensive and periodic) and radiographs;
- preventive services including prophylaxis;
- emergency care visits;
- certain restorative services (fillings);
- certain prosthodontic services (full and partial dentures including repairs);
- extractions;
- anesthesia;
- treatment of complications related to surgery;
- certain oral surgery such as biopsies and soft-tissue surgery; and
- certain periodontal services, including gingivectomies, gingivoplasties, and periodontal scaling and root planing.

In addition, for members age 21 or over, there are limited exceptions that allow for topical fluoride when documented as medically necessary.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 17: **Nurse-Midwife Services**

Nurse-midwife services are provided by certified nurse-midwives in accordance with 42 CFR 440.165.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-A, p.1, Item 1.

Item 23: Pediatric or Family Nurse Practitioners' Services

Pediatric and family nurse practitioner services are provided by certified nurse practitioners in accordance with 42 CFR 440.166.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-A, p.1, Item 1.

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Limitations to Services Provided to the Categorically Needy

Item 11: **Therapies and Related Services**

Speech, occupational and physical therapies to improve or prevent the worsening of a congenital or acquired condition are provided in accordance with 42 CFR 440.110. MassHealth pays for maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program. Diversional and recreational therapy are not reimbursable services.

Services that are subject to prior authorization include more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12 month period.

Audiologist Services are provided in accordance with 42 CFR 440.110. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60-month period without prior authorization.

Item 12: **Prescribed Drugs, Dentures, Prosthetic Services, and Eyeglasses**

a. **Prescribed Drugs** - Legend FDA-approved drugs and certain non-legend over-the-counter drugs are reimbursable subject to the conditions specified in 130 CMR 406.000. Prescribers must obtain prior authorization for non-generic multiple source drugs, and for any drug identified by the Division in accordance with 130 CMR 450.303. Insulins are reimbursable for recipients without restrictions.

Active pharmaceutical ingredients (APIs) and excipients that are included in an extemporaneously compounded prescription written by an authorized prescriber and dispensed by MassHealth pharmacy providers are covered if medically necessary.

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements of Section 1927 of the Social Security Act, the state has the following policies for the supplemental rebate program for the Medicaid population:

1. The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

2. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 31, 2016, and entitled, "State of Massachusetts Supplemental Rebate Agreement" has been authorized by CMS, and a value-based rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 12, 2019, and entitled, "State of Massachusetts Value-Based Supplemental Rebate Agreement" has been authorized by CMS.
3. Manufacturers with supplemental rebate agreements are allowed to audit utilization data. Supplemental rebates received by the state in excess of those required under the National Drug Rebate Agreement (NDRA) will be shared with the federal government on the same percentage basis as applied under the NDRA.
4. The unit rebate amount under the NDRA is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act. No substantial changes will be made to the supplemental rebate agreement without CMS authorization. Supplemental rebates received pursuant to these agreements are only for the MassHealth program.
5. All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provisions of the NDRA.
6. The prior authorization process for covered outpatient drugs conforms to Section 1927(d)(5) of the Social Security Act. The prior authorization process provides for a turnaround response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.
7. The state may agree within the terms of a supplemental rebate agreement that the covered drug(s) may or may not be subject to prior authorization, for as long as the agreement is in effect, and that the state may obtain supplemental drug rebates in either case. This may include instances in which the state imposes prior authorization on a drug or drugs for clinical purposes, instances in which the state imposes prior authorization on a drug or drugs as part of a "step-edit" approach, and instances in which the state imposes prior authorization on a drug or drugs (which may include a generic drug) when the application of the supplemental rebate on the preferred drug or drugs results in a lower net cost to the state. The state may also enter value- or outcome-based agreements.
8. Only drugs supplied to MassHealth members will be covered under these agreements. In addition to collecting supplemental rebates for fee-for-service claims, the state may, at its option, also collect supplemental rebates for MassHealth member utilization through MCE(s) under an agreement.
9. The state may continue to collect supplemental rebates under agreements that are currently in process or effect based on the form of agreement approved by CMS as part of MA-TN-012-005 until those agreements are otherwise terminated or amended to align with the CMS-approved forms referred to in paragraph 2, above.

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

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And Remedial Care and Services Provided to the Categorically Needy

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit –Part D.

☑ **The following excluded drugs are covered:**

☑ (a) agents when used for anorexia, weight loss, weight gain (for medically necessary appetite stimulants only)

☐ (b) agents when used to promote fertility

☑ (c) agents when used for the symptomatic relief cough and colds (covered only when dispensed to members residing in a nursing facility).

☑ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride-containing products

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☑ (f) nonprescription drugs, as follows:

Allergy Agents, Ophthalmic
Analgesics
Anthelmintic Agents
Antihistamines/Decongestants
Antimicrobials, Topical
Contraceptives, Oral
Dermatologic Agents, Topical
Gastrointestinal Products
Nonoxynol-9
Otic Agents
Pediculicides/Scabicides

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

b. **Dentures** - Dentures are provided in accordance with 42 CFR 440.120. See **Supplement to Attachment 3.1-A**, page 3, Item 10, above.

c. **Prosthetic Devices** Prosthetic devices (including orthotics) are provided in accordance with 42 CFR 440.120.

MassHealth covers medically necessary prosthetics and orthotic services, including repairs after exhaustion of manufacturer warranties.

Prosthetic services that are subject to prior authorization include: addition to lower extremity prosthesis, endoskeletal ankle foot system, microprocessor controlled, lower extremity prosthesis not otherwise specified, external power device, electronic elbow and accessories, upper extremity prosthesis not otherwise specified, breast prosthesis, unlisted procedures for miscellaneous prosthetic services.

Orthotic services that are subject to prior authorization include: compression garments, protective helmet, foot pressure off loading device, spinal orthosis not otherwise specified, lower extremity orthosis not otherwise classified, orthopedic foot wear and upper limb orthosis not otherwise specified.

Members of any age may obtain prior authorization for units in excess of the limits for service codes for all other prosthetic and orthotic services.

d. **Eyeglasses** Eyeglasses are provided in accordance with 42 CFR 440.120. The following are covered services: eyeglasses, eyeglass parts, eyeglass dispensing, contact lenses and other visual aids

Services that are limited to members who meet certain clinical criteria include: tinted lenses, coated lenses, and two pairs of eyeglasses instead of bifocals, cataract lenses and contact lenses..

Services that are subject to prior authorization include: extra or spare eyeglasses; the following types of contact lenses--PMMA color vision, deficiency, gas permeable or hydrophilic toric prism ballast, gas permeable or hydrophilic bifocal; low vision aids; glass lenses; special-needs lenses; tints other than "pink 1" and "pink 2" that are available for plastic lenses only, and, polycarbonate lenses for members aged 21 or older or for any member who is amblyopic or monocular.

Exclusions consist of absorptive lenses of greater than 25% absorption, prisms obtained by decentration; contact lenses for extended wear use; invisible bifocals; and Welsh 4-drop Lens.

The volume purchase of eyeglasses limits the selection of frames and lenses to a basic assortment from the optical supplier.

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State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

Item 16: Inpatient Psychiatric Facility Services for Individuals under 22 Years of Age

Preadmission screening will be required for all non-court-ordered admissions of Medicaid recipients (as per 42 CFR 441.152). Such certification of the need for services for conversion cases (people applying for Medicaid eligibility while hospitalized in an inpatient psychiatric facility) will be made by the team responsible for the plan of care (42 CFR 441.153(b)). Periodic reviews of use will be performed by the Medicaid agency or its designee.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

Item 15: **Intermediate Care Facilities**

Effective November 1, 1993, coverage is limited to state school ICF/MR (these schools have more than 15 beds). The reimbursement methodology for these services is described in Attachment 4.19-D (3).

State Plan under Title XIX of the Social Security Act
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and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

k. **Limited Services Clinic**

MassHealth covers vaccines and immunizations, as well as medical evaluation, testing, screening, treatment, and clinical laboratory services for episodic, urgent care relating to an illness provided in state-licensed limited services clinics.

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Amount, Duration, and Scope of Medical and Remedial Care and Services
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Item 20: **Extended Services for Pregnant Women**

The major categories of services available to pregnant women as pregnancy-related services include inpatient hospital, outpatient hospital, laboratory and X-ray, family planning, physician, clinic, dental, prescription drug, and nurse-midwife services.

Extended services to pregnant women may be provided by physicians and community health centers. Such extended services include coordinated medical management, health-care counseling, obstetrical-risk assessment and monitoring and rehabilitation services including treatment for alcoholism and drug dependency.

Item 24.d: **Nursing Facility Services for Patients under 21 Years of Age**

Skilled nursing facility services for patients under 21 years of age are covered if a Department of Public Health review team approves the facility.

Item 26. Personal Care Services

Personal care services provided through the state plan are provided either through Personal Care Attendant Services or Transitional Living Services.

A. Personal Care Attendant (PCA) Services

All personal care services provided by a Personal Care Attendant (PCA) through the state plan are consumer directed, and the consumer (the MassHealth member) is the employer of his/her PCAs.

PCA services furnished under the state plan are limited to "employer authority" only. That is, all PCA funds under the PCA state plan must be used solely to pay for employer required tasks, and cannot be used for any other purpose, such as the purchase of products and services other than those provided by a PCA to meet the consumer's personal care needs. Personal care services provided by PCAs are performed by Medicaid enrolled providers. The state will ensure the requirements for provider agreements found at 42 CFR 431.107 are met prior to initial payment of Personal Care Attendants (PCAs) being hired as PCAs.

All consumers are responsible for recruiting, screening, hiring, firing, training and scheduling PCAs, as well as submitting activity forms (PCA timesheets) to the fiscal intermediary (FI) for processing and payment. If the consumer is not able to perform these activities on his/her own, the consumer must appoint a surrogate to assist him/her to manage PCA services.

The state contracts with fiscal intermediaries (FIs) in accordance with the requirements of 42 CFR 434.10 to perform employer required tasks and administrative tasks on behalf of consumers. The FI receives and processes the PCA timesheet, and submits a claim for PCA services through the state's MMIS system. The state processes the claim and pays the FI to perform all employer required tasks on behalf of the consumer, including filing and paying employer required taxes, withholding PCA taxes, purchasing workers' compensation insurance on behalf of each consumer, and sending a check in the PCA's name to the consumer to pay the PCA, unless the PCA has elected direct deposit.

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1. For the state to pay for personal care services provided by a PCA to a consumer (the MassHealth member), the consumer must be able to be appropriately cared for in the home and the following conditions must be met:

   a. The personal care services must meet the state's medical necessity criteria and must be authorized by the state prior to being provided in accordance with a state approved service plan.

   b. The personal care services must, in accordance with 42 CFR 440.167, be authorized for an individual in accordance with a service plan approved by the state.

   c. The consumer, as authorized by the state under a state approved service plan,, must require physical assistance in two or more of the following ADLs:

      1). mobility – physically assisting a consumer who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
      2). assistance with medication – physically assisting a consumer to take medications prescribed by a physician that otherwise would be self-administered;
      3). bathing or grooming – physically assisting a consumer with basic care such as bathing, personal hygiene, and grooming skills;
      4). dressing – physically assisting a consumer to dress or undress;
      5). passive range-of-motion exercises – physically assisting a consumer to perform range-of-motion exercises;
      6). eating – physically assisting a consumer to eat; and
      7). toileting – physically assisting a consumer with bowel and bladder needs.

2. If the conditions in 1 above are met, the state will pay for a consumer to receive physical assistance with the ADLs identified in 1.c above and the IADLs listed below.

   a. household services – physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;

   b. meal preparation and clean-up – physically assisting a member to prepare meals;

   c. transportation – accompanying the member to medical providers; and

   d. special needs – assisting the member with:

      1). the care and maintenance of wheelchairs and adaptive devices. This includes, but is not limited to, charging the batteries on a powered wheelchair and cleaning and sanitizing medical equipment (wheelchairs and wheelchair accessories, walkers, hoya lifts, and standers). The state assures that routine maintenance performed by PCAs does not duplicate repair services covered under the DME benefit and provided by DME providers.

      2). completing the paperwork required for receiving personal care services. This includes the paperwork required by the PCA program, such as employer forms required by the fiscal intermediary. If the consumer has a surrogate, the state expects the surrogate to complete the paperwork required by the PCA program.

      3). other special needs approved by the state as being instrumental to the health care of the member.

B. Transitional Living Services

Personal care services provided by a Transitional Living provider are provided in a community-based setting operated by the Transitional Living provider and delivered by direct care staff of the Transitional Living provider. Transitional Living services are not provided in an Institute for Mental Disease servicing individuals 22-64.

A member who is eligible to receive personal care services provided by a Transitional Living provider may obtain those services from a qualified Transitional Living provider participating in MassHealth. Personal care services are provided by Transitional Living provider's direct care staff and in accordance with a written individual service plan that is developed with the participation of the member (and the member's surrogate, if applicable), describing in detail the responsibilities of the member, the member's surrogate, if applicable, and the Transitional Living provider.

1. For the state to pay for personal care services provided by a Transitional Living provider to a member, the member must be able to be appropriately cared for in the provider's Transitional Living provider setting and the following conditions must be met:

   a. The personal care services provided to the member by the Transitional Living provider's direct care staff must meet the state's medical necessity criteria and must be authorized by the state prior to being provided in accordance with a state approved service plan.

   b. The personal care services provided by the Transitional Living provider's direct care staff must, in accordance with 42 CFR 440.167, be authorized for an individual in accordance with a service plan approved by the state.

   c. The member, as authorized by the state under a state approved service plan, must require physical assistance in two or more of the following ADLs:

      1). mobility – physically assisting a consumer who has a mobility impairment that prevents unassisted transferring, walking, or use of prescribed durable medical equipment;
      2). assistance with medication – physically assisting a consumer to take medications prescribed by a physician that otherwise would be self-administered;
      3). bathing or grooming – physically assisting a consumer with basic care such as bathing, personal hygiene, and grooming skills;
      4). dressing – physically assisting a consumer to dress or undress;
      5). passive range-of-motion exercises – physically assisting a consumer to perform range-of-motion exercises;
      6). eating – physically assisting a consumer to eat; and
      7). toileting – physically assisting a consumer with bowel and bladder needs.

2. If the conditions in 1 above are met, the state will pay for a member to receive physical assistance with the ADLs identified in 1.c above and the IADLs listed below.

   a. household services – physically assisting with household management tasks that are incidental to the care of the member, including laundry, shopping, and housekeeping;

   b. meal preparation and clean-up – physically assisting a member to prepare meals;

   c. transportation – accompanying the member to medical providers; and

   d. special needs – assisting the member with:

      1). the care and maintenance of wheelchairs and adaptive devices. This includes, but is not limited to, charging the batteries on a powered wheelchair and cleaning and sanitizing medical equipment (wheelchairs and wheelchair accessories, walkers, hoya lifts, and standers). The state assures that routine maintenance performed by a Transitional Living Services provider does not duplicate repair services covered under the DME benefit and provided by DME providers

      2). other special needs approved by the state as being instrumental to the health care of the member and ability to manage PCA services once transitioned to independent living.

(C) Provider qualifications:

1. Personal Care Attendant Services. The state has established the following minimum qualifications for PCAs:
   a. PCAs cannot be the consumer's family member, surrogate or foster parent;
   b. PCAs must be legally authorized to work in the United States;
   c. PCAs must be able to understand and carry out directions given by the consumer or the consumer's surrogate;
   d. PCAs must be willing to receive training and supervision in all PCA tasks from the consumer or the consumer's surrogate; and
   e. A PCA cannot be listed on the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE)

2. Transitional Living Services. The state has established the following minimum qualifications for Transitional Living Services providers:

   a. To provide Transitional Living Services a provider must:
      1) Submit a proposal for review by the state in accordance with the state's proposal

requirements for transitional living.

2) Obtain written approval from the state to become a MassHealth provider of transitional living services
3) Demonstrate the appropriate licensure or program accreditation by a recognized body for the provider's type of program (if applicable); and
4) Obtain a MassHealth provider identification number.

b. Direct care staff employed by a Transitional Living Services Provider and providing personal care services to a member:

1) Cannot be the member's family member, surrogate or foster parent;
2) Must be legally authorized to work in the United States;
3) Must be able to understand and carry out directions given by the Transitional Living Services provider or the member, or the member's surrogate;
4) Must be willing to receive training and supervision in all personal care services tasks from the Transitional Living Provider or the member, or the member's surrogate; and
5) Cannot be listed on the Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE)

State Plan under Title XIX of the Social Security Act
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And Remedial Care and Services Provided to the Categorically Needy

Case Management Services

A. Target Group:

See pages 1a through 1q

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1919 (g) (1) of the Act is invoked to provide services less than statewide:

C. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of services:

See pages 1a through 1q

E. Qualifications of provider:

See pages 1a through 1q

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
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Reserved

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Reserved

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Reserved

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RESERVED

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Reserved

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Reserved

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Amount, Duration, and Scope of Medical
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Case Management Services (cont.)

H. **Children Served by the Department of Social Services**

1. Target Group

The target group consists of Medicaid eligible children who have been reported to the Department of Social Services as potentially abused or neglected, or are receiving services from the Department of Social Services after being determined to either be at risk of abuse or neglect or substantiated as being abused or neglected children.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social, and other services.

Case management will include:

1. collection of assessment data;
2. development of an individualized plan of care;
3. coordination of needed services and providers;
4. home visits and collateral contracts as needed;
5. maintenance of case records; and
6. monitoring and evaluation of client progress and service effectiveness.

3. Qualifications of Providers

The case manager must be a qualified social worker according to the requirements of the Massachusetts Department of Social Services.

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And Remedial Care and Services Provided to the Categorically Needy

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
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Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

K. Children Provided Case Management Services by the Department of Youth Services

1. Target Group:

The target group consists of Medicaid recipients who (1) are between the ages of 7 through 22, (2) are committed to the Department of Youth Services (DYS) by a court of competent jurisdiction in the Commonwealth until the age specified in their commitment (up to their 21st birthday), or voluntarily agree to the continuation of DYS case management services beyond their eighteenth birthday up to their 22nd birthday, and (3) as a result either of their original placement or conditional release forma public institution, reside in placements that include, but are not limited to, their own homes, the homes of relatives, community based residences, or residential treatment facilities.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medial, social, educational and other services.

3. Case Management will include:

1. Collection of assessment data;
2. Development of an individualized plan of care;
3. Coordination of needed services and providers;
4. Home visits and collateral contacts as needed;
5. Maintenance of case records; and
6. Monitoring and evaluating client progress and service effectiveness.

4. Qualifications of Providers:

The case manager must have, or work directly under, the supervision of an individual with at least three years of full or equivalent part-time, professional or paraprofessional experience in social work, social casework, guidance, vocational counseling, employment counseling, or educational counseling, the major duties of which include providing such services to juveniles, or in a corrections institutions work, the major duties of which include the custodial care, treatment, counseling and/or rehabilitation of juveniles.

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Case Management Services (cont.)

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

1. Target Group

Target group includes Medicaid beneficiaries who are either:

A. 18 years of age or older with intellectual disability, meaning significantly sub-average intellectual functioning existing concurrently and related to significant limitation in adaptive functioning that manifests before 18.

B. under 18 years of age,
   a. with a verified diagnosis of intellectual disability or a closely related developmental condition or, with respect to persons from birth to age five, a developmental delay. Developmental delay means a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided; and
   b. who demonstrate severe functional impairments, with severe functional impairments meaning functional impairments in at least three specified areas of adaptive functioning, based upon normative expectations of the types of skills normally acquired as the child develops, as measured by standardized assessment or comparable data. The areas of adaptive functioning are: self-care, communication, learning, mobility, and self-direction and, for individuals age 14 years or older, capacity for independent living and economic self-sufficiency.

☒ Target group includes individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions.

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and at least annual periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted at least annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with
  - Medical, social, educational providers or
  - Other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities typically occur monthly and include at least one annual monitoring meeting to adequately address the needs of the eligible individuals, and care plan services may be reevaluated at any time. The Monitoring and follow up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring meeting, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

5. Qualifications of provider:

The Department of Developmental Services (DDS) has been designated to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions at the Department of Developmental Services in the Human Services Coordinator series. Minimal entrance requirements for the Human Services Coordinator position include at least three years of full-time, or equivalent part-time professional experience in human services work or social work. One year of professional work experience must have involved working with individuals with intellectual or other developmental disabilities. A Bachelor's or higher degree in social work, psychology, sociology, counseling, counseling education, education of the physically or emotionally handicapped, education of the multiple handicapped, education of the learning disabled, human services, rehabilitation, rehabilitation counseling, nursing, recreation therapy, art therapy, dance therapy, music therapy, or physical education may be substituted for two years of the required experience on the basis of two years of education for one year of experience.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b), Massachusetts designates the Department of Developmental Services as the provider of services covered under this section of the State Plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

1. Target Group

To be eligible for this target group, an individual must meet the following criteria:

Clinical Criteria

An individual who is 19 year of age or older must: have a mental illness, as determined by the Department of Mental Health (DMH) in accordance with DMH regulations and meet the following criteria:

1. Includes a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life;
2. Has lasted or is expected to last at least one year;
3. Has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and
4. Meets diagnostic criteria specified within the current edition of Diagnostic and Statistical Manual of Mental Disorders, which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by substance related disorders, mental retardation or organic disorders due to a general medical condition not elsewhere classified.

An individual who is under 19 years of age must have a mental illness as determined by DMH which meet the following criteria:

1. Has lasted, or is expected to last, at least one year;
2. Has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities; and
3. Meets diagnostic criteria specified within the current edition of the Diagnostic and Statistical Manual of Mental Disorders, but is not solely within one or more of the following categories:
    a. Developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation;
    b. Cognitive disorders, including delirium, dementia or amnesia;
    c. Organic disorders due to a general medical condition not elsewhere classified; or
    d. Substance-related disorders.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

☒ Target group includes individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted at least annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history; and
- Identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
  - Medical, social, educational providers; or
  - Other programs and services that are capable of providing needed services, to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities are conducted at least annually, or more frequently as necessary, to adequately address the needs of the eligible individual, and care plan services may be reevaluated at any time. These Monitoring and follow-up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

5. Qualifications of providers:

The Department of Mental Health (DMH) has been designated to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions in the Human Services Coordinator series. Qualified personnel must have demonstrated applicable education and/or professional work experience with the target population.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b), Massachusetts designates the Department of Mental Health as the provider of services covered under this section of the State Plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

9. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted care management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

10. Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred; and
- Activities for which third parties are liable to pay as described in 42 USC 1396n(4)(A)

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

1. Target Group

A Medicaid member is eligible for targeted case management services described below if the member:

A. is eighteen years of age or older;

B. receives a statement from a physician verifying the AIDS diagnosis. Such a diagnosis shall be based on the most recent AIDS definition published by the Federal Center for Disease Control (CDC) as it may from time to time be amended.

C. lives in a staffed, congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program which require that a person be HIV positive, and in which no more than three mentally and/or physically impaired individuals share a single bedroom and bathroom; and

D. requires and receives from the congregate residential program staff assistance with either activities of daily living (ADL) such as bathing, dressing/grooming, mobility/transfer, eating or toileting and/or instrumental activities of daily living (IADL) such as laundry, shopping, transportation and housekeeping.

☐ Target group includes individuals transitioning to a community setting during a covered stay in an institutional setting.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

2. Areas of state in which services will be provided:

☒ Entire state .

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history and
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or
  - other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

5. Qualifications of provider:

To be qualified to provide case management services, a provider must possess the following minimal qualifications: a Masters degree in social work or related field, a registered nurse, or three or more years of documented case management experience working with the disabled in a community setting.

6. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of other medical care under the plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records:

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

8. Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

9. Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n(4)(A).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Categorically Needy

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. **Target Group:** The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. **Areas of State in Which Services Will be Provided**

   Services are available state-wide

3. **Comparability of Services**

   Services are not comparable in amount, duration and scope. (Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B)

4. **Definition of Services**

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or

deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

Program of All-Inclusive Care for the Elderly (PACE)

1. Target Group

All medically needy and categorically needy individuals who are at least 55 years old, live in the PACE service area, and are certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

2. Definition of Services

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participant's needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services), which are integrated for a seamless provision of total care. PACE organizations provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services.

3. Qualification of Providers

PACE providers must meet with all the requirements found at 42 CFR Part 460.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

Name and address of State Administering Agency, if different from the State Medicaid Agency.

I. **Eligibility**

The state determines eligibility for PACE enrollees under rules applying to community groups.

☒ A. The state determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The state has elected to cover under its State Plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the state determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

Eligibility Groups	**Regulatory Reference**
Special level income equal to 300% of the SSI Federal benefit	42 CFR 435.236 42 CFR 435.217

☐ B. The state determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.)

☒ C. The state determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the state's approved HCBS waiver(s).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

Regular Post Eligibility

☒ 1. SSI State. The state is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) Sec. 435.726 — states which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☒ 1. The following standard included under the State plan (check one):

- ☐ (a) SSI
- ☐ (b) Medically Needy
- ☐ (c) The special income level for the institutionalized
- ☐ (d) Percent of the Federal Poverty Level: ___%
- ☒ (e) Other (specify):300% SSI Federal benefit rate

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

- ☐ 1. SSI Standard
- ☐ 2. Optional State Supplement Standard
- ☐ 3. Medically Needy Income Standard
- ☐ 4. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 5. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
- ☐ 6. The amount is determined using the following formula:
  _____
  _____
- ☒ 7. Not applicable (N/A)

(C) Family (check one):

- ☐ 1. AFDC need standard

☐ 2. Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

☐ 3. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 4. The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.

☐ 5. The amount is determined using the following formula:
_____
_____

☐ 6. Other

☒ 7. Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

☐ 2. 209(b) state, a state that is using more restrictive eligibility requirements than SSI. The state is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735** — States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☐ 1. The following standard included under the State plan (check one):

☐ (a) SSI
☐ (b) Medically Needy
☐ (c) The special income level for the institutionalized
☐ (d) (Percent of the Federal Poverty Level: _____%
☐ (e) ___Other (specify): _____

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:
Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B) Spouse only (check one):

- ☐ 1. The following standard under 42 CFR 435.121:

  _____

- ☐ 2. The medically needy income standard

  _____

- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- ☐ 5. The amount is determined using the following formula:

  _____

  _____

- ☐ 6. Not applicable (N/A)

(C) Family (check one):

- ☐ 1. AFDC need standard
- ☐ 2. Medically needy income standard
  The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of_____ standard.
- ☐ 5. The amount is determined using the following formula:

  _____

  _____

- ☐ 6. Other
- ☐ 7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

☐ 3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)

☐ (A) The following standard included under the State plan (check one):

- ☐ 1. SSI
- ☐ 2. Medically Needy
- ☐ 3. The special income level for the institutionalized
- ☐ 4. Percent of the Federal Poverty Level: _____%
- ☐ 5. Other (specify): _____

☐ (B) The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ (C) The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the Individual's maintenance needs in the community:

_____

_____

_____

_____

_____

_____

State Plan under Title XIX of the Social Security Act
State: Massachusetts
PACE State Plan Amendment Pre-Print

II. **Rates and Payments**

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in free-for service.

☐ 1. Rates are set at a percentage of fee-for-service costs
☐ 2. Experience-based (Contractors/State's costs experience or encounter data) (please describe)
☐ 3. Adjusted Community Rate (please describe)
☒ 4. Other (please describe)

EOHHS contracts with an actuary to develop the capitation rates for PACE providers in accordance with 42 USC 1396u-4 and 42 CFR 460.182, which rates do not exceed the amount that would otherwise have been paid under the State plan if the participants were not enrolled under the PACE program and take into account the comparative frailty of PACE participants. Each year, Capitation Rates are established for the PACE contract period, which is the same as a calendar year, January 1 through December 31.

The contracted actuary uses the following data sources in developing the rates:

1. Calculate Base Data
   - Collect and analyze Medicaid claims and eligibility data from the most recent Base Year available
   - Adjust base data for any payments made outside MMIS
   - Apply separate claims completion factors by calendar year (CY) and consolidated Category of Service (COS) to account for any unpaid claims liability
   - Develop per member per month (PMPM) costs by SFY, region, rating category, and COS
   - Utilize actual member months and the Base Year PMPMs to calculate total Base Year costs
2. Adjustments
   - Apply trend factors to bring claims forward from the Base Year to the rate year
   - Adjust for program changes
   - Certify actuarial equivalence of the populations
3. The State establishes the capitation rates, which are equal to or less than the State's adjusted costs experience, as computed above, by its contracted actuary. The same methodology is applied to all PACE providers.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

William M. Mercer

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

III. **Enrollment and Disenrollment**

The state assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the state and the state Administering Agency. The state assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the state's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

Aged, Disabled, AFDC and Under 21

The following ambulatory services are provided.

Ambulatory services are those services, reimbursable by Medicaid, that are provided under circumstances that do no involve an overnight stay by the recipient in a hospital or long-term care facility. Such services may be provided in a hospital outpatient department, clinic, private practitioner's office, or other medical setting, or in the recipient's place of residence; provided that, if the recipient's place of residence is a hospital or ling-term care facility, any services that are included in the per diem rate of such hospital or facility shall not constitute ambulatory services.

Physician services (including radiologists, psychiatrists, ophthalmologists)
Dental services *
Services provided by a licensed practitioner:
- Optometrists' services
- Physical, occupational and speech therapy
- Services provided by registered nurses
- Services provided by licensed practical nurses

Pharmacy services
Psychologists' services
Home health agency services
Laboratory services
Hospital outpatient department services
Freestanding clinic services (including community health centers, mental health centers, rehabilitation clinics)
Medical supplies and durable goods
Family planning services
Transportation services
Health maintenance organization services
Adult foster care
Adult day care
Rehabilitation services in a day facility
Services for centers for independent living
Personal care attendant services
EPSDT
Psychiatric day treatment
Nurse-midwife services
Case management services

See Attachment 3.1-A , p.1 (91-21) for FQHC Coverage

* Description provided on attachment.

State Plan under Title XIX of the Social Security Act -
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy

4.d. 1) Face-to-face tobacco cessation counseling services for pregnant women provided:

☒ (i) By or under supervision of a physician;*

☒ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services *other* than tobacco cessation services;* or

☐ (iii) Any other healthcare professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.

* Describe if there are any limits on who can provide these counseling services

All healthcare professionals except physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists and physician assistants must complete a training course to provide tobacco cessation counseling services. Healthcare professionals must be under the supervision of a physician if required under state law.

2) Face-to-face tobacco cessation counseling services benefit package for pregnant women

☒ Provided: ☐ No limitations ☒ With limitations*

* Any benefit package that consists of *less* than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12-month period (eight (8) per year) should be explained below.

Please describe any limitations:

Prior authorization is required for more than a total of 16 group and individual counseling sessions per member per 12 month cycle. Prior authorization is required for more than two intake sessions (quit attempts) per member per 12 month cycle.

Aged, Disabled, AFDC and Under 21 (cont.)

1. Inpatient hospital services other than those provided in an institute for mental disease.
*Effective 12/1/91, under 18

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

2. a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

See **Attachment 3.1-A, p.1 (91-21) for FQHC Coverage.**

3. Other laboratory and X-ray services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

c. Family planning services and supplies for individuals of childbearing age.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on attachment.

Aged, Disabled, AFDC and Under 21 (cont.)

5. a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with § 1905 (a) (5) (B) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations*

* Description provided on attachment.

6. Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. **Podiatrists' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. **Optometrists' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. **Chiropractors' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. **Other Practitioners' Services**

☒ Provided: Identified on attached sheet with description of limitations, if any.
☐ Not provided.

e. **Audiologists' Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

f. **Midlevel Practitioner Services**

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

7. **Home Health Services**

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

☒ Provided: ☒ No limitations ☐ With limitations*

b. Home health aide services provided by a home health agency.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Medical supplies, equipment, and appliances suitable for use in the home.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Limitations are described in **Supplement to Attachment 3.1-B**.

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

8. Private duty nursing services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided:

* Limitations are described in **Supplement to Attachment 3.1-B**.

Aged, Disabled, AFDC and Under 21 (cont.)

9. Clinic services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

10. Dental services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

11. Physical therapy and related services.

a. Physical therapy

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Occupational therapy.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist

a. Prescribed drugs.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Dentures.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on attachment.
** See Page 3 of **Supplement to Attachment 3.1-A**.

Aged, Disabled, AFDC and Under 21 (cont.)

c. Prosthetic devices.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

d. Eyeglasses.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Screening services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

c. Preventive services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

d. Rehabilitative services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

14. Services for individuals age 65 or older in institution for mental diseases.

a. Inpatient hospital services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

b. Skilled nursing facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

* Description provided on attachment.

Aged, Disabled, AFDC and Under 21 (cont.)

c. Intermediate care facility services.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with Section 1902 (a) (31) (a) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☒ Provided: ☒ No limitations ☐ With limitations*
☐ Not provided.

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

17. Nurse-midwife services
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

18. Hospice care (in accordance with Section 1905 (o) of the Act).

☒ Provided: ☒ No limitations ☐ With limitations*

☒ Provided in accordance with section 2302 of the Affordable Care Act

☐ Not provided

* Description provided on attachment.

Aged, Disabled, AFDC and Under 21 (cont.)

19. Case management services and Tuberculosis related services.

a. Case management services as defined in, and to the group specified in, **Supplement 1 to Attachment 3.1-A** (in accordance with Section 1905 (a) (19) or Section 1915 (g) of the Act).

☒ Provided: ☐ No limitations ☒ With limitations
☐ Not provided.

b. Special tuberculosis (TB) related services under Section 1902 (z) (2) (F) of the Act.

☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

☒ Provided:[+] ☐ Additional coverage[++]
☐ Not provided.

b. Services for any other medical conditions that may complicate pregnancy.

☒ Provided:[+] ☐ Additional coverage[++] ☐ Not provided.
☐ Not provided.

21. Certified pediatric or family nurse practitioners' services.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

* Description provided on attachment.

[+] Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

[++] Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

Aged, Disabled, AFDC and Under 21

22. Respiratory care services (in accordance with Section 1902 (e) (9) (A) through (C) of the Act).

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

23. Any other medical care and any other type of remedial care recognized under state law, specified by the Secretary.

a. Transportation

☒ Provided: ☐ No limitations ☒ With limitations**
☐ Not provided.

Brokered Transportation

MassHealth provides non-emergency transportation to MassHealth Standard, CommonHealth and CarePlus members through selective broker contracts when no public transportation is available that is suitable to a member's condition within a specified distance from an authorized point of origin and destination. Payment for the non-emergency transportation services arranged through a broker is claimed as medical assistance. Delivery methods consist of ambulatory and non-ambulatory transport, including taxi, livery, ferry, and chair car service, or other methods suitable to the member's condition. MassHealth requires prior authorization to determine the medical necessity of non-emergency transportation provided through the brokerage system. Transportation requests are approved by EOHHS and implemented by the brokers. The state will operate the broker program without regard to freedom of choice of providers (section 1902(a)(23) of the Social Security Act).

The state assures that the six Regional Transit Authorities that serve as transportation brokers were selected by the MassHealth agency pursuant to a competitive procurement conducted consistent with federal requirements, and based on the state's evaluation of the broker's experience, performance, references, resources, qualifications, and cost. Each broker is responsible for arranging with its contracted network of transportation providers to deliver non-emergency transportation to and from medically necessary MassHealth covered services for members in the broker's contractually designated service area.

The state assures that its brokerage contracts are subject to regular auditing and oversight by the state to ensure the quality and timeliness of the transportation services provided, and the adequacy of beneficiary access to medical care and services. In addition, the state requires each broker to undertake extensive oversight activities with respect to its network of transportation providers, and assures that brokers have oversight procedures to monitor beneficiary access and complaints and ensure that transportation is timely and transport personnel are licensed, qualified, competent and courteous.

The state assures that transportation services will be provided under contracts with brokers who comply with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and

requirements as the Secretary determines to be appropriate). The brokerage contract requires the brokers to comply with 42 CFR § 440.170(a)(4) governing the provision of non-emergency medical transportation, including prohibitions on referrals and conflicts of interest, and provides for the broker to be liable for the full cost of services resulting from a prohibited referral or relationship, as specified in the contracts. Specifically, the brokers are prohibited from directly providing non-emergency medical transportation services, and are prohibited from making a referral or subcontracting to a transportation service provider if the broker has a financial relationship with the transportation provider as defined at 42 CFR § 411.354(a); or if the broker has an immediate family member, as defined at 42 CFR § 411.351, that has a direct or indirect financial relationship with the transportation provider.

The brokerage contract prohibits the broker from withholding necessary transportation from a MassHealth member for the purpose of financial gain or any other purpose; authorizing transportation that is not the most appropriate and a cost effective means of transportation for that member for the purpose of financial gain or any other purpose; soliciting or accepting any payment or other form of remuneration, including any kickback, rebate, cash, gift, or service in kind from a transportation provider or any other party in order to influence referrals or subcontracting for non-emergency medical transportation provided to a MassHealth member.

Payments under the brokerage contracts are structured to ensure cost-effectiveness. Brokers are required to competitively procure and contract with their network of transportation providers and develop competitive methods of awarding trips and routes to transportation providers. Brokers schedule trips with the lowest cost qualified transportation provider, and the brokers receive reimbursement at cost from the state for their payments to transportation providers.

Brokers are paid a broker-specific average monthly trip cost for each eligible trip. For demand-response trips, the average monthly trip cost is calculated by dividing the broker's total expenditures for demand-response trips by the number of demand-response trips in that month. For program based trips, the average monthly trip cost for each broker is calculated by first determining route-specific average monthly trip rates, and then calculating a combined average trip rate for all routes. To further encourage cost savings, brokers also receive a shared ride incentive payment if they can achieve a target rate of shared ambulatory trips.
A fixed monthly broker management fee paid under the brokerage contract is claimed as an administrative expense. The broker management fee is negotiated between EOHHS and the broker based on the broker's reasonable costs of performing the broker management function, exclusive of direct transportation costs.

The source of the non-federal share of payments for brokered transportation services to MassHealth members is general fund appropriations to the state Medicaid agency.

****** Description of non-brokered transportation is provided on **Attachment 3.1-D**

b. Services of Christian Science nurses.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

c. Care and services provided in Christian Science sanitaria.

☐ Provided: ☐ No limitations ☐ With limitations
☒ Not provided

d. Skilled nursing facility services provided for patients under 21 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.

e. Emergency hospital services.

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

* Description provided on **Supplement to Attachment 3.1-B.**

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration and Scope of Services Provided Medically Needy Groups

Aged, Disabled, AFDC and Under 21 (cont.)

f. Critical Access Hospital Services

☒ Provided: ☒ No limitations ☐ With limitations
☐ Not provided.

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described, and limited in **Supplement 2 to Attachment 3.1-A**, and **Appendices A-G to Supplement 2 to Attachment 3.1-A**.

☐ Provided ☒ Not Provided

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical and Remedial Care and Services
Provided to the Medically Needy

Item 26: Personal Care Services

Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

☒ Provided:
- ☒ State Approved (Not Physician) Service Plan Allowed
- ☒ Services Outside the Home Also Allowed
- ☒ Limitations Described on Supplement to Attachment 3.1-A

☐ Not provided

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical and Remedial Care
and Services Provided to the Categorically Needy

Aged, Disabled, AFDC and Under 21 (cont.)

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in **Supplement 3 to Attachment 3.1-B**.

☒ Election of PACE: by virtue of this submittal, the state elects PACE as an optional State Plan service.

☐ No election of PACE: by virtue of this submittal, the state elects to not add PACE as an optional State Plan service.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy

28. Freestanding Birth Center Services

i. Licensed or Otherwise State-Approved Freestanding Birth Centers

☒ Provided: ☐ No limitations ☒ With limitations

☐ None licensed or approved

Please describe any limitations:

Freestanding birth center services are covered for women with low risk pregnancies. Freestanding birth center services include care during pregnancy, labor, delivery, and recovery following delivery, including newborn nursery and post-partum care.

ii. Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

☒ Provided: ☐ No limitations ☒ With limitations

☐ Not applicable (There are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations:

The limitations to the practitioners' services are the same limitations as noted in their respective section of the State Plan.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan: Physicians and certified nurse midwives.

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy

Item 1: **Inpatient Hospital Services**

1. Utilization Management. As a condition of payment, MassHealth requires preadmission screening for all elective admissions to acute hospitals and for all admissions to a chronic disease and rehabilitation hospital, except for members with other insurance (including Medicare).
2. Prior Authorization: MassHealth requires prior authorization for certain acute inpatient hospital services based on medical necessity, including certain drugs and biologics administered in the acute inpatient hospital setting.

Item 2.a: **Outpatient Hospital Services**

MassHealth requires prior authorization for certain outpatient hospital services based on medical necessity, including for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period; and for certain drugs and biologics administered in the acute outpatient hospital setting.

DEP/ESPs provide crisis assessment, stabilization, special services and other interventions in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. To qualify as a DEP/ESP, a provider of hospital services must be designated as such by the Commonwealth.

Item 4.a: **Nursing Facilities Services**

If a utilization review team recommends that a recipient in a multi-level long-term-care facility be changed to a lower level of care, the facility is responsible for relocating a recipient to the recommended level of care within the facility. The recipient has the right to appeal the recommendation.

Item 4b: Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found.

In addition to all other medically necessary services covered for individuals under age 21, the following services are covered as Rehabilitation services as defined in 42 USC 1396d (a) (13). These services are provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual:

a. Mobile Crisis Intervention (Services described in this section are effective July 1, 2009.)

Mobile Crisis Intervention provides a short term service that is mobile, on-site, face-to-face therapeutic response to a youth experiencing a behavioral health (mental health or substance abuse) crisis for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Services are available 24 hours a day, 7 days a week. Phone contact and consultation may be provided as part of the intervention. Mobile crisis services may be provided by a single crisis worker or by a team of professionals that are qualified providers who are trained in crisis intervention.

Mobile Crisis Intervention includes the following activities when performed to resolve the immediate crisis:

- Assessment;
- Crisis counseling including individual and family counseling;
- Clinical consultation and coordination with other health care providers;
- Psychopharmacological management, including availability of on-site prescriber;
- Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support;
- Development of a risk management/safety plan. In cases where the youth does not already have such a plan, Mobile Crisis Intervention creates a risk management/safety plan in concert with the parent(s)/guardian(s)/caregiver(s) and any existing service providers (e.g., ICC, In-Home Therapy Services, outpatient therapist); and
- Referral to other services as needed.

Settings: Mobile Crisis Intervention is provided where the child is located.

Providers: Components of Mobile Crises Crisis Intervention are provided by practitioners, as described below. Practitioners must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers and other clinics.

- **Assessment** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Crisis counseling including individual and family counseling** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is
- **Clinical consultation and coordination with other health care providers** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, bachelor-level counselors/paraprofessionals, LADC Is

- **Psychopharmacological management** - Psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, board-certified or board-eligible child psychiatrists, psychiatry residents.

- **Identification and inclusion of professional and natural supports (e.g., therapist, neighbors, relatives) who can assist in stabilizing the situation and offer ongoing support** - LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

- **Development of a risk management/safety plan** -LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns

- **Referral to other services as needed:** LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns, social work interns, associate-level counselors/paraprofessionals, bachelor-level counselors/paraprofessionals, CADACs, CADAC IIs, LADC Is, LADC IIs, LADC IIIs, LSWs, and LSWAs.

b. In-Home Behavioral Services: (Services described in this section are effective October 1, 2009.)

This service provides for the development of a highly specific behavior plan; supervision and coordination of interventions; and training other interveners to address specific behavioral objectives or performance goals in order to treat challenging behaviors that interfere with the youth's successful functioning. An In-Home Behavioral service includes two components: behavior management therapy and behavior management monitoring. It is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff.

1. Behavior management therapy: Behavior management therapy includes activities that are required to develop, implement, monitor and update a behavior plan, including overseeing activities of the behavior management monitor. Behavior management therapy is performed by a licensed clinician who meets the qualifications of a Behavior management therapist as described in the provider qualifications section below.

   Behavior management therapy includes the following:

   - Functional behavioral assessment;
   - Development of a focused behavior plan that identifies specific behavioral and measurable objectives or performance goals and interventions that are designed to diminish, extinguish, or improve specific behaviors related to a youth's behavioral health (mental health or substance abuse) condition(s);
   - Development or revision of a youth's risk management/safety plan to address the specific behavioral needs of the youth;
   - Counseling the parent(s)/guardian(s)/caregiver(s) on how to implement strategies identified in the behavior plan;
   - Working closely with the behavior management monitor to ensure the behavior plans and risk management/safety plan are implemented as developed, and to make any necessary adjustments to the plans;
   - Clinical consultation and coordination with other behavioral health (mental health or substance abuse) care providers; and
   - Referral to other services as needed.

2. Behavior management monitoring. This service includes activities related to the implementation of the behavior plan and a risk management/safety plan as needed. Behavioral management monitoring also includes monitoring the youth's behavior, reinforcing implementation of the behavior plan by the parent(s)/guardian(s)/caregiver(s), and reporting to the behavior management therapist on implementation of the behavior plan and progress toward behavioral objectives or performance goals.

   Behavioral management monitoring is performed by a paraprofessional who meets the qualifications of a behavior management monitor as described in the definitions section below.

   Behavior management monitoring includes the following:

   - Monitoring the youth's progress on implementation of the goals of the behavior plan developed by the behavior management therapist;
   - Assisting the youth in implementing the goals of the behavior plan developed by the behavioral management therapist;
   - Providing guidance to the parent(s)/guardian(s)/caregiver(s) in implementing the plan; and
   - Working closely with the behavior management therapist to ensure the behavior plans and risk management/safety plan are implemented as developed.

Settings: In-Home Behavioral Services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

Providers The following practitioners may provide any component of behavior management therapy as described above: Developmental-behavioral pediatricians, developmental-behavioral pediatric fellows, LICSWs, LCSWs, LMFTs, LMHCs, licensed psychologists, master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinical specialist trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns and social work interns. Behavior management monitors may provide any component of behavior management monitoring as described above.

Qualified Practitioners of behavior management therapy also must have two years relevant experience providing direct services to youth and families who require behavior management to address behavioral health (mental health or substance abuse) needs; course work and training in conducting functional behavioral assessments, and selecting, implementing and evaluating intervention strategies; supervised experience conducting functional behavioral assessments and designing, implementing, and monitoring behavior analysis programs for clients and other qualifications established by the state. Practitioners must be working under an employment or contractual agreement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth. .

c. In-Home Therapy Services: (Services described in this section are effective November 1, 2009.)

This service provides for the development of an individualized treatment plan; supervision and coordination of interventions for the purpose of treating the youth's mental health and substance abuse needs. The intervention is designed to enhance and improve the family's capacity to improve the youth's functioning in the home and community and may prevent the need for the youth's admission to an inpatient hospital, psychiatric residential treatment facility or other treatment setting. This service is delivered by one or more members of a team of qualified providers consisting of professional and paraprofessional staff, offering a combination of medically necessary in home therapy and therapeutic training and support.

1.

In Home Therapy: In-home therapy is a structured, consistent, strength-based therapeutic relationship between a licensed clinician and the youth and family. The licensed clinician, in collaboration with the family and youth, develops an individualized treatment plan and, using established psychotherapeutic techniques, and intensive family therapy works with the entire family or a subset of the family to implement focused structural or strategic interventions to advance therapeutic goals. In addition, the clinician assists in identifying and utilizing community resources and develops and maintains natural supports for the youth and parent(s)/guardian(s)/caregiver(s) in order to promote sustainability of treatment gains. Phone contact and consultation are provided as part of the intervention. In-Home therapy is performed by a licensed clinician who meets the qualifications of an in-home therapist as described section below.

In-Home Therapy includes the following:

- Assessments;
- Development of an individualized treatment plan by the qualified practitioner in partnership with the youth and parent(s)/guardian(s)/caregiver(s) and, with required consent, in consultation with other providers that is designed to address the youth's mental health or substance abuse condition;
- Ongoing monitoring and modification of the individualized treatment plan as indicated;
- Review/development of a risk management/safety plan;
- Phone and face-to-face consultation with other providers, individuals and entities who may impact the youth's treatment plan;
- Family counseling through which the licensed clinician works with the entire family, or a subset of the family, to advance therapeutic goals; and
- Referral to other services as needed.

2. Therapeutic training and support is a service provided by an associate-level or bachelor-level paraprofessional working under the supervision of a clinician to support implementation of the in-home therapists treatment plan in order to achieve the goals of the that plan. The paraprofessional assists a licensed clinician in implementing the therapeutic objectives of the individualized treatment plan. Phone contact and consultation may be provided as part of the intervention.

   Therapeutic training and support includes the following:

   - Providing guidance to the youth and parent(s)/guardian(s)/caregiver(s) in implementing the treatment plan;
   - Providing skills training for youth and parent(s)/guardian(s)/caregiver(s) in support of the treatment plan goals; and
   - Monitoring the youth's and parent(s)/guardian(s)/caregiver(s) progress on achieving treatment plan goals and communicating regularly with the clinician so that the treatment plan can be modified and necessary.

   Settings: In home therapy services may be provided in any setting where the child is naturally located including, but not limited to, the home (including foster homes and therapeutic foster homes), schools, child care centers, and other community settings.

   Providers: The following practitioners may provide any component of in-home therapy as described above: In-home therapy services are delivered by the following practitioners: LICSW, LCSW, LMFT, LMHC, Licensed psychologist, Master's level counselors, marriage and family therapy interns, mental health counselor interns, psychiatric nurse mental health clinical specialists, psychiatric nurse mental health clinic specialists trainee, psychiatric nurses, psychiatrists, psychiatry residents, psychology interns. The following practitioners may provide any component of therapeutic training and support as described above: Associate-level counselors / paraprofessionals, bachelor-level counselors / paraprofessionals. Practitioners must be working under an employment or contractual arrangement with one of the following outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

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d. Therapeutic Mentoring Services: (Services described in this section are effective October 1, 2009.)

Therapeutic mentoring services are structured, one-to-one, strength-based services that are designed to help ameliorate behavioral health (mental health or substance abuse) related conditions which prevent the youth from appropriate social functioning. These services must be delivered according to an individualized treatment plan developed by either an outpatient clinician, an in-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. Progress toward meeting the identified goal(s) must be documented and reported regularly to the provider responsible for the youth's treatment plan.

The therapeutic mentor does not provide social, educational, artistic, athletic, recreational or vocational services.

Settings: Therapeutic mentoring services are provided to youth in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), school, child care centers and other community settings. .

Providers: Therapeutic mentoring services are delivered by therapeutic mentors. Practitioners must be working under an employment or contractual arrangement with on of the following: outpatient hospitals, community health centers, mental health centers, other clinics, and private agencies certified by the Commonwealth**.** Providers of therapeutic mentoring utilize therapeutic mentors to provide these services.

e **Family Support and Training:** (Services described in this section are effective July 1, 2009.)

A family support and training partner addresses goals established in an individualized treatment plan in order to resolve or ameliorate the youth's mental health, behavioral and emotional needs through enhancing the capacity of the parent(s)/guardians/caregivers) to implement activities required to meet the goals of the plan. Family support and training is a skill-building support and not a form of therapy or counseling. The individualized treatment plan must be developed by either an outpatient clinician, an In-home therapy clinician or, for youth enrolled in Intensive Care Coordination, a care planning team. These services include the following when they are relevant to the goals in the youth's individualized care plan:

- providing guidance to parent(s)/guardians(s)/caregiver(s) on navigating systems that support youth with mental health, behavioral and emotional needs, such as working effectively with state agency case managers, school system officials, provider agency staff and clinicians;
- fostering empowerment of parent(s)/guardian(s)/caregiver(s) by offering supportive guidance for parents of youth with mental health needs and encouraging participation in peer/parent support and` self-help groups;
- providing guidance to the parent(s)/guardian(s)/caregiver(s) how to find, access and use formal and informal community-based resources (e.g., after-school programs, food assistance, housing resources, youth-serving systems, etc.); and
- modeling these skills for parent(s)/guardians(s)/caregiver(s).

Family support and training services do not include respite care or child care services.

Settings: Family support and training services are provided in any setting where the youth resides, such as the home (including foster homes and therapeutic foster homes), and other community settings.

Providers: Family support and training services are delivered by a family support and training partner. A family support and training partner must be working under an employment or contractual arrangement with one of the following: outpatient hospitals, community health centers, mental health centers, other clinics and private agencies certified by the Commonwealth. .

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Definitions:

Associate-level counselors/paraprofessional
Associate-level counselors/paraprofessionals must have an associate's degree in a human services field from an accredited academic institution and one (1) year of relevant experience working with families or youth. If the associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Associate-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Bachelor-level counselors/paraprofessional
Bachelor-level counselors/paraprofessionals must have a bachelor's degree in a human services field from an accredited academic institution and one year of relevant experience working with families or youth. If the bachelor's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Bachelor-level counselors/paraprofessionals are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Behavior Management Monitor
Behavioral management monitors must have a bachelor's degree in a human services field from an accredited university and one (1) year of relevant experience working with families, children or adolescents who require behavior management, or an associate's degree and a minimum of two (2) years of relevant experience working with families, children or adolescents who require behavior management. Behavior management monitors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Certified Alcoholism/Drug Abuse Counselor (CADAC)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC certification requires a combination of either a Master's degree in a "behavioral science area" and 2,000 hours of supervised experience or a Bachelor's degree in a behavioral science area and 4,000 hours of supervised experience or an Associates' degree in a behavioral science area and 6,000 hours of supervised experience. Certification also requires documentation of having received a minimum of 270 clock hours of continuing education related to the five domains for alcohol and other drug abuse. Consistent with applicable state licensure requirements, certified alcoholism/drug abuse counselors are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Certified Alcoholism/Drug Abuse Counselor II (CADAC II)
Certified by the private Massachusetts Board of Substance Abuse Counselor Certification (MBSACC). CADAC II certification requires a master's degree (or higher) from a regionally accredited academic institution in a human services behavioral sciences field with a clinical application (i.e., practicum); 2,000 hours of supervised experience and documentation of completion of 300-hour practicum. Consistent with applicable State licensure requirements, certified alcoholism/drug abuse counselor IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist..

Developmental-Behavioral Pediatrician
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and either board-eligible or board-certified in Developmental-Behavioral Pediatrics

Developmental-Behavioral Pediatric Fellow
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is board-certified in Pediatrics and enrolled in a training program in Developmental-Behavioral Pediatrics accredited by the Accreditation Council for Graduate Medical Education (ACGME). Services provided by the Developmental-Behavioral Pediatric Fellow must be provided in a setting approved for training by the sponsoring training institution, under supervision of a board certified or eligible Developmental-Behavioral Pediatrician, consistent with applicable state licensure requirements.

Family Support and Training Partner
A family support and training worker must have experience as a caregiver of a youth with special needs, preferably youth with behavioral health needs, experience in navigating any of the youth and family-serving systems and teaching family members who are involved with the youth and family serving systems, and either: a bachelor's degree in a human services field from an accredited academic institution, or an associate's degree in a human services field from an accredited academic institution and one (1) year of experience working with children/adolescents/transition-age youth and families, or a high school diploma or General Education Development (GED) and a minimum of two (2) years of experience working with children/adolescents/transition age youth and families. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Family partners are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor I – LADC I
A person licensed by the Department of Public Health to conduct an independent practice of alcohol and drug counseling, and to provide supervision to other alcohol and drug counselors, as defined in 105 CMR 168.000. These requirements include: a master's or doctoral degree in behavioral sciences, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience.

Licensed Alcohol and Drug Counselor II – LADC II
A person licensed by the Department of Public Health to practice alcohol and drug counseling under clinical supervision, as defined in 105 CMR 168.000. These requirements include: a high school diploma or equivalent, a minimum of 270 hours of training in substance abuse counseling, 300 hours of supervised practical training and 6,000 hours of supervised alcohol and drug counseling work experience (4,000 if applicant holds a bachelor's degree). Consistent with applicable state licensure requirements, LADC IIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Alcohol and Drug Counselor Assistant – LADC III
A person licensed by the Department of Public Health to provide recovery based services under direct clinical and administrative supervision, as defined in 105 CMR 168.000. These requirements include a high school diploma or equivalent, 2,000 hours of work experience in the alcohol or drug abuse field and a minimum of 50 hours of training in substance abuse counseling. Consistent with applicable state licensure requirements LACD IIIs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Independent Clinical Social Worker (LICSW)
A person with a current, valid, unrestricted license to practice as an LICSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education and two years supervised experience.

Licensed Clinical Social Worker (LCSW)
A person with a current, valid, unrestricted license to practice as an LCSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: master's or doctoral degree in Social Work from a program accredited by the Council on Social Work Education. Consistent with applicable state licensure requirements, LCSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Worker (LSW)
A person with a current, valid, unrestricted license to practice as an LSW, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: a bachelor's degree in Social Work from a program accredited by the Council on Social Work Education or a bachelor's degree in any subject and 3500 hours of supervised experience providing social work services. Consistent with applicable state licensure requirements, LSWs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Social Work Associate (LSWA)
A person with a current, valid, unrestricted license to practice as an LSWA, issued by the Massachusetts Board of Registration of Social Workers. These requirements include: an associate degree, or at least sixty credit hours of college education, in the fields of social work, psychology, counseling or other similar human services field, from an accredited college or university; or a baccalaureate degree in any field from an accredited college or university; or a minimum of one thousand (1000) hours of education in social work theory and methods in courses or programs approved by the Board of Registration of Social Workers. Consistent with applicable state licensure requirements, LSWAs are supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Licensed Marriage and Family Therapist (LMFT)
A person with a current, valid, unrestricted license to practice as a LMFT, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Mental Health Counselor (LMHC)
A person with a current, valid, unrestricted license to practice as a LMHC, issued by the Massachusetts Board of Registration of Allied Mental Health Professionals. These requirements include: a master's degree in the mental health field (including, but not restricted to, counseling, family therapy, psychology, etc.) from an accredited college or university and two years supervised experience.

Licensed Psychologist
A person with current, valid, unrestricted license to practice psychology issued by the Massachusetts Board of Registration in Psychology. These requirements include a doctoral degree from a program accredited by the American Psychological Association and two years supervised experience .

Marriage and Family Therapy Intern
The marriage and family therapy intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in marriage and family therapy or a master's in a counseling program that is fully accepted by the Board of Allied Mental Health and Human Services Profession. The marriage and family therapy intern must provide services under the direct supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist consistent with applicable state licensure requirements.

Master's Level Counselor
A person with a master's or doctoral degree in a mental health field (including, but not restricted to, counseling, family therapy, social work, psychology, etc.) from an accredited college or university who is supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse, or Nurse Clinical Specialist.

Mental Health Counselor Intern
The Mental Health Counselor Intern must be a second-year, clinical-track student in a structured field placement that is a component of a master's in mental health counseling or a master's in a counseling psychology program that is fully accepted by the Board of Allied Mental Health and Human Services Profession Consistent with applicable state licensure requirements, the Mental Heath Counselor Intern provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Board of Registration in Nursing, a master's degree in the mental health fields and one (1) year of experience delivering mental health services to families and youth. Consistent with applicable state licensure requirements, the Psychiatric Nurse provides services under the supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Psychiatric Nurse Mental Health Clinical Specialist
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing and current, valid, unrestricted authorization by the Massachusetts Board of Registration in Nursing to practice as a Psychiatric Nurse Mental Health Clinical Specialist.

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Psychiatric Nurse Mental Health Clinical Specialist Trainee
A person with a current, valid, unrestricted license to practice as a registered nurse issued by the Massachusetts Board of Registration in Nursing who is enrolled in a Psychiatric Nurse Mental Health Clinical Specialist training program recognized by the Massachusetts Board of Registration in Nursing. Consistent with applicable state licensure requirements, services provided by the Psychiatric Nurse Mental Health Clinical Specialist trainee are provided under supervision of a Psychiatric Nurse Mental Health Clinical Specialist.

Psychiatric Resident
A person with a current, valid, full or limited license to practice medicine issued by the Massachusetts Board of Registration in Medicine, who is enrolled in an Accreditation Council for Graduate Medical Education (ACGME)-accredited residency training program in either adult psychiatry or child and adolescent psychiatry. Services provided by the Psychiatric intern are provided in a setting approved for residency training by the sponsoring training institution, under supervision of a board certified or eligible child psychiatrist, consistent with applicable state licensure requirements.

Psychiatrist
A person with a current, valid, unrestricted license to practice medicine issued by the Massachusetts Board of Registration in Medicine. Psychiatrists treating youth ages 0 to 19 shall be board-certified or board-eligible in child and adolescent psychiatry. Psychiatrists treating youth ages 19 to 21 shall be trained in adult psychiatry.

Psychology Intern
The psychology intern must be admitted to doctoral candidacy in a structured clinical, or counseling, American Psychological Association (APA)-approved doctoral program. Consistent with state licensure requirements, services provided by a psychology intern are provided under the direct supervision of a licensed psychologist.

Social Work Intern
The Social Work Intern must be a second-year, clinical-track student in a structured field practicum that is a component of an MSW program that is fully accredited by the Council on Social Work Education. Consistent with applicable state licensure requirements, services are provided under the direct supervision of a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist.

Therapeutic Mentors
Therapeutic mentors must be 21 years of age or older and have either: a bachelor's degree in a human service field from an accredited academic institution and one (1) year of relevant experience working with children/adolescents/transition age youth; or, an associate's degree in a human services field from an accredited academic institution and one (1) year of relevant experience working with children/adolescents/transition age youth; or, a high school diploma or General Educational Development (GED) and a minimum of two (2) years of experience working with children/adolescents/transition age youth. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Therapeutic mentors must be supervised by a LICSW, LMFT, LMHC, LCSW, LADC I, Psychologist, Psychiatric Nurse or Nurse Clinical Specialist. .

In addition to all other medically necessary services covered for individuals under age 21, the following services are covered as services provided by Other Licensed Practitioners as defined in 42 USC 1396d (a) (6).

Applied Behavior Analyst Services
Coverage is for services for individuals under age 21 that are provided by a licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice, or provided directly by a licensed assistant applied behavior analyst or non-licensed para-professional under the supervision of a licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice.

Non-licensed paraprofessionals must be 18 years old and must have either: (1) a high school diploma or a General Education Development (GED) and have 12 months experience working with persons with developmental disabilities/children/adolescents/transition age youth and families; or (2) must have either an associate's degree in either a human, social, or educational services discipline, or a degree or certification related to behavior management, from an accredited community college or educational institution, and have six months experience working with persons with developmental disabilities/ children/adolescents/transition age youth and families.

The supervising provider ensures that all ABA staff under their supervision completes training related to the clinical and psychosocial needs of the target population upon employment and annually thereafter.

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Pursuant to MGL Chapter 112 §165, applied behavior analysts must be licensed by the Commonwealth of Massachusetts Board of Registration of Allied Mental Health and Human Services Professions. Licensed applied behavior analysts or licensed physicians, psychologists or psychiatrists working under the scope of their practices may bill for applied behavior analyst services provided directly by a licensed assistant applied behavior analysts or a non-licensed para-professional, when the services are performed under the supervision of the licensed applied behavior analyst or licensed physician, psychologist or psychiatrist working under the scope of his or her practice and the provided services are within the scope of practice for a licensed applied behavior analyst.

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Item 5: **Physician's Services**

Physician services are provided in accordance with 42 CFR 440.50.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Services that are subject to prior authorization include certain surgery services, including reconstructive surgery and gender reassignment surgery; and certain practitioner-administered drugs. MassHealth covers one application of fluoride varnish every three months for members under 21 years of age without prior authorization; additional applications are covered with medical justification.

See also Supplement to Attachment 3.1-B, p.1, Item 1.

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G. School-Based Services:

School-Based Services (SBS) are services that are listed in a recipient student's Individualized Education Plan (IEP), a section 504 accommodation plan pursuant to 34 C.F.R. § 104.36, an Individualized Health Care Plan, an Individualized Family Service Plan, or are otherwise medically necessary, that are coverable under one or more of the service categories described in Section 1905(a) of the Social Security Act, and that are necessary to correct or ameliorate defects or physical or mental illnesses or conditions discovered by an EPSDT screen.

Service providers shall be licensed or otherwise qualified under the applicable State practice act or comparable licensing criteria by the State Department of Public Health, and shall meet applicable qualifications under 42 CFR Part 440. Identification of defects, illnesses or conditions and services necessary to correct or ameliorate them is done by practitioners qualified to make those determinations within their licensed scope of practice.

Covered services include: physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR § 440.110; physician services under 42 CFR § 440.50(a); optometry services provided by a qualified professional under 42 CFR § 440.60; respiratory therapy provided by a qualified professional under 42 CFR § 440.60; nursing services coverable under 42 CFR § 440.80 and 42 CFR § 440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse; nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated to individuals who receive appropriate teaching, direction, and supervision from a Registered Nurse or Practical Nurse; fluoride varnish performed by a dental hygienist under 130 CMR § 420.424(b) in accordance with 42 CFR § 440.100; personal care services coverable and performed by individuals qualified under 42 CFR § 440.167; services performed by licensed practitioners within the scope of their practice for individuals with behavioral health (mental health and substance abuse) disorders, as defined under state law, and coverable as medical or other remedial care under 42 CFR § 440.60; diagnostic, screening, preventive, and rehabilitative services covered under 42 CFR § 440.130; medical nutritional services provided by a qualified professional under 42 CFR § 440.60; and sports related or other injury assessment and therapy provided by a qualified professional under 42 CFR § 440.60. Assessments and independent evaluations are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

Item 6: **Licensed Practitioners Services**

Licensed Practitioner Services are provided in accordance with 42 CFR 440.60.

a. **Podiatrists' Services** – Coverage is for podiatry services that are considered medically necessary. Office visits are limited to one initial visit, one limited visit per 30 day period, one extended visit per 30 day period, and one follow up visit per week. Out of office visits are limited to one visit in a 30 day period in a long-term-care facility or the member's home and two visits in a 30 day period in a hospital setting.

b. **Optometrists' Services** –

Members under age 21 are limited to one comprehensive examination within a 12 month period; additional services are provided when medically necessary. . Members aged 21 or older are limited to one comprehensive eye examination within a 24 month period; additional services are provided when medically necessary.

Services that are subject to prior authorization include: fundus photography; non-plastic prosthetic eyes; unlisted services; and vision training.

Exclusions consist of treatment for congenital dyslexia.

c. **Chiropractic Services** – include chiropractic manipulative treatment and radiology services. Services are limited to medically necessary treatment related to a neuromusculoskeletal condition. The MassHealth agency limits payment for chiropractor services for any combination of office visits and chiropractic manipulative treatments. Any office visits or chiropractic manipulative treatments in excess of 20 per member per calendar year are subject to prior authorization.

d. **Other Practitioners' Services** – Other practitioners' services also include psychologists' services, which are limited to psychological testing only; hearing instrument specialist services and public health dental hygienist services. Hearing instrument specialist services are limited to the practice of fitting and dispensing of hearing aids which means the measurement of human hearing solely for the purpose of making selections, adaptations or sales of hearing aids intended to compensate for impaired hearing. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60 month period without prior authorization.

Public health dental hygienist services are limited to services provided in public health settings within the scope of practice governed by the Massachusetts Board of Registration in Dentistry and covered by the MassHealth agency.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Medically Needy

Item 6: **Licensed Practitioners Services (continued)**

f. Midlevel Practitioner Services – Midlevel practitioner services include the services of certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric clinical nurse specialists licensed under state law. The services of all midlevel practitioners are limited to their scope of practice authorized by state law and must be provided in accordance with applicable state licensure and other applicable federal and state requirements.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided

Item 7: **Home Health Services**

c. Medical supplies, equipment, and appliances must be prescribed or ordered by the recipient's physician and must be furnished and claimed directly by appropriate vendors in accordance with the Division's regulations relative to drugs, restorative services, and rehabilitative services. Home health agencies must transmit such prescriptions and orders to vendors who are providers in the Medical Assistance Program.

Item 8: Private Duty Nursing Services

a. Private duty nursing services are provided in accordance with 42 CFR 440.80
b. Private duty nursing services are not provided in a hospital or skilled nursing facility.
c. Private duty nursing services are subject to prior authorization

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

Item 9: **Clinic Services**

Clinic Services are covered with limitations, including those specified in Item 9. MassHealth does not cover experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments, or nonmedical services (e.g., vocational and educational services, research).

Specific clinic services covered by MassHealth include the following:

a. Designated Emergency Mental Health Provider

Designated Emergency Mental Health Providers/Emergency Services Programs (DEP/ESPs) provide crisis assessment, interventions, and stabilization services in advance of a hospital admission for psychiatric treatment. Such services are available 24 hours a day, 7 days a week in order to ensure appropriate access to inpatient hospitalization and diversion from inpatient hospitalization when possible. DEP/ESP services are provided in freestanding facilities. DEP/ESPs operate under the direction of a psychiatrist. To qualify as a DEP/ESP, a provider must be designated as such by the Commonwealth.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

b. Freestanding Ambulatory Surgery Centers

MassHealth covers the following services in freestanding ambulatory surgery centers (FASCs) - outpatient same-day surgical, diagnostic, and medical services requiring general, local or regional anesthesia, a dedicated operating room, and a postoperative recovery room to patients who require constant medical supervision for a limited amount of time upon completion of the surgery or procedure, and are not expected to require hospitalization or overnight services. FASC services also include anesthesia, laboratory, radiology, drugs, biologicals, equipment, and supplies, related to the provision of the surgery or procedure.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in FASCs when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

FASCs must obtain prior authorization for FASC services provided out of state when the FASC is located more than 50 miles from the Massachusetts border.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

c. Family Planning Clinics

MassHealth covers family planning-related services, including medical examinations, counseling, follow-up health care, laboratory tests, procedures, supplies and drugs, including contraceptive supplies and drugs, provided in a family planning clinic.

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services (including anesthesia, laboratory, radiology, drugs, equipment, and supplies) in family planning clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

The family planning agency may be paid for a maximum of one HIV pre-test counseling visit and one HIV post-test counseling visit per member per test per day. The MassHealth agency pays for a maximum of four HIV pre-test counseling visits and four HIV post-test counseling visits per calendar year.

(Item 9 Clinic Services, continued)

d. Sterilization Clinics

MassHealth covers sterilization – any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing – and sterilization-related services, including anesthesia, laboratory, radiology, drugs, equipment, and supplies provided in sterilization clinics.

Sterilization is covered in sterilization clinics when the member has voluntarily given informed consent in the manner and at the time required by federal law.

MassHealth does not cover the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does cover diagnosis of male or female infertility.

(Item 9 Clinic Services, continued)

e. Radiation Oncology Centers

MassHealth covers radiation oncology and related services provided in radiation oncology centers, including radiologic procedures, drugs, equipment and supplies, and routine laboratory tests necessary for the diagnosis, detection, and treatment of disease, and for the maintenance of the health of MassHealth members.

(Item 9, Clinic Services continued)

f. Renal Dialysis Clinics

MassHealth covers renal dialysis and related services, including supplies, drugs and routine laboratory tests, provided in renal dialysis clinics. MassHealth covers home dialysis training, including self-dialysis (hemodialysis, intermittent peritoneal dialysis, and continuous cycling peritoneal dialysis) and continuous ambulatory peritoneal dialysis training only when the MassHealth member attends such training at the clinic site.

(Item 9 Clinic Services, continued)

g. Rehabilitation Centers

MassHealth covers the following services in freestanding rehabilitation centers for individuals requiring physical rehabilitation: rehabilitation evaluations conducted by physicians; and physical, occupational and speech/language therapy visits and evaluations performed by licensed therapists to improve or prevent the worsening of a congenital or acquired condition.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the rehabilitation center to obtain prior authorization for more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12-month period. Diversional and recreational therapy are not covered.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

h. Speech and Hearing Centers

MassHealth covers the following services in a freestanding speech and hearing center: audiological services, and speech, hearing or language services performed by a licensed, certified audiologist or licensed, certified speech therapist.

MassHealth covers maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program.

MassHealth requires the speech and hearing center to obtain prior authorization for more than 35 speech and language pathology visits, including group therapy visits, for a member in a 12-month period. Diversional and recreational therapy are not covered.

MassHealth covers up to one individual treatment and one group therapy session per member per day at the speech and hearing center.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

(Item 9 Clinic Services, continued)

i. Mental Health Centers

MassHealth covers diagnosis and treatment of mental and emotional disorders at mental health centers. Such services include diagnostic services, psychological testing, individual therapy, couple therapy, family therapy, group therapy, medication visit, case consultation, family consultation and psychotherapy for crisis/emergency services.

MassHealth does not cover nonmedical services provided by mental health centers (e.g., vocational, educational, recreational, community, and life-enrichment services) or diagnostic or treatment services provided at a mental health center as an integral part of a planned and comprehensive program (e.g., a residential, day activity, or drop-in program) that is organized to provide primarily non-medical or other nonreimbursable services. Play therapy, as an alternative to strictly verbal expression, is not considered a recreational service and is covered.

MassHealth covers multiple treatment modalities for a member on the same day, except for diagnostics. MassHealth does not cover more than one session of a single type of service provided to an individual member on the same day, except for the provision of psychotherapy for crisis.

Group Therapy is limited to a maximum of 12 members per group.

Psychotherapy for crisis is limited to one initial unit of service and up to three add-on units of service per date of service.

(Item 9 Clinic Services, continued)

j. Substance Use Disorder Treatment Clinics

MassHealth covers individual, group, and family/couple substance abuse rehabilitative counseling, case consultation, and acupuncture detoxification at substance abuse outpatient counseling programs.

MassHealth covers medication assisted treatment for opioid dependency at opioid treatment service centers, in accordance with applicable clinical standards. Prior authorization is required for buprenorphine.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Categorically Needy

(Item 9 Clinic Services, continued)

k. **Limited Services Clinic**

MassHealth covers vaccines and immunizations, as well as medical evaluation, testing, screening, treatment, and clinical laboratory services for episodic, urgent care relating to an illness provided in state-licensed limited services clinics.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
and Remedial Care and Services Provided to the Medically Needy Groups

Item 10: **Dental Services**

A. For members under age 21, all medically necessary dental services, including comprehensive and periodic oral evaluations and all dental services needed for maintenance of dental health, restoration of teeth, and relief of pain and infections are covered.

B. For members age 21or over the following dental services are covered:

- diagnostic services including oral evaluation (comprehensive and periodic) and radiographs;
- preventive services including prophylaxis;
- emergency care visits;
- certain restorative services (fillings);
- certain prosthodontic services (full and partial dentures including repairs);
- extractions;
- anesthesia;
- treatment of complications related to surgery;
- certain oral surgery such as biopsies and soft-tissue surgery; and
- certain periodontal services, including gingivectomies, gingivoplasties, and periodontal scaling and root planing.

In addition, for members age 21 or over, there are limited exceptions that allow for topical fluoride when documented as medically necessary.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 17: **Nurse-Midwife Services**

Nurse-midwife services are provided by certified nurse-midwives in accordance with 42 CFR 440.165.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-B, p.1, Item 1.

Item 23: Pediatric or Family Nurse Practitioners' Services

Pediatric and family nurse practitioner services are provided by certified nurse practitioners in accordance with 42 CFR 440.166.

Services that are not covered include experimental, unproven, cosmetic, or otherwise medically unnecessary procedures or treatments; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs and procedures associated with such treatment); however, diagnosis of male or female infertility is covered.

Limits on covered services can be exceeded when medically necessary, with prior authorization.

See also Supplement to Attachment 3.1-B, p.1, Item 1.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Limitations to Services Provided to the Categorically Needy

Item 11: **Therapies and Related Services**

Speech, occupational and physical therapies to improve or prevent the worsening of a congenital or acquired condition are provided in accordance with 42 CFR 440.110. MassHealth pays for maintenance therapy performed by a licensed therapist when the therapist's specialized knowledge and judgment are required to perform services that are part of a maintenance program. Diversional and recreational therapy are not reimbursable services.

Services that are subject to prior authorization include more than 20 occupational therapy visits, 20 physical therapy visits, or 35 speech/language therapy visits, including group therapy visits, for a member within a 12 month period.

Audiologist Services are provided in accordance with 42 CFR 440.110. The MassHealth agency does not pay for more than one hearing aid per ear per member in a 60-month period without prior authorization.

Item 12: **Prescribed Drugs, Dentures, Prosthetic Services, and Eyeglasses**

a. **Prescribed Drugs** - Legend FDA-approved drugs and certain non-legend over-the-counter drugs are reimbursable subject to the conditions specified in 130 CMR 406.000. Prescribers must obtain prior authorization for non-generic multiple source drugs, and for any drug identified by the Division in accordance with 130 CMR 450.303. Insulins are reimbursable for recipients without restrictions.

Active pharmaceutical ingredients (APIs) and excipients that are included in an extemporaneously compounded prescription written by an authorized prescriber and dispensed by MassHealth pharmacy providers are covered if medically necessary.

The state is in compliance with Section 1927 of the Social Security Act. Based on the requirements of Section 1927 of the Social Security Act, the state has the following policies for the supplemental rebate program for the Medicaid population:

1. The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

2. A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 31, 2016, and entitled, "State of Massachusetts Supplemental Rebate Agreement" has been authorized by CMS, and a value-based rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on March 12, 2019, and entitled, "State of Massachusetts Value-Based Supplemental Rebate Agreement" has been authorized by CMS..
3. Manufacturers with supplemental rebate agreements are allowed to audit utilization data. Supplemental rebates received by the state in excess of those required under the National Drug Rebate Agreement (NDRA) will be shared with the federal government on the same percentage basis as applied under the NDRA.
4. The unit rebate amount under the NDRA is confidential and cannot be disclosed in accordance with Section 1927(b)(3)(D) of the Social Security Act. No substantial changes will be made to the supplemental rebate agreement without CMS authorization. Supplemental rebates received pursuant to these agreements are only for the MassHealth program.
5. All drugs covered by the program, irrespective of a supplemental rebate agreement, will comply with the provisions of the NDRA.
6. The prior authorization process for covered outpatient drugs conforms to Section 1927(d)(5) of the Social Security Act. The prior authorization process provides for a turnaround response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.
7. The state may agree within the terms of a supplemental rebate agreement that the covered drug(s) may or may not be subject to prior authorization, for as long as the agreement is in effect, and that the state may obtain supplemental drug rebates in either case. This may include instances in which the state imposes prior authorization on a drug or drugs for clinical purposes, instances in which the state imposes prior authorization on a drug or drugs as part of a "step-edit" approach, and instances in which the state imposes prior authorization on a drug or drugs (which may include a generic drug) when the application of the supplemental rebate on the preferred drug or drugs results in a lower net cost to the state. The state may also enter value- or outcome-based agreements.
8. Only drugs supplied to MassHealth members will be covered under these agreements. In addition to collecting supplemental rebates for fee-for-service claims, the state may, at its option, also collect supplemental rebates for MassHealth member utilization through MCE(s) under an agreement.
9. The state may continue to collect supplemental rebates under agreements that are currently in process or effect based on the form of agreement approved by CMS as part of MA-TN-012-005 until those agreements are otherwise terminated or amended to align with the CMS-approved forms referred to in paragraph 2, above.

Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration and Scope of Medical
And Remedial Care and Services Provided to the Medically Needy

Medicare Prescription Drug Benefit –Part D.

☑ **The following excluded drugs are covered:**

☑ (a) agents when used for anorexia, weight loss, weight gain (for medically necessary appetite stimulants only)

☐ (b) agents when used to promote fertility

☑ (c) agents when used for the symptomatic relief cough and colds (covered only when dispensed to members residing in a nursing facility)

☑ (d) prescription vitamins and mineral products, except prenatal vitamins and fluoride-containing products

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Medical
And Remedial Care and Services Provided to the Medically Needy

☑ (f) nonprescription drugs, as follows:

Allergy Agents, Ophthalmic
Analgesics
Anthelmintic Agents
Antihistamines/Decongestants
Antimicrobials, Topical
Contraceptives, Oral
Dermatologic Agents, Topical
Gastrointestinal Products
Nonoxynol-9
Otic Agents
Pediculicides/Scabicides

☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

b. **Dentures** - Dentures are provided in accordance with 42 CFR 440.120. See **Supplement to Attachment 3.1-A**, page 3, Item 10, above.

c. **Prosthetic Devices** Prosthetic devices (including orthotics) are provided in accordance with 42 CFR 440.120.

MassHealth covers medically necessary prosthetics and orthotic services, including repairs after exhaustion of manufacturer warranties.

Prosthetic services that are subject to prior authorization include: addition to lower extremity prosthesis, endoskeletal ankle foot system, microprocessor controlled, lower extremity prosthesis not otherwise specified, external power device, electronic elbow and accessories, upper extremity prosthesis not otherwise specified, breast prosthesis, unlisted procedures for miscellaneous prosthetic services.

Orthotic services that are subject to prior authorization include: compression garments, protective helmet, foot pressure off loading device, spinal orthosis not otherwise specified, lower extremity orthosis not otherwise classified, orthopedic foot wear and upper limb orthosis not otherwise specified.

Members of any age may obtain prior authorization for units in excess of the limits for service codes for all other prosthetic and orthotic services.

d. **Eyeglasses** Eyeglasses are provided in accordance with 42 CFR 440.120. The following are covered services: eyeglasses, eyeglass parts, eyeglass dispensing, contact lenses and other visual aids

Services that are limited to members who meet certain clinical criteria include: tinted lenses, coated lenses, and two pairs of eyeglasses instead of bifocals, cataract lenses and contact lenses..

Services that are subject to prior authorization include: extra or spare eyeglasses; the following types of contact lenses--PMMA color vision, deficiency, gas permeable or hydrophilic toric prism ballast, gas permeable or hydrophilic bifocal; low vision aids; glass lenses; special-needs lenses; tints other than "pink 1" and "pink 2" that are available for plastic lenses only, and, polycarbonate lenses for members aged 21 or older or for any member who is amblyopic or monocular.

Exclusions consist of absorptive lenses of greater than 25% absorption, prisms obtained by decentration; contact lenses for extended wear use; invisible bifocals; and Welsh 4-drop Lens.

The volume purchase of eyeglasses limits the selection of frames and lenses to a basic assortment from the optical supplier.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Item 16: Inpatient Psychiatric Facility Services for Individuals under 22 Years of Age

Preadmission screening will be required for all non-court-ordered admissions of Medicaid recipients (as per 42 CFR 441.152). Such certification of the need for services for conversion cases (people applying for Medicaid eligibility while hospitalized in an inpatient psychiatric facility) will be made by the team responsible for the plan of care (42 CFR 441.153(b)). Periodic reviews of use will be performed by the Medicaid agency or its designee.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Item 15: **Intermediate Care Facilities**

Effective November 1, 1993, coverage is limited to state school ICF/MR (these schools have more than 15 beds). The reimbursement methodology for these services is described in Attachment 4.19-D (4).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Amount, Duration, and Scope of Services Provided to Medically Needy Groups

Item 20: **Extended Services for Pregnant Women**

The major categories of services available to pregnant women as pregnancy-related services include inpatient hospital, outpatient hospital, laboratory and X-ray, family planning, physician, clinic, dental, prescription drug, and nurse-midwife services.

Extended services to pregnant women may be provided by physicians and community health centers. Such extended services include coordinated medical management, health-care counseling, obstetrical-risk assessment and monitoring and rehabilitation services including treatment for alcoholism and drug dependency.

Item 23.d: **Nursing Facility Services for Patients under 21 Years of Age**

Skilled nursing facility services for patients under 21 years of age are covered if a Department of Public Health review team approves the facility.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Case Management Services

A. Target Group:

See pages 1a through 1q

B. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1919 (g) (1) of the Act is invoked to provide services less than statewide:

C. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

D. Definition of services:

See pages 1a through 1q

E. Qualifications of provider:

See pages 1a through 1q

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

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State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

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State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

H. **Children Served by the Department of Social Services**

1. Target Group

The target group consists of Medicaid eligible children who have been reported to the Department of Social Services as potentially abused or neglected, or are receiving services from the Department of Social Services after being determined to either be at risk of abuse or neglect or substantiated as being abused or neglected children.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with a specific person within the case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social, and other services.

Case management will include:

1. collection of assessment data;
2. development of an individualized plan of care;
3. coordination of needed services and providers;
4. home visits and collateral contracts as needed;
5. maintenance of case records; and
6. monitoring and evaluation of client progress and service effectiveness.

3. Qualifications of Providers

The case manager must be a qualified social worker according to the requirements of the Massachusetts Department of Social Services.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Services: General Provisions

Reserved

K. Children Provided Case Management Services by the Department of Youth Services

1. Target Group

The target group consists of Medicaid recipients who (1) are between the ages of 7 through 22, (2) are committed to the Department of Youth Services (DYS) by a court of competent jurisdiction in the Commonwealth until the age specified in their commitment (up to their 21st birthday), or voluntarily agree to the continuation of DYS case management services beyond their eighteenth birthday up to their 22nd birthday, and (3) as a result either of their original placement or conditional release from a public institution, reside in placements that include, but are not limited to, their own homes, the homes of relatives, community based residences or residential treatment facilities.

2. Definition of Services

Targeted case management is a set of interrelated activities under which the responsibility for locating, coordinating, and monitoring appropriate services for an individual rests with the specific persons within case management provider agency. The purpose of case management is to assist individuals in gaining access to needed medical, social educational and other services.

3. Case management will include:

1. Collection of assessment data;
2. Development of an individual plan of care;
3. Coordination of needed services and providers;
4. Home visits and collateral contacts as needed
5. Maintenance of case records; and
6. Monitoring and evaluating client progress and service effectiveness

4. Qualifications of Providers

The case manager must have, or work directly under the supervision of an individual with, at least three years of full or equivalent part-time, professional or paraprofessional experience in social work, social casework, guidance, vocational counseling, employment counseling, or educational counseling, the major duties of which include providing such services to juveniles, or in corrections institution work, the major duties of which include the custodial care, treatment counseling and/or rehabilitation of juveniles.

Case Management Services (cont.)

F. The state assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902 (a) (23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

1. Target Group

Target group includes Medicaid beneficiaries who are either:

A. 18 years of age or older,
   a. With intellectual disability, meaning significantly sub-average intellectual functioning existing concurrently and related to significant limitation in adaptive functioning that manifests before 18.

B. under 18 years of age,
   a. with a verified diagnosis of intellectual disability or a closely related developmental condition or, with respects to persons from birth to age five, a developmental delay. Developmental delay means a substantial developmental delay or specific congenital or acquired condition with a high probability of resulting in a developmental disability if services are not provided; and
   b. who demonstrate severe functional impairments, with severe functional impairments meaning functional impairments in at least three specified areas of adaptive functioning, based upon normative expectations of the types of skills normally acquired as the child develops, as measured by standardized assessment or comparable data. The areas of adaptive functioning are: self-care, communication, learning, mobility , and self-direction and, for individuals age 14 years or older, capacity for independent living and economic self-sufficiency.

☒ Target group includes individuals transitioning to a community setting and case management services will be made available for up to 180 consecutive days of the covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions.

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

1. Comprehensive Assessment and at least annual periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history;
- Identifying the individual's needs and completing related documentation; and
- Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with
  - Medical, social, educational providers or
  - Other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities typically occur monthly and include at least one annual monitoring meeting to adequately address the needs of the eligible individuals, and care plan services may be reevaluated at any time. The Monitoring and follow up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring meeting, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

Case management services are coordinated with and do not duplicate activities provided as a part of institutional services and discharge planning activities.

5. Qualifications of provider:

The Department of Developmental Services (DDS) has been designed to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions at the Department of Developmental Services in the Human Services Coordinator series. Minimal entrance requirements for the Human Services Coordinator position include at least three years of full-time, or equivalent part-time professional experience in human services work or social work. One year of professional work experience must have involved working with individuals with intellectual or other developmental A Bachelor's or higher degree in social work, psychology sociology, counseling, counseling education, education of the physically or emotionally handicapped, education of the multiple handicapped, education or the learning disabled, human services, rehabilitation, rehabilitation counseling, nursing, recreation therapy, art therapy, dance therapy, music therapy, or physical education may be substituted for years of the required experience on the basis of two years of education for one year of experience.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b) Massachusetts designates the Department of Developmental Services as the provider of services covered under this section of the State Plan.

7. Access to Services:

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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Case Management Services Provided to the Medically Needy Groups

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other
services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

1. Target Group

To be eligible for this target group, an individual must meet the following criteria:

Clinical Criteria

An individual who is 19 year of age or older must: have a mental illness, as determined by the Department of Mental Health (DMH) in accordance with DMH regulations and meet the following criteria:

1. Includes a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life;
2. Has lasted or is expected to last at least one year;
3. Has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and
4. Meets diagnostic criteria specified within the current edition of Diagnostic and Statistical Manual of Mental Disorders, which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by substance related disorders, mental retardation or organic disorders due to a general medical condition not elsewhere classified.

An individual who is under 19 years of age must have a mental illness as determined by DMH which meet the following criteria:

1. Has lasted, or is expected to last, at least one year;
2. Has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities; and
3. Meets diagnostic criteria specified within the current edition of the Diagnostic and Statistical Manual of Mental Disorders, but is not solely within one or more of the following categories:
    a. Developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation;
    b. Cognitive disorders, including delirium, dementia or amnesia;
    c. Organic disorders due to a general medical condition not elsewhere classified; or
    d. Substance-related disorders.

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Case Management Services Provided to the Medically Needy Groups

☒ Target group includes individuals transitioning to a community setting and case-management services will be made available for up to 180 consecutive days of the covered stay in the medical institution. The target group does not include individuals between ages 22 and 64 who are in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

2. Areas of state in which services will be provided:

☒ Entire state.

☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (10) (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Assessment and reassessment of individual needs to determine the need for any medical, educational, social or other services. Reassessments are conducted at least annually, or more frequently if necessary, to address changes in an individual's condition. These assessment activities include:

- Taking client history; and
- Identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

Development (and periodic revision) of a specific care plan that:

- Is based on the information collected through the assessment;
- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- To help an eligible individual obtain needed services including activities that help link an individual with:
  - Medical, social, educational providers; or
  - Other programs and services that are capable of providing needed services, to address identified needs and achieve goals specified in the care plan, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities are conducted at least annually, or more frequently as necessary, to adequately address the needs of the eligible individual, and care plan services may be reevaluated at any time. These Monitoring and follow-up activities include:

- Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - Services are being furnished in accordance with the individual's care plan;
  - Services in the care plan are adequate; and
  - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

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State: Massachusetts
Case Management Services Provided to the Categorically Needy Groups

5. Qualifications of providers:

The Department of Mental Health (DMH) has been designated to serve as the exclusive source of case management services with respect to the target group. Case management services will be provided by qualified personnel hired into state positions in the Human Services Coordinator series. Qualified personnel must have demonstrated applicable education and/or professional work experience with the target population.

6. Freedom of choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of any qualified Medicaid provider of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception:

☒ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services. Consistent with 42 CFR 441.18(b), Massachusetts designates the Department of Mental Health as the provider of services covered under this section of the State Plan.

7. Access to Services:

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Case Management Services Provided to the Categorically Needy Groups

The State assures that:

- Case management services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

9. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted care management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

10. Limitations:

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred; and
- Activities for which third parties are liable to pay as described in 42 USC 1396n(4)(A)

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Case Management Services Provided to the Categorically Needy Groups

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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State: Massachusetts
Case Management Services

RESERVED

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy Groups

1. Target Group

A Medicaid member is eligible for targeted case management services described below if the member:

A. is eighteen years of age or older;

B. receives a statement from a physician verifying the AIDS diagnosis. Such a diagnosis shall be based on the most recent AIDS definition published by the Federal Center for Disease Control (CDC) as it may from time to time be amended. The following is a list of conditions on which the CDC currently bases an AIDS diagnosis; however, such diagnosis must at all times be consistent with the most recently published definition of amendments to that definition:

i. The development of an opportunistic disease process indicating defective cell-mediating immunity (i.e. PCP, Kaposi's Sarcoma); or
ii. Lack of an established cause of profound immunosuppression; or
iii. HIV infection and CD4+ T-lymphocyte count<200 cells/ul (or CD4+ percent<14); or
iv. HIV infection and pulmonary tuberculosis; or
v. HIV infection and recurrent pneumonia (within a 12 month period); or
vi. HIV infection and invasive cervical cancer;

C. lives in a staffed, congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program which require that a person be HIV positive, and in which no more than three mentally and/or physically impaired individuals share a single bedroom and bathroom; and

D. requires and receives from the congregate residential program staff assistance with either activities of daily living (ADL) such as bathing, dressing/grooming, mobility/transfer, eating or toileting and/or instrumental activities of daily living (IADL) such as laundry, shopping, transportation and housekeeping.

☐ Target group includes individuals transitioning to a community setting during a covered stay in an institutional setting.

2. Areas of state in which services will be provided:

☒ Entire state .

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☐ Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide)

3. Comparability of services

☐ Services are provided in accordance with Section 1902 (a) (100 (B) of the Act.

☒ Services are not comparable in the amount, duration, and scope. Authority of Section 1915 (g) (1) of the Act is invoked to provide services without regard to the requirements of Section 1902 (a) (10) (B) of the Act.

4. Definition of services:

Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Case Management includes the following assistance:

Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include

- taking client history and
- identifying the individual's needs and completing related documentation; and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Development (and periodic revision) of a specific care plan that:

- is based on the information collected through the assessment;
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities:

- to help an eligible individual obtain needed services including activities that help link an individual with
  - medical, social, educational providers or

- other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

Monitoring and follow-up activities:

- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
  - services are being furnished in accordance with the individual's care plan;
  - services in the care plan are adequate; and
  - there are changes in the needs or status of the individual, and if so, making necessary adjustments in the care plan and service arrangements with providers.

Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual to access services.

5. Qualifications of provider:

To be qualified to provide case management services, a provider must be on the staff of a congregate residential program which meets the Department of Public Health (DPH) funding requirements for the AIDS/HIV Bureau, Supportive Residential Services program. Such a program must assure that each client is managed by a case manager who possesses the following minimal qualifications: a Masters degree in social work or related field, a registered nurse, or three or more years of documented case management experience working with the disabled in a community setting.

6. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

A. Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
B. Eligible recipients will have free choice of the providers of other medical care under the plan.

7. Access to Services:

The State assures that case management services will not be used to restrict an individual's access to other services under the plan.

The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

8. Case Records:

Providers maintain case records that document for all individuals receiving case management the following: the name of the individual; dates of the case management services; the name of the provider agency (if relevant) and the person providing the case management service; the nature, content, and whether goals specified in the care plan have been achieved; whether the individual has declined services in the care plan; the need for, and occurrences of, coordination with other case managers; the timeline for obtaining needed services; and a timeline for reevaluation of the plan.

9. Payment:

Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose**.**

10. Limitations:

Case Management does not include the following:

- Case management activities that are an integral component of another covered Medicaid service;
- The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
- Activities integral to the administration of foster care programs; and

- Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

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State: Massachusetts
Case Management Services

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State: Massachusetts
Case Management Services Provided to the Medically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. Target Group: The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. Areas of State in Which Services Will be Provided

Services are available state-wide

3. Comparability of Services

Services are not comparable in amount, duration and scope. (Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B)

4. Definition of Services

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or

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deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

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State: Massachusetts
Case Management Services Provided to the Medically Needy

M. Targeted Case Management – Individuals under 21 with Serious Emotional Disturbance (SED)

1. Target Group: The target group includes individuals under 21 with a Serious Emotional Disturbance (SED) including individuals with co-occurring conditions.

2. Areas of State in Which Services Will be Provided

Services are available state-wide

3. Comparability of Services

Services are not comparable in amount, duration and scope. (Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of § 1902(a)(10)(B)

4. Definition of Services

Targeted Case Management Services (Intensive Care Coordination) is defined as follows:

1. Assessment: The Care Manager, working with the Care Planning Team, may use multiple tools, including a strengths-based standardized assessment instrument, in conjunction with a comprehensive psychosocial assessment and other clinical information to organize and guide the development of an individualized care plan. The Care Planning Team is a source for information needed to form a complete assessment of the child. The Care Planning Team includes, as appropriate, the Care Manager, providers, case managers from state agencies that provide services to the child, family members, and natural supports such as neighbors, friends and clergy. Assessment activities include, without limitation: the Care Manager 1) assisting the family to identify appropriate members of the Care Planning Team; 2) facilitating the Care Planning Team to identify strengths and needs of the child and strengths and needs of family in meeting the child's needs and 3) collecting background information and plans from other agencies. The assessment process will determine the needs of the child for any medical, educational, social or other services. Further assessments will be provided as medically necessary.

2. Development of an individualized care plan: Using the information collected through an assessment, the Care Manager, convenes and facilitates the Care Planning Team, together with the Team develops a person and family-centered, Individual Care Plan that specifies the goals and actions to address the medical, social, educational and other services needed by the eligible individual. The Care Manager works directly with the child, the family (or the child's authorized health care decision maker) and others to identify the strengths, needs and goals of the child and the strengths, needs and goals of the family in meeting the child's needs. .

3. Referral and Related Activities: Using the individual Care Plan, the Care Manager (1) convenes, coordinates and communicates with the Care Planning Team to implement the Individual Care Plan; (2) works directly with the child and family to implement elements of the Individual Care Plan; (3) prepares, monitors and modifies the Individual Care Plan in concert with the Care Planning Team; (4) coordinates the delivery of available services, including services reimbursable under 42 USC 1396d(a) and educational, social or other services; (5) develops, in concert with the Care Planning Team, a transition plan when the child has achieved the goals of the Individual Care Plan; and (6) collaborates with other service providers on the child and family's behalf.

4. Monitoring and follow-up activities include reviewing the Individual Care Plan every quarter and convening the Care Planning Team at least annually to update the Plan of Care to reflect the changing needs of the child. The Care Manager and the Care Planning Team perform such reviews and include (1) whether services are being provided in accordance with the Individual Care Plan (2) whether the services in the Individual Care Plan are adequate and (3) whether there are changes in the needs or status of the individual and if so, adjusting the Care Plan as necessary.

Services may include contact with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individuals to access services.

5. Qualifications of Providers:

Providers are agencies known as Community Service Agencies (CSAs) that meet requirements established by the single state Medicaid Agency. To meet such requirements, CSAs must have at least three years' experience providing behavioral health services to youth, from birth to 21 years old, and their families. CSAs are community based child and family service organizations such as community mental health centers, not-for-profit social service agencies and other service providing agencies. CSAs must employ or contract with licensed behavioral health clinicians or non-licensed staff or paraprofessionals supervised by licensed behavioral health clinicians to provide case management services known as Intensive Care Coordination (ICC). Non-licensed staff or paraprofessionals include staff members with a master's degree or a bachelor's degree or with an associates degree and at least five years of experience working with the target population. The case manager, known as the Care Manager, develops and coordinates a child specific care planning team that develops an individualized, child centered, family and strengths-based Plan of Care.

6. Free Choice of Providers

a. Free choice of providers of case management services may be restricted in accordance with the provision of 1915(g)(1) of the Medicaid Act as amended by Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 and 42CFR 431.51.

b. Eligible members will have free choice of providers of other medical care under the plan

7. Non-Duplication of Payment

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

8. Intensive Care Coordination Services To Individuals in Institutions

Nothing in the definition excludes the provision of Intensive Care coordination to individuals who are in hospitals, ICF-MRs, Institutions for Mental Disease (IMDs), Psychiatric Residential Treatment Facilities (PRTFs), and Skilled Nursing Facilities who meet the definition of the target population described above.

a. Such Intensive Care Coordination Services may by provided to individuals transitioning to a community setting. Intensive Care Coordination Services will be made available for up to 180 consecutive days of the covered stay in the medical institution.

b. These activities shall be coordinated with, and not duplicate, institutional discharge planning.

c. The amount, duration, and scope of Intensive Care Management activities will be documented in the Member's Individual Care Plan

d. Transitional Intensive Care Coordination is provided by and reimbursed only to CSAs

e. The Commonwealth will monitor compliance with these provisions through a system that includes periodic audits and claims reviews.

9. Limitations on Qualified Providers

Providers are limited to regionally based, Community Service Agencies that MassHealth determines are most qualified to provide Intensive Care Coordination to members with SED including co-occurring disorders. These limitations will ensure that individuals within the target group receive needed services by establishing a defined group of providers who have and maintain expertise in the special service needs of this population.

10. Additional Assurances

The State assures that:

- Case management services will be provided in a manner consistent with the best interest of recipients and will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or conditional receipt of other Medicaid services on receipt of case management services;
- Providers of case management services do not exercise the agency's authority to authorize or

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Case Management Services Provided to the Medically Needy

deny the provision of other services under the plan.

Case Management does not include the following:

- Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act;
- The direct delivery of an underlying medical, educational, social, foster care or other service to which an eligible individual has been referred.
- Activities for which third parties are liable to pay as described in 42 USC 1396n (4) (A).

Reserved

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Program of All-Inclusive Care for the Elderly (Pace) Providers

1. Target Group

All medically needy and categorically needy individuals who are at least 55 years old, live in the PACE service area, and are certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

2. Definition of Services

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participant's needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services), which are integrated for a seamless provision of total care. PACE organizations provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services.

3. Qualification of Providers

PACE providers must meet with all the requirements found at 42 CFR Part 460.

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

Name and address of State Administering Agency, if different from the State Medicaid Agency.

I. **Eligibility**

The state determines eligibility for PACE enrollees under rules applying to community groups. Spousal income and resources are not counted.

☐ A. The state determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The state has elected to cover under its State Plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the state determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

☒ B. The state determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.)

☐ C. The state determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the state's approved HCBS waiver(s).

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

Regular Post Eligibility

☐ 1. SSI State. The state is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) Sec. 435.726 — States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☐ 1. The following standard included under the State Plan (check one):

☐ (a) SSI
☐ (b) Medically Needy
☐ (c) The special income level for the institutionalized
☐ (d) Percent of the Federal Poverty Level: ___%
☐ (e) Other (specify):_____

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:
_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):

☐ 1. SSI Standard
☐ 2. Optional State Supplement Standard
☐ 3. Medically Needy Income Standard
☐ 4. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
☐ 5. The following percentage of the following standard that is not greater than the standards above: ___% of ___ standard.
☐ 6. The amount is determined using the following formula:
_____
_____
☐ 7. Not applicable (N/A)

(C) Family (check one):

☐ 1. AFDC need standard

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

☐ 2. Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

☐ 3. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 4. The following percentage of the following standard that is not greater than the standards above:_____%
of_____ standard.

☐ 5. The amount is determined using the following formula:
_____
_____

☐ 6. Other

☐ 7. Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

☐ 2. 209(b) state, a state that is using more restrictive eligibility requirements than SSI. The state is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735** — States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A) Individual (check one)

☐ 1. The following standard included under the State Plan (check one):

☐ (a) SSI
☐ (b) Medically Needy
☐ (c) The special income level for the institutionalized
☐ (d) (Percent of the Federal Poverty Level: _____%
☐ (e) ___Other (specify): _____

☐ 2. The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ 3. The following formula is used to determine the needs allowance:_
Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B) Spouse only (check one):

- ☐ 1. The following standard under 42 CFR 435.121:
  _____
- ☐ 2. The medically needy income standard
  _____
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- ☐ 5. The amount is determined using the following formula:
  _____
  _____
- ☐ 6. Not applicable (N/A)

(C) Family (check one):

- ☐ 1. AFDC need standard
- ☐ 2. Medically needy income standard
  The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.
- ☐ 3. The following dollar amount: $_____
  Note: If this amount changes, this item will be revised.
- ☐ 4. The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
- ☐ 5. The amount is determined using the following formula:
  _____
  _____
- ☐ 6. Other
- ☐ 7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

Spousal Post Eligibility

☐ 3. State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:

1. Individual (check one)

☐ (A) The following standard included under the State plan (check one):

- ☐ 1. SSI
- ☐ 2. Medically Needy
- ☐ 3. The special income level for the institutionalized
- ☐ 4. Percent of the Federal Poverty Level: _____%
- ☐ 5. Other (specify): _____

☐ (B) The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

☐ (C) The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the Individual's maintenance needs in the community:

_____

_____

_____

_____

_____

_____

Program of All-Inclusive Care for the Elderly (PACE) Providers (cont.)

II. **Rates and Payments**

See **Attachment 4.19-B**.

III. **Enrollment and Disenrollment**

The state assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the state and the state Administering Agency. The state assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the state's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

The following is a description of the methods that are used to assure that the medical and remedial care and services are of high quality.

a) The State agency has an agreement with the DPH to recommend appropriate standards for high quality care. The agreement also includes utilization review of all Tile XIX skilled nursing homes, intermediate care facilities, home health agencies, special nursing homes for disabled children under 18, and facilities for the mentally retarded under 18.

b) The Department continues to develop and has developed many conditions of participation with the cooperation of the DPH, providers, and special consultants, affecting the quality as well as scope of services provided under the MA Program

c) The Department conducts open-mouth review of dental patients whenever there is reason to question the quality and extent of dental services under the program

d) Professional Standards Review Organizations (PSROs) review length of hospital stay in an increasing number of acute hospitals: the review affects the quality as well as duration of treatment in acute care facilities. The Department monitors PSROs with trained Utilization Review coordinators through sample reviews

e) The quality of items and services and supplies under the pharmacy program are under increasing scrutiny by administration and support staff.

f) Participation in the program and issuance of provider numbers are withheld from neighborhood health centers, and mental health rehabilitation, and hearing clinics until certification standards have been met.

g) The staff is aware and constantly involved in provisions for and development of policy in new program areas such as renal dialysis and Early and Periodic Screening, Diagnosis and Treatment.

h) The Department works closely with Medicare, the medical and dental societies and other provider groups in maintaining surveillance of individual providers as well as expectations and general standards of medical services.

i. PACE organizations shall adhere to the federal regulations for Quality Assessment and Performance Improvement found at 42 CFR 460.130.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Transportation

MassHealth assures necessary transportation for eligible members to and from providers of medically necessary MassHealth covered services. MassHealth provides for cost-effective, suitable transportation as follows within a reasonable geographic area.

1. Brokered Transportation – see Attachment 3.1-A, item 24.a, and Attachment 3.1-B, item 23.a. for a description of brokered transportation

2. Non-brokered Transportation

MassHealth provides non-brokered in-state non-emergency and emergency transportation through MassHealth transportation providers, which is claimed as medical assistance. MassHealth also provides for non-brokered transportation to School-Based Medicaid services, which is claimed as an administrative expense. MassHealth claims school-based transportation expenditures only when the need for transportation is provided on a specially equipped or adapted vehicle. MassHealth uses an allocation method to approximate reasonable costs for time spent receiving transportation services to Medicaid-covered services. Delivery methods for in-state non-brokered, non-emergency transportation include chair car, ground ambulance, or other methods suitable to the member's condition. For in-state non-brokered non-emergency transportation claimed as medical assistance, all qualified and willing providers may participate as MassHealth providers. Such transportation is provided state-wide for any member eligible for non-emergency transportation services for whom such service is medically necessary and not otherwise furnished to such member under a selective broker contract. MassHealth makes direct payments to the MassHealth provider for such transportation services. Delivery methods for in-state non-brokered emergency transportation include ground ambulance, air ambulance, or other methods suitable to the member's condition.

MassHealth also provides for out-of-state non-brokered, non-emergency and emergency transportation by licensed carriers, which is claimed as an administrative expense. Delivery methods for out-of-state non-brokered, non-emergency transportation include airplane, bus, train, or other methods suitable to the member's condition. Prior authorization is required for out-of-state non-brokered, non-emergency transportation. Delivery methods for out-of-state non-brokered, emergency transportation include ground ambulance, air ambulance, or other methods suitable to the member's condition.

Members who use public transportation to MassHealth covered medically necessary services may receive reimbursement for their public transportation expenses. Members may also be reimbursed for expenses incurred for transportation other than public transportation. Personal reimbursement is claimed as an administrative expense.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The State reimburses those facilities that have received a Determination of Need from the Department of Public Health. The Determination of Need approval is evaluated against the guidelines developed by the Massachusetts Task Force on Organ Transplantation (October 1984). The Determination of Need conditions assure that similarly situated individuals are treated alike and that services are accessible and of high quality care.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Standard Alternative Benefit Plan

See TN-014-007, TN-015-008
Standard ABP MMDL

And TN-014-008, TN-015-007
Care Plus ABP MMDL

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

☒ A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. ☒ Individuals receiving SSI under Title XVI or state supplementation, who are categorically needy under the state's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act or under the Railroad Retirement System are included:

   ☒ Yes ☐ No

2. ☐ Individuals receiving SSI under Title XVI, state supplementation, or a money payment under the state's approved Title XIX plan.

   Persons receiving benefits under Title II of the Act of under the Railroad Retirement System are included:

   ☐ Yes ☒ No

3. ☐ All individuals eligible under the state's approved Title XIX plan.

☐ B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

☒ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

All Title XIX recipients who are also eligible for Part B of Title XVIII.

This relates only to comparability of devices – benefits under XVIII to what groups – not how XIX pays. …if state has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group., e.g. deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

Citation

SECTION 4: GENERAL PROGRAM ADMINISTRATION

4.1 Methods of Administration

42 CFR 431.15
AT-79-29

The Medicaid agency employs methods of administration found by the Secretary of Health and Human Services to be necessary for the proper and efficient operation of the plan.

Citation

4.2 Hearings for Applicants and Recipients

42 CFR 431.202
AT-79-29
AT-80-34

The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

Citation	4.3 Safeguarding Information on Applicants and Recipients
42 CFR 431.301 AT-79-29	Under state statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967	All other requirements of 42 CFR Part 431, Subpart F, are met.

Citation

4.4 Medicaid Quality Control

42 CFR 431.800 (c)
50 FR 21839
1903 (u) (1) (D) of the Act,
P.L. 99-509
(Section 9407)

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The state operates a claims processing assessment system that meets the requirements of 431.800 (e), (g), (h), and (k).

☐ Yes.

☒ Not applicable. The state has an approved Medicaid Management Information System (MMIS).

4.5 Medicaid Audit Recovery Program

Citation

Section 1902(a)(42)(B)(i) of the Social Security Act

☐The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under any waiver of the State plan.

☒The State is seeking an exception to establishing such program for the following reasons:

The state has mitigated the need for the RAC contractor through the following state processes and agreements:

- Anti-fraud, waste, and abuse activities, including pre-payment and post-payment reviews, financial and provider audits, and utilization management activities, carried out by MassHealth's managed care plans (MCOs and PHIP).
- Physical health provider audits and other recovery activities carried out by the Provider Compliance Unit.
- LTSS provider audits and other recovery activities carried out by LTSS third party administrator vendor.
- Acute hospital utilization management including pre-payment and post-payment reviews carried out by acute hospital utilization control vendor.
- Dental provider audits carried out by dental third party administrator vendor.
- Third party liability program integrity activities carried out by third party liability unit.
- Financial audits of hospitals and nursing facilities carried out by the Financial Compliance Unit.
- Pre-pay reviews carried out by MassHealth Program Integrity Unit through its NetReveal system.
- Provider and program audits carried out by the Massachusetts Office of Inspector General.

- Provider and program audits carried out by the Massachusetts Office of the State Auditor.
- Provider investigations carried out by the Massachusetts Attorney General Office's Medicaid Fraud Division.

Section 1902(a)(42)(B)(ii)(I) of the Act

☐ The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

☐The State will make payments to the RAC(s) only from amounts recovered.

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

☐ The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee):

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

4.5 Medicaid Audit Recovery Program

☐ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

☐ The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act

☐ The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee):
Specific payment methodology is not yet determined as the State has not yet entered into a contract

Section 1902 (a)(42)(B)(ii)(III) of the Act

☐ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).

Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act

☐ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.

Section 1902(a)(42)(B)(ii)(IV(bb) of the Act

☐ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.

Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act

☐ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

Citation	4.6 Reports
42 CFR 431.16 AT-79-29	The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Citation

4.7 Maintenance of Records

42 CFR 431.17
AT-79-29

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with federal requirements. All requirements of 42 CFR 431.17 are met.

Citation

42 CFR 431.18 (b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency, are maintained in the state office and in each local and district office for examination, upon request by individuals, for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Citation	4.9 Reporting Provider Payments to Internal Revenue Service
42 CFR 433.37 AT-78-90	There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 6041) with respect to payment for services under the plan.

Citation

42 CFR 431.51
AT-78-90
46 FR 48524
48 FR 23212
1902 (a) (23)
of the Act
P.L. 100-93
(sec. 8 (f))

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that any individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual

(1) under an exception allowed under 42 CFR 431.54,

(2) under a waiver approved under 42 CFR 431.55, or

(3) by an individual or entity excluded from participation in accordance with section 1902 (p) of the Act.

Citation

42 CFR 431.610
AT-78-90
AT-80-34

4.11 Relations with Standard-Setting and Survey Agencies

(a) The state agency utilized by the secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is the: **Department of Public Health.**

(b) The state authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): the **Department of Public Safety**.

(c) **Attachment 4.11-A** describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Citation

4.11 Relations with Standard-Setting and Survey Agencies (cont.)

42 CFR 431.610
AT-78-90
AT-89-34

(d) The **Department of Public Health** (agency) which is the state agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610 (e), (f) and (g) are met.

Citation

4.12 Consultation to Medical Facilities

42 CFR 431.105 (b)
AT-78-90

(a) Consultative services are provided by health and other appropriate state agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105 (b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105 (b).

☐ Yes, as listed below:

☒ Not applicable. Similar services are not provided to other types of medical facilities.

Citation

4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107

(a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.

42 CFR Part 483
1919 of the Act

(b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.

42 CFR Part 483, Subpart D

(c) For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.

1920 of the Act

(d) For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920 (b) (2) and (c) are met.

☐ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

Citation

4.13 Required Provider Agreement (cont.)

1902 (a) (58)
1902 (w)

(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902 (w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, health maintenance organizations and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State law (whether

Citation 4.13 Required Provider Agreement (cont.)

(e) statutory or recognized by the courts) concerning advance directives; and

(f) provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1) (a) to all adult individuals at the time specified below:

(a) Hospitals: at the time an individual is admitted as an inpatient.

(b) Nursing facilities: when the individual is admitted as a resident.

(c) Providers of home health care or personal care services: before the individual comes under the care of the provider;

(d) Hospice programs: at the time of initial receipt of hospice care by the individual from the program; and

(e) Health maintenance organizations: at the time of enrollment of the individual with the organization.

(3) **Attachment 4.34A** describes law of the state (whether statutory or as recognized by the courts of the state) concerning advance directives.

☐ Not applicable. No state law or court decision exists regarding advance directives.

Citation

4.14 Utilization Control

42 CFR 431.630
42 CFR 456.2
50 FR 15312

(a) A statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

☒ Directly, and under contract.

1902 (a) (30) (C) and 1902 (d) of the Act, P.L. 99-509 (Section 9431)

☐ By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO:

(1) meets the requirements of §434.6 (a);

(2) includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) identifies the services and providers subject to PRO review;

(4) ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

☐ Quality review requirements described in section 1902 (a) (30) (C) of the Act relating to services furnished by HMOs under contract are undertaken through contract with the PRO designated under 42 CFR Part 462.

1902 (a) (30) (C) and 1902 (d) of the Act, P.L. 99-509 (Section 9431)

☒ By undertaking quality review of services furnished under each contract with an HMO through a private accreditation body.

Citation

4.14 Utilization Control (cont.)

(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

☒ Utilization and medical review for acute hospitals is performed by a QIO-like entity.

☒ The agency has assumed direct responsibility for assuring that utilization review requirements for chronic disease and rehabilitation hospitals are met through an interdepartmental service agreement.*

* The state performs the reviews in state-owned non-acute hospitals.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H that specifies the conditions of a waiver of the requirements of Subpart C for:

☐ All Hospitals (other than mental hospitals)

☐ Those specified in the waiver.

☒ No waivers have been granted.

Citation

4.14 Utilization Control (cont.)

42 CFR 456.2
50 FR 15312

(c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

☒ Utilization and medical review are performed under a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ All mental hospitals

☐ Those specified in the waiver.

☒ No waivers have been granted.

Citation

4.14 Utilization Control (cont.)

42 CFR 456.2
50 FR 15312

(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

☒ Utilization and medical review are performed under a contract with the agency to perform those reviews.

☐ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H that specifies the conditions of a waiver of the requirements of Subpart D for:

☐ All skilled nursing facilities.

☐ Those specified in the waiver.

☒ No waivers have been granted.

Citation

4.14 Utilization Control (cont.)

42 CFR 456.2
50 FR 15312

☒ (e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through

- ☐ Facility-based review
- ☐ Direct review by personnel of the medical assistance unit of the state agency
- ☒ Personnel under contract to the medical assistance unit of the state agency
- ☐ Utilization and Quality Control Peer Review Organizations
- ☐ Another method as described in **Attachment 4.14-A**
- ☐ Two or more of the above methods. **Attachment 4.14-B** describes the circumstances under which each method is used.

☐ Not applicable. Intermediate care facility services are not provided under this plan..

Citation
1902 (a) (30) and 1902 (d) of the Act, P.L. 99-509 (Section 9431)

☒ 4.14 (f)

The Medicaid agency meets the requirements of section 1902 (a) (30) of the Act for control of the utilization of services furnished by each health maintenance organization under contract with the Medicaid agency. Independent, external quality reviews are performed annually by:

☐ A Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

☒ A private accreditation body.

Citation

4.15 Inspection of Care in Intermediate Care Facilities for the Mentally Retarded, Facilities Providing Inpatient Psychiatric Services for Individuals Under 21, and Mental Hospitals

42 CFR Part 456 Subpart I, and 1902 (a) (31) and 1903 (g) of the Act

☐ The state has contracted with a Peer Review Organization (PRO) to perform inspection of care for:

☐ ICFs/MR;

☐ Inpatient psychiatric facilities for recipients under age 21; and

☐ Mental Hospitals.

42 CFR Part 456 Subpart A and 1902 (a) (30) of the Act

☒ All applicable requirements of 42 CFR Part 456, Subpart I, are met with respect to periodic inspections of care and services.

☐ Not applicable with respect to intermediate care facilities for the mentally retarded services; such services are not provided under this plan.

☐ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

☐ Not applicable with respect to inpatient psychiatric services for individuals under age 21; such services are not provided under this plan.

Citation

42 CFR 431.615 (c)
AT-78-90

4.16 Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with state health and vocational rehabilitation agencies and with Title V grantees that meet the requirements of 42 CFR 431.615.

Attachment 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Citation

4.17 Liens and Adjustments or Recoveries

42 CFR 433.36 (c)
1902(a)(18) and
1917(a) and (b) of the Act

(a) Liens

☑ The state imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The state complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c)-(g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

☑ The state imposes liens on real property on account of benefits incorrectly paid.

☑ The state imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the state for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in **Attachment 4.17-A**. (***Note:*** If the state indicates in its State Plan that it is imposing TEFRA liens, then the state is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.)

☑ The state imposes liens on both real and personal property of an individual after the individual's death.

Citation

4.17 Liens and Adjustments or Recoveries (cont.)

(b) Adjustments or Recoveries

The state complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h) – (i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

☑ Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) ☑ The state determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under §1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services.

☑ In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for all other medical assistance provided under the State Plan except as listed below:

Medicare cost sharing identified at 4.17(b)(3) (continued)

Pursuant to the Agreement between the State of Massachusetts and Centers for Medicare and Medicaid Services ("Demonstration of HHA Settlement for Dual Eligibles") for any dually eligible individuals (i.e., Medicare and Medicaid dually eligible) who received medical assistance, the state will not make adjustments or recoveries of Medicaid home health services claims paid from the individual's estate for dates of service from October 1, 1999 through September 30, 2007.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Liens and Adjustments or Recoveries

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

Citation

4.17 Lien and Adjustments or Recoveries (cont.)

The state uses the following methods in lieu of the methods described in item (4) on page 53b.

* The state disregards, for purposes of eligibility, homes of permanently institutionalized individuals who don't intend on returning home and who receive or are entitled to receive benefits under a long term care insurance policy.

** For permanently institutionalized individuals who have long term care insurance and do intend on returning home, the state recovers from the individual's estate all medical assistance including payments for nursing facility and other long term care services.

*** For permanently institutionalized individuals who have long term care insurance and do not intend on returning home, the state excludes from recovery from the individual's estate payments for nursing facility and other long term care services.

**** For permanently institutionalized individuals who have long term care insurance and do intend on returning home, the state recovers from the individual's estate all medical assistance including payments for nursing facility and other long term care services. For permanently institutionalized individuals who have long term care insurance and do not intend on returning home, the state recovers all medical assistance provided except payments for nursing facility and other long term care services.

Citation

4.17 Lien and Adjustments or Recoveries (cont.)

(4) ☐ The state disregards assets or resources for individuals who receive or are entitled to receive benefits under a long term care insurance policy as provided for in **Attachment 2.6-A, Supplement 8b.**

☐ The state adjusts or recovers from the individual's estate on account of all medical assistance paid for nursing facility and other long term care services provided on behalf of the Individual. (States other than California, Connecticut, Indiana, Iowa, and New York that provide long term care insurance policy-based asset or resource disregard must select this entry. These five states may either check this entry or one of the following entries.)

☐ The state does not adjust or recover from the individual's estate on account of any medical assistance paid for nursing facility or other long term care services provided on behalf of the individual.

☐ The state adjusts or recovers from the assets or resources on account of medical assistance paid for nursing facility or other long term care services provided on behalf of the individual to the extent described below:

Citation

4.17 Lien and Recoveries (cont.)

(c) Adjustments or Recoveries: Limitations

The state complies with the requirements of section 1917 (b) (2) of the Act and regulations at 42 CFR §433.36 (h)-(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the state determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the state will not seek adjustment or recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the state that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

Citation

4.17 Lien and Recoveries (cont.)

(d) **Attachment 4.17-A**

(1) Specifies that procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36 (d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36 (f).

(3) Defines the following terms:

- ☐ estate (at a minimum, estate as defined under state probate law). Except for the grandfathered states listed in section 4.17 (b) (3), if the state provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also devices such as joint tenancy, life estate, living trust, or other arrangement), *
- ☐ individual's home,
- ☐ equity interest in the home,
- ☐ residing in the home for at least 1 or 2 years,
- ☐ on a continuous basis,
- ☐ discharge from the medical institution and return home, and
- ☐ lawfully residing.

* As noted earlier, the state has believed it should have been named as grandfathered state. It therefore has continued to exempt from recovery estates of individuals who had long term care insurance.

Citation

4.17 Lien and Adjustments or Recoveries (cont.)

(4) Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.

(5) Defines when adjustments or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.

(6) Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

Citation

4.18 Recipient Cost Sharing and Similar Cases

42 CFR 447.51 through 447.58

(a) Unless a waiver under 42 CFR 431.55 (g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916 (a) and (b) of the Act

(b) Except as specified in items 4.18 (b) (4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905 (p) (1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under:

☒ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(b) (2) (iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in an hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a health maintenance organization in which the individual is enrolled.

1916 of the Act, P.L. 99-272, (Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(b) (3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b) (2).

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older.

☒ 19 or older

☐ 20 or older

☐ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but under age 21.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(b) (3) (iii) For the categorically needy and qualified Medicare beneficiaries, **Attachment 4.18-A** specifies the:

(A) service(s) for which a charge(s) is applied;

(B) nature of the charge imposed on each service;

(C) amount(s) of and basis for determining the charge(s);

(D) method used to collect the charge(s);

(E) basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and

(G) cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a specified time period.

☐ Not applicable.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

1916 (c) of the Act

(b) (4) ☐ A monthly premium is imposed on pregnant women and infants who are covered under section 1902 (a) (10) (A) (ii) (IX) of the Act and whose income equals or exceeds 150 percent of the federal poverty level applicable to a family of the size involved. The requirements of section 1916 (c) of the Act are met. **Attachment 4.18-D** specifies the method the state uses for determining what constitutes undue hardship for waiving payment of premiums by recipients.

1902 (a) (52) and 1925 (b) of the Act

(5) ☐ For families receiving extended benefits during a second six month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925 (b) (4) and (5) of the Act.

1916 (d) of of the Act

(6) ☐ A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1920 (a) (10) (E) (ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the federal poverty level applicable to a family of the size involved. The requirements of section 1916 (d) of the Act are met. **Attachment 4.18-E** specifies the method and standards the state uses for determining the premium.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(c) ☒ Individuals are covered as medically needy under this plan

(1) ☐ An enrollment fee, premium or similar charge is imposed. **Attachment 4.18-B** specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52 (b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under—

☒ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable:

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

42 CFR 447.51 through 447.58

(c) (2) (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an impatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enrolled individuals.

☐ Not applicable.

Charges are imposed on services provided by a Managed Care Organization under a contract authorized by the Commonwealth's demonstration project pursuant to 1115 of the Act.

Charges are not imposed on services provided by a Senior Care Organization (SCO) under a contract pursuant to Section 1915(a) of the Act.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

(c) (3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed on services that are not excluded from such charges under item (b) (2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☒ 19 or older

☐ 20 or older

☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Citation

4.18 Recipient Cost Sharing and Similar Charges (cont.)

447.51 through 447.58

(c) (3) (iii) For the medically needy, and other optional groups, **Attachment 4.18-C** specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service;

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53 (b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☐ Not applicable.

Citation

4.19 Payment for Services

42 CFR 447.252
1902 (a) (13)
and 1923 of
the Act

(a) The Medicaid agency meets the requirements of 42 CFR 447, Subpart C, and sections 1902 (a) (13) and 1923 of the Act with respect to payment for inpatient hospital services.

Attachment 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

☒ Inappropriate level of care days are covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861 (v) (1) (G) of the Act.

☐ Inappropriate level of care days are not covered.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902 (a) (13) (E)
1903 (a) (l) and (n), 1920, and 1926 of the Act

(b) In addition to the services specified in paragraphs 4.19 (a), (d), (k), (l), and (m), the Medicaid agency meets the following requirements.

(1) Section 1902 (a) (13) (E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under section 1905 (a) (2) (C) of the Act. The agency meets the requirements of section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services. **Attachment 4.19-B** describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost-reports, cost or budget reviews, or sample surveys).

(2) Sections 1902 (a) (13) (E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

Attachment 4.19-B describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902 (a) (10) and 1902 (a) (30) of the Act

Supplement 1 to Attachment 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/coinsurance.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.40
AT-78-90

(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

☒ Yes. The State's policy is described in **Attachment 4.19-C**.

☐ No.

Citation

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19 Payment for Services (cont.)

(d) ☒ 1. The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services.

Attachment 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services.

☐ 2. The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

☐ At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

☐ At a rate established by the state, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☒ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

☐ 3. The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

☐ At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

☐ At a rate established by the state, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

☒ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

☐ 4. Section 4.19 (d) (1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this state plan.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.45 (c)
AT-79-50

(e) The Medicaid agency meets all the requirements of 42 CFR 447.45 for timely payment of claims.

Attachment 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.15
AT-78-90
AT-80-34
48 FR 5730

(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.

No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55 (g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.201
42 CFR 447.202
AT-78-90

(g) The Medicaid agency assures appropriate audit of records when payment is based on cost of services or on a fee plus cost of materials.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.201
42 CFR 447.203
AT-78-90

(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.201
42 CFR 447.204
AT-78-90

(i) The Medicaid agency payments are sufficient to enlist enough provider's so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Citation

4.19 Payment for Services (cont.)

42 CFR 447.201 and 447.205

(j) The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.

1903 (v) of the Act

(k) The Medicaid agency meets the requirements of section 1903 (v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in section 1903 (v) of the Act.

Citation

4.19 Payment for Services (cont.)

1903 (i) (14) of the Act

(l) The Medicaid agency meets the requirements of section 1903 (i) (14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Citation

4.19 Payment for Services (cont.)

(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928 (c) (2) (C) (ii) of the Act

(i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928 (c) (2) (C) (ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administered as follows.

(ii) The State:

☒ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

☐ sets a payments rate below the level of regional maximum established by the DHHS Secretary.

☐ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

The State pays the following rate for the administration of a vaccine;

1926 of the Act

(iii) Medicaid beneficiary access to immunizations is assure through the following methodology:

- As a universal state, Medicaid in Massachusetts does not reimburse for the cost of vaccines. This encourages doctors to join VFC program to have access for free vaccines.

- State administers Medicaid through a Managed Care program where all children do not have other insurance are linked to a Primary Care Clinician who has responsibility for following ESPDT vaccination protocols.

- State compares Department of Public Health's Vaccine for Children provider file to Medicaid's provider file and outreaches all Primary Care Medicaid practitioners not participating in VFC program.

Citation

42 CFR 447.25 (b)
AT-78-90

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

☐ Yes, for ☐ physicians' services

☐ dentists' services

Attachment 4.20-A specifies the conditions under which such payments are made.

☐ Not applicable. No direct payments are made to recipients.

☒ Direct payments are made to certain recipients as specified in **Attachment 4.20-B**.

Citation

4.21 Prohibition Against Reassignment of Provider Claims

42 CFR 447.10 (C)
AT-78-90
46 FR 42699

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 47.10.

Citation 4.22 Third Party Liability

42 CFR 447.13 (a) The Medicaid agency meets all the requirements of:

(1) 42 CFR 433.138 and 433.139
(2) 42 CFR 433.145 through 433.148
(3) 42 CFR 433.151 through 433.154
1902 (a) (25) (H) and (I) of the Act. (4) Sections 1902 (a) (25) (H) and (I) of the Act.

42 CFR 433.138 (f) (b) **Attachment 4.22-A** —

(1) Specifies the frequency with which the data exchanges required in Section 433.138 (d) (l), (d) (3) and (d) (4) and the diagnosis and trauma code edits required in Section 433.138 (e) are conducted;

42 CFR 433.138 (g) (l) (ii) and (2) (ii) (2) Describes the methods the agency uses for meeting the following requirements contained in Section 433.138 (g) (l) (i) and (g) (2) (ii);

42 CFR 433.138 (g) (3) (i) and (iii) (3) Describes the methods the agency uses for following up on information obtained through the s tate motor vehicle accident report file data exchange required under Section 433.138 (d) (4) (ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the following that identifies legally liable third party resources; and

42 CFR 433.138 (g) (4) (i) through (iii) (4) Describes the methods the agency uses for following up on paid claims identified under Section 433.138 (e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the followup that identifies legally liable third party resources.

Citation

4.22 Third Party Liability (cont.)

42 CFR 433.139 (b) (3) (ii) (A)

☒ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.

(d) **Attachment 4.22-B** specifies the following:

42 CFR 433.139 (b) (3) (ii) (C)

(1) The method used in determining a provider's compliance with the third party billing requirements at Section 433.139 (b) (3) (ii) (C).

42 CFR 433.139 (f) (2)

(2) The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139 (f) (3)

(3) The dollar amount or time period the state uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

42 CFR 447.20

(e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Citation

4.22 Third Party Liability (cont.)

42 CFR 433.151 (a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for medical assistance with the following: (Check as appropriate.)

☒ State title IV-D agency. The requirements of 42 CFR 433.152 (b) are met.

☒ Other appropriate state agency(s) —

Department of Youth Services
Department of Social Services

☐ Other appropriate agency(s) of another state —

☐ Courts and law enforcement officials.

1902 (a) (60) of the Act

(g) The Medicaid agency assures that the state has in effect the laws relating to medical child support under section 1908 of the Act. *

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

☐ The Secretary's method as provided in the state Medicaid Manual, Section 3910.

☒ The state provides methods for determining cost effectiveness on **Attachment 4.22-C**.

* The Commonwealth has enacted legislation, Chapter 460 of the Acts of 1993, incorporating into state law most provisions of Section 1908 of the Social Security Act relating to medical child support. State legislation is required to implement the remaining provisions of Section 1908.

Citation

4.23 Use of Contracts

42 CFR Part 434
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR 434. All contracts meet the requirements of 42 CFR Part 434.

☐ Not applicable. The state has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

☑ a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2*

☐ a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

☐ a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2

☐ Not applicable

* This State Plan provision governs Senior Care Organization (SCO) contracts only. The Medicaid agency's other MCO contracts are governed by the Commonwealth's 42 USC 1315 demonstration waiver ("the 1115 waiver").

State Plan Under Title XIX of the Social Security Act
State: Massachusetts

Citation

42 CFR 431.702
AT-78-90

4.25 Program for Licensing Administrators of Nursing Homes

The state has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Citation

4.26 Drug Utilization Review Program

1927 (g)
42 CFR 456.700

A. 1. The Medicaid agency meets the requirements of Section Section 1927 (g) of the Act for drug use review (DUR) program for the outpatient drug claims.

1927 (g) (1) (A)

2. The DUR program assures that prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

1927 (g) (1) (a)
42 CFR 456.705 (b) and 456.709 (b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

1927 (g) (1) (B)
42 CFR 456.703 (d) and (f)

C. The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopeia-Drug Information
- American Medical Association Drug Evaluations

Citation

4.26 Drug Utilization Review Program (cont.)

1927 (g) (1) (D)
42 CFR 456.703 (b)

D. DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60 The state has never-the-less chosen to include nursing home drugs in:

☐ Prospective DUR

☒ Retrospective DUR.

1927 (g) (2) (A)
42 CFR 456.705 (b)

E. 1. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.

1927 (g) (2) (A) (i)
42 CFR 456.705 (b), (1) – (7)

2. Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Drug-interactions with non-prescription or over-the-counter drugs
- Incorrect drug dosage or duration of drug treatment
- Drug allergy interactions
- Clinical abuse/misuse

1927 (g) (2) (A) (ii)
42 CFR 456.705 (c) and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by State law and maintenance of patient problems.

1927 (g) (2) (B)
42 CFR 456.709 (a)

F. 1. The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

Citation 4.26 Drug Utilization Review Program (cont.)

927 (g) (2) (C)
42 CFR 456.709 (b)

F. 2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Clinical abuse/misuse

1927 (g) (2) (D)
42 CFR 456.711

3. The DUR program through its state DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927 (g) (3) (A)
42 CFR 456.716 (a)

G. 1. The DUR program has established a State DUR Board either:

☐ Directly, or

☒ Under contract with a private organization

1927 (g) (3) (B)
42 CFR 456.716
(A) and (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs.
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention.
- Medical quality assurance.

927 (g) (3) (C)
42 CFR 456.716 (d)

3. The activities of the DUR Board include:

- Retrospective DUR,
- Application of Standards as defined in section 1927 (g) (3) (C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the course of retrospective DUR.

Citation 4.26 Drug Utilization Review Program (cont.)

1927 (g) (3) (C)
42 CFR 456.711
(a) – (d)

G. 4. The interventions include in appropriate instances.

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-Face discussions
- Intensified monitoring/review of prescribers/ dispensers

1927 (g) (3) (D)
42 CFR 456.712
(A) and (B)

H. The state assures that it will prepare and submit an annual report to the Secretary, which incorporates a report from the State DUR Board, and that the state will adhere to the plans, steps, procedures as described in the report.

1927 (h) (1)
42 CFR 456.722

☐ I. 1. The state establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- real time eligibility verification
- claims data capture
- adjudication of claims
- assistance to pharmacists, etc. applying for and receiving payment.

1927 (g) (2) (A) (i)
42 CFR 456.705 (b)

☐ 2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

1927 (j) (2)
42 CFR 456.703 9 (c)

J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs.

U. S. G.P.O. :1993-342-239:80043

Citation	4.27 Disclosure of Survey Information and Provider or Contractor Evaluation
42 CFR 431.115 (c) AT-78-90 AT-79-74	The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

Citation	4.28 Appeals Process	
42 CFR 431.152; AT-79-18 52 FR 22444; Secs. 1902 (a) (28) (D) (i) and 1919 (e) (7) of the Act; P.L. 100-203 (Sec. 4211 (c))	(a)	The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.152 and 431.154.
	(b)	The state provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the preadmission and annual resident review requirements of 42 CFR 483 Subpart C.

Citation

4.29 Conflict of Interest Provisions

Sec. 1902 (a) (4) (C) of the Act P.L. 95-559, sec. 14 AT-79-42

The Medicaid agency meets the requirements of Section 1902 (a) (4) (C) of the Act concerning the prohibition against acts, with respect to any activity under the plan, that are prohibited by Section 207 or 208 of title 18, United States Code.

Citation

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

42 CFR 1002.203
AT-79-54
48 FR 3742
51 FR 34772

(a) All requirements of 42 CFR Part 1002, Subpart B are met.

☒ The agency, under the authority of the state law, imposes broader sanctions.

Citation

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals (cont.)

1902 (p) of the Act
P.L. 100-93
(secs. 7)

(b) Medicaid meets the requirements of - -

(1) Section 1902 (p) of the Act by excluding from participation

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866 (b) (2).

(B). Any HMO (as defined in section 1903 (m) of the Act) or an entity furnishing services under a waiver approved under section 1915 (b) (1) of the Act, that - -

(i) Could be excluded under section 1128 (b) (8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128 (b) (8) (B) of the Act.

Citation

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals (cont.)

1902 (a) (39) of the Act
P.L. 100-93
(secs. 8 (f))

(2) Section 1902 (a) (39) of the Act by - -

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with section 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(c) The Medicaid agency meets the requirements of - -

1902 (a) (41),
of the Act
P.L. 96-272,
(sec. 308 (c))

(1) Section 1902 (a) (41) of the Act with respect to prompt notification to HFCA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participation under this State plan; and

1902 (a) (49) of the Act
P.L. 100-93
(sec. 5 (a) (4))

(2) Section 1902 (a) (49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

Citation

455.103
44 FR 41644
1902 (a) (38)
of the Act
P.L. 100-93
(sec. 8 (F))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and sections 1128 (b) (9) of the Act.

435.940
through 435.960
52 FR 5967
54 FR 8738

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960. **(Section 1137 of the Act and 42 CFR 435.940 through 435.960)**

(b) **Attachment 4.32-A** describes, in accordance with 42 CFR 435.948 (a) (6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individuals eligible for covered title XIX services consistent with applicable PARIS agreements.

Citation

1902 (a) (48) of the Act, P.L. 99-570 (Section 1105) P.L. 100-93 (sec. 5 (a) (3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual eligible under the state's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) **Attachment 4.33-A** specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

Citation

1137 of the Act,

P.L. 99-603 (sec. 121)

4.34 Systematic Alien Verification for Entitlements

(a) The state Medicaid agency has established procedures for the verification of alien status through the Immigration and Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1998.

☐ The state Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

☒ The state Medicaid agency has requested the following type(s) of waiver from participation in SAVE.

☒ Total waiver.

☐ Alternative system

☐ Partial implementation

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.402 (f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-state operated NF, the state provides notification in accordance with 42 CFR Section 488.402 (f).

(i) The notice (except for civil money penalties and state monitoring) specifies that:

(1) nature of noncompliance,
(2) which remedy is imposed,
(3) effective data of the remedy, and
(4) right to appeal the determination leading to the remedy.

42 CFR §488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR Section 488.434.

42 CFR §488.402 (f) (2)

(iii) Except for civil money penalties and state monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR §488.456 (c) (d)

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The state must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 442.

(b) Factors to be Considered in Selecting Remedies

42 CFR §488.488.404 (b) (1)

(i) In determining the seriousness of deficiencies, the state considers the factors specified in 42 CFR Section 488.488.404 (b) (1) and (2).

☐ The state considers additional factors. **Attachment 4.35-A** describes the state's other factors.

Citation

4.35 Enforcement of Compliance for Nursing Facilities

42 CFR §488.410

(c) Application of Remedies

(i) If there is immediate jeopardy to resident health or safety, the state terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within twenty-three days.

42 CFR §488.417 (b) §1919 (h) (2) (C) of the Act.

(ii) The state imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into substantial compliance within three months after the last day of the survey.

42 CFR §488.408 §1919 (h) (2) (D) of the Act.

(iii) The state imposes the denial of payment for new admissions remedy as specified in Section 488.417 (or its approved alternative) and a state monitor as specified in Section 488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys.

42 CFR §488.408 1919 (h) (2) (A) of the Act.

(iv) The state follows the criteria specified at 42 CFR §488.408 (c) (2), Section 488.408 (d) (2), and), Section 488.408 (e) (2), when it imposes remedies in place of or in addition to termination.

42 CFR §488.412 (a)

(v) When immediate jeopardy, does not exist, the state terminates an NF's provider agreement no later than 6 months from the finding of noncompliance, if the conditions of 42 CFR Section 488.412 (a) are not met.

(d) Available Remedies

42 CFR §488.406 (b) §1919 (h) (2) (A) of the Act.

(i) The state has established the remedies defined in 42 CFR 488.406 (b).

- ☒ (1) Termination
- ☐ (2) Temporary Management
- ☐ (3) Denial of Payment for New Admissions
- ☒ (4) Civil Money Penalties
- ☒ (5) Transfer of Residents; Transfer of Residents with Closure of Facility
- ☒ (6) State Monitoring

Attachments for 4.35-B through 4.35-G describe the criteria for applying the above remedies.

Citation

4.35 Enforcement of Compliance for Nursing Facilities (cont.)

(d) Available Remedies (cont.)

42 CFR §488.406 (b) §1919 (h) (2) (B) (ii) of the Act.

(ii) ☒ The state uses alternative remedies. The state has established alternative remedies that the state will impose in place of a remedy specified in 42 CFR Section 488.406 (b).

- ☒ (1) Temporary Management
- ☒ (2) Denial of Payment for New Admissions
- ☐ (3) Civil Money Penalties
- ☐ (4) Transfer of Residents; Transfer of Residents with Closure of Facility
- ☐ (5) State Monitoring

Attachments for 4.35-B through 4.35-G describe the alternative remedies and the criteria for applying them.

42 CFR §488.303 (b) §1919 (h) (2) (F) of the Act. Payments

(e) ☐ State Incentive Program

- ☐ (1) Public recognition.
- (2) Incentive

Citation

1902 (a) (ll) (C) and 1902 (a) (53) of the Act

4.36 Required Coordination Between the Medicaid and WIC Program

The Medicaid agency provides for the coordination between the Medicaid program and the special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902 (a) (53) of the Act.

RESERVED

Citation

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

Secs.
1902 (a) (28) (D) (i)
and 1919 (e) (7) of
the Act;
P.L. 100-203
(Sec. 42111 (c));
P.L. 101-508
(Sec. 4801 (b)).

(a) The Medicaid agency has in effect a written agreement with the state mental health and mental retardation authorities that meet the requirements of 42 CFR 431.621 (c).

(b) The state operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The state does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 431.118 (c) (1), the state does not claim as "medical assistance under the State Plan" the cost of NF services to individuals who are found not to require NF services.

☒ (e) **Attachment 4.39** specifies the state's definition of specialized services.

Citation

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities (cont.)

☐ (f) Except for residents identified in 42 CFR 483.118 (c) (1), the state mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the state in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The state describes any categorical determinations it applies in **Attachment 4.39-A**.

RESERVED

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

Citation	
1902(a) (77) 1902(a) (39) 1902(kk); P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING ☒ Assures that the State Medicaid agency complies with the process for screening providers under section 1902 (a) (39), 1902 (a) (77) and 1902 (kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS ☒ Assures enrolled providers will be screened in accordance with42 CFR 455.400 et seq. ☒ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plans or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES ☒ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT ☒ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT ☒ Assures that the State Medicaid agency will comply with section 1902 (a) (39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT ☒ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460

42 CFR 455.422 APPEAL RIGHTS

☒ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 4.55.416 will have appeal rights available under procedures established by State law or regulations. *

42 CFR 455.432 SITE VISITS

☒ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434 CRIMINAL BACKROUND CHECKS

☒ Assures that providers, as a condition of enrollment will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436 FEDERAL DATABASE CHECKS

☒ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440 NATIONAL PROVIDER IDENTIFIER

☒ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450 SCREENING LEVELS FOR MEDICAID PROVIDERS

☒ Assures that the State Medicaid agency complies with 1902(a) (77) and 1902 (kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

* Appeal rights are not available under state law or regulations to applicants denied enrollment.

42 CFR 455.460 APPLICATION FEE

☒ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866 9j) (2) © of the Act and 42 CFR 455.460.

42 CFR 455.470 TEMPORARY MORATORIUM ON ENROLLMETN OF NEW PROVIDERS OR SUPPLIERS

☒ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866 (j) (7) and 1902 (kk) (4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical care.

Citation

4.41 Resident Assessment for Nursing Facilities

Sections 1919 (b) (3) and 1919 (e) (5) of the Act

(a) The state specifies the instrument to be used by nursing facilities for conducting a comprehensive, accurate, standardized, reproductible assessment of each resident's functional capacity as required in Section 1919 (b) (3) (A) of the Act.

1919 (e) (5) (A) of the Act

(b) The state is using:

☒ the resident assessment instrument designated by Health Care Financing Administration (see Transmittal #241 of the State Operations Manual) [Section 1919 (e) (5) (A)]; or

1919 (e) (5) (B) of the Act

☐ a resident assessment instrument that the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines as specified by the Secretary (see Section 4470 of the State Medicaid Manual for the Secretary's approval criteria) [Section 1919 (e) (5) (B)].

Citation
1902(a) (68) of the Act, P.L. 109-171 (section 6032)

4.42 Employee Education About False Claims Recoveries

(a) The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a) (68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

(1) Definitions

(A) An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental

health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

(B) An "employee" includes any officer or employee of the entity.

(C) A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions or is involved in the monitoring of health care provided by the entity.

(2) The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

(3) An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(4) The requirements of this law should be incorporated into each State's provider enrollment agreements.

(5) The State will implement this State Plan amendment on January 1, 2007

(b) **ATTACHMENT 4.42-A** describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

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Citation 1902(a)(69) of the Act, P.L. 109-171 (section 6034)	4.43	Cooperation with Medicaid Integrity Program Efforts The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

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Section 4 General Program Administration

Citation		
Section 1902 (a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)	4.44	Medicaid Prohibition on Payments to Institutions or Entities Located Outside the United States
	☒	The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
General Program Administration

RELATIONS WITH STANDARD-SETTING AND SURVEY AGENCIES

1. The type of institution specified above are subject to the following standard-acting authority (ies): The Massachusetts Department of Public Health.

   The following citations to state legislation show (a) that authority is a state authority as distinguished from a local authority: and (b) that the authority is empowered and has the duty to establish and maintain standards for the types of institutions where medical care and services may be provided under the State Plan:

   Massachusetts General Laws, Chapter III Section 71.
   Licensing of Hospitals, sanitaria, etc: hearing etc; appeals; fees, etc.

   Section 72. Classification; rules and regulations; inspections.
   Section 73. Keeping etc; unlicensed hospital, etc; and other violations penalized; duplicate licenses, posting.

   Chapter 800 - Acts of 1969

2. The Massachusetts Department of Public Health utilize a manual of Rules and Regulations for the licensing of long term care facilities dated January 12, 1971. In addition the following standards are utilized for hospitals, clinics and ambulances.

HOSPITALS	EFFECTIVE DATE
Licensure Rules and Regulations for Hospitals Includes:	July 1, 1950, as amended January 20, 1965, November 8, 1966 and May 27, 1969
Rules and Regulations Governing Out-of-Hospital Dialysis Unit	September 4, 1970

Separately printed additions or amendments:

Chapter 2, Sec. VII Nursing Services	October 1, 1972
Chapter 2, Sec. 9 Continuing Care Services	August 18, 1971
Chapter 3, Sec. 4 Obstetrical Services	March 1, 1971
Chapter 3, Sec. 5 Newborn Services	September 30, 1970
Chapter 3, Sec. XIV Radiation Therapy Services	January 1, 1972
Chapter 3, Sec. XV Intensive Care Units	October 1, 1972

CLINICS	
Licensure Rules and Regulations for Clinics	June 10, 1964, as amended December 14, and December 21, 1966 and by statutory mandate Chapter 891 of the Acts of 1967.
Radiation Therapy Services in Clinics	January 1, 1972

HOSPITALS AND CLINICS	
Rules and Regulations Relative to the Use of Blood and Other Tissues for the Purposes of Transfusion	March 2, 1970
Regulations for Ambulatory Gynecological	February 14, 1973 and amendment

RELATIONS WITH STANDARD-SETTING AND SURVEY AGENCIES (cont.)

HOSPITALS AND CLINICS

Surgery in Licensed Hospitals and Licensed Clinics	February 28, 1973
Ambulances	April 10, 1968 (not in effect after January 21, 1974)

"Rules and Regulations Relative to Ambulances."

3. The Department of Public Safety –

"Laws Relating to the Erection, Alteration, Inspection and Use of Building" (General Laws, Chapter 143) and "Regulations for the Uniform Enforcement of G.L." (Ter. ED), Chapter 143, Sections 15 to 52, as Amended. "Applicable to Buildings" issued by the Massachusetts Department of Public Safety have been previously submitted to the Department of Health, Education, and Welfare by Form FS 553 No. 18A, dated June 19, 1953. Also Section 51 and 71 of Chapter III, Massachusetts General Laws and STD 10 (Building Code) of the Board of Standards.

In addition the Department of Public Welfare has entered into an agreement with the Department of Public Safety for the administration of, the Life Safety Code of 1967 (National Fire Protection Association) relating to Medical Facilities.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
General Program Administration

UTILIZATION REVIEW PLAN

The Medicaid agency provides for the review of Medicaid acute hospital services through (l) contracts with the four Massachusetts PSROs; (2) a contract with a health care foundation; and (3) direct performance of reviews of acute hospital services by the Department.

The Medicaid agency will comply with the provisions of 42 CFR Part 463 relating to the activities of the PSROs. The contracts with the PSROs meet all the requirements of paragraphs (a), (b), (c), (g), (h), (i), (m), and (n) of Section 431.503.

The contract with the health care foundation meets all the requirements of paragraphs (a), (b), (c), (g), (h), (i), (m), and (n) of Section 431.503.

The reviews conducted by the Department and the contracted parties meet the applicable requirements of 42 CFR Part 456.

A monitoring and evaluation plan is in effect that assures satisfactory performance by the contracted parties.

Services and providers subject to review pursuant to the contracts are specified in each contract and include inpatient hospital services of licensed acute hospitals within each contracted party's specified geographic area.

Review activities performed pursuant to the contracts are not inconsistent with review activities for Title XVIII.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Cooperative Arrangements with State Health and State Vocational Rehabilitation Agencies with Title V Grantees

Agreement with the Department of Public Health Relative to the Implementation of Title XIX

Preamble

The Department of Public Welfare is the single state agency designated by the Legislative and recognized by the U.S. Department of Health, Education and Welfare to administer the program of medical assistance under Title XIX of the Social Security Act. As such the Department is responsible and accountable for the performance of all functions and activities performed to meet the Federal requirements and regulations of Title XIX.

The Department of Public Health is the State Agency designated by law to set standards for, to license and inspect health facilities; to administer and supervise maternal and child health services and crippled children services under Title V of the Social Security Act. The purpose of this agreement is to obtain maximum utilization of each others services in the provision of medical assistance under Title XIX.

I. Standards and Conditions of Participation

Standards of service and conditions of participation for health care providers shall be established for each provider group eligible to participate in the medical assistance program. The purposes of such standards and conditions shall be to:

a) Clearly define the items of service reimbursable under the medical assistance program for each provider group.
b) Clearly define the mutual obligations of the provider and the respective state agencies.
c) Insure that services of adequate quality will be provided to Title XIX recipients.

In respect to standards and conditions the Department of Public Welfare shall:

a) Actively participate with the Department of Public Health in the development of such a standards and conditions.
b) Conduct a public hearing prior to implementation of such standards and conditions.

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With Title V Grantees

Agreement with the Department of Public Health
Relative to the Implementation of Title XIX (cont.)

I. Standards and Conditions of Participation (cont.)

c) Print and distribute such standards and conditions to the appropriate provider groups.
d) Recommend changes and modifications in such standards and conditions.
e) Obtain Federal review and approval where required.

The Department of Public Health shall:

a) Develop standards and conditions of participation for each vendor group eligible to participate in the Title XIX program.
b) Convene meetings of provider representatives in respect to the development of such standards and conditions.
c) Conduct studies of actual practice to insure that such standards and conditions are implementable and for the purpose of appropriate revisions.
d) Involve the Department of Public Welfare in the development of such standards and conditions.

The two Departments jointly shall:

a) Determine the priorities for development of such standards and conditions.

II. Certification of Health Providers

The Department of Public Welfare shall certify that the health providers participating in the medical assistance program meet the definition stated in CFR Title 45. Chapter II Section 249.10, b (1-15) and such additional standards and conditions of participation as may be promulgated.

The Department of Public Health shall:

a) Provide the Department of Public Welfare with all relevant information regarding the licensing status of a health facility or provider under Department of Public Health jurisdiction.
b) Provide Department of Public Welfare with all relevant information regarding certification status of facilities participating under Title XVIII.
c) Conduct on-site reviews to determine certification status of particular facilities when requested by Department of Public Welfare and to report on such reviews within 60 days of such request.
d) Conduct the program of nursing home review described below in part 3 of this section.

The Department of Public Welfare shall:

a) Receive all requests for certification from providers and transmit them to the Department of Public Health.
b) Inform providers of the process of certification and provide necessary information and forms.
c) Be responsible for negotiation with the Rate Setting Commission for the establishment of rates of payment to newly certified providers.

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

II. Certification of Health Providers (cont.)

d) Inform the provider of his certification status and where appropriate execute a signed agreement.
e) Request re-inspections when situations of abuse or failure to follow standards is detected.

Skilled nursing home:

To assure that payment for skilled nursing home services are made by the State Welfare Department only to those facilities that meet all applicable Federal and State requirements for participation in the program, including but not limited to (1) meeting the conditions necessary to qualify as a skilled nursing home (as defined in 45 CFR 249.10 (b) (4) (i) and (2) compliance with the specific requirements (as set forth in 45 CFR 249.33, the following delineation of function for each agency is agreed upon.

A. Functions of the Department of Public Health

1. Obtains evidence through survey arrangements that skilled nursing homes are meeting the requirements in compliance with the standards for payment or that they are participating providers under Title XVIII and meet the Title XIX requirements which are in addition to those for Title XVIII with respect to:

a. Compliance with state requirements for licensure of nursing home administrators.
b. The provision of information regarding ownership of the facility.
c. Arrangements with hospitals.
d. Meet (after December 31, 1969) such provisions of the Life Safety Code of the National Fire Protection Association (21st Edition, 1967) as are applicable to nursing homes; except that the state agency may waive in accordance with regulations set forth in paragraph (c) of this section for such periods as it deems appropriate, specific provisions of such code, which if rigidly applied, would result in unreasonable hardship upon a nursing home, but only if such agency makes a determination (and keeps a written record setting forth the basis of such determination) that such waiver will not adversely affect the health and

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

A. Functions of the Department of Public Health (cont.)

safety of the patients of such skilled nursing homes; and except that the requirements of this subdivision need not apply in any state if the Secretary finds that in such state there is in effect a fire and safety code, imposed by state law; which adequately protects patients in nursing homes.

e. Participation in medical review program.

2. Reviews and evaluates statements obtained from skilled nursing homes regarding staffing to determine whether requirements relating to personnel were met during the quarter.

3. Makes at least one on-site inspection by qualified personnel during the term of an agreement with a skilled nursing home. The term may not exceed a period of one year for a facility in compliance or six months for a facility in substantial compliance, except that for extended care facilities in substantial compliance, the term may extend until 90 days after the inspections. For definition of compliance and substantial compliance, refer to section "Definitions."

4. Documentation of all waivers – On all waivers permitted under the provisions of Program Regulations 40-12 (C-1), the agency will clearly document in writing all waivers against the following conditions for waiver:

a. The provision, if rigidly applied, would result in unreasonable hardship upon the skilled nursing home.
b. The waiver of a specific provision would not adversely affect the health and safety of patients in the facility. A written justification is kept in the file.
c. Structural changes in the facility necessary to meet a provision, are economically impracticable and the delay in making such changes would not adversely affect the health and safety of the patients. An explanation of this is maintained on file.

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

A. Functions of the Department of Public Health (cont.)

5. Re-determines at the time of each survey the conditions of waiver, maintaining on file written evidence of such redetermination, and recommends to rescind the waiver at any time any of the conditions above are found no longer to apply.

6. Monitors utilization review activities for patients under Title XIX in skilled nursing homes. This includes:

a Assisting facilities to develop utilization plans.
b. Approving plans.
c. Maintaining surveillance of utilization review committees.
d. Supply consultation to the utilization review committees.

7. Sets state standards for skilled nursing homes to be adopted by the Department of Public Welfare.

8. Determines that the skilled nursing home administrators is licensed under the provision of the Massachusetts State Law.

B. Functions of State Welfare Department

1. Certifies skilled nursing homes as in compliance or substantial compliance with Federal and State requirements following the evidence obtained through survey arrangements with the State Department of Public Health.

2. Executes agreements with the skilled nursing homes certified as being in compliance or substantial compliance with the Federal and State requirements for participation in the Title XIX program.

The facility, under the agreement, agrees (a) to keep records which will disclose the services provided to patients receiving assistance under Title XIX; and (b) to furnish the State Welfare Department with information regarding payments claimed by the

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

B. Functions of State Welfare Department (cont.)

facility for providing services to patients receiving assistance under Title XIX.

3. Waives requirements under specified circumstances as recommended and documented by the State Health Department.

4. Rescinds waivers when the State Department of Public Health finds that the condition for which the specific requirement was waived by the State Welfare Department, no longer exist.

5. Reviews the information obtained by the State Health Department during the on-site inspection of skilled nursing homes, made at least once during the term of an agreement, except that this requirement may be considered as met by skilled nursing homes certified under Title XVIII.

6. Makes payments to the skilled nursing homes during the term of an agreement not to exceed one year, or in the case of a facility certified to be in compliance except for deficiencies, the term of the agreement may not exceed six months, except that an extended care facility certified with deficiencies may not exceed ninety days after the next inspection.

7. Participates in setting state standards for skilled nursing homes. Continuous liaison and coordination of activities of both agencies will be maintained through the designation of a staff member of the Division of Medical Care, Department of Public Health and the Office of Medical Assistance, Department of Public Welfare.

Definitions

Compliance means the facility meets all applicable federal and state requirements for participating under Title XIX.

Substantial compliance means that the facility meets the applicable federal

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

Definitions (cont.)

requirements except for deficiencies provided that:

Deficiencies can probably be corrected within six months. Skilled nursing homes provides in writing an acceptable plan for correction to the State Welfare Department (through the survey arrangement with the State Health Department).

Deficiencies do not jeopardize the health and safety of the patients. State Welfare Department keeps on file a written statement justifying that the deficiencies do not jeopardize the health and safety of the patients.

No more than two successive six month agreements are executed with any skilled nursing home having deficiencies and no second agreement if the same deficiencies exist as they did for the first agreement unless the State Welfare Department is confident that the facility is improving and continues in its efforts to improve.

State Department of Mental Health Hospitals

The State Department of Public Health shall conduct on-site reviews of state Mental Health facilities on an as needed basis to insure that they meet certification standards to be eligible for Federal reimbursement for services to patients, 65 years and older.

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

III. Utilization Review

Utilization review includes all organized activities relative to the quality, quantity and timeliness of services provided under the medical assistance program.. Prior approval procedures, pre-admission screening and that service profile review are elements of utilization review.

The Department of Public Welfare shall:

1. Develop and maintain a plan of utilization review for each item of service provided under the medical assistance program.
2. In accordance with Federal regulations, delegate utilization review responsibilities to the DPH for in-patient hospital services and skilled nursing home services.
3. Designate other items of service, which can be most effectively reviewed by DPH.
4. Work cooperatively with DPH in the utilization review process.

The Department of Public Health shall:

1. Conduct utilization review of in-patient hospital and extended care services for all such providers in the Title XIX program according to the requirements of Title XVIII.
2. Conduct utilization review of skilled nursing home (Level II) and intermediate care services (Level III) according to the requirements of the DPH Rules and Regulations for Long-term Care Facilities January 1971.
3. Provide consultation and supervision to DPW Dental consultants prior approval activities and open-mouth examination reviews.
4. Provides for a regular program of medical review in skilled nursing homes, including a medical evaluation of each patient's need for skilled nursing home care. Periodic inspections will be made by one or more medical review teams, composed of a physician and other appropriate personnel relative to the following:

    a) Quality of care being provided to patients receiving assistance under Title XIX.
    b) The adequacy of services available in the facility to meet the current needs of the patients.
    c) The necessity and desirability to the continued placement of the patients in the facility.

Agreement with the Department of Public Health
Relative to the Implementation of Title XIX (cont.)

III. Utilization Review (cont.)

d) Feasibility of meeting their needs through alternative institutional or non-institutional services.

IV. Maternal and Child Health Services

Chapter II of Title 45 of the Code of Federal Regulations, Part 251 provides for cooperative arrangements between the Title XIX agency and State Health and Title V agencies. In accordance with the provisions of Part 251, the DPW shall:

1. Be responsible for reimbursing providers, eligible under the medical assistance program, for approved services rendered to persons eligible as both Title V and Title XIX recipients within the limits of budgetary appropriations.
2. Utilize Title V programs and services in furnishing care and services included in the State Plan for Medical Assistance.
3. Include, where requested according to 45 CFR, Chapter II, Part 251 provision, for reimbursement of the cost of care and services furnished by a Title V program or service which are included in the State Plan for Medical Assistance.

The Department of Public Health shall:

1. Be responsible for the quality of care offered by programs and services under Title V.
2. Refer eligible persons to DPW for enrollment in the medical assistance program.
3. Provide necessary budgetary information to DPW to determine cost of Title V services and appropriateness of fiscal controls.

In addition, two Departments shall, by joint agreements, memoranda of understanding and other means, accomplish the following for each program:

1. The mutual objectives and respective responsibilities of the parties to the agreement.
2. Arrangements for early identification of individuals under 21 years of age in need of medical or remedial care and services.
3. The services each offers and in what circumstances.
4. The cooperative and collaborative relationships at the state level.

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Agreement with the Department of Public Health Relative to the Implementation of Title XIX (cont.)

IV. Maternal and Child Health Services (cont.)

5. The kinds of services to be provided by local agencies.
6. Arrangements for reciprocal referrals.
7. Arrangements for payment or reimbursement.
8. Arrangements for exchange of reports of services provided to recipients of medical assistance under Title XIX.
9. Methods to coordinate plans relating to the recipients of medical assistance.
10. Plans for joint evaluation of policies that affect the cooperative work of the parties.
11. Arrangements for periodic review of the agreements and joint planning for changes in the agreements.
12. Arrangements for continuous liaison and designation of staff responsible for liaison activities at state and local levels.

V. Renal Dialysis

The medical assistance program covers all those services listed in Massachusetts General Laws, Chapter 118 E, Section 1, Sub-section 6, for any eligible recipient irrespective of medical diagnosis. In recognition of the need for appropriate delivery of renal dialysis services, the Department of Public Welfare shall:

1. Reimburse only those hospital renal dialysis programs, approved by the Department of Public Health.
2. Reimburse only those non-hospital facilities which are part of a regional dialysis center, and approved by the Department of Public Health.
3. Reimburse only those home dialysis programs which are part of a regional dialysis center and approved by the Department of Public Health.

The Department of Public Health shall:

1. Approve renal dialysis programs, and inform the Department of Public Welfare.

   Be responsible for the quality of care rendered.

Agreement with the Department of Public Health
Relative to the Implementation of Title XIX (cont.)

V. Renal Dialysis (cont.)

2. Provide machines and supplies to home dialysis patients, pending the development of an all-inclusive rate by the Rate Setting Commission.

Review the medical necessity of dialysis treatment for each Title XIX patient receiving care.

Exchange of Information, Reimbursement, Disputes

1. The two Departments shall exchange all reports, policies, guides, studies and related documents as are pertinent to assuring full knowledge of each others progress and operations, and to carry out this agreement.
2. The Department of Public Welfare shall make arrangements for reimbursement to the Commonwealth for the costs incurred by DPH in providing the above services in accordance with Federal and State Regulations.
3. The DPH shall provide to DPW organizational charts, descriptions of staffing patterns, duties and qualifications of staff, position members, time studies, and an annual budget as the basis for Federal reimbursement.
4. Any unresolved questions or disputes arising from this agreement shall be presented singularly or jointly to the Secretary of Human Services by the respective Commissioners.

This agreement shall be reviewed annually.

This agreement may be terminated by either Department upon 90 days written notice to the other and to the Secretary of Human Services.

Effective Date

This agreement shall take effect upon signing.

_____ _____
DPW Commissioner

_____ _____
DPW Commissioner

State Plan under Title XIX of the Social Security Act
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General Program Administration

Liens and Adjustments or Recoveries

1. The state uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

   The Medical Director of the nursing home or the attending physician in an acute hospital provides the state with information regarding the individual's medical condition, prognosis, and his or her opinion as to the expected discharge date. The state reviews this information as well as the availability of community resources. The state sends notice to the individual of the state's intention to make its determination and provide the individual with an opportunity for a hearing.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR Section 433.36 (f):

   The state reviews documentation regarding the child's residency. The state also requires documentation that the individual could not have remained at home without the care given by the child. The verification may include a statement from a competent medical authority or other professional caregiver, or other uncontroverted evidence satisfactory to the state.

3. The state defines the terms below as follows:

   - estate – all real and personal property that passes through the individual's probate estate upon death.
   - individual's home – his or her principal place of residence.
   - equity interest in the home – any legal or beneficial interest in the principal place of residence.
   - residing in the home for at least one or two years on a continuous basis, and – using the individual's principal place of residence as his or her own principal place of residence for at least one or two years without significant interruptions.
   - lawfully residing – living in the property with the permission of the owner or person with proper legal authority.

Liens and Adjustments or Recoveries (cont.)

4. The state defines undue hardship as follows:

   a. For claims presented on or after November 15, 2003, if the sale of real property would be required to satisfy a claim, repayment is waived if an individual who was using the property as a principal place of residence on the date of the recipient's death meets all of the following conditions: (1) the individual lived in the property on a continual basis for at least a year immediately prior to the recipient becoming eligible and continues to live in the property at the time the Commonwealth first presented its claim for recovery against the recipient's estate; (2) the individual was left an interest in the property under the deceased recipient's will, inherited the property under the laws of intestacy, or the recipient's legal title or interest otherwise passes to the individual by operation of law; (3) the individual is not being forced to sell the property by other devisees or heirs; and (4) at the time the state first presented its claim, the annual gross income of the individual's family group was less than or equal to 133% of the applicable poverty level income standard.

   b. The waiver will be conditional for a period of two years from the date that the state or a court of competent jurisdiction determines that the waiver conditions have been met. If, at the end of that period, all circumstances and conditions that must exist for the state to waive recovery still exist and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period the circumstances and conditions that must exist for the state to waive recovery no longer exist, the state will be notified and the state's claim will be payable in full.

   c. For claims presented prior to November 15, 2003, that are still outstanding as of November 15, 2003, the state applies the definition of undue hardship that existed at the time the claim was presented. Namely, for claims presented on or after April 1, 1995 through June 30, 1997, undue hardship existed and repayment is waived if the sale of the real property would be required to satisfy a claim and if an individual who was using the property as a principal place of residence on the date of the recipient's death meets all of the following conditions: (1) the individual lived in the property on a continual basis for at least a year immediately prior to the recipient becoming eligible; (2) the individual was left an interest in the property under the deceased recipient's will or inherited the property under the laws of intestacy; and (3) the individual is not being forced to sell the property by other devisees or heirs. For claims presented on or after July 1, 1997 through November 14, 2003, all the above conditions for waiver must be met, as well as (4) at the time the state first presented its claim, the individual's annual net income was less than or equal to 200% of the applicable poverty level income standard, and his or her assets met the applicable asset standards for qualifying for medical assistance.

Liens and Adjustments or Recoveries (cont.)

5. The following standards and procedures are used by the state for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective: When the state presents its claim, it notifies the estate of the requirements for undue hardship and requests that the estate within 60 days submit verification and documentation that the individual meets the requirements set forth in #4 above. If the state disagrees with the estate's contention that the requirements for undue hardship have been met, it files suit to enforce its claim and a Court makes the determination as to the state's rights. Criteria for determining cost-effectiveness are set forth below and are considered on a case-by-case basis.

6. The state defines cost-effective as follows (include methodology/thresholds used to determine cost-effective): In determining cost-effectiveness, the state considers the costs and availability of resources, the amount of its claim, the assets in the estate, and the likelihood of actual recovery.

7. The state uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved): with respect to claims filed against the recipient's probate estate, the state may present its claim by filing notice with the Probate Court within four months of the executor or administrator being appointed or by filing a civil suit within one year of date of death; with respect to claims filed against any real and personal property and other assets not includable in the recipient's probate estate, but in which the recipient immediately prior to death had any legal title or interest, the state may within one year of date of death or within four months of receipt of a complete estate asset form, give notice to the person or entity to whom the recipient's legal title or interest passed, and in the case of real property, file a written notice of claim with the registry of deeds where the property lies. The state notifies the estate when it presents its claim of the requirements for undue hardship. (See #5 above.) If the estate disallows the state's claim either because it does not believe the claim to be valid or because of hardship, the state has 60 days to file suit and a Court makes the determination of the state's rights.

Charges Imposed on the Medically Needy

The following enrollment fee, premium or similar charge is imposed the medically needy:

Gross Family Income (per mo.)	Charge Family Size			Liability Period	Frequency of Charge
	1 or 2	3 or 4	5 or more		
(1)	(2)	(3)	(4)	(5)	(6)
$150 or less -					
151 - 200					
201 - 250					
251 - 300					
301 - 350					
351 - 400					
401 - 450					
451 - 500					
501 - 550					
551 - 600					
601 - 700					
701 - 750					
751 - 800					
801 - 850					
851 - 900					
901 - 950					
951 - 1000					
More than $1000					

Other: See Attachments 4.18 A,C

Charges Imposed on the Medically Needy (cont.)

Effect on recipient of non-payment of enrollment fees, premium, or similar charge:

☒ Non-payment does not affect eligibility

☐ Effect is as described below

Charges Imposed on the Categorically Needy

(A) Services for which a charge is applied include those Medicaid-reimbursable prescribed drugs and non-psychiatric acute inpatient hospital stays that are not excluded from cost sharing under federal law.

(B) Nature of the charge imposed on each service is a copayment.

(C) Amount and basis for determining the charge is:

1. $3.00 for each non-psychiatric acute inpatient hospital stay;

2. $1.00 for each prescription and refill for generic drugs and over-the-counter drugs covered by MassHealth in the following classes: antihyperglycemics, antihypertensives, and antihyperlipidemics;

3. $3.65 for each prescription and refill for all other generic, brand-name, and over-the-counter drugs covered by MassHealth.

4. Copayment amounts are set no higher than the amounts permissible according to the chart set forth at 42 CFR §447.54(a)(3). The copayment amounts are fixed, and based on the average or typical payment for services according to 42 CFR §447.55.

(D) Method used to collect the charge is edits in the claims processing system which automatically deducts the copayment amount unless the provider codes the claim indicating that the recipient or service meets the criteria contained in 42 CFR §447.53 (b).

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers is the individual's statement to the provider that he or she does not have the money to pay for the service at the time the service or prescription is provided.

(F) Procedures for implementing and enforcing the exclusions from cost sharing include notices to recipients and providers regarding the copayment requirements, edits to the claims processing system.

To enforce the premiums and cost sharing protections for American Indians/Alaska Natives (AI/AN) contained in Section 5006 of the American Recovery and Reinvestment Act of 2009, the state uses MA-21 eligibility flags and MMIS ethnicity codes to identify individuals eligible for these protections (including those who present an Active/Previous User Letter). The state's MA-21 program will suppress their premiums and the state's MMIS and POPS systems will suppress their copayments. The state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

If an AI/AN has been furnished a service by an Indian health care provider operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or by non-Indian health care providers through referral, or if he or she is eligible to receive such services, the state's MA-21 program will suppress their premiums.

If an AI/AN has ever been furnished a service by an Indian Health care provider operated by the Indian Health Service (HIS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or by non-Indian health care providers through referral, the state's MMIS and POPS systems will not charge that individual a copayment for services received from any Medicaid provider and the state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

(G) Cumulative maximum that applies to copayment requirements:
(1) $200 per year per person for pharmacy services, and
(2) $36 per year per person for non-pharmacy services.

(A) Services for which a charge is applied include those Medicaid-reimbursable prescribed drugs and non-psychiatric acute inpatient hospital stays that are not excluded from cost sharing under federal law.

(B) Nature of the charge imposed on each service is a copayment.

(C) Amount and basis for determining the charge is:

1. $3.00 for each non-psychiatric acute inpatient hospital stay;

2. $1.00 for each prescription and refill for generic drugs and over-the-counter drugs covered by MassHealth in the following classes: antihyperglycemics, antihypertensives, and antihyperlipidemics;

3. $3.65 for each prescription and refill for all other generic, brand-name, and over-the-counter drugs covered by MassHealth.

4. Copayment amounts are set no higher than the amounts permissible according to the chart set forth at 42 CFR §447.54(a)(3). The copayment amounts are fixed, and based on the average or typical payment for services according to 42 CFR §447.55.

(D) Method used to collect the charge is edits in the claims processing system which automatically deducts the copayment amount unless the provider codes the claim indicating that the recipient or service meets the criteria contained in 42 CFR §447.53 (b).

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers is the individual's statement to the provider that he or she does not have the money to pay for the service at the time the service or prescription is provided.

(F) Procedures for implementing and enforcing the exclusions from cost sharing include notices to recipients and providers regarding the copayment requirements, edits to the claims processing system.

To enforce the premiums and cost sharing protections for American Indians/Alaska Natives (AI/AN) contained in Section 5006 of the American Recovery and Reinvestment Act of 2009, the state uses MA-21 eligibility flags and MMIS ethnicity codes to identify individuals eligible for these protections (including those who present an Active/Previous User Letter). The state's MA-21 program will suppress their premiums and the state's MMIS and POPS systems will suppress their copayments. The state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

If an AI/AN has been furnished a service by an Indian health care provider operated by the Indian Health Service (IHS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U), or by non-Indian health care providers through referral, or if he or she is eligible to receive such services, the state's MA-21 program will suppress their premiums.

If an AI/AN has ever been furnished a service by an Indian Health care provider operated by the Indian Health Service (HIS), an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) or by non-Indian health care providers through referral, the state's MMIS and POPS systems will not charge that individual a copayment for services received from any Medicaid provider and the state will ensure that provider payments may not be reduced by any coinsurance, copayment or deductible that has been exempted for the AI/AN patient.

(G) Cumulative maximum that applies to copayment requirements:
(1) $200 per year per person for pharmacy services, and
(2) $36 per year per person for non-pharmacy services.

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902 (a) (10) (A) (ii) (A) and (B) of the Act:

(Not applicable)

B. A description of the billing method used is as follows (include due date of the premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

* Description provided on attachment.

Premiums Imposed on Low Income Pregnant Women and Infants (cont.)

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment.

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a) (10) (E) (ii) of the Act:

(not applicable)

A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

* Description provided on attachment

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals (cont.)

C. State or local funds under other programs are used to pay for premiums:

☐ Yes ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

* Description provided on attachment

State Plan Under Title XIX of the Social Security Act
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Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute inpatient hospital services for RY19.

1. Except as provided in subsection 2, and in subsection 6, below, the payment methodologies specified in this Attachment 4.19-A(1) apply to:

   - RY19 admissions at in-state Acute Hospitals beginning on or after October 1, 2018 through September 30, 2019, and

   - inpatient payments made to in-state Acute Hospitals on an administrative day, psychiatric or rehabilitation per diem basis for RY19 dates of service on or after October 1, 2018 through September 30, 2019.

2. In-state Critical Access Hospitals will be paid in accordance with the methods set forth in **Exhibit 1**, which is attached hereto and incorporated by reference into this Attachment, for inpatient admissions occurring in RY19 on or after October 1, 2018 through September 30, 2019**.**

3. The supplemental payments for FY19 specified in **Sections III.J.1 through III.J.7** apply to dates of service from October 1, 2018 through September 30, 2019.

4. The Pay-for-Performance payment methodology specified in **Section III.K** is effective in RY19 beginning October 1, 2018 through September 30, 2019.

5. In-state Acute Hospitals are defined in **Section II**.

6. This **Section I.A.6** describes the payment methods to out-of-state acute hospitals for inpatient hospital services. Components of the out-of-state payment methods that are based on the in-state methods will simultaneously adjust effective with the 2nd RY19 Period (as defined in **Section II**) to reflect updates implemented effective with the 2nd RY19 Period to the in-state method, as applicable.

   Except if **subsection 6(e)** applies, below, payment for out-of-state acute inpatient hospital services is as follows:

   (a) Payment Amount Per Discharge.
   (i) Out-of-State APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge ("Out-of-State APAD") for inpatient services; provided that the out-of-state APAD is not paid for inpatient services that are paid on a per diem basis under **subsections 6(b) or (c)** and that payment for certain APAD carve-out services (as described in **subsection 6(d)**, below) is governed by **subsection 6(d)**, and not this **subsection 6(a)**. The discharge-specific Out-of-State APAD is equal to the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in

effect for in-state acute hospitals, multiplied by the MassHealth DRG Weight assigned to the discharge using information on the claim.

(ii) Out-of-State Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, the out-of-state acute hospital is also paid an outlier payment for that discharge ("Out-of-State Outlier Payment"). The Out-of-State Outlier Payment is equal to the Marginal Cost Factor in effect for in-state acute hospitals multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The "calculated cost of the discharge" equals the out-of-state acute hospital's allowed charges for the discharge, multiplied by the applicable inpatient cost-to-charge ratio. For High MassHealth Volume Hospitals, the inpatient cost-to-charge ratio is hospital-specific. For all other out-of-state acute hospitals, the median in-state acute hospital inpatient cost-to-charge ratio in effect, based on MassHealth discharge volume, is used. An out-of-state acute hospital's charges for any APAD carve-out services (as described in **subsection 6(d),** below) will not be included in this calculation.
b. The "discharge-specific outlier threshold" equals the sum of the hospital's Out-of-State APAD corresponding to the discharge, and the Fixed Outlier Threshold in effect for in-state acute hospitals.

(b) Out-of-State Transfer Per Diem:

(i) Out-of-state acute hospitals are paid the out-of-state transfer per diem for inpatient services as calculated and capped as set forth in **subsection 6(b)(ii)** ("Out-of-State Transfer Per Diem") in the following circumstances.

a. If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid the Out-of-State Transfer Per Diem for the period during which the Member was an inpatient at the transferring hospital.
b. MassHealth will pay the Out-of-State Transfer Per Diem in such other additional circumstances as MassHealth determines in-state acute hospitals would be paid the in-state Transfer Per Diem, as applicable.

(ii) The out-of-state transfer per diem equals the sum of the hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period during which the transfer per diem is payable, as calculated by EOHHS, divided by the mean in-state acute hospital all payer length of stay for the applicable APR-DRG that is assigned. Total out-of-state transfer per diem payments for a given hospital stay are capped at the sum of the hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment that would have otherwise applied for the transfer per diem period.

(c) Out-of-State Psychiatric Per Diem: If an out-of-state acute hospital admits a MassHealth patient primarily for Behavioral Health Services, the out-of-state acute hospital will be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem most recently in effect for in-state acute hospitals ("Out-of-State Psychiatric Per Diem"), and no other payment methods apply.

(d) Payment for APAD Carve-Outs.

(i) Long-Acting Reversible Contraception (LARC) devices: Out-of-state acute hospitals will be paid for LARC Devices (as defined in **Section II)** in accordance with Section 8.d. of Attachment 4.19-B of the State Plan if the LARC procedure occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay for clinically appropriate members. No other payment methods apply to such devices.

(ii) APAD Carve-Out Drugs: Out-of-state acute hospitals will be paid for APAD Carve-Out Drugs (as defined in **Section II**) in accordance with the payment method applicable to such drugs as in effect for in-state acute hospitals on the date of service.

(e) For medical services payable by MassHealth that are not available in-state, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid the rate of payment established for the medical service under the other state's Medicaid program (or equivalent) or such other rate as MassHealth determines necessary to ensure member access to services.

(f) For purposes of this **Section I.A.6**, a "High MassHealth Volume Hospital" is any out-of-state acute hospital provider that (i) as applicable to the 1st RY19 Period, had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available, and (ii) as applicable to the 2nd RY19 Period had at least 100 MassHealth discharges during the most recent federal fiscal year for which complete data is available.

(g) The payment methods in this **Section I.A.6** are the same for private and governmental providers.

B. Non-Covered Services

The payment methods specified in this Attachment do not apply to the following Inpatient Hospital Services:

1. Behavioral Health Services for Members Enrolled with the Behavioral Health Contractor

MassHealth contracts with a Behavioral Health (BH) Contractor to provide Behavioral Health Services to Members enrolled with the BH Contractor. Hospitals are not entitled to, and may not claim for, any payment from EOHHS for any services that are BH Contractor-covered services or are otherwise payable by the BH Contractor.

2. MCO Services

MassHealth contracts with Managed Care Organizations (MCOs) to provide medical services, including Behavioral Health Services, to Members enrolled with the MCO.

3. Air Ambulance Services

In order to receive payment for air ambulance services, providers must have a separate contract with EOHHS for such services.

4. Non-Acute Units and Other Separately Licensed Units in Acute Hospitals

This Attachment shall not govern payment to Acute Hospitals for services provided to Members in separately licensed units within an Acute Hospital or in Non-Acute Units other than Rehabilitation Units (see **Section III.H below**).

II. Definitions

The definitions set forth in the "**1st RY19 Period**" column, below, apply during the **1st RY19 Period** (as defined below). The definitions set forth in the "**2nd RY19 Period**" column, below, apply during the **2nd RY19 Period** (as defined below), unless (i) that column specifies that there is no change to the definition, or (ii) for purposes of the APAD, Outlier Payment, and Transfer Per Diem payment methodologies set forth in **Sections III.B** through **III.D**, below, the admission occurred in the 1st RY19 Period, in which case the definitions in the **1st RY19 Period** column continue to apply.

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
1st RY19 Period	The "1st RY19 Period" is the portion of RY19 from October 1, 2018 through October 31, 2018.	No change to definition.
2nd RY19 Period	The "2nd RY19 Period" is the portion of RY19 from November 1, 2018 through the end of RY19.	No change to definition.
Accountable Care Organization (ACO)	An entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, where in the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans (ACPPs), Primary Care ACOs, and MCO-Administered ACOs.	No change to definition.
Accountable Care Partnership Plan (ACPP)	A type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), and which is organized primarily for the purpose of providing health care services.	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Actual Acquisition Cost	For purposes of **Section III.I.2**, the Hospital's "actual acquisition cost" of the Drug is the Hospital's invoice price for the Drug, net of all on- or off- invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member while the Member was admitted in the Hospital, including any efficacy-, outcome-, or performance-based guarantee (or similar arrangements), whether received pre- or post-payment.	No change to definition.
Acute Hospital	See Hospital.	No change to definition.
Adjudicated Payment Amount Per Discharge (APAD)	A Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge, which is the complete fee-for-service payment for such acute hospitalization, excluding the additional payment of any Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a Transfer Per Diem, Psychiatric Per Diem or Rehabilitation Per Diem basis under this Attachment. The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in **Section III.I**. Calculation of the APAD is discussed in **Section III.B** (utilizing the 1st RY19 Period methodology)**.**	A Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge, which is the complete fee-for-service payment for such acute hospitalization, excluding the additional payment of any Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a Transfer Per Diem, Psychiatric Per Diem or Rehabilitation Per Diem basis under this Attachment. The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in **Section III.I**. Calculation of the APAD is discussed in **Section III.B** (utilizing the 2nd RY19 Period methodology)**.**

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Administrative Day (AD)	A day of inpatient hospitalization on which a Member's care needs can be provided in a setting other than an Acute Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available.	No change to definition.
All Patient Refined–Diagnostic Related Group (APR-DRG or **DRG)**	The All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper, version 34, unless otherwise specified.	No change to definition.
APAD Base Year	The hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY16, using FY16Massachusetts Hospital cost reports as screened and updated as of June 30, 2017.	The hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY17, using FY17Massachusetts Hospital cost reports as screened and updated as of July 24, 2018 .
APAD Carve-Out Drugs	Drugs that are carved out of the APAD payment and separately paid pursuant to **Section III.I.2.** APAD Carve-Out Drugs are identified on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List.	No change to definition.
Average (or Mean) Length of Stay	The sum of non-psychiatric acute inpatient days for relevant discharges, divided by the number of discharges. Average Length of Stay is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.	No change to definition.
Behavioral Health (BH) Contractor	The entity with which EOHHS contracts to provide, arrange for and coordinate Behavioral Health Services to enrolled Members on a capitated basis, and which meets the	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	definition of prepaid inpatient health plan at 42 C.F.R. § 438.2.	
Behavioral Health Services (or Behavioral Health)	Services provided to Members who are being treated for psychiatric disorders or substance use disorders.	No change to definition.
Casemix Index	A measure of intensity of services provided by a Hospital to a group of patients, using the APR-DRG methodology, as specified in this Attachment. A Hospital's Casemix Index is calculated by dividing a Hospital's APR-DRG cumulative MassHealth or all-payer weights (using Massachusetts weights) by the Hospital's MassHealth or all-payer discharges. The weight for each APR-DRG is based on Massachusetts data.	No change to definition.
Center for Health Information and Analysis (CHIA)	The Center for Health Information and Analysis established under M.G.L. c. 12C.	No change to definition.
Community-based Physician	Any physician or physician group practice, excluding interns, residents, fellows, and house officers, who is not a Hospital-Based Physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths.	No change to definition.
Contract	See RFA and Contract.	No change to definition.
Critical Access Hospital (CAH)	An acute hospital that, prior to October 1, 2017, was designated by CMS as a Critical Access Hospital, and that continues to maintain that status.	An acute hospital that, prior to October 1, 2018, was designated by CMS as a Critical Access Hospital, and that continues to maintain that status.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
DMH-Licensed Bed	A bed in a Hospital that is located in a unit licensed by the Massachusetts Department of Mental Health (DMH).	No change to definition.
Discharge-Specific Case Cost	The product of the Hospital's MassHealth allowed charges for a specific discharge and the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY16 Massachusetts Hospital cost report. For applicable discharges, a Hospital's charges corresponding to LARC Devices or APAD Carve-Out Drugs are excluded in calculating the Discharge-Specific Case Cost.	The product of the Hospital's MassHealth allowed charges for a specific discharge and the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY17 Massachusetts Hospital cost report. For applicable discharges, a Hospital's charges corresponding to LARC Devices or APAD Carve-Out Drugs are excluded in calculating the Discharge-Specific Case Cost.
Discharge-Specific Outlier Threshold	The sum of the Pre-Adjusted APAD for a specific discharge (utilizing the methodology applicable to the 1st RY19 Period), and the Fixed Outlier Threshold.	The sum of the APAD for a specific discharge (utilizing the methodology applicable to the 2nd RY19 Period), and the Fixed Outlier Threshold.
Drugs	Drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified form and strength. Each dosage form and strength is a separate Drug.	No change to definition.
Excluded Units	Non-Acute Units as defined in this section; any unit which has a separate license from the Hospital; psychiatric and substance use disorder units; and non-distinct observation units.	No change to definition.
Executive Office of Health and Human Services (EOHHS)	The single state agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	XXI of the Social Security Act and other applicable laws and waivers.	
Fiscal Year (FY)	The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. This period coincides with the federal fiscal year (FFY). FY19 begins on October 1, 2018 and ends on September 30, 2019.	No change to definition.
Fixed Outlier Threshold	For the 1st RY19 Period, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $25,500.00.	For the 2nd RY19 Period, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $27,200.00.
Freestanding Pediatric Acute Hospital	A Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.	No change to definition.
Gross Patient Service Revenue	The total dollar amount of a Hospital's charges for services rendered in a Fiscal Year.	No change to definition.
High Medicaid Volume Freestanding Pediatric Acute Hospital	A Freestanding Pediatric Acute Hospital with more than 1,000 Medicaid discharges in FY12 for which a SPAD was paid, as determined by paid claims in MMIS as of May 11, 2013, and for which MassHealth was the primary payer.	No change to definition.
High Medicaid Volume Safety Net Hospital	An Acute Hospital which had a ratio of Medicaid inpatient days to total inpatient days that was greater than 45% in FY14 based on the Hospital's FY14 403 cost report.	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Hospital	Any health care facility which: a. operates under a hospital license issued by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111 § 51; b. is Medicare certified and participates in the Medicare program; and c. has more than fifty percent (50%) of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds, as determined by DPH and currently utilizes more than fifty percent (50%) of its beds exclusively as such, as determined by EOHHS.	No change to definition.
Hospital-Based Physician	Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Inpatient Services to Members at a site for which the Hospital is otherwise eligible to receive payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Hospital Discharge Data (HDD)	Hospital discharge filings for FY16 provided and verified by each hospital, submitted to CHIA, and screened and updated by CHIA. HDD is used for determining casemix as part of the APAD rate development for purposes of **Section III.B**, as applicable to the 1st RY19 Period.	Hospital discharge filings for FY17 provided and verified by each hospital, submitted to CHIA, and screened and updated by CHIA. HDD is used for determining casemix as part of the APAD rate development for purposes of **Section III.B**, as applicable to the 2nd RY19 Period.
Inflation Factors for Administrative Days	An inflation factor that is a blend of the Centers for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factor for Administrative Days is as follows: • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18.	An inflation factor that is a blend of the Centers for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factor for Administrative Days is as follows: • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18. • 2.183% reflects the price changes between RY18 and RY19.
Inflation Factors for Capital Costs	The inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index. The Inflation Factors for Capital Costs between RY04 and RY18 are as follows: • 0.7% reflects the price changes between RY04 and RY05 • 0.7% reflects the price changes between RY05 and RY06 • 0.8% reflects the price changes between	For price changes between RY04 and RY18, the inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index. For price changes between RY18 and RY19, the inflation factors for capital cost are the factors used by CMS to update capital payments made by Medicare and are based on the CMS Capital Input Price Index; plus a RY19 capital enhancement factor of 0.9%, The Inflation

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	RY06 and RY07 • 0.9% reflects the price changes between RY07 and RY08 • 0.7% reflects the price changes between RY08 and RY09 • 1.4% reflects the price changes between RY09 and RY10 • 1.5% reflects the price changes between RY10 and RY11 • 1.5% reflects the price changes between RY11 and RY12 • 1.2% reflects the price changes between RY12 and RY13 • 1.4% reflects the price changes between RY13 and RY14 • 1.5% reflects the price changes between RY14 and RY15 • 1.3% reflects the price changes between RY15 and RY16 • 0.9% reflects the price changes between RY16 and RY17. • 1.3% reflects the price changes between RY17 and RY18.	Factors for Capital Costs between RY04 and RY19 are as follows: • 0.7% reflects the price changes between RY04 and RY05 • 0.7% reflects the price changes between RY05 and RY06 • 0.8% reflects the price changes between RY06 and RY07 • 0.9% reflects the price changes between RY07 and RY08 • 0.7% reflects the price changes between RY08 and RY09 • 1.4% reflects the price changes between RY09 and RY10 • 1.5% reflects the price changes between RY10 and RY11 • 1.5% reflects the price changes between RY11 and RY12 • 1.2% reflects the price changes between RY12 and RY13 • 1.4% reflects the price changes between RY13 and RY14 • 1.5% reflects the price changes between RY14 and RY15 • 1.3% reflects the price changes between RY15 and RY16 • 0.9% reflects the price changes between RY16 and RY17. • 1.3% reflects the price changes between RY17 and RY18. • 2.1% reflects the price changes between RY18 and RY19.
Inflation Factors for Operating Costs	For price changes between RY04 and RY07, and between RY09 (starting with admissions beginning December 7, 2008) and RY18, the inflation factor for operating costs is a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component	For price changes between RY04 and RY07, and between RY09 (starting with admissions beginning December 7, 2008) and RY19, the inflation factor for operating costs is a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY09 (for admissions through December 6, 2008), the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY18 are as follows: • 1.186% reflects price changes between RY04 and RY05 • 1.846% reflects price changes between RY05 and RY06 • 1.637% reflects price changes between RY06 and RY07 • 3.300% reflects price changes between RY07 and RY08 • 3.000% reflects price changes between RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008 • 1.424% reflects price changes between RY08 and RY09 for admissions beginning from December 7, 2008 through September 30, 2009 • 0.719% reflects the price changes between RY09 and RY10* • 1.820% reflects the price changes between RY10 and RY11 • 1.665% reflects the price changes between RY11 and RY12 • 1.775% reflects the price changes between RY12 and RY13 • 1.405% reflects the price changes between RY13 and RY14 • 1.611% reflects the price changes between RY14 and RY15 • 1.573% reflects the price changes between RY15 and RY16 • 1.937% reflects the price changes between RY16 and RY17 • 2.26% reflects the price changes between RY17 and RY18.	of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY09 (for admissions through December 6, 2008), the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY19 are as follows: • 1.186% reflects price changes between RY04 and RY05 • 1.846% reflects price changes between RY05 and RY06 • 1.637% reflects price changes between RY06 and RY07 • 3.300% reflects price changes between RY07 and RY08 • 3.000% reflects price changes between RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008 • 1.424% reflects price changes between RY08 and RY09 for admissions beginning from December 7, 2008 through September 30, 2009 • 0.719% reflects the price changes between RY09 and RY10* • 1.820% reflects the price changes between RY10 and RY11 • 1.665% reflects the price changes between RY11 and RY12 • 1.775% reflects the price changes between RY12 and RY13 • 1.405% reflects the price changes between RY13 and RY14 • 1.611% reflects the price changes between RY14 and RY15 • 1.573% reflects the price changes between RY15 and RY16 • 1.937% reflects the price changes between RY16 and RY17 • 2.26% reflects the price changes between RY17 and RY18.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	** The Inflation Factor for Operating Costs reflecting price changes between RY09 and RY10 was calculated based on the RY09 rate in effect for admissions beginning from December 7, 2008 through September 30, 2009.*	• 2.183% reflects the price changes between RY18 and RY19. ** The Inflation Factor for Operating Costs reflecting price changes between RY09 and RY10 was calculated based on the RY09 rate in effect for admissions beginning from December 7, 2008 through September 30, 2009.*
Inpatient Services (also Inpatient Hospital Services)	Medical services, including Behavioral Health Services, provided to a Member admitted to a Hospital.	No change to definition.
Long-Acting Reversible Contraception (LARC) device (LARC Device)	Long-acting reversible contraception (LARC) device refers to intrauterine devices and contraceptive implants. LARC Device does not refer to the procedure, itself.	No change to definition.
Managed Care Organization (MCO)	Any entity with which EOHHS contracts to provide primary care and certain other medical services, including Behavioral Health Services, to Members on a capitated basis, and which meets the definition of an MCO at 42 CFR §438.2. For clarity purposes, MCO also includes Accountable Care Partnership Plans (ACPPs).	No change to definition.
Marginal Cost Factor	As used in the calculation of an Outlier Payment, the percentage of payment made for the difference between the Discharge-Specific Case Cost and the Discharge-Specific Outlier Threshold (utilizing the 1st RY19 Period methodology). For the 1st RY19 Period, the Marginal Cost Factor is 80%.	As used in the calculation of an Outlier Payment, the percentage of payment made for the difference between the Discharge-Specific Case Cost and the Discharge-Specific Outlier Threshold (utilizing the 2nd RY19 Period methodology). For the 2nd RY19 Period, the Marginal Cost Factor is 50%.
Massachusetts-specific Wage Area Index	Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage.	Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	Massachusetts Hospitals' wages and hours were determined based on CMS's FY2018 April-28-17-Wage Index_PUFs(5) zip file, downloaded May 1, 2017. Wage areas were assigned according to the same CMS file unless re-designated in a written decision from CMS to the Hospital provided to EOHHS by May 12, 2017.	Massachusetts Hospitals' wages and hours were determined based on CMS's FY2019-April-27-2018-Wage-Index-PUF zip file, downloaded May 1, 2018 (the "CMS File"). Wage areas were assigned according to the same CMS File, except that BayState Franklin Medical Center was assigned to (and its wages and hours included in) the Springfield wage area, and PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined from their hospital's license. The area's Wage Index is the Massachusetts-specific Wage Area Index for each Hospital assigned to the area, except for any Hospital that was re-designated in a written decision from CMS to the Hospital provided to EOHHS by March 30, 2018. For any such redesignated Hospital, its Massachusetts-specific Wage Area Index was calculated based on the wages and hours, determined from the CMS File, of (i) the redesignated Hospital, (ii) all other Hospitals redesignated to that same area, and (iii) all Hospitals assigned to that area, combined.
MassHealth (also Medicaid)	The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.	No change to definition.
MassHealth DRG Weight	The MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI),	The MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI),

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	applicable to the 1st RY19 Period.	applicable to the 2nd RY19 Period.
Medicaid Management Information System (MMIS)	The state-operated system of data processes, certified by CMS that meets federal guidelines in Part 11 of the State Medicaid Manual.	No change to definition.
Member	A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.	No change to definition.
Non-Acute Unit	A chronic care, Rehabilitation, or skilled nursing facility unit within a Hospital.	No change to definition.
Outlier Payment	A hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section III.C,** utilizing the methodology applicable to the 1st RY19 Period.	A hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section III.C,** utilizing the methodology applicable to the 2nd RY19 Period.
Pediatric Specialty Unit	A designated pediatric unit, pediatric intensive care unit, or neonatal intensive care unit in an Acute Hospital other than a Freestanding Pediatric Acute Hospital, in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20.	No change to definition.
Pre-Adjusted APAD	The amount calculated by EOHHS utilizing the APAD payment methodology applicable to the 1st RY19 Period set forth in **Section III.B**, below, for a specific discharge, but excluding the final step of applying any adjustment for Potentially Preventable Readmissions pursuant to **Section IV**, utilizing the 1st RY19 Period methodology.	Not Applicable.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Primary Care ACO	A type of ACO with which the MassHealth agency contracts under its ACO program.	No change to definition.
Primary Care Clinician Plan (PCC Plan)	A comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive primary care, Behavioral Health, and other medical services	No change to definition.
Rate Year (RY)	Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table: Rate Year* / Dates RY04 10/1/2003 – 9/30/2004 RY05 10/1/2004 – 9/30/2005 RY06 10/1/2005 – 9/30/2006 RY07 10/1/2006 – 10/31/2007 RY08 11/1/2007 – 9/30/2008 RY09 10/1/2008 – 10/31/2009 RY10 11/1/2009 – 11/30/2010 RY11 12/01/2010–09/30/2011 RY12 10/01/2011 --9/30/2012 RY13 10/01/2012 –09/30/2013 RY14 10/1/2013 – 09/30/2014 RY15 10/1/2014 – 9/30/2015 RY16 10/1/2015 – 9/30/2016 RY17 10/1/2016 – 9/30/2017 RY18 10/1/2017 – 9/30/2018 RY19 10/1/2018 - 9/30/2019 *In future rate years, Hospitals will be paid in in accordance with this Attachment (until amended).	No change to definition.
Rehabilitation Services	Services provided in an Acute Hospital that are medically necessary to be provided at a	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	hospital level of care, to a Member with medical need for an intensive rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his/her ability to function with a reasonable expectation of significant improvement that will be of practical value to the Member measured against his/her condition at the start of the rehabilitation program.	
Rehabilitation Unit	A distinct unit of rehabilitation beds licensed by the Department of Public Health (DPH) as rehabilitation beds, in a licensed Acute Hospital that provides comprehensive Rehabilitation Services to Members with appropriate medical needs.	No change to definition.
RFA and Contract	The Request for Applications and the agreement executed between each selected Hospital and EOHHS that incorporates all of the provisions of the RFA	No change to definition.
State Fiscal Year (SFY)	The time period of 12 months beginning on July 1 of any calendar year and ending on June 30 of the immediately following calendar year. SFY19 begins on July 1, 2018, and ends on June 30, 2019.	No change to definition.
Standard Payment Amount Per Discharge (SPAD)	A payment methodology that was utilized in prior Rate Years. The SPAD was a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which was the complete fee-for-service payment for an acute episode of	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	illness, excluding additional fee-for-service payment for services as described in prior acute inpatient hospital SPAs, including TN-013-020. Calculation of the SPAD was discussed in **Section III.B** of TN-013-020. This payment methodology was replaced by the APAD payment methodology in RY15.	
Total Case Payment	The sum, as determined by EOHHS, of the Pre-Adjusted APAD and, if applicable, any Outlier Payment, adjusted for Potentially Preventable Readmissions pursuant to **Section IV** (applying the 1st RY19 Period methodology(ies)).	The sum, as determined by EOHHS, of the APAD and, if applicable, any Outlier Payment (applying the 2nd RY19 Period methodology(ies)).
Total Transfer Payment Cap	The Total Case Payment amount calculated by EOHHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in **Section III.B and III.C**, respectively, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis under **Section III.D** (applying the 1st RY19 Period methodology(ies)).	The Total Case Payment amount calculated by EOHHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in **Section III.B and III.C**, respectively, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis under **Section III.D** (applying the 2nd RY19 Period methodology(ies)).
Transferring Hospital	an Acute Hospital that is being paid on a Transfer Per Diem basis, pursuant to **Section III.D**.	No change to definition.
Wholesale Acquisition Cost (WAC)	The wholesale acquisition cost (WAC) of the Drug as published by First Data Bank or other national price compendium designated by EOHHS.	No change to definition.

III. Payment for Inpatient Services

A. Overview

1. Except as otherwise provided in **subsections C through I** below, and in **Exhibit 1**, fee-for-service payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be a Hospital-specific, DRG-specific Adjudicated Payment Amount per Discharge (APAD) (see **subsection B** below).

   For qualifying discharges, Hospitals may also be paid an Outlier Payment in addition to the APAD, under the conditions set forth in, and calculated as described in, **subsection C**, below.

   Payment separate from the APAD may also be made to Hospitals for LARC Devices and APAD Carve-Out Drugs, respectively, as described in **subsection I.1** and **I.2**, respectively.

2. **Subsections C through I** describe non-APAD fee-for-service payments, including, as applicable, Outlier Payments, and payment for Behavioral Health Services, transfer patients, Hospital-Based Physician services, Administrative Days, Rehabilitation Unit services in Acute Hospitals, LARC Devices and APAD Carve-Out Drugs. Payment for other unique circumstances is described in **subsection J**, and **Exhibit 1**. Pay-for-Performance payments are described in **subsection K.**

3. For Inpatient Services paid on a per diem basis, MassHealth pays the lesser of (i) the per diem rate, or (ii) 100% of the Hospital's actual charge submitted.

B. Calculation of the Adjudicated Payment Amount Per Discharge (APAD)

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the APAD payment methodology. The APAD methodology is set forth in **Section III.B** below. The "**1st RY19 Period"** column applies to admissions occurring in the 1st RY19 Period, and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The "**2nd RY19 Period**" column applies to admissions occurring in the 2nd RY19 Period, and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. The 1st RY19 Period APAD methodology is the same methodology that applied during the 2nd RY18 Period, effective March 1, 2018, under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
1. APAD Overview The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge (exclusive of any separate payment for LARC Devices or APAD Carve-Out Drugs, if applicable, as described in **Section III.I)**. The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific Wage Area Index; (2) the Statewide Capital Standard per Discharge; (3) the discharge-specific MassHealth DRG Weight; and (4) a Hospital-specific adjustment, where applicable, for Potentially Preventable Readmissions (PPR) pursuant to **Section IV**. Each of these components, and the calculation of the APAD, is described more fully below. The APAD Base Year is FY16.	**1. APAD Overview** The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge (exclusive of any separate payment for LARC Devices or APAD Carve-Out Drugs, if applicable, as described in **Section III.I)**. The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific Wage Area Index; (2) the Statewide Capital Standard per Discharge; and (3) the discharge-specific MassHealth DRG Weight. Each of these components, and the calculation of the APAD, is described more fully below. The APAD Base Year is FY17.
2. Statewide Operating Standard per Discharge The Statewide Operating Standard per Discharge is determined by multiplying: • the weighted average of the APAD Base Year standardized cost per discharge, where any Hospital's standardized cost per discharge that exceeds the efficiency standard is limited by the efficiency standard; by • an outlier adjustment factor of 93.0% and by • the Inflation Factors for Operating Costs to	**2. Statewide Operating Standard per Discharge** The Statewide Operating Standard per Discharge is determined by multiplying: • the weighted average of the APAD Base Year standardized cost per discharge, where any Hospital's standardized cost per discharge that exceeds the efficiency standard is limited by the efficiency standard; by • an outlier adjustment factor of 96.8%; and by • the Inflation Factors for Operating Costs to trend APAD Base Year costs forward to the

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<table>
<tr><th>1st RY19 Period
(for admissions occurring
in the 1st RY19 Period)</th><th>2nd RY19 Period
(for admissions occurring
in the 2nd RY19 Period)</th></tr>
<tr><td>trend APAD Base Year costs forward to RY18.

These elements are described in greater detail below. The Statewide Operating Standard per Discharge is $10,998.11.</td><td>current Rate Year.

These elements are described in greater detail below. The Statewide Operating Standard per Discharge is $11,176.16.</td></tr>
<tr><td>a. APAD Base Year Standardized Cost per Discharge

The APAD Base Year standardized cost per discharge is based on the average all-payer cost per discharge for each Hospital, adjusted as described below.

The average cost per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. APAD Base Year costs and discharges are determined using the Hospital's APAD Base Year Massachusetts Hospital cost report as screened and updated as of June 30, 2017. Specific costs and discharges are included and excluded as follows:

Average Cost per Discharge: treatment of costs and discharges

<u>Included</u>

Total non-excluded costs of providing Inpatient Services

Routine outpatient costs associated with admissions from the Emergency Department

Routine and ancillary outpatient costs resulting from admissions from

<u>Excluded</u>

Costs and discharges from Excluded Units.

Professional services

Capital costs and direct medical education costs.

Costs associated with postpartum LARC Devices</td><td>a. APAD Base Year Standardized Cost per Discharge

The APAD Base Year standardized cost per discharge is based on the average all-payer cost per discharge for each Hospital, adjusted as described below.

The average cost per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. APAD Base Year costs and discharges are determined using the Hospital's APAD Base Year Massachusetts Hospital cost report as screened and updated as of July 24, 2018. Specific costs and discharges are included and excluded as follows:

Average Cost per Discharge: treatment of costs and discharges

<u>Included</u>

Total non-excluded costs of providing Inpatient Services

Routine outpatient costs associated with admissions from the Emergency Department

Routine and ancillary outpatient costs resulting from admissions from

<u>Excluded</u>

Costs and discharges from Excluded Units.

Professional services

Capital costs and direct medical education costs.

Costs associated with postpartum LARC Devices</td></tr>
</table>

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
Observation status Cost centers identified as the supervision component of physician compensation and other direct physician costs All other non-excluded medical and non-medical patient care-related staff expenses Malpractice costs and organ acquisition costs	Observation status Cost centers identified as the supervision component of physician compensation and other direct physician costs All other non-excluded medical and non-medical patient care-related staff expenses Malpractice costs and organ acquisition costs
The APAD Base Year average cost per discharge for each Hospital is then adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the APAD Base Year all-payer Casemix Index. This adjusted value is the APAD Base Year standardized cost per discharge.	The APAD Base Year average cost per discharge for each Hospital is then adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the APAD Base Year all-payer Casemix Index. This adjusted value is the APAD Base Year standardized cost per discharge.
b. **Efficiency Standard** All Hospitals are ranked with respect to their APAD Base Year standardized costs per discharge, and the efficiency standard is set at the 67th percentile of the cumulative frequency of FY16 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $13,127.31.	b. **Efficiency Standard** All Hospitals are ranked with respect to their APAD Base Year standardized costs per discharge, and the efficiency standard is set at the 60th percentile of the cumulative frequency of FY17 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $12,397.19.
c. **Outlier Adjustment Factor and Inflation Factors for Operating Costs** The weighted average of the APAD Base Year standardized cost per discharge, as limited by the efficiency standard, is multiplied by the	c. **Outlier Adjustment Factor and Inflation Factors for Operating Costs** The weighted average of the APAD Base Year standardized cost per discharge, as limited by the efficiency standard, is multiplied by the

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
outlier adjustment factor referenced above, and by the Inflation Factors for Operating Costs reflecting price changes between RY16 and RY18, to result in the Statewide Operating Standard per Discharge.	outlier adjustment factor referenced above, and by the Inflation Factors for Operating Costs reflecting price changes between RY17 and RY19, to result in the Statewide Operating Standard per Discharge.

3. Statewide Capital Standard per Discharge

The Statewide Capital Standard per Discharge is calculated based on the APAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the APAD Base Year and RY18. The calculation is summarized in the following chart:

Statewide Capital Standard per Discharge		
APAD Base Year statewide capital cost per discharge (**subsection a**),	a. the APAD Base Year all-payer capital cost per discharge b. adjusted by the APAD Base Year all payer casemix index c. capped at the capital efficiency standard d. multiplied by the FY16 Hospital-specific MassHealth discharges e. summed and divided by the total FY16 statewide MassHealth discharges	$758.22
trended to RY18 using the Inflation Factors for Capital Costs (**subsection b**),		$774.99

3. Statewide Capital Standard per Discharge

The Statewide Capital Standard per Discharge is calculated based on the APAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the APAD Base Year and the current Rate Year. The calculation is summarized in the following chart:

Statewide Capital Standard per Discharge		
APAD Base Year statewide capital cost per discharge (**subsection a**),	a. the APAD Base Year all-payer capital cost per discharge b. adjusted by the APAD Base Year all payer casemix index c. capped at the capital efficiency standard d. multiplied by the FY17 Hospital-specific MassHealth discharges e. summed and divided by the total FY17 statewide MassHealth discharges	$716.03
trended to the current rate year using the Inflation Factors for Capital Costs (**subsection b**),		$740.65

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
a. **APAD Base Year statewide capital cost per discharge** The APAD Base Year statewide capital cost per discharge is the discharge-weighted average over all Hospitals of the all payer casemix-adjusted capital cost per discharge capped at the capital efficiency standard. For each Hospital, the total inpatient capital costs include the Buildings and Fixtures and Movable Equipment categories reported on the APAD Base Year Massachusetts Hospital cost report. Total capital costs for Buildings and Fixtures are allocated to inpatient services through the square-footage-based allocation formula, and total capital costs for Movable Equipment are allocated to inpatient services through the dollar-value-based allocation formula, of the APAD Base Year Massachusetts Hospital cost report. Capital costs for Excluded Units are omitted to derive net inpatient capital costs. Each Hospital's capital cost per discharge is calculated using APAD Base Year Massachusetts Hospital cost reports by dividing total net inpatient capital costs by the Hospital's total all-payer discharges, net of Excluded Unit discharges. Each Hospital's capital cost per discharge is then adjusted by the APAD Base Year all-payer Casemix Index. All Hospitals are then ranked with respect to their casemix-adjusted capital cost per discharge, and the capital efficiency standard is set at the 67th percentile of the cumulative frequency of FY16 discharges where MassHealth is the primary payer in MMIS. Each Hospital's capital cost per discharge that	a. **APAD Base Year statewide capital cost per discharge** The APAD Base Year statewide capital cost per discharge is the discharge-weighted average over all Hospitals of the all payer casemix-adjusted capital cost per discharge capped at the capital efficiency standard. For each Hospital, the total inpatient capital costs include the Buildings and Fixtures and Movable Equipment categories reported on the APAD Base Year Massachusetts Hospital cost report. Total capital costs for Buildings and Fixtures are allocated to inpatient services through the square-footage-based allocation formula, and total capital costs for Movable Equipment are allocated to inpatient services through the dollar-value-based allocation formula, of the APAD Base Year Massachusetts Hospital cost report. Capital costs for Excluded Units are omitted to derive net inpatient capital costs. Each Hospital's capital cost per discharge is calculated using APAD Base Year Massachusetts Hospital cost reports by dividing total net inpatient capital costs by the Hospital's total all-payer discharges, net of Excluded Unit discharges. Each Hospital's capital cost per discharge is then adjusted by the APAD Base Year all-payer Casemix Index. All Hospitals are then ranked with respect to their casemix-adjusted capital cost per discharge, and the capital efficiency standard is set at the 60th percentile of the cumulative frequency of FY17 discharges where MassHealth is the primary payer in MMIS. Each Hospital's capital cost per discharge that

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
exceeds the capital efficiency standard is then limited by the capital efficiency standard. The APAD Base Year statewide capital cost per discharge is the statewide average of these adjusted costs per discharge, weighted based on each Hospital's number of FY16 MassHealth discharges.	exceeds the capital efficiency standard is then limited by the capital efficiency standard. The APAD Base Year statewide capital cost per discharge is the statewide average of these adjusted costs per discharge, weighted based on each Hospital's number of FY17 MassHealth discharges.
b. **Inflation Factors for Capital Costs** The Inflation Factors for Capital Costs reflecting price changes between RY16 and RY18 are applied to trend the APAD Base Year statewide capital cost per discharge forward to RY18.	b. **Inflation Factors for Capital Costs** The Inflation Factors for Capital Costs reflecting price changes between RY17 and RY19 are applied to trend the APAD Base Year statewide capital cost per discharge forward to the current Rate Year.
4. MassHealth DRG Weights The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). The discharge-specific MassHealth DRG Weight is assigned to the discharge based on information contained in a properly submitted inpatient Hospital claim and determined using the 3M APR-DRG Grouper and Massachusetts weights applicable to the 1st RY19 Period.	**4. MassHealth DRG Weights** The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). The discharge-specific MassHealth DRG Weight is assigned to the discharge based on information contained in a properly submitted inpatient Hospital claim and determined using the 3M APR-DRG Grouper and Massachusetts weights applicable to the 2nd RY19 Period.
5. Potentially Preventable Readmissions (PPR) Adjustment The hospital-specific adjustment for PPRs, if applicable, is calculated as set forth in **Section IV**, below, utilizing the PPR methodology applicable to the 1st RY19 Period.	**5. [Reserved]**

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
6. Calculation of the APAD Each APAD is determined by the following steps: (1) multiplying the labor portion of the Statewide Operating Standard per Discharge by the Hospital's Massachusetts-specific Wage Area Index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to result in the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "**APAD Base Payment**"), (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight, and (5) then adjusting that result, where applicable, for Potentially Preventable Readmissions under **Section IV**. For purposes of step (1) in this **subsection 6**, above, the Hospital's Massachusetts-specific Wage Area Index which is multiplied by the labor portion of the Statewide Operating Standard per Discharge, is determined as specified in the definition of "Massachusetts-specific Wage Area Index" in **Section II** as applicable to the 1st RY19 Period, except that for this purpose, Baystate Medical Center's wages and hours were also included in the Springfield area index. For discharges from Freestanding Pediatric Acute Hospitals for which the MassHealth DRG Weight assigned to the discharge is 3.5 or greater, the APAD Base Payment will be adjusted to include an additional 45% for purposes of step (4), above, in this **subsection 6**, in the calculation of the APAD.	**6. Calculation of the APAD** Each APAD is determined by the following steps: (1) multiplying the labor portion of the Statewide Operating Standard per Discharge by the Hospital's Massachusetts-specific Wage Area Index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to result in the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "**APAD Base Payment**"), and (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight. For purposes of step (1) in this **subsection 6**, above, the Hospital's Massachusetts-specific Wage Area Index which is multiplied by the labor portion of the Statewide Operating Standard per Discharge, is determined as specified in the definition of "Massachusetts-specific Wage Area Index" in **Section II** as applicable to the 2nd RY19 Period. For qualifying discharges from Freestanding Pediatric Acute Hospitals and the Hospital with a Pediatric Specialty Unit for which the MassHealth DRG Weight assigned to the discharge is 3.5 or greater, the APAD Base Payment will be adjusted to include an additional 45% for purposes of step (4), above, in this **subsection 6**, in the calculation of the APAD. A qualifying discharge for this purpose is one that (i) meets this minimum MassHealth DRG Weight requirement, and (ii) in the case of the Hospital with a Pediatric Specialty Unit, is for a Member who is under the age of 21 at the time of admission.

The following is an illustrative example of the calculation of the Total Case Payment for a standard APAD claim that does not also qualify for an Outlier Payment under **Section III.C**, below. The example assumes the 2nd RY19 Period applies.

Table 1: Standard APAD claim - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	**Sample Hospital**		
DRG:	**203, Chest Pain. Severity of Illness (SOI) = 2.**		
Line	**Description**	**Value**	**Calculation or Source**
1	Statewide Operating Standard per Discharge	$11,176.16	Section III.B.2 (2nd RY19 Period)
2	Hospital's Masschusetts-specific wage area index	1.0728	Varies by hospital
3	Labor Factor	0.68257	Determined annually
4	Hospital's Wage Adjusted Operating Standard per Discharge	$11,731.52	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0-Line 3))
5	Statewide Capital Standard per Discharge	$740.65	Section III.B.3 (2nd RY19 Period)
6	APAD Base Payment	$12,472.17	Line 4 + Line 5
7	MassHealth DRG Weight	0.3598	Determined based on claim information
8	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$4,487.49**	Line 6 * Line 7

C. Outlier Payment

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the Outlier Payment methodology. The Outlier Payment methodology is set forth in this **Section III.C**; provided that, (i) the "1st RY19 Period" column applies to admissions occurring in the 1st RY19 Period, and incorporates applicable definitions from **Section II** that apply to the 1st RY19 Period; (ii) the "2nd RY19 Period" column applies to admissions occurring in the 2nd RY19 Period, and incorporates applicable definitions from **Section II** that apply to the 2nd RY19 Period; and (iii) all references in this **Section III.C** to the APAD method (or any component of the APAD) shall refer to the APAD (or APAD component) as calculated utilizing the methodology that applies to the specific admission (1st RY19 Period method for admissions in the 1st RY19 Period, or 2nd RY19 Period method for admissions in the 2nd RY19 Period). The 1st RY19 Period Outlier Payment methodology is the same methodology that applied during the 2nd RY18 Period, effective March 1, 2018, under approved SPA TN-017-015, as amended by approved SPA TN 018-001.

1st RY19 Period (for admissions occurring in the 1st RY19 Period)	**2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)**
A Hospital will be paid a discharge-specific Outlier Payment for a discharge in addition to the APAD (see **Section III.B**., above) if all of the following conditions are met:	A Hospital will be paid a discharge-specific Outlier Payment for a discharge in addition to the APAD (see **Section III.B**., above) if all of the following conditions are met:

1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
1. the Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge; 2. the Hospital continues to fulfill its discharge planning duties as required in MassHealth's regulations; 3. the patient is not in a DMH-licensed bed on any part of the discharge; and 4. the patient is not a patient in an Excluded Unit within the Hospital. In cases where an Outlier Payment applies, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold. In such a case, the adjustment under **Section IV** for Potentially Preventable Readmissions (PPR), if applicable, is applied against the sum of the Pre-Adjusted APAD and the Outlier Payment.	1. the amount of the APAD for the discharge exceeds $0. 2. the Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge; 3. the patient is not in a DMH-licensed bed on any part of the discharge; and 4. the patient is not a patient in an Excluded Unit within the Hospital. In cases where an Outlier Payment applies, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold.

The following is an illustrative example of the calculation of the Total Case Payment for a claim that also involves an Outlier Payment. The example assumes the 2nd RY19 Period applies.

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Table 2: Claim with Outlier Payment - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	**Sample Hospital**		
DRG:	**203, Chest Pain. Severity of Illness (SOI) = 2.**		
Line	**Description**	**Value**	**Calculation or Source**
1	APAD (must be > $0)	$4,487.49	Table 1, Line 8, above
2	Allowed charges	$50,000.00	Determined from claim
3	Hospital's Inpatient Cost-to-Charge Ratio	72.00%	FY17 Massachusetts Hospital Cost Report
4	Discharge-Specific Case Cost	$36,000.00	Line 2 * Line 3
5	Fixed Outlier Threshold	$27,200	Section II Definition (2nd RY19 Period)
6	Discharge-Specific Outlier Threshold	$31,687.49	Line 1 + Line 5
7	Does Discharge-Specific Case Cost exceed Discharge-Specific Outlier Threshold?	TRUE	Is Line 4 > Line 6? If TRUE, then Outlier Payment is due
8	Marginal Cost Factor	50%	Determined annually
9	Outlier Payment	$2,156.26	(Line 4 - Line 6) * Line 8
10	**Total Case Payment = APAD plus Outlier Payment**	**$6,643.74**	Line 1 + Line 9

D. Transfer Per Diem Payments

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the Transfer Per Diem payment methodology. The Transfer Per Diem payment methodology is set forth in this **Section III.D**; provided that, (i) for admissions in the 1st RY19 Period, applicable definitions from **Section II** that apply to the 1st RY19 Period are incorporated; (ii) for admissions in the 2nd RY19 Period, applicable definitions from **Section II** that apply to the 2nd RY19 Period are incorporated; (iii) all references in this **Section III.D** to the APAD and Outlier Payment methodologies in **Sections III.B** and **III.C** shall refer to the methodology that applies to the specific admission (1st RY19 Period method for admissions in the 1st RY19 Period or 2nd RY19 Period method for admissions in the 2nd RY19 Period); and (iv) any other differences in the Transfer Per Diem methodology as between the 1st RY19 Period and the 2nd RY19 Period are as specified below. The 1st RY19 Period Transfer Per Diem payment methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

Hospitals will be paid a Transfer Per Diem under the circumstances specified in this section. In general, total payments made on a Transfer Per Diem basis are capped at the Hospital's Total Transfer Payment Cap.

The Transfer Per Diem rate is case-specific and is calculated as set forth in **Section III.D.1**, below.

1. Transfer between Hospitals

In general, a Hospital that transfers a patient to another Acute Hospital will be paid at the Transfer Per Diem rate, up to the Transferring Hospital's Total Transfer Payment Cap.

In general, the Hospital that is receiving the patient will be paid (a) on a per discharge basis in accordance with the APAD, and, if applicable, Outlier Payment methodology(ies) specified in **Sections III.B and III.C, above**, if the patient is actually discharged from that Hospital; or (b) on a Transfer Per Diem basis, capped at the Hospital's Total Transfer Payment Cap, if the Hospital transfers the patient to another Acute Hospital or back to the Acute Hospital from which it received the patient.

The Transfer Per diem rate will equal the following. For admissions in the 1st RY19 Period, the "1st RY19 Period" column applies. For admissions in the 2nd RY19 Period, the "2nd RY19 Period" column applies.

1st RY19 Period (for admissions occurring in the 1st RY19 Period)	**2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)**
The Transfer Per Diem rate equals the Transferring Hospital's Total Case Payment amount, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG Massachusetts-specific weight file applicable to the 1st RY19 Period. For purposes of this calculation, the Total Case Payment amount is calculated utilizing the APAD, and if applicable, Outlier Payment methodology(ies) set forth in **Section III.B.** and **III.C**., above, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis pursuant to this **Section III.D**. Payment on a Transfer Per Diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap.	The Transfer Per Diem rate equals the Transferring Hospital's Total Case Payment amount, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG Massachusetts-specific weight file applicable to the 2nd RY19 Period. For purposes of this calculation, the Total Case Payment amount is calculated utilizing the APAD, and if applicable, Outlier Payment methodology(ies) set forth in **Section III.B.** and **III.C**., above, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis pursuant to this **Section III.D**. Payment on a Transfer Per Diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap.

See **Table 3: Claim with Transfer (APAD only)** and **Table 4: Claim with Transfer (APAD and Outlier)**, respectively, below, for illustrative examples of the calculation of the Transfer Per Diem, Total Transfer Payment Cap, and corresponding Total Transfer Case Payment, that would apply to the case. These illustrative examples apply to all subsections of **Section III.D**, and assume that the 2nd RY19 Period applies.

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Table 3: Claim with Transfer (APAD only) - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	**Sample Hospital**		
DRG:	**203, Chest Pain. Severity of Illness (SOI) = 2.**		
Line	**Description**	**Value**	**Calculation or Source**
1	APAD (Total Case Payment Amount)	$4,487.49	Table 1, line 8, above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.08	Determined from Massach. weight file (2nd RY19 Period)
4	Transfer per diem	$2,161.35	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	$4,322.69	Line 4 * Line 2
6	Total Transfer Payment Cap	$4,487.49	Table 3, Line 1
7	**Total Transfer Case Payment**	**$4,322.69**	**Lower of Line 5 or Line 6**

Table 4: Claim with Transfer (APAD and Outlier) - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	**Sample Hospital**		
DRG:	**203, Chest Pain. Severity of Illness (SOI) = 2.**		
Line	**Description**	**Value**	**Calculation or Source**
1	Total Case Payment amount (Claim with Outlier Payment)	$6,643.74	Table 2, Line 10 above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.08	Determined from Massach. weight file (2nd RY19 Period)
4	Transfer per diem	$3,199.88	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	$6,399.76	Line 4 * Line 2
6	Total Transfer Payment Cap	$6,643.74	Table 4, Line 1
7	**Total Transfer Case Payment**	**$6,399.76**	**Lower of Line 5 or Line 6**

2. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be paid on a Transfer Per Diem basis, capped at the Hospital's Total Transfer Payment Cap. This section outlines payment under some specific transfer circumstances.

a. Transfer to/from a Non-Acute, Skilled Nursing, or other Separately Licensed Unit within the Same Hospital

If a patient is transferred from an acute bed to a Non-Acute bed (except for a DMH-licensed bed or any separately licensed unit in the same Hospital), the transfer is considered a discharge. EOHHS will pay the Hospital's discharge-specific APAD for the portion of the stay that preceded the patient's discharge to any such unit.

b. **MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment from the PCC Plan, Primary Care ACO, or Fee-for-Service to an MCO (or vice versa) during a Hospital Stay, or in the Event of Exhaustion of (or eligibility for) Other Insurance**

When a patient becomes MassHealth-eligible (or loses MassHealth eligibility), after the date of admission and prior to the date of discharge, changes enrollment from the PCC Plan, a Primary Care ACO, or Fee-for-Service to an MCO (or vice versa) during the course of a Hospital stay, or exhausts other insurance benefits (or becomes eligible for other insurance benefits) after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap, or if the patient is at the Administrative Day level of care, at the applicable AD per diem rate, in accordance with **Section III.G.**

c. **Admissions Following Outpatient Surgery or Procedure**

If a patient who requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure at the Hospital, the Hospital shall be paid at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap.

d. **Transfer between a DMH-licensed Bed and Any Other Bed within the Same Hospital**

Payment for a transfer between a DMH-licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, whether the Hospital is part of the BH network, and the type of service provided. See also **subsection e,** below.

When a Member who is not enrolled with the BH Contractor transfers between a DMH-licensed Bed and a non-DMH-licensed Bed in the same Hospital during a single admission, EOHHS will pay the Hospital at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap for the non-DMH-licensed bed portion of the stay, and on a Psychiatric Per Diem basis (see **Section III.E**, below) for the DMH-licensed bed portion of the stay.

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-licensed bed portion of the stay only if it is for medical (i.e., non-Behaviorial Health) treatment. In that case, such payment will be at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap.

e. **Change of BH Managed Care Status during a Behavioral Health Hospitalization**

When a Member is enrolled with the BH Contractor during a Behavioral Health admission, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor is payable by the BH Contractor. The portion of the Hospital stay

during which the Member was not enrolled with the BH Contractor will be paid by EOHHS on a Psychiatric Per Diem basis (see **Section III.E,** below) for Behavioral HealthServices in a DMH-licensed Bed, or at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-licensed Bed.

E. Payments for Behavioral Health Services (Psychiatric Per Diem)

1. Overview

a. Services provided to MassHealth Members in DMH-licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid on an all-inclusive Psychiatric Per Diem basis.

b. The statewide standard Psychiatric Per Diem rate is the sum of the three Psychiatric Per Diem Base Year Operating Standards (see **subsection 2**) and the Psychiatric Per Diem Base Year Capital Standard (see **subsection 3**), adjusted for the current Rate Year (see **subsection 4**).

c. Payment for Behavioral Health Services provided in beds that are not DMH-licensed Beds shall be made on a Transfer Per Diem basis, as described in **Section III.D**, above. See **Sections III.D.2.d and e** for payment rules involving transfers to and from DMH-licensed Beds and BH managed care status.

d. The Psychiatric Per Diem Base Year is RY04. MassHealth utilizes the costs, statistics, and revenue reported in the 2004 -403 cost reports as screened and updated as of March 10, 2006.

e. RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying this Psychiatric Per Diem payment methodology. Differences in the methodology and the final per diem rate that applies to dates of services in the 1st RY19 Period and the 2nd RY19 Period, respectively, are identified in **Section III.E.4**, below. The methodology is otherwise the same for both periods. The 1st RY19 Period methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

2. Determination of the Psychiatric Per Diem Base Year Operating Standards

a. **Standard for Inpatient Psychiatric Overhead Costs**

The Standard for Inpatient Psychiatric Overhead Costs is the median of the inpatient psychiatric overhead costs per day for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Overhead Costs is $363.28.

b. **Standard for Inpatient Psychiatric Direct Routine Costs**

The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the inpatient psychiatric direct routine costs per day (minus direct routine physician costs) for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Direct Routine Costs is $325.13.

c. **Standard for Inpatient Psychiatric Direct Ancillary Costs**

The Standard for Inpatient Psychiatric Direct Ancillary Costs is the median of the inpatient psychiatric direct ancillary costs per day for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Direct Ancillary Costs is $56.83.

3. Determination of the Psychiatric Per Diem Base Year Capital Standard

The Standard for Inpatient Psychiatric Capital Costs is the median of the inpatient psychiatric capital costs per day for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Capital Costs is $30.73.

a. Each Hospital's base year psychiatric capital cost per day equals the base year psychiatric capital cost divided by the greater of: the actual base year psychiatric days or eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.

b. Each Hospital's base year capital costs consist of the Hospital's actual Psychiatric Per Diem Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the Hospital's capital expenses.

4. Adjustment to Base Year Standards

In calculating the final statewide standard Psychiatric Per Diem rate applicable to dates of service in the 1st RY19 Period, the additional steps set forth in the "1st RY19 Period" column, below, are applied. In calculating the final statewide standard Psychiatric Per Diem rate applicable to dates of service in the 2nd RY19 Period, the additional steps set forth in the "2nd RY19 Period" column, below, are applied.

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The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see **Section II above).** The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see **Section II** above). The Inflation Factors for Operating Costs (see **Section II above**) between RY08 and RY10 and between RY12 and RY18 were then applied to the rate calculated above to determine the statewide standard Psychiatric Per Diem rate applicable to dates of service in the 1st RY19 Period. The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs for the 1st RY19 Period Psychiatric Per Diem is $145.02. The statewide standard Psychiatric Per Diem rate applicable to dates of service in the 1st RY19 Period is $920.99.	The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see **Section II above).** The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see **Section II** above). The Inflation Factors for Operating Costs (see **Section II above**) between RY08 and RY10 and between RY12 and RY19 were then applied to the rate calculated above to determine the statewide standard Psychiatric Per Diem rate applicable to dates of service in the 2nd RY19 Period. The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs for the 2nd RY19 Period Psychiatric Per Diem is $165.13. The statewide standard Psychiatric Per Diem rate applicable to dates of service in the 2nd RY19 Period is $941.10.

F. Physician Payment

1. For physician services provided by Hospital-Based Physicians to MassHealth patients, the Hospital will be paid for the professional component of Hospital-Based Physician services in accordance with Section 8.d. of Attachment 4.19-B of the State Plan.

2. Hospitals will be paid for Hospital-Based Physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service.

3. Physician services provided by residents and interns are not reimbursable separately. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in **Section II**.

4. Hospitals shall not be paid for inpatient physician services provided by Community-Based Physicians.

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G. Payments for Administrative Days

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the payment methodology for Administrative Days. The methodology in the "1st RY19 Period" column of this **Section III.G**, below, applies to dates of service in the 1st RY19 Period and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The methodology in the "2nd RY19 Period" column applies to dates of service in the 2nd RY19 Period and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. The 1st RY19 Period methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	**2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)**
1. Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.	1. Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.
2. The AD rate is a base per diem payment and an ancillary add-on.	2. The AD rate is a base per diem payment and an ancillary add-on.
3. The base per diem payment is $201.63, which represents the median nursing facility rate that was effective October 1, 2015 for all nursing home rate categories, as determined by EOHHS.	3. The base per diem payment is $201.63, which represents the median nursing facility rate that was effective October 1, 2015 for all nursing home rate categories, as determined by EOHHS.
4. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.	4. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.
5. These ratios are 0.278 and 0.382, respectively. The resulting AD rates were then updated by the Inflation Factor for Administrative Days between RY16 and RY18. The resulting AD rates for the 1st RY19 Period	5. These ratios are 0.278 and 0.382, respectively. The resulting AD rates were then updated by the Inflation Factor for Administrative Days between RY16 and RY19. The resulting AD rates for the 2nd RY19 Period

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)
are $268.61 for Medicaid/Medicare Part B eligible patients and $290.47 for Medicaid-only eligible patients. 6. The Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status.	are $274.47 for Medicaid/Medicare Part B eligible patients and $296.81 for Medicaid-only eligible patients. 6. The Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status.

H. Rehabilitation Unit Services in Acute Hospitals

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the Rehabilitation Unit per diem payment. The methodology in the "1st RY19 Period" column of this **Section III.H**, below, applies to dates of service in the 1st RY19 Period and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The methodology in the "2nd RY19 Period" column applies to dates of service in the 2nd RY19 Period and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. The 1st RY19 Period methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)
A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Rehabilitation Unit. For dates of service in the 1st RY19 Period, the per diem rate for such Rehabilitation Services will equal the median MassHealth RY18 Rehabilitation Hospital group per diem rate for Chronic Disease and Rehabilitation hospitals. Acute Hospital Administrative Day rates (see **Section III.G above**) will be paid for all days that a patient remains in the Rehabilitation Unit while not at hospital level of care.	A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Rehabilitation Unit. For dates of service in the 2nd RY19 Period, the per diem rate for such Rehabilitation Services will equal the median MassHealth RY19 Rehabilitation Hospital group per diem rate for Chronic Disease and Rehabilitation hospitals. Acute Hospital Administrative Day rates (see **Section III.G above**) will be paid for all days that a patient remains in the Rehabilitation Unit while not at hospital level of care.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

I. APAD Carve-Outs

1. Payment for LARC Device

A Hospital may be paid separate from the APAD for a LARC Device if the LARC procedure is performed immediately after labor and delivery during same inpatient hospital labor and delivery stay for clinically appropriate members. For qualifying discharge, Hospitals will be reimbursed for LARC Devices in accordance with Section 8.d. of Attachment 4.19-B of the State Plan.

2. Payment for APAD Carve-Out Drugs

Payment to Hospitals for APAD Carve-Out Drugs administered to Members during an inpatient admission will be the lowest of (1) the Hospital's Actual Acquisition Cost of the Drug; (2) the Wholesale Acquisition Cost (WAC) of the Drug; and (3) if available, the Medicare Part B rate for the Drug, each as determined by EOHHS.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

J. Payment for Unique Circumstances

1. High Public Payer Hospital Supplemental Payment

a. **Eligibility**

In order to qualify for this supplemental payment, a Hospital must have received greater than 63% of its Gross Patient Service Revenue (GPSR) in FY17 from government payers and uncompensated care as determined by the Hospital's FY17 Massachusetts Hospital Cost Report.

b. **Supplemental Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to qualifying Hospitals.

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of $6.5 million to qualifying hospitals on a pro rata basis according to each qualifying hospital's number of MCO, Primary Care ACO, and PCC Plan inpatient discharges in FY19, with each qualifying hospital's FY19 MCO and Primary Care ACO discharge volume weighted at 60% and each qualifying hospital's FY19 PCC Plan discharge volume weighted at 40%.

For purposes of this calculation, "MCO, Primary Care ACO, and PCC Plan inpatient discharges in FY19" refer to paid inpatient discharges from the qualifying hospital for MassHealth Members enrolled in an MCO, a Primary Care ACO, or the PCC Plan, as determined by EOHHS utilizing, for the MCO discharge volume, MCO encounter data submitted by each MCO for FY19 and residing in the MassHealth data warehouse as of March 31, 2020, and for the PCC Plan and Primary Care ACO discharge volume, Medicaid paid claims data for FY19 residing in MMIS as of March 31, 2020, for which MassHealth is primary payer. "MCO" for purposes of this **Section III.J.1** refers to all MCOs as defined in **Section II**, except Senior Care Organizations and One Care plans. Only MCO encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section III.J.1.a**) is considered in determining the pro rata share.

2. Essential MassHealth Hospitals

a. **Eligibility**

In order to qualify for payment as an Essential MassHealth Hospital, a Hospital must itself meet, or be within a system of Hospitals, any one of which meets, at least four of the following criteria, as determined by EOHHS, provided that all Hospitals within such system are owned or controlled, directly or indirectly, by a single entity that (i) was created by state legislation prior to 1999; and (ii) is mandated to pursue or further a public mission:

(1) The Hospital is a non-state-owned public Acute Hospital.

(2) The Hospital meets the current MassHealth definition of a non-profit teaching Hospital affiliated with a Commonwealth-owned medical school.

(3) The Hospital has at least 7% of its total patient days as Medicaid days.

(4) The Hospital is an acute care general Hospital located in Massachusetts which provides medical, surgical, emergency and obstetrical services.

(5) The Hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

Based on these criteria, Cambridge Health Alliance (CHA) and the UMass Memorial Health Care, Inc. Hospitals (UMass Hospitals) are the only Hospitals eligible for this payment.

b. **Supplemental Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, EOHHS will make a supplemental payment to Essential MassHealth Hospitals. This payment is based on approval by EOHHS of the Hospital's accurately submitted and certified EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report (UCCR) for the hospital fiscal year corresponding with the payment.

For the UMass Hospitals, the Federal Fiscal Year 2019 (FFY19) inpatient payment amount will be $6,000 times the total number of inpatient days for admissions beginning during FFY19, not to exceed $18.88 million. Notwithstanding such maximum inpatient amount, EOHHS may make inpatient payments to the UMass Hospitals of up to an additional 10% of the UMass Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, and satisfying all other conditions of this **Section III.J.2.b** as it applies to the UMass Hospitals, so long as the total FFY19 inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to the UMass Hospitals under this paragraph and under **Section III.F.2** of Attachment 4.19-B(1) (TN-018-018) do not, in the aggregate, exceed the UMass Total Maximum Essential Amount. The UMass Total Maximum Essential Amount is $26.696 million.

For CHA, the Federal Fiscal Year inpatient payment amount will be the difference between the non-state-owned public hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $7.5 million. Notwithstanding such maximum inpatient amount, EOHHS may make inpatient payments to CHA of up to an additional 10% of the CHA Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, and satisfying all other conditions of this **Section III.J.2.b** as it applies to CHA, so long as the total inpatient and outpatient Essential MassHealth Hospital

supplemental payment amounts to CHA for the Federal Fiscal Year under this paragraph and under **Section III.F.2** of Attachment 4.19-B(1) (TN-018-018) do not, in the aggregate, exceed the CHA Total Maximum Essential Amount. The CHA Total Maximum Essential Amount is $20.0 million.

The 10% provisions referenced above in this section may be invoked if, upon reconciliation, an applicable outpatient hospital limit would be exceeded if the UMass Hospitals or CHA (as applicable) were paid their maximum FFY19 outpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.F.2** of Attachment 4.19-B(1) (TN-018-018), or if the UMass Hospitals or CHA (as applicable) have insufficient outpatient utilization or otherwise to support the payment of such maximum outpatient payment amount.

Essential MassHealth Hospital payments will be made after EOHHS' receipt of the hospital's certified UCCR, finalization of payment data and applicable payment amounts, and receipt of any necessary approvals, but no later than 1 year after receipt of the hospital's final reconciliation UCCR (which must be submitted by 45 days after the Hospital's Medicare 2552 Report for the payment year has been finalized by Medicare's Fiscal Intermediary).

3. High Medicaid Volume Freestanding Pediatric Acute Hospitals

a. **Eligibility**

Based on the definition of High Medicaid Volume Freestanding Pediatric Acute Hospital as defined in **Section II**, Boston Children's Hospital is the only Hospital eligible for this payment.

b. **Supplemental Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to High Medicaid Volume Freestanding Pediatric Acute Hospitals to account for high Medicaid volume.

The supplemental payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the hospital Federal Fiscal Year. The Federal Fiscal Year payment is based on Medicaid payment and cost data. The payment equals the variance between the Hospital's inpatient Medicaid payments and inpatient Medicaid costs, not to exceed $3,850,000. High Medicaid Volume Freestanding Pediatric Acute Hospital payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

4. Acute Hospitals with High Medicaid Discharges

a. **Eligibility**

In order to qualify for payment as an Acute Hospital with High Medicaid Discharges, a Hospital must be an Acute Hospital that has more than 2.7% of the statewide share of Medicaid discharges, determined by dividing each Hospital's total Medicaid discharges as reported on the Hospital's Massachusetts Hospital Cost Report by the total statewide Medicaid discharges for all Hospitals.

b. **Supplemental Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Acute Hospitals that have higher Medicaid discharges when compared with other participating MassHealth Hospitals.

The payment amount is based on Medicaid payment, cost and charge data for the federal fiscal year. The payment equals the variance between the Hospital's inpatient Medicaid payment and inpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Interim payments to Acute Hospitals with High Medicaid Discharges will be reconciled within 12 months after final settlement of the applicable Health Safety Net year.

5. [Reserved]

6. [Reserved]

7. High Medicaid Volume Safety Net Hospital Supplemental Payment

a. **Eligibility**

In order to qualify for this payment, a Hospital must be a High Medicaid Volume Safety Net Hospital as defined in **Section II**, and must enter into a separate payment agreement with EOHHS relating to payment as a High Medicaid Volume Safety Net Hospital. Based on these criteria, Boston Medical Center is the only hospital eligible for this payment.

b. **Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, EOHHS will make a supplemental payment to High Medicaid Volume Safety Net Hospitals to account for high Medicaid volume. The payment amount will be based on Medicaid payment and charge data for the federal fiscal year. The payment will be an amount up to the variance between the Hospital's FY19 MMIS-based inpatient

hospital charges and its other inpatient hospital payments made under this Attachment for the applicable federal fiscal year, not to exceed $13.45 million.

8. Infant and Pediatric Outlier Payment Adjustments

a. **Infant Outlier Payment Adjustment**

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for inpatient services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay based on the prior year's claims data from the Medicaid Management Information System (MMIS).

i. Eligibility

In order to qualify for an infant outlier payment, a Hospital must provide services to infants less than one year of age, and must have one of the following during the Rate Year for individuals less than one year of age:

- An average Medicaid inpatient length of stay that equals or exceeds the statewide weighted average plus two standard deviations; or
- An average cost per inpatient Medicaid discharge that equals or exceeds the Hospital's average cost per Medicaid inpatient discharge plus two standard deviations for individuals of all ages.

ii. Payment to Hospitals

Annually, each Hospital that qualifies for an infant outlier adjustment receives an equal portion of $50,000. For example, if two Hospitals qualify for an outlier adjustment, then each Hospital receives $25,000.

b. **Pediatric Outlier Payment Adjustment**

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for inpatient services furnished to children greater than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay based on the prior year's discharge data from MMIS.

i. Eligibility

In order to qualify for a pediatric outlier payment, a Hospital must provide services to children greater than one year of age and less than six years of age, and must have one of the following during the Rate Year for individuals within this age range:

- An average Medicaid inpatient length of stay that equals or exceeds the statewide weighted average plus two standard deviations; or

- An average cost per inpatient Medicaid discharge that equals or exceeds the Hospital's average cost per Medicaid inpatient discharge plus two standard deviations for individuals of all ages.

ii. Payment to Hospitals

Annually, each Acute Hospital qualifying for a pediatric outlier adjustment will receive $1,000.

K. Pay-for-Performance (P4P) Payment

Pay-for-Performance (P4P) is MassHealth's method for quality scoring and converting quality scores to P4P payments contingent upon Hospital adherence to quality standards and achievement of performance thresholds and benchmarks. P4P incentive payments will be based on pay-for-performance (see **Section III.K.3**, below).

A Hospital will qualify to earn P4P payments if it meets data accuracy and completeness requirements, including data validation requirements where applicable, and achieves performance thresholds for the P4P measures listed below. Each measure is evaluated using the methods outlined below to produce measure rates or values which result in performance scores that are converted into incentive payments. A Hospital's performance scores are calculated as described in **Section III.K.3.c**, below.

The P4P program applies to inpatient services for MassHealth Members where Medicaid is the primary payer. In general, payment calculations are based on a combination of performance scores, which utilize all-Medicaid payer data for certain measures and all payer data for other measures, and the number of eligible discharges, which includes only individuals enrolled in the Primary Care Clinician (PCC) Plan or a Primary Care ACO, and members with fee-for-service coverage.

1. Performance Measures

Quality performance goals and measures focus on areas where improvement is likely to have most impact on the health outcomes for this Member population. The specific hospital quality performance measures for which RY19 P4P incentive payments will be based are identified in the following **Table K-1**, organized by Quality Measure Category, which may then be broken down further into Subcategories or Components.

Table K-1: Hospital Quality Performance Measures

Measure ID#	Measure Name	Quality Measure Category
	Obstetric/Neonate Clinical Process Measure Subcategory (2 measures)	Clinical Process
MAT-4	Cesarean Birth, NTSV	
NEWB-1	Exclusive breast milk feeding	
	Care Coordination Clinical Process Measure Subcategory (3 measures)	
CCM-1	Reconciled medication list received by discharged patient	
CCM-2	Transition record with specified data elements received by discharge patient	
CCM-3	Timely transmission of transition record within 48 hours at discharge	
HD-2	Health Disparities Composite	
PSI-90 HAI	**Component 1-** Patient Safety and Adverse Events Composite **Component 2-** Healthcare-Associated Infections *5 measures*: 1. Central Line-Associated Bloodstream Infection 2. Catheter-Associated Urinary Tract Infection 3. Methicillin-Resistant Staphylococcus Aureus bacteremia 4. Clostridium difficile infection 5. Surgical Site Infections (colon and abdominal hysterectomy surgeries)	Safety Outcomes
HCAHPS	Hospital Consumer Assessment of Healthcare Provider and Systems Survey (HCAHPS) *7 survey dimensions* (1. nurse communication, 2. doctor communication, 3. responsiveness of hospital staff, 4. communication about medicines, 5. discharge information, 6. overall rating, and 7. three-item care transition)	Patient Experience and Engagement

2. Data Accuracy and Completeness Requirements

a. Clinical Process Measure Category

The measures in the Clinical Process Measure Category include five individual clinical process measures, and one composite measure (HD-2). For RY19, the individual clinical process measures (MAT-4, NEWB-1, CCM-1, CCM-2 and CCM-3) are grouped into two Clinical Process Measure Subcategories as identified on **Table K-1:** (1) the "Obstetric / Neonate Clinical Process Measure Subcategory" - consisting of two measures MAT-4 and NEWB-1; and (2) the Care Coordination Clinical Process Measure Subcategory -

consisting of three measures CCM-1, CCM-2 and CCM-3. Hospitals collect and report all Medicaid payer data on the clinical process measures to EOHHS.

In order to ensure the accuracy and reliability of the submitted data, all reported clinical process measures are subject to data validation requirements. The submitted electronic data must meet a minimum reliability standard. The minimum reliability standard is defined as an 80 percent match for data elements. Hospitals are considered to have "passed" validation if the overall agreement rate of 80 percent has been met, based on the two quarters of CY2018 data (Q3-2018 and Q4-2018) required for performance evaluation.

b. Safety Outcomes Measure Category

The Safety Outcomes Measure Category consists of two components:

Component 1: *Patient Safety and Adverse Events Composite Measure (PSI-90)* -- The PSI-90 composite measure consists of ten (10) Agency for Healthcare Research and Quality (AHRQ) quality indicators (PSI-3, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14 and PSI-15) that represent potentially preventable complications and adverse events. This measure is claims-based and will be collected by EOHHS on all Medicaid payer data from MMIS and the MassHealth Data Warehouse. Data accuracy and completeness requirements apply.

Component 2: Healthcare-Associated Infections (HAI) Measures -- The five HAI measures listed in **Table K-1**, are reported by Hospitals to the National Healthcare Safety Network (NHSN) registry surveillance tracking system maintained by the Centers for Disease Control and Prevention (CDC). EOHHS will access the relevant information for these measures, which are based on all payer data, for each Hospital from the NHSN system for the relevant period. EOHHS will rely on data accuracy and completeness of the data as accessed from this system.

c. Patient Experience and Engagement Measure Category

The Patient Experience and Engagement Measure Category includes a modified Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure comprised of seven (7) national survey-based dimensions (see **Table K-1**, above) developed by AHRQ for CMS. Survey results are collected and submitted by Hospitals to CMS. EOHHS will collect the relevant archived data results for each Hospital, which are based on all payer data, from the CMS Hospital Compare website. EOHHS will rely on data accuracy and completeness of the data as set forth on the CMS Hospital Compare website.

3. <u>Payment Methodology</u>

P4P incentive payments will be based on pay-for-performance, and are available with respect to each **P4P Category** listed in **Table K-2** (see Section **III.K.3.b.i**, below). The term "P4P Category" or "P4P Categories" will refer to the P4P Category(s) listed in such Table K-2.

Formula: Incentive payments for each P4P Category are calculated by multiplying:

- the Hospital's eligible Medicaid discharges for the P4P Category, by
- the P4P Category per Discharge Amount, by
- the Total Performance Score for the P4P Category.

Incentive payments will be made as lump sum payments to eligible Hospitals, after finalization of the performance measure data and applicable payment amounts.

a. **Eligible Medicaid Discharges**

For purposes of this **Section III.K.3.a.,** "FY18 MMIS Discharge Data" refers to Hospital discharge data from MMIS paid claims for FY18 PCC Plan, Primary Care ACO and Fee-for-Service discharges, only, for which MassHealth is the primary payer.

Eligible Medicaid discharges are used to determine the volume of a Hospital's discharges that are included in the RY19 Pay-for-Performance payment calculations. The volume of eligible Medicaid discharges is determined as follows utilizing FY18 MMIS Discharge Data as the data source:

i. **Obstetric/Neonate Clinical Process Measure Subcategory and Care Coordination Clinical Process Measure Subcategory.** For the P4P Categories that are the two Clinical Process Measure Subcategories (i.e., the Obstetric/Neonate Clinical Process Measure Subcategory; and the Care Coordination Clinical Process Measure Subcategory), the eligible Medicaid discharges will be determined based on the number of Hospital discharges in the FY18 MMIS Discharge Data that meet the specific ICD requirements corresponding to the individual clinical process measures in that P4P Category. For certain individual clinical process measures (MAT-4 and NEWB-1), the ICD requirements are published in the *Specifications Manual for National Hospital Inpatient Quality Measures* (available at www.qualitynet.org), or the *Specifications Manual for the Joint Commission National Quality Measures* (available at https://manual.jointcommission.org/bin/view/Manual/WebHome). Specifications for the care coordination (CCM-1, CCM-2 and CCM-3) measures are available on the MassHealth Quality Exchange website at www.mass.gov/masshealth/massqex.

ii. **Health Disparities Composite Measure (HD-2).** For the P4P Category that is the Health Disparities Composite Measure (HD-2), the eligible Medicaid discharges will be determined based on the total number of "unique discharges" for the underlying individual clinical process measures considered as a whole, so that each unique discharge is only counted once. A unique discharge is a single paid claim from the FY18 MMIS Discharge Data for a Hospital discharge that meets the ICD population requirement for one or more of the underlying individual clinical process measures (MAT-4, NEWB-1, CCM-1, CCM-2 and CCM-3), and that meets the criteria for the HD-2 composite measure calculation.

iii. **Safety Outcomes Measure**. For the Safety Outcomes Measure (PSI-90 and HAI) P4P Category, the eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY18 MMIS Discharge Data that meet the medical and surgical All Payer Refined Diagnosis Related Group (APR-DRG) codes associated with the specified AHRQ clinical measure specification manuals.

iv. **Patient Experience and Engagement Measure:** For the Patient Experience and Engagement Measure (HCAHPS) P4P Category, the eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY18 MMIS Discharge Data that meet the specified medical, surgical, and cesarean All Payer Refined Diagnosis Related Group (APR-DRG) service line codes.

b. **P4P Category per Discharge Amount**

The P4P Category per Discharge Amount for each P4P Category will be determined by dividing the **maximum allocated amount** for the P4P Category by the **statewide eligible Medicaid discharges** for that P4P Category.

i. **Maximum Allocated Amount**

P4P incentive payments will cumulatively total no more than the maximum amount allotted for each P4P Category in the following table:

Table K-2: P4P Categories & Maximum Allocated Amounts

P4P Category	Maximum Allocated Amount
Obstetric/Neonate Clinical Process Measure Subcategory (MAT-4 and NEWB-1)	$ 5,500,000
Care Coordination Clinical Process Measure Subcategory (CCM-1, CCM-2, and CCM-3)	$ 7,000,000
Health Disparities Composite Measure (HD-2)	$ 1,500,000
Safety Outcomes Measure (PSI-90 and HAI)	$ 5,000,000
Patient Experience and Engagement Measure (HCAHPS)	$ 6,000,000
TOTAL	$25,000,000

ii. Statewide Eligible Medicaid Discharges

The statewide eligible Medicaid discharges for each P4P Category, are the sum of all eligible Medicaid discharges (see **Section III.K.3.a**, above) across all Hospitals for that category.

c. Total Performance Score

i. Obstetric/Neonatal Clinical Process Measure Subcategory (MAT-4 and NEWB-1) and **Care Coordination Clinical Process Measure Subcategory (CCM-1, CCM-2 and CCM-3)**

The Total Performance Score for each of these P4P Categories (Obstetric/Neonate Clinical Process Measure Subcategory; and Care Coordination Clinical Process Measure Subcategory) is a percentage of **quality points** awarded out of the total possible points for that P4P Category, based on the following formula:

(Total Awarded Quality Points / Total Possible Points) x 100% = Total Performance Score.

The quality points awarded for each individual clinical process measure in the relevant P4P Category is the higher of the **attainment** or the **improvement points** earned, and all quality points awarded for each individual clinical process measure in that P4P Category are then summed together to determine the total awarded quality points for the P4P Category.

Quality points are awarded for the individual clinical process measures based on each Hospital's performance during the Comparative Measurement Period relative to the attainment threshold (the median performance of all Hospitals in the Baseline Measurement Period) and the benchmark (the mean of the top decile of all Hospitals in the Baseline Measurement Period).

The **Comparative Measurement Period** and the **Baseline Measurement Period** for the individual clinical process measures are as follows:

	Comparative Measurement Period	Baseline Measurement Period
Individual Clinical Process Measures	7/1/2018 - 12/31/2018	CY 2017

Performance benchmarks for the individual clinical process measures are calculated based on Hospital data reported to MassHealth.

If the Hospital failed validation for a measure in the previous reporting year, data from that period is considered invalid for use in calculating year over year

performance. Therefore, the Hospital would not be eligible for improvement points. However, it may be eligible for attainment points in the current reporting year based on calculation of the current reporting year's data reported for the measure if it passed validation in the current year and if the hospital has passed validation and established a baseline rate for the measure in a prior year.

(A) Attainment Points

A Hospital can earn points for attainment based on relative placement between the attainment threshold and benchmark, as follows:

- if a Hospital's score for a measure is equal to or less than the attainment threshold, it will receive zero points for attainment,
- if a Hospital's score for a measure is greater than the attainment threshold but below the benchmark, it will receive 1-9 points for attainment, and
- if a Hospital's score for a measure is greater than or equal to the benchmark, it will receive the maximum 10 points for attainment.

(B) Improvement Points

The Hospital can earn points for improvement based on how much its performance score on the measure has improved from the Baseline Measurement Period as follows:

- if a Hospital's score for a measure is less than or equal to its score for the Baseline Measurement Period, it will receive zero (0) points for improvement.
- if a Hospital's score for a measure is greater than its score for the Baseline Measurement Period, it will receive 0-9 points for improvement.

(C) Example

The following is an example pay-for-performance calculation for the P4P Category that is the Obstetric/Neonatal Clinical Process Measure Subcategory, provided for illustrative purposes only.

Example for P4P Category: Obstretric / Neonatal Clinical Process Measure Subcategory

Statewide calculations	
Maximum allocated amount	$5,500,000
Statewide eligible Medicaid discharges	13,551
P4P Category per Discharge Amount	$5,500,000/13,551 = $406
Hospital-specific calculations	
Hospital's awarded quality points for the P4P Category (sum of the measure-specific attainment or improvement points corresponding to the P4P Category)	32
Maximum possible P4P Category quality points	40
Total Performance Score for P4P Category	(32 points / 40 points) x 100% = 80%
Eligible Medicaid discharges	500
Hospital-specific total incentive payment for the P4P Category	**500 x $406 x 80% = $162,400**

ii. **Health Disparities Composite Measure (HD-2)**

For each Hospital, the Health Disparities Composite Measure (HD-2) is comprised of aggregate data from all of the individual clinical process measures (i.e., MAT-4, NEWB-1, CCM-1, CCM-2 and CCM-3) on which the Hospital reports. The Hospital's composite measure compares the Hospital's performance among race/ethnicity groups and all groups combined, and is converted to a disparity composite value. The composite measure and disparity composite value are calculated only for Hospitals that report on more than one racial group in their electronic data files.

(A) Performance Assessment

Performance for the Health Disparities Composite Measure (HD-2) will be assessed using the following methodology.

1. Decile Rank Method. Disparity composite values are calculated for Hospitals that meet the measure calculation criteria. Performance will be assessed using a method that determines the Hospital's rank, relative to other Hospitals, based on the decile ranking system.

2. Disparity Composite Value Ranking. All Hospital disparity composite values are rounded to six decimal places. All composite values are then divided into ten equal groups and ranked from highest to lowest so approximately the same number of Hospitals falls in each decile group.

3. Target Attainment Threshold. The target attainment threshold represents the minimum level of performance that must be achieved to earn incentive

payments. The target attainment is defined as the boundary for a disparity composite value that falls above the 2nd decile group, as shown in the "Decile Performance Thresholds" table below.

4. Conversion Factor. Each decile group is assigned a weighted conversion factor associated with the decile threshold, as shown in the table below:

Decile Group Thresholds

Performance Threshold	Decile Group	Conversion Factor
Top Decile	10th decile	1.0
	9th decile	.90
	8th decile	.80
	7th decile	.70
	6th decile	.60
	5th decile	.50
	4th decile	.40
Target Attainment	3rd decile	.30
Lower Deciles	2nd decile	(zero)
	1st decile	(zero)

To meet the target attainment threshold, the Hospital's disparity composite value must exceed the value above the 2nd decile cut-off point to fall in the next decile. Disparity composite values that fall into the 1st and 2nd decile group are assigned a conversion factor of zero. All disparity composite values that fall within the same given decile group are assigned the same conversion factor.

(B) Total Performance Score for Health Disparities Composite Measure (HD-2)**.**

A Hospital's Total Performance Score for the Health Disparities Composite (HD-2) Measure P4P Category is the assigned conversion factor as shown in the Decile Group Thresholds table, above, multiplied by 100%. Performance scores are calculated only for Hospitals that meet the measure calculation criteria and validation requirements, using only the Hospital's current year reported data for the period July 1, 2018 through December 31, 2018.

iii. Safety Outcomes Measure (PSI-90 and HAI)

For the Safety Outcomes Measure, each Hospital will be evaluated using both the Hospital's PSI-90 composite value and the Hospital's SIR output values for each of the five HAI measures, as applicable.

Component 1: The PSI-90 composite value is calculated as a weighted average of the risk-adjusted and reliability adjusted rates for the ten AHRQ quality indicators, combined, for the Hospital. The relevant evaluation period is discharges in the 24 month period from October 1, 2013 through September 30, 2015. If a Hospital has

fewer than 3 eligible discharges for the ten indicators combined, a PSI-90 composite value will not be calculated.

Component 2 -- For each of the five HAI measures, EOHHS will obtain the Hospital's standard infection ratio (SIR) output value for each measure, as calculated by the CDC, from the NHSN system. The relevant evaluation period is the 24 month period of January 1, 2015 through December 31, 2016. The Hospital will not have a SIR output value for an HAI measure(s) if the CDC was unable to calculate a SIR output value for the Hospital for that HAI measure based on its criteria.

(A) Winsorization Method

Each Hospital's performance will be assessed in comparison to all eligible Hospital's values for the PSI-90 composite and each of the HAI measures using a Winsorization method, which transforms each Hospital's measure values into a standardized score. The Winsorization method evaluates performance using the defined period(s) only and does not use comparison year data.

1. A Winsorized measure result is obtained by creating a continuous rank distribution of all eligible Hospitals' measure values, and truncating the outliers to determine the relative position of where each measure value falls in the distribution. This Winsorization process is performed separately with respect to each measure (i.e., for the PSI-90 composite measure value and for each SIR output value for the HAI measures).

   i. If *the Hospital's measure value* falls between the minimum and the 5th percentile, then *the Hospital's Winsorized measure result* is equal to the measure value that corresponds to the 5th percentile.
   ii. If the Hospital's measure value falls between the 95th percentile and the maximum, then *the Hospital's Winsorized measure result* is equal to the measure value that corresponds to the 95th percentile.
   iii. If the Hospital's measure value falls between the 5th and 95th percentiles, then *the Hospital's Winsorized measure result* is equal to the Hospital's measure value.

2. A Winsor Z-score will be calculated for each Hospital for each measure; it is the difference between a Hospital's Winsorized measure result from #1 above and the mean of the Winsorized measure results across all eligible hospitals, which difference is divided by the standard deviation of the Winsorized measure results from all eligible Hospitals' data.

The Hospital's **Overall Safety Outcomes Measure score** is calculated as the weighted average of the Hospital's Winsor z-score for Component 1 (PSI-90) and the Hospital's z-score for Component 2 (HAI), which contribute 60% and 40%, respectively, unless the Hospital has a score for only one of the two

components, in which case that one component contributes 100% to the Hospital's Overall Safety Outcomes Measure score. The Hospital's z-score for Component 2 (HAI) is equal to the average of the Hospital's five HAI Winsor z-scores; if the Hospital has Winsor z-scores for less than the five HAI measures, then the average is computed based on the number of HAI measures that do have a Winsor z-score.

(B) Setting Performance Thresholds

The Hospital's Overall Safety Outcomes Measure score will be assessed using the methods described below.

1. *Interquartile Rank Method*. Performance will be assessed using a method that determines the Hospital's rank with respect to its Overall Safety Outcomes Measure score, relative to other Hospitals, and divides the ranked results into four approximately equal quartile groups. The Hospitals' Overall Safety Outcomes Measure scores are rounded to eight decimal points and ranked highest (worse) to lowest (best) in performance.

2. *Minimum Attainment Threshold*. The minimum attainment threshold represents the minimum level of performance that must be attained to earn incentive payments. Subject to the exception for RY19 specified below, the minimum attainment threshold is defined as the boundary for the Overall Safety Outcomes Measure score that falls above the 1st quartile group, as shown in the "Quartile Group Thresholds" table, below.

3. *Conversion Factor*. Each quartile group is assigned a conversion factor as shown in the table below:

Quartile Group Thresholds

Performance Threshold	Quartile Group	Conversion Factor
Top Quartile (Lowest score)	4th quartile	1.0
	3th quartile	.75
Target Attainment	2nd quartile	.50
Lowest Quartile (Highest score)	1st quartile	(zero)*

All Overall Safety Outcome Measure scores that fall within the same quartile group are assigned the same conversion factor.

*For RY19 only, the minimum attainment threshold will not apply, and Hospital Overall Safety Outcome Measure scores falling within the 1st quartile will be assigned a weight of .25 instead of zero.

(C) Total Performance Score for Safety Outcomes Measure (PSI-90 and HAI).

A Hospital's Total Performance Score for the Safety Outcomes Measure (PSI-90 and HAI) P4P Category is the assigned conversion factor as shown in the Quartile Group Thresholds table, above, multiplied by 100%. As noted, for RY19, the conversion factor that applies to the Lowest Quartile will be .25 instead of zero for purposes of this calculation.

iv. Patient Experience and Engagement Measure (HCAHPS)

EOHHS will obtain the Hospitals' archived HCAHPS measure "top box" results corresponding to the relevant periods directly from the CMS Hospital Compare Website for each of the seven survey dimensions in the Patient Engagement and Experience Measure (HCAHPS) category. The "top box" results reflect the percentage of a Hospital's patients who chose the most positive (top box) response to a survey item, as adjusted and calculated by CMS. If CMS was not able to calculate results for a Hospital due to insufficient volume of completed surveys, the Hospital will not receive performance scores or incentive payments for this P4P Category.

The **Total Performance Score** for the Patient Experience and Engagement (HCAHPS) Measure P4P Category is a percentage of **quality points** awarded out of the total possible points for the P4P Category, based on the following formula:

(Total Awarded Quality Points / Total Possible Points) x 100% = Total Performance Score.

The quality points awarded for each survey dimension in the HCAHPS measure is the higher of the **attainment** or the **improvement points** earned for that dimension. The quality points awarded for the seven survey dimensions, as applicable, are then summed together to determine the total awarded quality points for the P4P Category.

Quality points are awarded for the seven survey dimensions based on each Hospital's performance during the Comparison Year Period relative to the attainment threshold (the median performance of all Hospitals in the Prior Year Period) and the benchmark (the mean of the top decile of all Hospitals in the Prior Year Period).

The **Comparison Year Period** and the **Prior Year Period** are as follows:

	Comparison Year Period	Prior Year Period
Patient Experience and Engagement (HCAHPS) Measure	CY 2017	CY 2016

All attainment and improvement points earned on each survey dimension will be calculated using the same formulas for calculating attainment points and improvement

points as described in **Section III.K.3.c.i.(A) and (B)**. For these calculations, the "Baseline Measurement Period" refers instead to the "Prior Year Period" referenced above.

Attainment and benchmark performance thresholds on the HCAHPS survey dimensions are calculated using HCAHPS state-level data obtained from the CMS Hospital Compare website corresponding to the Prior Year Period for this measure.

Attainment and improvement points cannot be calculated and, if applicable, awarded to a Hospital unless it has previously established a baseline rate for each survey dimension, based on evidence from data files downloaded by EOHHS from the CMS Hospital Compare website

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IV. Potentially Preventable Readmissions (PPRs) *(1st RY19 Period Only)*

The Potentially Preventable Readmission (PPR) adjustment (if applicable) described in this **Section IV** that is incorporated into the 1st RY19 Period APAD, Outlier Payment and Transfer Per Diem payment methodologies set forth in **Sections III.B** through **III.D**, above, applies solely to the 1st RY19 Period, and does not apply to the 2nd RY19 Period. The PPR methodology set forth below applies when the 1st RY19 Period APAD, Outlier Payment or Transfer Per Diem payment methodology(ies) apply. The 1st RY19 Period PPR methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

Hospitals with a greater number of Actual Potentially Preventable Readmission (PPR) Chains than Expected PPR Chains, based on data specified in **Section IV.B**, below, will be subject to a percentage payment reduction per discharge calculated using the methodology described below. This reduction will be applied to Hospitals identified using the methodology described below.

A. Definitions

Actual PPR Chains: The actual number of PPR Chains for a specific Hospital.

Actual PPR Volume: The number of Actual PPR Chains for the time period.

Actual PPR Rate: The number of Initial Admissions with one or more qualifying Clinically Related PPRs within a 30-day period divided by the total number of At-risk Admissions.

APR-DRG: The All Patient Refined-Diagnostic Related Group and Severity of Illness (SOI) combination assigned using the 3M PPR Grouper, version 33.

At-risk Admissions: The number of Total Admissions considered at risk for readmission, as determined by the 3M PPR methodology, excluding mental health and substance abuse primary diagnoses.

Clinically Related: A requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior Hospital admission.

Expected PPR Chains: The number of PPR Chains a Hospital, given its mix of patients as defined by APR-DRG category, would have experienced had its rate of PPRs been identical to that experienced by a reference or normative set of Hospitals.

Expected PPR Rate: The number of Expected PPR Chains divided by the total number of At-risk Admissions. The expected rate for each APR-DRG is the statewide average Actual PPR Rate for that APR-DRG.

Excess PPR Volume: The number of Actual PPR Chains above the number of Expected PPR Chains, as calculated by the 3M PPR methodology, for a specific Hospital. For a Hospital for which

the number of Actual PPR Chains is equal to or less than the number of Expected PPR Chains, there is no Excess PPR Volume.

Hospital Discharge Volume: The number of Hospital discharges in FY16 for which an APAD was paid, as determined by EOHHS based on claims in MMIS as of June 7, 2017 and for which MassHealth is the primary payer.

Initial Admission: An admission that is followed by a Clinically Related readmission within a specified readmission time interval. Subsequent readmissions relate back to the care rendered during or following the Initial Admission. The Initial Admission initiates a PPR Chain.

Potentially Preventable Readmission (PPR): A readmission chain (return hospitalization within the specified readmission time interval) that is Clinically Related to the Initial Admission.

PPR Chain: A PPR or a sequence of PPRs. A PPR Chain can extend beyond 30 days, as long as the time between each discharge and subsequent readmission is within the 30-day time frame. Therefore, if Patient X is admitted on October 4th, readmitted on October 20th, and readmitted again on November 18th, that sequence is calculated as one (1) PPR Chain.

Readmission: A return hospitalization to an acute care Hospital that follows a prior Initial Admission from an acute care Hospital. Intervening admissions to non-acute care facilities are not considered readmissions. A readmission may be to an in-state or out-of-state acute care Hospital.

Total Admissions: The total number of Medicaid Fee For Service/PCC Plan admissions for the time period.

B. Determination of Readmission Rates and Volumes

PPRs are identified in adjudicated and paid inpatient Hospital claims residing in MMIS as of June 7, 2017, for which MassHealth is the primary payer, by using the 3M PPR software version 33. The time period for identifying Total and At-risk Admissions was from October 1, 2015 to August 31, 2016, based on date of discharge. The time period for identifying PPRs associated with these At-risk Admissions was from October 1, 2015 to September 30, 2016 based on date of admission.

1. Statewide Average PPR Rate

The statewide average Actual PPR Rate for each APR-DRG is calculated and represents the PPR benchmark for that APR-DRG.

2. Hospital-specific Actual PPR Volume

Each Hospital's Actual PPR Volume is the number of PPR Chains in the specified time period.

3. Hospital-specific Expected PPR Volume

In order to derive the Hospital-specific Expected PPR Volume, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions by APR-DRG for the time period specified above and summed across all of the Hospital's APR-DRGs.

The Expected PPR Volume therefore reflects how a given Hospital should have performed on each APR-DRG recorded in their MMIS claims, as specified in **Section IV.B.**

4. Hospital-specific Excess PPR Volume

The Hospital-specific Excess PPR Volume is calculated as the number of Actual PPR Chains in excess of the number of Expected PPR Chains, as calculated by the 3M PPR methodology, for a specific Hospital. For a Hospital for which the number of Actual PPR Chains is equal to or less than the number of Expected PPR Chains, there is no Excess PPR Volume.

5. Hospital-specific Actual PPR Rate

Each Hospital's Actual PPR Rate is derived by dividing the number of Actual PPR Chains in the specified time period by the total number of At-risk Admissions.

6. Hospital-specific Expected PPR Rate

In order to derive the Hospital-specific Expected PPR Rate, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions by APR-DRG casemix. The Expected PPR Rate is therefore risk-adjusted and reflects how a given Hospital should have performed on each APR-DRG for the time period specified above.

7. Hospital-specific Actual-to-Expected (A:E) PPR Ratio

Each Hospital's Actual-to-Expected (A:E) ratio is calculated as:

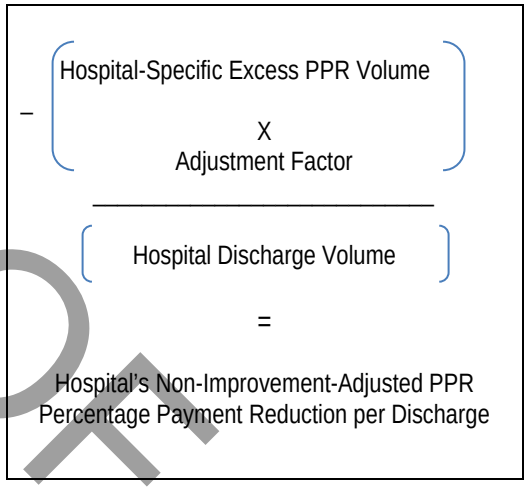
$$\frac{\text{Actual PPR Rate}}{\text{Expected PPR Rate}}$$

C. Calculation of PPR Percentage Payment Reduction Per Discharge

1. General Initial Calculation

Hospitals with Excess PPR Volume are subject to a PPR Percentage Payment Reduction per Discharge, applied as set forth in **Section IV.F**, below. Only Hospitals with more than 40 At-Risk Admissions are subject to a PPR Percentage Payment Reduction per Discharge, if applicable.

Each Hospital's PPR Percentage Payment Reduction per Discharge will initially be calculated as follows:



The result will be reflected as a negative value. The negative value illustrates this is a rate reduction.

The "Adjustment Factor" is 3 and is a multiplier intended to provide incentive for Hospitals to identify and implement methods to reduce PPRs.

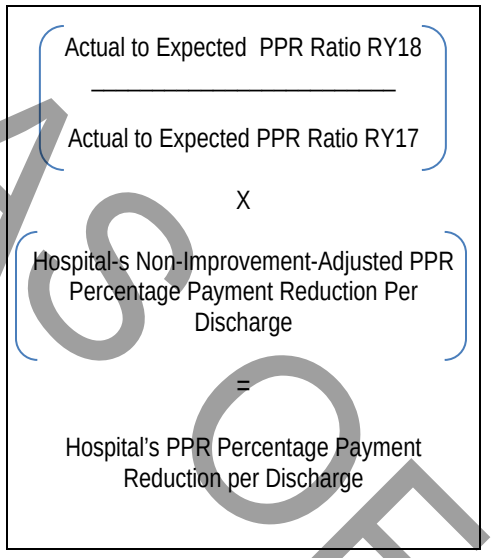
The remainder of the calculation depends on whether a Hospital qualifies for an Improvement Adjustment in accordance with **Section IV.D** below.

2. Hospitals not Qualifying for Improvement Adjustment

A Hospital with Excess PPR Volume that does not qualify for an Improvement Adjustment in accordance with **Section IV.D** below, will be subject to a "PPR Percentage Payment Reduction per Discharge" equal to the amount calculated as the Hospital's Non-Improvement-Adjusted PPR Payment Reduction per Discharge under **Section IV.C.1** above.

3. Hospitals Qualifying for Improvement Adjustment

A Hospital with Excess PPR Volume that qualifies for an Improvement Adjustment in accordance with **Section IV.D**, below, will be subject to a "PPR Percentage Payment Reduction per Discharge" that is calculated as follows:



The result will be reflected as a negative value. The negative value illustrates that this is a rate reduction.

D. Improvement Adjustment

If a Hospital has Excess PPR Volume for RY18 but has achieved an improvement as indicated by a decrease to its Actual-to-Expected PPR Ratio for RY18 compared to RY17, EOHHS shall adjust downward the PPR Percentage Payment Reduction per Discharge that the Hospital would otherwise receive. This "Improvement Adjustment" is calculated by applying the percent decrease in the Hospital's RY18 Actual-to-Expected PPR Ratio from RY17 to the Hospital's Non-Improvement Adjusted PPR Percentage Payment Reduction per Discharge. For example, if a Hospital had a RY17 Actual-to-Expected PPR Ratio of 1.30 and a RY18 Actual-to-Expected PPR Ratio of 1.17, which is a decrease of 10%, and a RY18 Non-Improvement Adjusted PPR Percentage Payment Reduction of -3%, its RY18 PPR Percentage Payment Reduction per Discharge would be adjusted as follows:

Hospital's PPR Percentage Payment Reduction per Discharge =

1.17 / 1.30 x -3% = 90% x -3% = -2.7% per Discharge.

The negative value illustrates this is a rate reduction.

E. Maximum per-Discharge Adjustment

Notwithstanding **Sections IV.C** and **IV.D**, a Hospital's PPR Percentage Payment Reduction per Discharge due to the Hospital's Excess PPR Volume is capped at -4.4%.

F. Application of PPR Percentage Payment Reduction per Discharge

The Hospital's PPR Percentage Payment Reduction per Discharge for the 1st RY19 Period is applied against the sum of the Pre-Adjusted APAD and Outlier Payment for discharges that qualify for an Outlier Payment under the 1st RY19 Period methodology (see **Section III.C**). It is applied against the Pre-Adjusted APAD for discharges that are paid under the 1st RY19 Period methodology and which do not qualify for an Outlier Payment (see **Section III.B**). These reductions apply when calculating the Transfer Per Diem rate, and when capping the Transfer Per Diem at the Total Transfer Payment Cap under **Section III.D**, as applicable to the 1st RY19 Period. As noted, this **Section IV** does not apply in calculating the 2nd RY19 Period APAD, Outlier Payment or Transfer Per Diem rates.

V. 30-Day Readmissions Policy *(2nd RY19 Period only)*

After a transitional period of not less than six months after the start of the 2nd RY19 Period, with the exception of certain exempt readmissions, MassHealth will deem claims to be non-payable for MassHealth Member readmissions to an in-state Acute Hospital occurring within 30 days of the date of discharge from an index admission to the same Acute Hospital for which MassHealth determines, after clinical review, are both clinically related to an index admission within a readmission chain and potentially preventable. This **Section V** does not apply to the 1st RY19 Period.

VI. Other Provisions

A. Federal Limits

If any portion of the reimbursement methodology is not approved by CMS or is in excess of applicable federal limits, EOHHS may recoup or offset against future payments, any payment made to a Hospital in excess of the approved methodology. Any such recovery shall be proportionately allocated among affected Hospitals.

B. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital RFA and Contract in effect on that date.

C. [Reserved]

D. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital during the effective period of the state plan, EOHHS, in its sole discretion, shall determine, on a case-by-case basis (1) whether the Hospital qualifies for payment under the state plan, and, if so, (2) the appropriate rates of payment. Such rates of payment shall be determined in accordance with the provisions of the state plan to the extent EOHHS deems possible. EOHHS's determination shall

be based on the totality of the circumstances. Any such rate may, in EOHHS's sole discretion, affect computation of the statewide average or statewide standard payment amount and/or any efficiency standard.

E. Data Sources

When groupers used in the calculation of the APAD and per diem rates are changed and modernized, it may be necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" has been a feature of the Medicare Diagnosis-Related Group (DRG) program since its inception. EOHHS reserves the right to update to a new grouper.

If data sources specified in this Attachment are not available, or if other factors do not permit precise conformity with the provisions of this Attachment, EOHHS shall select such substitute data sources or other methodology(ies) that EOHHS deems appropriate in determining Hospitals' rates.

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VII. Provider Preventable Conditions

Citation

Payment Adjustment for Provider Preventable Conditions

42 CFR 447,434,438 and 1902(a) (4), 1902 (a) (6) and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902 (a) (4), 1902 (a) (6) and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health-Care Acquired Conditions for non-payment under Attachment 4.19-A(1), (Acute Inpatient Hospital Services) under this State plan.

☒ Hospital Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-A(1), (Acute Inpatient Hospital Services) under this State plan.

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒ Additional Other Provider-Preventable Conditions identified below.

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-

risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low-risk delivery.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen,
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reduction in provider payment may be limited to the extent that the following apply: (i) the identified provider preventable conditions would otherwise result in an increase in payment; (ii) the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs") listed above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above.

When a Hospital reports a PPC that the Hospital indicates was not present on admission, MassHealth will reduce payments to the Hospital as follows:

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1. APAD, Outlier Payment, and Transfer per diem payments:
    a. MassHealth will not pay the APAD, Outlier Payment, or Transfer per diem payment if the Hospital reports that only PPC-related services were delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
    b. MassHealth will pay the APAD, Outlier Payment, or Transfer per diem payment, in each case as adjusted to exclude PPC-related costs or services, if the Hospital reports that non-PPC related services were also delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Psychiatric, Rehabilitation, or Administrative Day Per Diem payments:
    a. MassHealth will not pay the per diem if the Hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
    b. MassHealth will pay the per diem if the Hospital reports that non-PPC related services were also delivered on that day, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

3. Inpatient Hospital payments for Hospital-Based Physician Services: MassHealth will not pay for inpatient Hospital-based physician services reported as PPC-related services.

4. Follow-up Care in Same Hospital: If a hospital reports that it provided follow-up inpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the Hospital reports that non-PPC-related services were provided during the follow-up stay, payment will be made, but adjusted in the case of APAD, Outlier payment, or Transfer per diem payments to exclude the PPC-related costs or services, and MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for service, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursement according to the methodology above.

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VIII. Serious Reportable Events

The non-payment provisions set forth in this Section VIII apply to the following serious reportable events (SREs):

1. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances
3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient/resident of any age.
5. Sexual abuse/assault on a patient or staff member within or on the grounds of the healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital and Hospital-Based Physician services include:

1. All services provided during the inpatient admission during which a preventable SRE occurred; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

    a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

    b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

The non-payment provision also applies to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital and Hospital-Based Physician services provided to the patient following a preventable SRE.

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Exhibit 1: RY19 Payment Method for Critical Access Hospitals Effective October 1, 2018 through September 30, 2019

EXHIBIT 1
Rate Year 2019 Payment Method Applicable to Critical Access Hospitals Effective October 1, 2018 through September 30, 2019

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY19 (October 1, 2018 through September 30, 2019).

Section II. Payment Method - General

EOHHS will pay Critical Access Hospitals an amount equal to 101 percent of the Hospital's allowable costs as determined by EOHHS utilizing the Medicare cost-based reimbursement methodology for the hospital's state plan services in RY19 (October 1, 2018 through September 30, 2019), as more fully described below. Interim payments will be made to Critical Access Hospitals based on the rates and methods set forth in this **Exhibit 1**, which payments are provisional in nature and subject to the completion of a cost review and settlement for the time period beginning October 1, 2018 through September 30, 2019, as described in **Section II(B)** of this **Exhibit 1**, below. Subject to this **Exhibit 1**, **Attachment 4.19-A(1)** otherwise applies to Critical Access Hospitals. If a Hospital loses its designation as a Critical Access Hospital, the payment methods for such hospital shall revert to the standard acute hospital rate methodologies, and payments may be adjusted accordingly. Reversion to any such rate methodologies shall not affect the payment rates to other participating acute hospitals for the applicable rate year.

(A) Payment for Inpatient Services

For inpatient admissions occurring in RY19, Critical Access Hospitals (CAHs) will be paid for Inpatient Services in accordance with **Attachment 4.19-A(1)** with the following changes.

Critical Access Hospitals will be paid an Adjudicated Payment Amount per Discharge (APAD) for those Inpatient Services for which all other in-state acute hospitals are paid an APAD.

Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring in the 1st RY19 Period, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY16 cost and discharge data:

(1) EOHHS calculated a cost per discharge for inpatient services for each Critical Access Hospital, which was determined by dividing the amount reported on worksheet E-3, part VII, column 1, line 21, of the Hospital's FY16 CMS-2552-10 cost report, by the Hospital's number of FY16 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY16 paid claims data residing in MMIS as of May 23, 2017 for which MassHealth is the primary payer.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services
Exhibit 1: RY19 Payment Method for Critical Access Hospitals Effective
October 1, 2018 through September 30, 2019

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY16 and RY18, resulting in the 1st RY19 Period cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's 1st RY19 Period cost per discharge, as determined above, by each Hospital's FY16 inpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 1st RY19 Period CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the APAD Base Payment used in the APAD calculations for all other Hospitals for admissions in the 1st RY19 Period.

(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the 1st RY19 Period CAH-Specific Total Standard Rate per Discharge by the applicable 1st RY19 Period discharge-specific MassHealth DRG Weight.

(6) Critical Access Hospitals will not be subject to any adjustment under **Section IV** of **Attachment 4.19-A(1)**.

Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring in the 2nd RY19 Period, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY17 cost and discharge data:

(1) EOHHS calculated a cost per discharge for inpatient services for each Critical Access Hospital, which was determined by dividing the amount reported on worksheet E-3, part VII, column 1, line 21, of the Hospital's FY17 CMS-2552-10 cost report, by the Hospital's number of FY17 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY17 paid claims data residing in MMIS as of March 21, 2018, for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY17 and RY19, resulting in the inflation-adjusted 2nd RY19 Period cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's 2nd RY19 Period inflation-adjusted cost per discharge, as determined above, by each Hospital's FY17 inpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 2nd RY19 Period CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the APAD Base Payment used in the APAD calculations for all other Hospitals for admissions in the 2nd RY19 Period.

(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the 2nd RY19 Period CAH-Specific Total Standard Rate per Discharge by the applicable 2nd RY19 Period discharge-specific MassHealth DRG Weight.

The following is an illustrative example of the calculation of the Total Case Payment for a CAH's standard APAD claim that does not also qualify for an Outlier Payment. This example assumes the 2nd RY19 Period applies.

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Table 5: Critical Access Hospital Interim APAD claim - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	**Sample Critical Access Hospital**		
DRG:	**203, Chest Pain. Severity of Illness (SOI) = 2.**		
Line	**Description**	**Value**	**Calculation or Source**
1	2nd RY19 Period CAH-Specific Total Standard Rate per Discharge	$14,543.22	Exhibit 1 to Attachment 4.19-A(1)
2	MassHealth DRG Weight	0.3598	Determined based on claim information
3	Total Case Payment = Adjudicated Payment Amount per Discharge (Interim APAD)	$5,232.65	Line 1 * Line 2

Outlier Payments and Transfer Per Diem rates for Critical Access Hospitals are calculated and paid as described in **Sections III.C and III.D of Attachment 4.19-A(1),** respectively, except that the APAD used for purposes of those calculations is the CAH's APAD as calculated as set forth in **Section II.A of Exhibit 1**, above, utilizing the appropriate methodology that applies to the admission (1st RY19 Period or 2nd RY19 Period, as applicable), and that **Section IV** of **Attachment 4.19-A(1)** does not apply to CAHs.

(B) Post RY19 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2019 review to determine whether the Critical Access Hospital received aggregate interim payments in an amount equal to 101% of allowable costs utilizing the Medicare cost-based reimbursement methodology for the hospital's state plan services for FY19 as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY19 CMS-2552-10 cost reports (including completed Medicaid (Title XIX) data worksheets) and such other information that EOHHS determines is necessary, to perform this post RY19 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for FY19, but excluding, if applicable, any state plan payments to a Critical Access Hospital under Section III.K of Attachment 4.19-A(1), and any supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in Section III.J.1 of Attachment 4.19-A(1).

If the Critical Access Hospital was paid less than 101% of allowable costs, EOHHS will pay the Critical Access Hospital the difference between 101% of allowable costs and the aggregate interim payments. If the Critical Access Hospital was paid more than 101% of allowable costs, the Critical Access Hospital shall pay to EOHHS, or EOHHS may recoup or offset against future payments, the amount that equals the difference between the aggregate interim payments and 101% of allowable costs.

This post Rate Year 2019 review and settlement will take place within twelve (12) months after EOHHS has obtained all accurate and complete data needed to perform the review and settlement calculation. EOHHS estimates that it will have accurate and complete data by September 30, 2020. Assuming this date, the settlement will be complete by September 30, 2021.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods for Establishing Payment Rates – Privately-Owned
Chronic Disease and Rehabilitation Inpatient Hospital Services

I. General Description of Payment Methodology

The following sections describe the methods and standards utilized by the Executive Office of Health and Human Services (EOHHS) to establish rates of payment by contract for services rendered by chronic disease and rehabilitation hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.*

A. Chief Components: The payment methods described in this attachment result in a comprehensive per-diem rate for each participating hospital. The daily rate applicable to each hospital covers both routine and ancillary services provided to inpatients

B. Patients Transferred from State Facilities: The following describes the payment method for Privately-Owned Chronic Disease and Rehabilitation Hospital services provided to former patients of Lakeville Hospital, a State-Owned Nonacute Hospital that has been closed.

The rate of payment in connection with this state facility closure has been set based on allowable actual costs under the methodology described herein and expenses that must be incurred by a provider in order to serve the particular patients transferred from this state facility. The Division of Health Care Finance and Policy (DHCFP) reviewed the budget costs of the hospital to which patients were to be transferred and found them to meet the reasonableness standards of the DHCFP rate methodology. Pursuant to such rate setting, the provider must demonstrate that items and services, furnished because of the special needs of the patients transferred, are necessary in the efficient delivery of necessary health care.

C. Provisions for a Hospital with no fewer than 500 Licensed Beds as of June 30, 2005

This section establishes payments for inpatient care to a privately-owned health care facility licensed by the Department of Public Health as a non-acute chronic hospital with no fewer than 500 licensed beds as of June 30, 2005, with no fewer than 150,000 Medicaid patient days in the state fiscal year ended June 30, 2006, and with an established geriatric teaching program for physicians, medical students, and other health professionals.

The hospital is paid one of two per diem rates for inpatient care. Per Diem Rate 2 is for more complex care patients. In order to bill for payment at Per Diem Rate 2, the hospital must obtain prior authorization of the admission and continuing inpatient stay from the Office of Medicaid or its designated screening entity based on services ordered by a physician and documented in the medical record showing a

need for daily physician intervention, 24 hour care or intensive multidisciplinary rehabilitation overseen by a physician board certified in rehabilitation medicine

1. Inpatient Per Diem Rates

The Inpatient Per Diem Rates are all-inclusive daily rates paid for any, and all, inpatient care and services. A rate adjustment may be incorporated whenever attributable to cost misreporting, audit findings, non-allowable cost, adjustments required under M.G.L. The Inpatient Per Diem Rates are derived using the following methods:

a. Per Diem Rate 1: the per diem rate is derived by using the following method: the sum of a hospital's base year operating costs and the allowable capital costs, divided by a hospital's base year patient days, inflated by the Adjustment to Base Year Operating and Capital Costs.

i. Data Sources.

1. The base year for inpatient costs is the hospital fiscal year (HFY) 2016. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2016 Massachusetts Hospital Cost Report filed with the Center for Health Information Analysis (CHIA).

2. Inpatient costs include only costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles. All references to tabs, columns and lines refer to the Massachusetts Hospital Cost Report filed with and reviewed by CHIA. Except where noted, all references are to the HFY 2016 version of the Massachusetts Hospital Cost Report.

3. The calculations use costs and statistics, as adjusted as a result of audits or reviews conducted by EOHHS. The MassHealth program may also request additional information, data and documentation from the hospital or CHIA as necessary to calculate rates.

4. If the specified data source is unavailable or inadequate, the MassHealth program will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data. If required information is not furnished by a hospital within the applicable time period, it may not receive any

increase to its rate.

ii. Determination of Base Year Inpatient Operating Costs. Base Year Inpatient Operating Costs are the sum of total Inpatient Direct Routine Costs, Inpatient Direct Ancillary Costs, and Inpatient Overhead Costs as described below.

1. Inpatient Direct Routine Costs. Inpatient Direct Routine Costs are the Total Inpatient Routine Costs derived from the Massachusetts Hospital Cost Report.

2. Inpatient Direct Ancillary Costs. Inpatient Direct Ancillary Costs are the Total Inpatient Ancillary Costs derived from the Massachusetts Hospital Cost Report.

3. Inpatient Overhead Costs. Inpatient Overhead Costs are the Total Inpatient Overhead Costs derived from the Massachusetts Hospital Cost Report.

iii. Calculation of the Base Year Inpatient Operating Per Diem. The Inpatient Operating Per Diem is calculated by dividing the sum of the Total Inpatient Operating Costs (Tab 2 Line 30.04 Column 8) by the total inpatient days (Tab 3 Line 3.01 Column 4).

iv. Inpatient Capital Costs: Base year capital costs consist of the hospital's actual HFY 2016 patient care capital requirement for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities (Tab 17 Line 30.04 Column 1 minus Tab 18 Line 30.04 Column 1).

v. Inpatient Capital Cost Per Diem. The Inpatient Capital Cost Per Diem is derived by dividing the total Inpatient Capital Costs by the total inpatient days (Tab 3 Line 3.01 Column 4).

vi. Adjustments to Base Year Costs. The update factor, covering the period from the base year to the rate year beginning October 1, 2018, is 3.0%.

b. Per Diem Rate 2**:** Per Diem Rate 2 is determined by averaging the current rate year payment rates under Section III of this attachment for Chronic Disease and Rehabilitation Hospitals identified by the MassHealth program as having similar characteristics of treatment and populations. The Hospitals used to calculate the payment are: Braintree Rehabilitation Hospital, New Bedford Rehabilitation

Hospital, New England Sinai Hospital, Kindred Hospital Northeast, Vibra Hospital of Western Mass., Spaulding Rehabilitation-Boston and Spaulding Hospital-Cambridge. This rate is comprehensive and all-inclusive covering both routine and ancillary services provided to inpatients by the hospital.

c. Quality Performance Incentive Payment. Subject to compliance with all applicable federal statutes, regulations, and state plan provisions in RY 2019, EOHHS will make $1.333M in total aggregate quality performance supplemental payments to qualifying CDR hospitals, as described herein:

i. Qualification. In order to qualify for a Quality Performance Incentive Payment, a qualifying CDR hospital must meet the following criteria:

1. Be a CDR Inpatient Hospital located in Massachusetts with no fewer than 500 licensed beds as of June 30, 2005, with no fewer than 150,000 Medicaid patient days in the state fiscal year ended June 30, 2006, and with an established geriatric teaching program for physicians, medical students, and other health professionals, and that serves MassHealth members; and,

2. Have recorded performance, for the period of July 1, 2016-June 30, 2017, on the following Centers for Medicare and Medicaid Services (CMS) 2019 Inpatient Rehab Facility Compare and Long Term Care Hospital Compare quality measure that is better than the national average, as reported by CMS: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened.

ii. Payment.
EOHHS will issue the RY 2019 Quality Performance Incentive Payment to qualifying CDR Hospitals. Payment to qualifying CDR Hospitals will be made in two installments during RY 2019, as follows: January 2019, first payment; April 2019, second payment.

D. Inpatient Per Diem Rate for Hospitals that Serve Solely Children and Adolescents.

The following sections describe the methods and rates of payment, effective October 1, 2018, for services rendered by chronic disease and rehabilitation (CDR hospitals) that serve solely children and adolescents (Pediatric CDR Hospitals).

1. Inpatient Per Diem Rate.

The Inpatient Per Diem Rate is an all-inclusive daily rate paid for any, and all, inpatient care and services provided by a Pediatric CDR Hospital to a MassHealth member, with the exception of any, and all, Administrative Days (see Section 2).

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Methods for Establishing Payment Rates – Privately-Owned
Chronic Disease and Rehabilitation Inpatient Hospital Services

The Inpatient Per Diem Rate is derived using the following method: (a) the sum of a hospital's base year inpatient Operating Cost (Section 1, paragraph b.) plus the Adjustment to Base Year Costs (Section 1, paragraph c.) is divided by a hospital's base year patient days; plus (b) the Allowance for Inpatient Capital are calculated as for RY2012. Then, in accordance with Section 271 of Chapter 224, MassHealth applies a factor of 1.6 times the hospital's rate year 2012 inpatient per diem rate established in RY 2012. After having applied the factor of 1.6 the update factors described in Section 1, paragraph c. and Section 1, paragraph d.iii.for RY14-15 are applied to determine the final per diem.

The administrative day per diem rate is calculated using the methodology described in Section 2 below.

a. Data Sources.

i. The base year for inpatient costs and the outpatient cost-to-charge ratio is the (HFY) 2003. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2003 HCFP-403 cost report.

ii. Inpatient costs include only costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§1395 *et seq*. as set forth in 42 CFR 413 *et seq*. and the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles. All references to specific schedules, columns and lines refer to the HCFP-403 report filed with and reviewed by the Division of Health Care Finance and Policy (DHCFP). Except where noted, all references are to the HFY 2003 version of the HCFP-403.

iii. The calculations use each hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by DHCFP or successor agency. The MassHealth program may also request additional information, data and documentation from a hospital or DHCFP or successor agency as necessary to calculate rates.

iv. If the specified data source is unavailable or inadequate, the MassHealth program will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data. If required information is not furnished by a hospital within the applicable time period, it may not receive any increase to its rate.

b. Determination of Base Year Inpatient Operating Costs.

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Chronic Disease and Rehabilitation Inpatient Hospital Services

Base Year Inpatient Operating Costs are the sum of Inpatient Direct Routine Costs, Inpatient Direct Ancillary Costs, and Inpatient Overhead Costs as described below.

i. Inpatient Direct Routine Costs. Inpatient Direct Routine Costs are a hospital's Total Inpatient Routine Costs derived from the HCFP-403.

ii. Inpatient Direct Ancillary Costs. Inpatient Direct Ancillary Costs are calculated as follows:

Inpatient Direct Ancillary Costs are calculated by multiplying each hospital's chronic and rehabilitation inpatient ancillary expenses times the ratio of Total Direct Ancillary Expenses to Total Ancillary Expenses (including overhead). The resulting product constitutes the Total Inpatient Direct Ancillary Cost. For hospitals that reported costs in Sch. XIV, Column 2, Line 15 (Central Service/Supplies) and/or Column 2, Line 16 (Pharmacy), those costs are removed from Overhead costs and reclassified to Ancillary costs pursuant to Section I.D.1.b.iii.a.

iii. Total Inpatient Overhead. Total Inpatient Overhead is calculated by comparing Total Inpatient Overhead to an efficiency standard as described below.

a. A HFY 2003 Inpatient Overhead per diem amount is computed for each hospital as follows:

1. Inpatient Routine Overhead cost is calculated by subtracting Direct Inpatient Routine Cost from Inpatient Routine Cost after step-down of overhead.

2. Inpatient Ancillary Overhead Cost is calculated by subtracting the Total Inpatient Direct Ancillary Cost determined in Section 1, paragraph b.ii from the Total Chronic and Rehabilitation Inpatient Ancillary Expenses reported on the HCFP-403.

3. The Central Service and Supplies and Pharmacy expenses are then reclassified to Ancillary costs as follows:

The Central Service/Supplies Direct Expense is multiplied by the ratio of the inpatient medical supplies patient service statistics to the total medical supplies patient service statistics, all as derived from the HCFP-403 report.

The Pharmacy Direct Expense is multiplied by the ratio of the inpatient drug patient service statistics to the total drug patient service statistics, all as derived from the HCFP-403 report.

The two products of these calculations are then added together to equal the Total Inpatient CSS and Pharmacy Expense.

4. The Allowable Chronic Disease and Rehab Inpatient Overhead Expense is then determined by adding together the amounts in i. and ii (above) and subtracting from this the amount determined in iii (above). The resulting amount is then divided by HFY 2003 Patient Days.

b. The efficiency standards for pediatric CDR hospitals are determined as follows:

The chronic disease hospital group consists of Kindred Hospital Northeast, Franciscan Hospital for Children, Radius Specialty Hospital, New England Sinai Hospital, Spaulding Hospital-North Shore, Vibra Hospital of Western Mass and Spaulding Hospital-Cambridge.

The Inpatient Overhead Per Diem Cost for each chronic disease hospital in the chronic disease hospital group is calculated and the median is set as the efficiency standard for pediatric CDR hospitals.

c. If a pediatric CDR hospital's Total Inpatient Overhead Per Diem Cost does not exceed the appropriate efficiency standard, its Total Inpatient Overhead Cost is calculated pursuant to Section I.D.1.b.iii.a., without further adjustment.

d. If a pediatric CDR hospital's Total Inpatient Overhead Per Diem Cost exceeds the appropriate efficiency standard, the hospital's Total Inpatient Overhead Cost is the efficiency standard multiplied by HFY 2003 Patient Days.

c. Adjustment to Base Year Operating Costs. Total Inpatient Routine Direct Costs, Total Inpatient Ancillary Direct Costs, and Total Inpatient Overhead Costs are updated using a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for

hospitals. The year-to-year update factors used in the rate calculation are 2003-2004 2.21%; 2004-2005 1.198%; 2005-2006 1.84%; 2006-2007 1.637%; 2007-2008 1.588%; 2008-2009 1.459%; 2009-2010 0.516%; 2012-2013 1.643%; 2013-2014 0.00; 2014-2015 1.672%; 2015-2016 0.0%; and 2016-2017 0.0%.

d. Allowance for Inpatient Capital.

i. Each hospital's base year capital costs consist of the hospital's actual HFY 2003 patient care capital requirement for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities.

ii. The limitations applicable to base year capital costs are:

a. Interest expense attributable to balloon payments on financed debt is excluded. Balloon payments are those in which the Final payment on a partially amortized debt is scheduled to be larger than all preceding payments.

b. Where there was a change of ownership after July 18, 1984, the basis of the fixed assets used in the determination of depreciation and interest expense is the lower of the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The depreciation expense is calculated using the full useful lives of the assets.

c. All costs (including legal fees, accounting, and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset after July 18, 1984 (by acquisition or merger), for which payment has previously been made by any payer, and which have been included in any portion of prior years' rates, are subtracted from capital costs.

iii. Each hospital's base year inpatient unit capital cost equals the base year inpatient capital cost divided by the greater of: (i) the actual base year routine patient days; or (ii) eighty-five percent (85%) of base year maximum licensed bed capacity, measured in days. The CMS Capital Input Price Index adjusts the base year inpatient unit capital cost to determine the Inpatient Unit Capital amount. The year-to-year update factors used in the rate calculation are 2003-2004 .7%; 2004-2005 .7%; 2005-2006 .7%; 2006-2007 .8%; 2008-2009 .7%; 2009-2010 1.2%; 2012-2013 1.2%; 2013-2014 0.0%; 2014-2015 1.5%; 2015-2016 0.0%; and 2016-2017 0.0%.

iv. The Inpatient Unit Capital amounts of all chronic hospitals in the Chronic Disease Hospital Group as set forth at Section I.D.1.b.iii.b. is calculated and the median is set as the efficiency standard, which serves as the Pediatric Chronic Disease Hospital Allowance for Inpatient Capital.

2. Determination of Rate for Administrative Day Patients.

A Pediatric CDR Hospital will be paid for Administrative Days using an Administrative Day Per Diem Rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each Administrative Day. The AD Rate is comprised of three components: a statewide AD routine per diem amount, a statewide AD ancillary per diem amount and a hospital-specific supplementary per diem amount. The statewide AD routine per diem amount is derived from the weighted average Medicaid payment rate for case mix category T (10) patients in nursing facilities in 2003. The statewide AD ancillary per diem amount is derived from the statewide weighted average Medicaid ancillary payment for AD patients in Chronic Disease and Rehabilitation Hospitals in FY 2003. The sum of the statewide AD routine and ancillary per diem amounts for RY 2018 is $513.05. For RY 2018, the supplementary per diem amount for each hospital is the AD routine and ancillary per diem amount of $513.05 increased by 80% of the difference between each hospital's Inpatient Per Diem Rate and the statewide AD routine and ancillary per diem amount of $513.05.

3. Quality Performance Incentive Payments.

Subject to compliance with all applicable federal statutes, regulations, and state plan provisions in RY 2019 EOHHS will make a total aggregate amount of $500,000 available for Quality Performance Incentive Payments to qualifying Pediatric CDR Hospitals, and as described below:

i. Qualification. In order to qualify for Quality Performance Incentive Payments, a Pediatric CDR Hospital must meet the following criteria:

a. Be a chronic disease and rehabilitation hospital that serves solely children and adolescents that is located in Massachusetts and serving MassHealth members;

b. For Quality Performance Incentive Payment A., have recorded performance, for the fourth quarter 2018 (October – December 2018) that meets or exceeds the Performance Measurement A criteria described in Section 3.ii.a. below, for the following measures, as reported by The Children's Hospitals' Solutions for Patient Safety National Children's Network:

1. Pressure Injury Prevention Bundle;

2. Rate of Adverse Drug Events (ADE) per 1,000 patient days.

c. For Quality Performance Incentive Payment B, have recorded performance for April 2018 – June 2018 that meets or exceeds the Performance Measurement B criteria described in Section 3.ii.b., below on the following measures, as reported by The Joint Commission:

1. Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed – Children (1 through 12 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1b;

2. Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed Adolescent (13 through 17 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1c.

ii. Performance Measurements.

a. Performance Measurement A. Performance will be measured based on
1. an average of the three months of data for the fourth quarter 2018 (October – December 2018) that is submitted to The Children's Hospitals' Solutions for Patient Safety, National Children's Network:
The number of audits completed with the bundle elements (Skin Assessment, Device Rotation, Patient Positioning, Appropriate Bed Surface, Moisture Management) completed, divided by the number of audits completed x 100, must be equal or greater than 75%; and,
2. an average of the three months of data for the second quarter 2018 (April – June 2018) that is submitted to The Children's Hospitals' Solutions for Patient Safety, National Children's Network:
The average rate of Adverse Drug Events (ADE) per 1,000 patient days is at or below 0.125 per 1000 patient days.

a. Performance Measurement B. Performance as reported by the Joint Commission for the second calendar quarter 2018 (April – June 2018)

on the following measures:

1. 80% for Admission Screening For Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed – Children (1 through 12 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1b;

2. 80% for Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths – Completed Adolescent (13 through 17 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1c.

ii. Payment.

a. EOHHS will issue the RY 2019 Quality Performance Incentive Payment A in a total aggregate amount of $300,000 and apportioned equally across the Pediatric CDR Hospitals that qualify for Payment A. Payment will be issued in two installments during RY 2019 as follows: April 2019 and July 2019.

b. EOHHS will issue the RY 2019 Quality Performance Incentive Payment B in a total aggregate amount of $200,000 and apportioned equally across the Pediatric CDR Hospitals that qualify for Payment B. Payment will be issued in one payment during April 2019.

E. Determination of Inpatient Hospital Rate for Out-of-State Chronic Disease or Rehabilitation Hospitals

Payment to an out-of-state chronic disease or rehabilitation hospital for any Inpatient Service payable by the MassHealth agency is the lowest of:

a. The rate of payment established for the medical service under the other state's Medicaid program;
b. The MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
c. The MassHealth rate of payment established for a comparable provider in Massachusetts.

When MassHealth is not able to determine the other state's inpatient rate, it pays out-of state chronic disease or rehabilitation hospitals a rate comparable to the median or weighted average in-state rate for comparable Hospitals.

II. Definitions

Administrative Day (AD). An inpatient day spent in a hospital by a patient who has been identified by the Executive Office of Health and Human Services (EOHHS), or its designee or by the Department of Public Health (DPH), or any combination of these organizations as a patient not requiring hospital level of care.

Administrative Day Per-diem Rate (AD Rate). An all-inclusive daily rate of payment paid to hospitals for Administrative Days. There are two AD payment rates for non-Pediatric CDR Hospitals paid under Section III: one for short-stay Administrative Days and one for long-stay Administrative Days. There is one AD payment rate for CDR Hospitals paid under Section I.C. and one AD payment rate for Pediatric CDR Hospitals under Section I.D.

Base Year. The base year is year identified in each payment section as the base year (See Section I.C. Section I.D., and Section III).

Center for Health Information and Analysis (CHIA) – An agency of the Commonwealth of Massachusetts established under M.G.L. .c 12C.

Chronic Disease and Rehabilitation Hospital (Hospital). A hospital facility licensed by the Massachusetts Department of Public Health under M.G.L. c. 111, §51, with a majority of its beds providing chronic care services and/or comprehensive rehabilitation services to patients with appropriate medical needs. This definition includes such a facility licensed with a pediatric specialty. Hospitals with 50 percent or more of their beds licensed as medical/surgical, intensive care, coronary care, burn, maternal (obstetrics) and neonatal intensive care beds (Level III) possess acute hospital licensure and do not meet the definition of a chronic Disease and Rehabilitation Hospital.

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 17, §1.

Direct Cost. The patient care costs of a cost center exclusive of overhead and capital.

Division of Health Care Finance and Policy (DHCFP). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 118G and from 2003 until the passage of Chapter 224 of the Acts of 2012. EOHHS is DHCFP's successor agency for rate setting functions, and the Center for Health Information and Analysis is DHCFP's successor agency for certain other functions. All references to DHCFP or DHCFP regulations also refer to the applicable successor.

Executive Office of Health and Human Services (EOHHS). The single state agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

Hospital Fiscal Year (HFY). The fiscal year used by an individual hospital.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual promulgated by DHCFP under 101 CMR 42.00.

Inpatient Per-diem Rate. An all-inclusive daily rate of payment for any and all Inpatient Services provided to a Recipient by a hospital.

Inpatient Services. Routine and ancillary services that are provided to Recipients admitted as patients to a Chronic Disease and Rehabilitation Hospital.

MassHealth Program (also MassHealth or Medicaid). The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions

Member. A person determined by EOHHS to be eligible for medical assistance under the MassHealth Program.

Overhead. Overhead consists of expenses for fringe benefits, administration, plant maintenance and repairs, plant operations, laundry, housekeeping, cafeteria, dietary, maintenance personnel, nursing administration, and in-service education, RN and LPN education, medical staff teaching and administration, post-graduate medical education, central service and supplies, pharmacy, medical records, medical care review, and social services.

Pediatric Chronic Disease and Rehabilitation Hospital (Pediatric CDR Hospital) – A hospital licensed by the Massachusetts Department of Public Health under M.G.L. c.111, §51, with a majority of its beds licensed to provide chronic care services and/or comprehensive rehabilitation services to patients with appropriate medical needs and licensed with a pediatric specialty that serves solely children and adolescents. Hospitals with 50 percent or more of their beds licensed as medical/surgical, intensive care, coronary care, burn, maternal (obstetrics) and neonatal intensive care beds (Level III) possess acute hospital licensure and do not meet the definition of a Chronic Disease and Rehabilitation Hospital.

Rate Year (RY). The period beginning October 1 and ending September 30.

III. Medicaid Payment Methodology for Privately-Owned Chronic Disease and Rehabilitation Hospitals

A. Determination of Inpatient Per-diem Rate

The Inpatient Per-diem Rate is an all-inclusive daily rate paid for any and all inpatient care and services provided by a hospital to a MassHealth Member, except for any and all Administrative Days (see Section III.C). The Inpatient Per-diem Rate is derived using the following method: (a) the sum of a hospital's base year inpatient Operating Costs (Section III.A.2)and the allowable capital costs (Section III.A.3) divided by a hospital's base year patient days, inflated by the Adjustment to Base Year Costs (Section III.A.4.).

1. Data Sources

a. The base year for inpatient costs is the Hospital Fiscal Year (HFY) 2014. The Masshealth program uses statistics and revenue reported in the HFY 2014 CHIA D403 cost report.

b. Inpatient costs include only costs incurred or to be incurred in the provision of hospital care and service, supplies and accommodations and determined according to the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§1395 *et seq*. as set forth in 42 CFR 413 *et seq*., the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles. All references to specific schedules, columns and lines refer to the CHIA D403 report filed with and reviewed by the Center for Health Information and Analysis (CHIA). Except where noted, all references are to the HFY 2014 version of the CHIA D403.

c. The calculations use each hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by CHIA. The MassHealth program may also request additional information, data and documentation from a hospital or CHIA as necessary to calculate rates.

d. If the specified data source is unavailable or inadequate, the MassHealth program will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data. If required information is not furnished by a hospital within the applicable time period, it may not receive any increase to its rate.

2. Determination of Base Year Inpatient Operating Costs.

Base Year Inpatient Operating Costs are the sum of Inpatient Direct Routine

Costs, Inpatient Direct Ancillary Costs, and Inpatient Overhead Costs as described below.

a. **Inpatient Direct Routine Costs.** Inpatient Direct Routine Costs are a hospital's Total Inpatient Routine Costs derived from the CHIA D403.

b. **Inpatient Direct Ancillary Costs.** Inpatient Direct Ancillary Costs are calculated as follows:

Inpatient Direct Ancillary Costs are calculated by multiplying each hospital's chronic and rehabilitation inpatient ancillary expenses times the ratio of Total Direct Ancillary Expenses to Total Ancillary Expenses (including overhead). The resulting product constitutes the Total Inpatient Direct Ancillary Cost.

c. **Total Inpatient Overhead**. Total Inpatient Overhead Costs are calculated as follows:

i. Inpatient Routine Overhead cost is calculated by subtracting Inpatient Direct Routine Cost from Inpatient Routine Cost after step-down of overhead.
ii. Inpatient Ancillary Overhead Cost is calculated by subtracting the Total Inpatient Direct Ancillary Cost determined in Section III, paragraph 2.b. from the Total Chronic and Rehabilitation Inpatient Ancillary Expenses reported on the CHIA D403.
iii. The Allowable Chronic Disease and Rehab Inpatient Overhead Expense is then determined by adding together the amounts in 1. and 2. (above).

3. Allowance for Inpatient Capital

a. Each hospital's base year capital costs consist of the hospital's actual HFY 2014 patient care capital requirement for historical depreciation for: building and fixed equipment; reasonable interest expenses; amortization and leases; and rental of facilities, subject to the limitations described below.

b. The limitations applicable to base-year capital costs are:

i. Interest expense attributable to balloon payments on financed debt is excluded. Balloon payments are those in which the proposed payment on a partially amortized debt is scheduled to be larger than all preceding payments.

ii. Where there was a change of ownership after July 18, 1984, the basis of the fixed assets used in the determination of depreciation and interest expense is the lower of the acquisition cost to the new owner or the basis allowed for reimbursement purposes to immediate prior owner. The depreciation expense is calculated using the full useful lives of the assets.

iii. All costs (including legal fees, accounting costs, and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset after July 18, 1984 (by acquisition or merger), for which payment has previously been made by any payer, and which have been included in any portion of prior years' rates, are subtracted from capital costs

c. Each hospital's base-year inpatient unit capital cost equals the base-year inpatient capital cost divided by the actual base-year routine patient days.

d. The Inpatient Unit Capital amounts of all chronic hospitals in the Chronic Disease Hospital Group (below) are calculated and the median is set as the efficiency standard, which serves as the Chronic Disease Hospital Allowance for Inpatient Capital. Each chronic hospital in the Chronic Disease Hospital Group will be paid the lower of their actual costs or the Chronic Disease Hospital Allowance for Inpatient Capital.

The Chronic Disease Hospital Group consists of Curahealth Hospital Stoughton, New England Sinai Hospital, Vibra Hospital of Western Mass, and Spaulding Hospital-Cambridge.

e. The Inpatient Unit Capital amounts of all rehabilitation hospitals in the Rehabilitation Hospital Group (below) are calculated and the median is set as the efficiency standard, which serves as the Rehabilitation Hospital Allowance for Inpatient Capital. Each rehabilitation hospital in the Rehabilitation Hospital Group will be paid the lower of their actual costs or the Rehabilitation Hospital Allowance for Inpatient Capital.

The Rehabilitation Hospital Group consists of Braintree Rehabilitation, HealthSouth Fairlawn Hospital, New Bedford Rehabilitation Hospital, New England Rehabilitation Hospital, Spaulding Hospital-Cape Cod, HealthSouth Hospital of Western Massachusetts, Spaulding

Rehabilitation Hospital-Boston, Whittier Rehabilitation Hospital-Bradford and Whittier Rehabilitation Hospital-Westborough.

4. Adjustment to Base Year Operating and Capital Costs.

Total Base Year Inpatient Operating Costs and Capital Costs are updated using a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for Inpatient Rehabilitation Facilities (IRF) hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS IRF-specific market basket. The update factor, covering the period from the base year to the rate year beginning October 1, 2018, is 6.95%.

B. Determination of Inpatient Rate for New Hospitals (i.e., Newly Licensed as Chronic Disease or Rehabilitation Hospitals after October 1, 2018).

1. The allowable overhead, routine and ancillary per diem costs will be established at the median of HFY 2014 per diem costs reported by chronic and rehabilitation hospitals, updated by the inflation factor calculated pursuant to Section III.A.4.
2. The allowable capital per diem costs will be established at the efficiency standards as calculated pursuant to Section III.A.3.

C. Determination of Rate for Administrative Day Patients

A hospital will be paid for Administrative Days using either a facility-specific short-stay or statewide standard long-stay Administrative Day Per Diem Rate (AD Rate). AD Rates are all-inclusive daily rates.

The short-stay and long-stay AD Rates are based on an AD Base Per Diem Rate comprised of the statewide AD routine per diem amount and the statewide AD ancillary per diem amount. The statewide AD routine per diem amount is derived from the weighted average Medicaid payment rate for case mix category T (10) patients in nursing facilities in 2003. The statewide AD ancillary per diem amount is derived from the statewide weighted average Medicaid ancillary payment for AD patients in Chronic Disease and Rehabilitation Hospitals in FY 2003. The sum of the routine per diem and ancillary add-on amount equals $513.05 which is then inflated by 6.95%, resulting in a RY 2019 AD base per diem rate of $548.71.

For RY 2019, the short-stay AD per diem rate is the AD base per diem rate of $548.71 increased by 64% of the difference between each hospital's Inpatient Per Diem Rate and the AD base per diem rate.

For RY 2019, the long-stay AD per diem rate is the AD base per diem rate of $548.71 increased by 35%, for a single statewide per diem rate of $740.75.

D. Quality Performance Incentive Payments to CDR Hospitals other than Pediatric CDR Hospitals

Subject to compliance with all applicable federal statutes, regulations, and state plan provisions in RY 2019 EOHHS will make a total aggregate amount of $3 Million available for Quality Performance Incentive Payments to qualifying CDR Hospitals, as described below:

1. **Qualification.** In order to qualify for a Quality Performance Incentive Payment for RY 2019, a CDR hospital must meet the following criteria:

   a. Be a CDR Hospital (other than a Pediatric CDR Hospital) located in Massachusetts and serve MassHealth members; and

   b. Have recorded performance, on the following two Centers for Medicare and Medicaid Services (CMS) 2018 Inpatient Rehabilitation Facility Compare and Long Term Care Hospital Compare measures, as reported by CMS and updated as of June 8, 2018:

      i. Quality Measure 1: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened (Measure Period: 7/1/2016-6/30/2017; Improvement Base Period: 7/1/2015-6/30/2016); and

      ii. Quality Measure 2: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities or Long Term Care Hospitals (Measure Period: 1/1/2014-12/31/2015; Improvement Base Period: 1/1/2013-12/31/2014).

2. **Performance Measurement**. A qualifying CDR Hospital's performance on each of the two selected quality measures will be calculated using a quality point system. CDR Hospitals may earn points based on where the CDR Hospital's Measure Rate falls, relative to the Attainment and Benchmark thresholds for the applicable Measure Period, and may earn points for improvement from the applicable Improvement Base Period for each Quality Measure.

   The Benchmark Threshold is the mean of the 10^{th} percentile scores for all hospitals in the national database during the Measure Period as applicable to each Quality Measure. The Attainment Threshold is the national median score during the Measure Period as applicable to each Quality Measure.

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a. Attainment Point Scale. CDR hospitals will be awarded Attainment Points as follows:
   1. 10 points if the Hospital's recorded performance is below the Attainment Threshold;
   2. 0.5-9.5 points if the Hospital's recorded performance is below the Attainment Threshold, but at or above the Benchmark Threshold; and,
   3. Zero (0) points if performance is at or above the Attainment Threshold.

b. Attainment Point Calculation. The number of Attainment points a CDR Hospital receives is determined by the ratio of the difference between the CDR Hospital's Measure Rate and the Attainment Threshold divided by the difference between the Benchmark Threshold and the Attainment Threshold. That ratio is then multiplied by 9 and the product is increased by 0.5.

   CDR Hospital's Attainment Points Earned =
   [((Attainment Threshold – hospital measure rate)/(Attainment Threshold – Benchmark)) x 9] + 0.5.

c. Improvement Point Scale. CDR Hospitals will be awarded Improvement Points based on how much the CDR hospital's recorded performance on each Quality Measure has improved from the applicable Improvement Base Period. A CDR hospital will be awarded between 0 and 10 points if performance improves over the previous year.

d. Improvement Point Calculation. The number of improvement points a CDR Hospital receives is determined by the ratio of the difference between the CDR Hospital's recorded performance and the previous year's recorded performance, as applicable to each Quality Measure, divided by the difference between the Benchmark Threshold and the previous year's recorded performance. This ratio is multiplied by 10 and the product is decreased by 0.5.

   CDR Hospital's Improvement Points Earned =
   [((CDR Hospital's recorded performance – Previous Year's recorded performance)/(Benchmark Threshold – Previous Year's recorded performance)) x 10] – 0.5.

3. Calculation of the Quality Performance Incentive Payment. EOHHS will calculate the amount of each qualifying CDR Hospital's Quality Performance Incentive Payment as follows:

a. For each CDR Hospital and each measure, the Hospital's point total is the sum of 60% of the Hospital's Attainment Point score and 40% of the Hospital's Improvement Point score.

b. For each CDR Hospital and each measure, an adjusted point total is calculated by multiplying the point total by the Hospital's Medicaid days, excluding Medicaid MCO days.

c. For Quality Measure 1, the CDR Hospital's payment equals the ratio of the Hospital's adjusted point total divided by the statewide sum of the adjusted point total for all eligible Hospitals, times $1.2 million.

d. For Quality Measure 2, the hospital's payment equals the ratio of the CDR Hospital's adjusted point total divided by the statewide sum of the adjusted point total for all eligible hospitals, times $1.8 million.

4. Payment. EOHHS will issue the RY 2019 Quality Performance Incentive Payment to qualifying CDR Hospitals in two installments during RY2019 as follows: January 2019 and July 2019.

IV. Pediatric Outlier:

A. For Infants Less Than One Year of Age

1. In accordance with section 1902 of the Social Security Act, as amended by Section 4604 of OBRA 90, effective July 1, 1991, the Commonwealth will make an annual payment adjustment to Privately-owned Chronic/Rehabilitation Hospitals for inpatient hospital services furnished to infants less than one year of age involving exceptionally high costs or exceptionally long lengths of stay.

2. Determination of Eligibility. Determination of eligibility for infants less than one year of age shall be made as follows:

a. Exceptionally long lengths of stay.

(i) First, calculate the statewide weighted average Medicaid inpatient length-of-stay. This shall be determined by dividing the sum of

Medicaid days for all Privately-owned Chronic/Rehabilitation Hospitals in the state by the sum of total discharges for all Privately-owned Chronic Disease and Rehabilitation Hospitals.

(ii) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length-of-stay statistics.

(iii) Third, add one and one-half times the statewide weighted standard deviation for Medicaid inpatient length-of-stay to the statewide weighted average Medicaid inpatient length-of-stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute an exceptionally long length-of-stay for purposes of payment adjustments under this section.

b. Exceptionally High Cost. For each Privately-owned Chronic/Rehabilitation Hospital providing services on or after July 1, 1991 to individuals under one year of age the Commonwealth shall: .

(i) First, calculate the average cost per Medicaid inpatient discharge for each hospital;

(ii) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital;

(iii) Third, add one and one-half times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost per Medicaid inpatient discharge. Any cost that equals or exceeds the sum of these two numbers shall constitute an exceptionally high cost for purposes of payment adjustments.

(a) The amount of funds allocated shall be twenty five thousand dollars ($25,000) annually. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Non-acute hospitals.

(b) Any hospital that qualifies for a payment adjustment for infants less than one year of age shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying Privately-owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

B. Children under age Six

1. **Eligibility for Payment**. Consistent with section 4604 of the Omnibus Reconciliation Act of 1990 (OBRA 90) outlier adjustments for medically necessary inpatient hospital services, effective July 1, 1991, involving exceptionally high costs or exceptionally long lengths of stay (as defined in sections V. A. 2a. and 2b. of this Plan) are extended to services for children who have not reached the age of six, if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923 (a) of the Social Security Act.

2. **Amount of Payment Adjustment**

   a. The amount of funds allocated shall be twenty five thousand dollars ($25,000) annually. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Non-acute hospitals.

   b. Any hospital that qualifies for a payment adjustment for children under six, pursuant to Section V. A.1. above, shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying Privately-owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

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V. Provider Preventable Conditions

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Attachment 4.19-A(2a) (Privately-Owned Chronic Disease and Rehabilitation Inpatient Hospital Services) of this State plan where applicable.

☒ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-A(2a) (Privately-Owned Chronic Disease and Rehabilitation Inpatient Hospital Services) of this State plan where applicable.

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒Additional Other Provider-Preventable Conditions identified below:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient.
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance).
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low-risk delivery.

9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above.

When a hospital reports a PPC that the hospital indicates was not present on admission, MassHealth will reduce payments to the hospital as follows:

1. Inpatient Per Diem Rate:
    a. MassHealth will not pay the Inpatient Per Diem Rate if the hospital reports that only PPC-related services were delivered on that day and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
    b. MassHealth will pay the Inpatient Per Diem Rate if the hospital reports that non-PPC related services were also delivered on that day but will exclude all

c. reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Administrative Per-Diem (AD) Rate:

a. MassHealth will not pay the per diem if the hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

b. MassHealth will pay the per diem if the hospital reports that non-PPC-related services were also delivered on that day but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

3. Follow-Up Care in Same Hospital: If a hospital reports that it provided follow-up inpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided on any day during the follow-up stay, payment will be made for that day, but MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for service, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

VI. Serious Reportable Events (SREs)

The non-payment provisions set forth in this Section VI apply to the following serious reportable events (SREs), where applicable:

1. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person.
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.
3. Any Instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist or other licensed health care provider.
4. Abduction of a patient/resident of any age.\
5. Sexual abuse/assault on a patient or staff member within or on the grounds of a health care setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for hospital services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the hospital license that was preventable, within the hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable hospital services include:

1. All services provided during the inpatient stay during which a preventable SRE occurred, from the date the SRE occurred through discharge, not to exceed 60 days; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

   a. at a facility under the same license as the hospital at which a non-billable SRE occurred; or

   b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

Non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

A hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary services provided to the patient following a preventable SRE.

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State: Massachusetts
Methods Used to Determine Rates of Payment for Privately-Owned Psychiatric Inpatient Hospital Services

I. General Description of Payment Methodology

The following sections describe the methods and standards utilized by the Executive Office of Health and Human Services (EOHHS), pursuant to the provisions of M.G.L. c. 118E, §13A, to establish the rates and terms of payment by contract for dates of service effective October 1, 2013 for services rendered by Privately-Owned Psychiatric hospitals and Substance Abuse Treatment Hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 et seq. These rates of payment do not apply to Members who are enrolled in MassHealth MCEs.

(1) EOHHS established a comprehensive inpatient per diem rate for all participating psychiatric hospitals, covering both routine and ancillary services provided to inpatients.

(2) EOHHS established an all-inclusive Administrative Day per diem Rate (AD Rate) for psychiatric hospitals for each Administrative Day. The AD Rate is an all-inclusive daily rate paid for each Administrative Day.

(3) EOHHS established a performance-based quality incentive payment for all eligible psychiatric hospitals based on performance and compliance with reporting requirements.

(4) EOHHS established a comprehensive inpatient per diem rate for all participating substance abuse treatment hospitals covering both routine and ancillary services provided to inpatients.

(5) EOHHS established a performance-based quality incentive payment for all eligible substance abuse treatment hospitals based on compliance with reporting requirements.

II. Definitions

Administrative Day (AD): A day of inpatient hospitalization on which a Member's care needs can be met in a less-intensive setting than a Psychiatric Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available.

Administrative Day Per Diem Rate (AD Rate): An all-inclusive daily rate of payment paid to hospitals for Administrative Days.

Behavioral Health (BH) Contractor: An entity with which EOHHS contracts to provide, arrange for and coordinate behavioral health services to enrolled Members on a capitated basis.

Department of Mental Health (DMH): An agency of the Commonwealth of Massachusetts established under M.G.L. c. 19, §1 et seq.

Department of Public Health (DPH): An agency of the Commonwealth of Massachusetts established under M.G.L. c. 17, §1.

Inpatient Per Diem Rate: An all-inclusive daily rate of payment for any and all Inpatient Psychiatric Services provided to a Member by a Privately-Owned Psychiatric Hospital or Substance Abuse Treatment Hospital.

Managed Care Organization (MCO): An entity with which EOHHS contracts to provide Primary Care and certain other medical services, including behavioral health services, to Members on a capitated basis and which meets the definition of an MCO as set forth in 42 CFR Part 438.2. In addition, MCOs include Accountable Care Partnership Plans, One Care plans and Senior Care Organizations (SCOs).

Managed Care Entity (MCE): An MCO or the behavioral health contractor which provides or arranges services for enrolled Members under a MassHealth contract.

MassHealth (also Medicaid): The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.

Member: A person determined by EOHHS to be eligible for medical assistance under the Medicaid Program.

Program For All Inclusive Care for the Elderly (PACE): PACE provides a complete package of acute and long-term care services to eligible frail elders, as described under Section 1934 of the Social Security Act and federal PACE regulations at 42 CFR 460.

Psychiatric Inpatient Hospital (Psychiatric Hospital): A hospital licensed by DMH pursuant to M.G.L. c. 19, § 19.

Rate Year (RY): The fiscal year beginning October 1 and ending September 30.

Substance Abuse Treatment Hospital Services: A hospital licensed byDPH, pursuant to 105 CMR 130.00 and 105 CMR 164.000, which govern the licensure or approval and operation of every substance abuse treatment program subject to licensure or approval

under M.G.L. c. 111B, §§6,6A; M.G.L.c.111E §7; M.G.L.c 111, §§51-56. Substance abuse hospitals provide short-term, twenty-four hour per day medical treatment for substance withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling and post-detoxification referrals provided by an inpatient unit licensed as an acute inpatient substance abuse treatment service by DPH.

III. **Payment Methodology**

A. Privately -Owned Psychiatric Hospitals

(1) The Inpatient Per Diem Rate is an all-inclusive daily rate for all participating psychiatric hospitals, covering both routine and ancillary services provided to inpatients. The base period standards were calculated using the FY 2008 HCF-403 cost reports. The Inpatient per diem Rate for the period beginning October 1, 2017 is derived from the 2008 operating and capital cost information for each hospital. The operating costs were updated from fiscal year 2008 using a composite index comprised of two cost categories: Labor and Non-labor. These categories were weighted according to weights used by CMS. The inflation proxy for the labor cost category was the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket. The RY 2008-2009 update factor for operating costs was 1.459%. The CMS Capital Input Price Index of 0.7% was used in computing an allowance for inpatient capital, which is derived from fiscal year 2008 patient care capital expenditure data. The update factor for operating costs used in the rate calculation for RY 2012-2013 is 1.775%. The update factor for operating costs used in the rate calculation for 2013-2014 is 1.571%. The update factor for operating costs used in the rate calculation for 2014-2015 is 1.672%. The update factor for operating costs used in the rate calculation for 2015-2016 is 0.00%. The update factor for operating costs used in the rate calculation for 2016-2017 is 0.00%. The update factor for operating costs used in the rate calculation for 2017-2018 is 0.00%. The update factor for operating costs used in the rate calculation for 2018-2019 is 0.0%. The CMS Capital Input Price Index adjusts the base year capital cost to determine the capital amount. The update factor for capital costs used in the rate calculation for 2012-2013 is 1.2%, for 2013-2014 it is 1.4%, for 2014-2015 it is 1.5%, for 2015-2016 it is 0.0%, for 2016-2017 it is 0.0%, for 2017-2018 it is 0.0%, and for 2018-2019 it is 0.0%.

The inpatient per diem rate is further increased by a factor of 2.295%.

(2) The base period operating standards were calculated using the FY 2008 HCF-403 cost reports. Standards were computed in three categories, the sum of which is the Statewide per diem: 1) standard for Inpatient Overhead costs; 2) standard for Inpatient Direct Routine Costs; 3) standard for Inpatient Direct Ancillary Costs.

Determination of Base Year Operating Standards

(3) The Standard for Inpatient Psychiatric Overhead Costs is based on the cost per day of the median licensed bed day. All hospitals were ranked from highest to lowest with respect to their cost per day; a cumulative frequency of licensed bed days for the hospitals was produced. The overhead cost standard was established at the cost per day corresponding to the position on the cumulative frequency of days that represent 50% of the total number of licensed bed days.

(4) The Standard for Inpatient Psychiatric Direct Routine Costs is based on the cost per day of the median licensed bed day. All hospitals were ranked from highest to lowest with respect to their cost per day; a cumulative frequency of licensed bed days for the hospitals was produced. The routine cost standard was established at the cost per day corresponding to the position on the cumulative frequency of days that represent 50% of the total number of licensed bed days.

(5) The Standard for Inpatient Psychiatric Direct Ancillary Costs is based on the cost per day of the median licensed bed day. All hospitals were ranked from highest to lowest with respect to their cost per day; a cumulative frequency of licensed bed days for the hospitals was produced. The direct ancillary cost standard was established at the cost per day corresponding to the position on the cumulative frequency of days that represent 50% of the total number of licensed bed days.

Determination of Base Year Capital Standard

(6) Each Hospital's base year capital costs consist of each hospital's actual Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. The standard for Inpatient Psychiatric Capital Cost is the median of all the hospital's Inpatient Psychiatric Capital Costs Per day.

Adjustment to Base Year Costs

(7) The Standards for Overhead Costs, Direct Routine Costs, and Direct Ancillary Costs were updated using a composite index, which is a blend of CMS Hospital Prospective Market Basket and the Massachusetts Consumer Price Index. The CMS Capital Input Price Index adjusts the base year capital cost to determine the capital amount. The year-to-year update factors described in Section III.A(1) were used in the rate calculation of the annual inflation rates for operating costs and capital costs.

Administrative Days

(8) A hospital will be paid for administrative days using an administrative day per diem rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each administrative day. The AD Rate is comprised of a base per diem payment and an ancillary add-on. The AD Rate is a base per diem payment and an ancillary add-on. For the period beginning October 1, 2018, the base per diem payment is $198.14, which represents the October 2013 median rate as determined by EOHHS.

(9) The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated for Medicaid/Medicare Part B eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997, to September 30, 1998. These ratios are 0.278 and 0.382 respectively. The ancillary add-on was updated for inflation using the update factor of 2.2670% for inflation between FY 03 and FY 04; 1.723% between FY 04 and FY 05; 2.548% between FY 05 and FY 06; 1.853% between FY 06 and FY 07; 1.968% between FY 07 and FY 08; 2.244% between FY 08 and FY 09; 1.775% between FY12 and FY13; 1.571% between FY13 and FY14.

The resulting AD rate (base and ancillary add-on) was updated for inflation using the update factor of 1.672% between FY14 and FY15. No inflation update will be given between RY15 and FY16, between RY16 and RY17, between RY17 and RY18, and between RY 18 and RY19. The resulting AD rate for FY19 is $257.46.

Determination of Quality Performance Incentive Payments

(10) Effective December 31, 2018, psychiatric hospitals can qualify for performance-based quality incentive payments.

(11) Achievement Threshold or Improvement over the Baseline. Psychiatric hospitals are evaluated for achievement of the threshold or, if achievement is not demonstrated, by improvement over baseline.

The achievement threshold for psychiatric hospitals is calculated by taking median performance of qualifying hospitals using CMS's Inpatient Psychiatric Facility Quality Reporting (IPFQR) for CY2017. Psychiatric hospitals will be awarded points if they meet or exceed the median performance.

Improvement over the baseline for psychiatric hospitals is calculated by comparing average improvement of qualifying hospitals for the CY2017 IPFQR over the CY2016 IPFQR psychiatric hospital performance. Psychiatric hospitals will be awarded points based on their improvement over the baseline relative to other qualifying hospitals.

(12) Performance Measurement. Performance for qualifying psychiatric hospitals is measured by achievement of the threshold or, if the achievement threshold is not met, improvement rates for the IPFQR measure. Performance for qualifying psychiatric hospitals is also measured by compliance with reporting requirements for other measures, including submission of Restraint and Seclusion data, and submission of a Quality Improvement Plan. Each measure is calculated out of a maximum of 10 points. The measures are weighted as follows: IPFQR - 10%; Reporting Restraint and Seclusion data - 40%; and submission of Quality Improvement Plan - 50%.

(13) Payment. Payment to psychiatric hospitals will be proportional to the performance measurement outcome. Payments for all quality performance measures will not exceed a total of $934,795.

B. Substance Abuse Treatment Hospitals

Determination of Inpatient per Diem Rates

1. The inpatient per diem rate is an all-inclusive daily rate paid for any and all inpatient care and services provided by a substance abuse treatment hospital to eligible Medicaid recipients. The per diem rate covers all treatment components such as room and board, routine nursing and hospital-based physician services, medications, initial substance abuse and psychiatric assessments, individual, family and group inpatient therapy services, radiology, ancillary services, overhead, and other services as is the customary practice among similar providers. The inpatient per diem rate is calculated as follows:

2. The base period per diem rate is calculated using payments and inpatient days reported on Medicaid substance abuse treatment hospital claims data during the period RY1997 through May 1999. Claims data and bed-days for MCE and PACE enrollees are not included in these calculations.

3. The inpatient per diem rate is calculated by taking an average of payments per day reported on claims data for the period HRY 1997 through May 1999. This amount was adjusted using the inflation factors of 2.14 % for HRY 1998; 1.90 % for HRY 1999; 1.43 % for HRY 2000; 2.00 % for HRY 2001; 1.152 % for HRY 2002; 2.226% for HRY 2003; (no inflation was given in HRY 2004); 1.186% for HRY 2005; 1.846% for HRY 2006; 1.64% for HRY 2007; 1.734% for HRY 2008; .719% for HRY 2009; 1.672% for HRY 2015; 0.00% for HRY16; 0.00% for HRY17; 0.00% for HRY18; and 0.0% for HRY19
The inpatient per diem rate is further increased by 2.90%. The current inpatient payment rate is $578.52.

Determination of Quality Performance Incentive Payments

4. Effective December 31, 2018, substance abuse treatment hospitals can qualify for performance-based quality incentive payments.

5. Performance Measurement. Qualifying substance abuse treatment hospitals will be measured by submission of meaningful use data and reporting on the quality improvement plan.

6. Payment. Payment to substance abuse treatment hospitals will be proportional to the completion of the meaningful use data submissions and reporting requirements.

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C. Provider Preventable Conditions

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Attachment 4.19-A(2b) (Privately-Owned Psychiatric Hospital Services) of this State plan, where applicable.

☒ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-A(2b) (Privately-Owned Psychiatric Hospital Services)of this State plan, where applicable.

_ ☒ ___ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

None.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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Payment Method

EOHHS will pay participating psychiatric hospitals and substance abuse and treatment hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions, effective for dates of service on or after July 1, 2012.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs consist of the three National Coverage Determinations (the "NCDs") that are listed above.

When a hospital reports a PPC that the hospital indicates was not present on admission, MassHealth will reduce payments to the hospital as follows:

1. Inpatient Per Diem Rate:
    a. MassHealth will not pay the Inpatient Per Diem Rate if the hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
    b. MassHealth will pay the Inpatient Per Diem Rate if the hospital reports that non-PPC related services were also delivered on that day, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Administrative Day Per-Diem Rate:
    a. MassHealth will not pay the per diem if the hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
    b. MassHealth will pay the per diem if the hospital reports that non-PPC-related services were also delivered on that day, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

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Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals

I. General Description of Payment Methodology

The following sections describe the methods and standards utilized by the Commonwealth of Massachusetts (the Commonwealth) to establish rates of payment by contract, to be effective July 1, 2003 (Rate Year (RY) 2004), for services rendered by State-owned Non-Acute Hospitals to patients entitled to medical assistance under the M.G.L. c. 118E, §1 *et seq.* State-owned Non-Acute Hospitals participating in the Massachusetts Medical Assistance Program include chronic disease and rehabilitation hospitals and psychiatric hospitals.

A. Hospital allowable costs, with the exception of the working capital component and the circumstances described in Section I.D below, are determined from a Base Year that has been fixed at FY93. Expenses disallowed in the Base Year are never rolled into payment rates for subsequent years. The establishment of a fixed Base Year, therefore, provides a strong incentive for cost efficiency. Rates of payment are adjusted to affect appropriate cost increases or decreases resulting from changes in volume, case-mix, inflation, and other factors. The working capital component is determined from the operating and capital requirements of the Rate Year.

B. Rates of payment have a direct relationship to the actual charges incurred by a patient based on the services utilized by that patient. Under this charge-based system hospitals are able to charge more for patients who require more or heavier care. Thus, this system is responsive to hospital financial needs in the face of changing casemix.

C. A payment on account factor (PAF), essentially a ratio of allowed hospital costs to allowed hospital charges, is also calculated for each hospital. A single payment on account factor will apply to a hospital's inpatient and outpatient services; Medicaid reimbursement will be equal to charges (or daily charge) times the payment-on-account factor. In no event shall the PAF exceed 100% of a hospital's charge for services.

D. Allowable costs for a State-Owned Non-Acute Hospital operated by the Department of Public Health are determined from a Base Year of FY2000.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

II. Definitions

Adjusted Base Year Volume: The actual Base Year volume adjusted to include the volume associated with recurring CBCs, new services, and transfers on of cost and exclude volume associated with Discontinued Services and transfers off of cost.

Base Year: The hospital's fiscal year 1993.

CBC: Cost Beyond Control.

Charge: The amount to be billed or charged by a hospital for each specific service within a revenue center.

Department of Mental Health (DMH): An agency of the Commonwealth of Massachusetts established under M.G.L. c. 19, §1 *et seq.*

Department of Public Health (DPH): An agency of the Commonwealth of Massachusetts established under M.G.L. c. 17, §1 *et seq.*

Division of Health Care Finance and Policy (DHCFP): An agency of the Commonwealth of Massachusetts established under M.G.L. c. 118G.

Discontinued Service: A health service, supply, or accommodation that: (a) is included in the adjusted Base Year cost and will not be offered during the Rate Year, or (b) is being offered and terminated during the Rate Year.

Direct Cost: The cost of a health service, supply, or accommodation, excluding administrative, overhead, and capital costs.

Gross Patient Service Revenue (GPSR): The total dollar amount of a hospital's Charges for services rendered during the reporting period, generally within a fiscal year.

Intermediate Year: The hospital fiscal year just before the current Rate Year.

Member: A person determined by the Commonwealth to be eligible for medical assistance under MassHealth.

Non-Acute Hospital: A hospital that is defined and licensed under M.G.L. c. 11, §51, with less than a majority of medical-surgical, pediatric maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, §29.

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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

Payment on Account Factor (PAF): A percentage applied to Charges to calculate a purchaser's discounted payment level.

Rate Year: The Rate Year will be 7/1 to 6/30.

Reasonable Financial Requirements (RFR): The sum of a hospital's Rate Year operating requirements, Rate Year capital requirements, and Rate Year working capital requirements.

State-Owned Non-Acute Hospital: A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical-surgical, pediatric, maternity, and obstetric beds, or any psychiatric facility operated by the Department of Mental Health (DMH).

Transfer of Cost: An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities that provide hospital care or services, and that change compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

III. Medicaid Payment Methodology for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health

For any particular Rate Year, a provider-specific Medicaid payment-on-account factor (PAF) will be calculated. This PAF is, in turn, applied to Charges billed to the Commonwealth by the hospital. The PAF is the result of dividing the ratio of the hospital's Rate Year allowable costs, called "RFR" by the Rate Year total Charges, called "GPSR." The process required to determine the Medicaid PAF involves the following steps:

- the determination of allowed Base-Year costs;
- the adjustment of allowed Base-Year costs to the Rate Year;
- the determination of Reasonable Financial Requirements (RFR) for the Rate Year; and
- the determination of approved gross patient revenue service for the Rate Year.

Each of these steps is explained in greater detail below.

A. Determination of Allowed Base-Year Costs

Each hospital must file with DHCFP reports of its costs, revenues, statistics, Charges, and other related information in accordance with time frames and reporting mechanisms specified by DHCFP.

1. Allowed Capital Costs

The Base-Year allowed capital cost is calculated as the sum of the Base Year cost of depreciation expense for building and fixed equipment, reasonable interest expense, amortization and leases and rental of facilities, subject to the following limitations.

a. Interest expense attributable to balloon payments on financed debt will not be allowed. Balloon payments are those in which the final payment on a partially amortized debt is scheduled to be larger than all preceding payments. Requests for interest associated with balloon-type payments must be adjusted to conform to the time period for conventional regular installment loans.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

b. Where there has been a change of ownership after July 18, 1984, the allowable basis of the fixed assets to be used in the determination of the depreciation and interest expense shall be the lower on the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The allowed depreciation expense shall be calculated using the full useful lives of the assets.

c. All costs (including legal fees, accounting, and administrative costs, travel costs and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any payer, and which have been included in any portion of the RFR, shall be subtracted from the capital requirement.

2. Allowed Operating Costs

a. The Base-Year allowed costs are established using actual 1993 fiscal year operating costs. This includes only costs incurred or to be incurred in the provision of hospital care and services, supplies, and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§1395 *et seq*. as set forth in 42 CFR 413 *et seq*. and the Provider Reimbursement Manual as well as Generally Accepted Accounting Principles.

b. The Base-Year allowed operating costs do not include costs of personnel or consultants where the primary purpose is, either directly or indirectly, to persuade hospital employees to support or oppose unionization.

c. The Base-Year allowed operating costs shall be adjusted whenever an audit discloses that Base Year operating costs expended by a hospital were not reasonable and necessary for the care of publicly-aided patients and did not meet the standards set forth in Section III.A.2.a above. The Base-Year allowed operating costs shall also be adjusted for discontinued costs and Transfer of Costs since the Base Year.

B. Adjustment of Allowed Base-Year Costs to the Rate Year

Allowed Base-Year operating and capital costs are adjusted for additional costs projected to occur in the Rate Year. These additional costs fall into the major categories of inflation, volume, costs beyond control (CBC), new services, and capital.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

1. Inflation

The allowed Base-Year operating costs are adjusted using a composite index comprised of two cost categories: labor and non-labor. These categories shall be weighted according to the weights used by the Centers for Medicare and Medicaid Services (CMS) for PPS-exempt hospitals. The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the non-labor category shall be the non-labor portion of the CMS market basket for hospitals. The composite inflation index will be increased by .02 in conformance with prior years' rate calculations.

2. Volume

Allowed Base-Year operating costs shall be further adjusted to reflect reasonable volume increases and decreases as follows:

a. DHCFP has required each hospital to report its costs, revenue, and volume data in accordance with its reporting requirements. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center shall equal the Base Year Direct Costs and indirect costs for that cost center divided by the year units. The volume associated the a Determination of Need (DoN) project, new service, or transfer on of cost shall be part of the volume used in the computation of the volume allowance. Any allowance due to new services, DoN, or transfer-on volume shall be netted out if the costs associated with it are submitted as new services, CBCs or transfers.

b. For projected volume increases or decreases from the Intermediate Year to the Rate Year that are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase shall be allowed without such explanation and documentation.

c. For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume shall be 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume shall be 60%. There shall be no upside corridors for volume increases.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

d. An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the Base Year to the Rate Year shall be calculated as the product of the projected increase in units multiplied by 50% of the allowed unit cost inflated by the base to Rate Year composite inflation index.

An increase in costs due to an increase in ancillary services volume from the Base Year to the Rate Year shall be calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost inflated by the base to Rate Year composite inflation index.

e. For routine inpatient care services, routine ambulatory services, and ancillary services, the allowed marginal cost for a unit decrease in volume shall be as follows:

Unit Decrease Cost	Allowed Marginal
Up to 5%	100.0%
Over 5% to 25%	50.0%
Over 25% to 50%	25.0%
Over 50% to 75%	12.5%
Over 75%	0.0%

There shall be no downside corridors for volume decreases.

f. A decrease in cost due to a decrease in routine inpatient care service, routine ambulatory care services or ancillary services volume shall be calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as described above, multiplied by the Allowed Unit Cost, inflated by the base to Rate Year composite inflation index.

3. Cost Beyond Control (CBC) of Hospital

a. Under specific circumstances, a State-Owned Non-Acute Hospital may request an increase in its allowed Base Year operating costs to include cost increases due to CBCs. A CBC is an unusual and unforeseen increase in reasonable and allowable costs, which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in the hospital's operating requirement.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

(1) A cost shall not be determined to be a CBC if in a prior fiscal year the DHCFP approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.

(2) The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted Base Year operating cost or in the inflation and volume allowances.

(3) The timing and amount of the increase in costs must be reasonably certain.

(4) A CBC shall be allowable only if the amount requested is greater than one-tenth of 1% of the hospital's total patient care costs.

(5) Multiple unrelated CBC requests for any one Cost Beyond Control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in (4) above.

(6) A CBC shall be allowable only if necessary for the appropriate provision of services to Members and if the costs cannot otherwise be met through efficient management and economic operation.

b. The following are the qualifying incidents or circumstances for CBCs:

(1) Costs generated by correcting deficiency contingencies or recommendations for failure to comply with changes in government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C. §§1395 *et seq*. and 42 U.S.C. §§1396 *et seq*. An example of this category is a cost incurred or expected to be incurred within six months to comply with a change in the manual issued after 1984 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a CBC. Hospitals that have not previously been accredited by JCAHO will be allowed reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost that would not be considered to be a CBC, is expanded emergency room coverage. Also, increased utilization review costs that are not due to any allowable CBC shall not be recognized. Documentation shall include a copy of the government requirement or contingency/ recommendation, verification of the increased costs, and verification that the increased costs are reasonable to meet the government requirement.

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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

(2) Costs generated by compliance with changes in government requirements that are set forth in federal or state regulations that mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by an inflation factor, it shall not be allowed as a cost beyond reasonable hospital control. Documentation shall include a copy of the government requirement or contingency/recommendation, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

(3) Costs generated by disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry or through negligence on the part of hospital management, such losses or costs shall not be approved.

(4) Allowed operating costs associated with a major capital expenditure or substantial change in services that is subject to and has received a determination of need (DoN) pursuant to M.G.L. c. 111 §§25B-25G. These costs must be segregated from other allowed operating costs. The hospital must demonstrate that the increased costs requests are reasonable. The hospital will not be permitted to make a volume adjustment for departments affected by a DoN if the hospital requests that the operating cost associated with the DoN be included as a CBC. Any volume allowance due to DoN shall be netted out if costs associated with it are submitted as a CBC.

(5) Wage parity adjustments resulting from mergers which are clearly demonstrated to be cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the individual hospitals have projected, and in no event are spending more than the combined projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring Cost Beyond Control and the costs associated with it will be subtracted from Rate Year costs for any year in which the Rate Year becomes the Base Year for future rates.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

(6) Intra-hospital wage and salary adjustments that are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments.

(a) Documentation shall provide a projection of the costs savings to be achieved as a result of adjustments to wages and salaries.

(b) This adjustment will be considered a non-recurring Cost Beyond Control. Costs associated with this CBC will be subtracted from Rate Year costs for any year in which the Rate Year becomes the Base Year for future Rate Years.

(7) Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This CBC is not to exceed actual expenditures for such increases.

(a) Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for CBC allowance.

(b) The CBC for reasonable increases in direct care staff salaries and wages is defined as the reasonable Rate-Year wage rate less the inflated Base-Year wage rate, times the lesser of the Rate Year FTE direct care labor force or the Base-Year FTE direct care labor force.

(c) The inflation allowance for direct care staff includes the full amounts granted in Section III.B.1.

(d) The reasonable Rate Year wage shall be the level of increase required to attract sufficient staff to ensure minimum availability of care as determined by the Department of Public Health for current patients. The wage rate will be determined by the Commonwealth with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

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(i) outlier wage rates as defined by the Commonwealth shall be excluded from the computation;

(ii) special weight shall be given to rates prevailing at Non-Acute Hospitals located in the hospital's Medicare labor market region;

(iii) if it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital shall be given special weight; and

(iv) in no case shall the reasonable Rate Year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application.

(v) the determined Medicare Labor Market Regions and their associated counties are as follows:

Medicare Labor Market Region	Counties
Eastern Mass	Bristol
	Essex
	Middlesex
	Norfolk
	Plymouth
	Suffolk
	Worcester
Berkshire	Berkshire
Springfield	Hampden
	Hampshire
Barnstable	Barnstable
	Dukes
	Nantucket
Rural	Franklin

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

(e) In order to be eligible for this exception, a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the following criteria:

(i) existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, Joint Commission on Accreditation of Health Care Organizations standards, or other qualifying guidelines utilized in Massachusetts to ensure adequate care;

(ii) persistent difficulty in recruitment given bona fide recruitment efforts to obtain staffing levels; and

(iii) existing dependency upon temporary nursing services in order to maintain staffing levels.

(8) An increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. The hospital shall have the burden of demonstrating a net increase in intensity from either the Base Year or the last year for which a casemix adjustment has been made (whichever was later) to the intermediate or Rate Year. The higher intensity level in the intermediate or Rate Year shall be used to adjust RFR.

(a) Psychiatric Hospitals may demonstrate that increases in certain intensity factors between the Base Year and the Intermediate Year have led to increases in service intensity (e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Intensity factors include, changes in: age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

(b) If the documentation for the increase in intensity is found to be acceptable, then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of intensity

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

(9) Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third-party reimbursers separately for their professional services. The amount of the approved exception allowance will be the net of all the increases already determined through the inflation allowance for malpractice insurance premiums from the Base Year forward and included in the hospital's Medicaid rates. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the hospital and do not bill separately for their services. The hospital may include in the CBC request the amount of any retroactive premium payments to be made during the Rate Year.

No costs other than those meeting the criteria set forth in one or more of the above categories shall constitute a cost beyond the reasonable control of the hospital.

4. New Services

Certain health services that were not offered by a hospital in the Base Year, meeting the data reporting and other requirements described in Section III.A herein, are included in the operating requirements as new services. The allowable cost for a new service is equal to the reasonable operating costs attributed to the new service cost centers.

5. Capital

The Base Year capital requirement shall be adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases and decreases in amortization, leases, and rentals, subject to the limitations contained in Section III.A.1 herein.

C. Determination of Reasonable Financial Requirements (RFR) for the Rate Year

The rate-year RFR is calculated with the following formula:

RFR = (Rate-Year Operating Requirement + Rate-Year Capital Requirement + Rate-Year Working Capital Requirement)

1. The Rate Year operating requirement is the sum of the Base-Year allowed operating cost and the adjustment of the Base-Year allowed operating costs to the Rate Year.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

2. The Rate Year capital requirement is the sum of the Base-Year allowed capital and the adjustment of the Base Year capital to the Rate Year.

3. The Rate Year working-capital requirement will be determined by multiplying the sum of the Rate-Year operating and capital requirements by 0.0055.

D. Determination of Approved Gross Patient Service Revenue for the Rate Year

A State-Owned Non-Acute Hospital's GPSR is its total dollar amount of its projected Charges for the Rate Year.

IV. Medicaid Payment Methodology for State-Owned Non-Acute Hospitals Operated by the Department of Public Health

For any Rate Year, a statewide Payment-on-Account Factor (PAF) will be calculated using the following formula:

A. **Data Source:** a single statewide PAF will be determined by using FY2000 HCFP-403 cost report data filed by State-Owned Non-Acute Hospitals operated by the Department of Public Health providing similar services.

B. **Calculation:** the sum of the Total Patient Service Expenses divided by the sum of the Total Gross Patient Service Revenue.

C. The Total Patient Service Expenses and the Total Gross Patient Service Revenue will include both inpatient and outpatient services.

D. The single, statewide PAF will apply to both inpatient and outpatient Charges.

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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

V. Rates of Payment for Medicaid Services

1. For all State-Owned Non-Acute Hospital services, the Medicaid rate of payment is equal to the PAF multiplied by the approved Charge for each eligible service provided to a MassHealth Member.

2. In the event that a State-Owned Non-Acute Hospital incurs patient care expenditures for services provided to MassHealth members that significantly exceeds the aggregate amount of MassHealth payments hereunder, the State Owned Non-Acute Hospital may request a retrospective reconciliation to adjust the PAF. Any request for retrospective reconciliation must be submitted to the state Medicaid agency no later than 120 days following the filing of cost reports applicable to the period for which the retrospective reconciliation is sought. Each such request shall be reviewed to ensure compliance with all applicable state and federal Title XIX requirements, including the federal upper payment limit requirements. In reviewing such a request for retrospective reconciliation, the state Medicaid agency shall compare the total patient care costs for services provided to MassHealth members with the aggregate amount of MassHealth payments during the period for which reconciliation is sought.

3. Following such review, the state Medicaid agency may compute a revised PAF that reflects any significant changes since the base year in utilization, cost trends or service delivery. If a revised PAF is computed, the state Medicaid agency shall notify the State-Owned Non-Acute Hospital in writing and, where applicable, shall issue an amendment to the provider agreement that specifies the revised PAF.

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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

VI. New Hospitals

For new hospitals that were not licensed and/or operated as State-Owned Non-Acute Hospitals in RY1998, or that did not have a Base Year previously established, the Commonwealth may consider alternative data sources to determine Base Year costs. Criteria for such review will include but not be limited to peer group analysis of costs incurred and the determination of approved rates for comparable facilities.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

VII. Medicaid Disproportionate Share Adjustments

The Medicaid program will assist hospitals that carry a disproportionate financial burden of caring for the uninsured and low-income persons of the Commonwealth. In accordance with Title XIX rules and requirements, the Commonwealth will make an additional payment adjustment for hospitals that qualify under the State Plan. The requirements to qualify for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described below.

A. To qualify for any type of disproportionate share payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing MassHealth patient days by total patient days) of not less that 1%.

B. In accordance with the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA), total disproportionate share adjustments for the two state fiscal years commencing on July 1, 2003 and July 1, 2004 for qualifying State-Owned Non-Acute Hospitals will not exceed 175% of the uncompensated cost of care to Medicaid-eligible and uninsured individuals.

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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

VIII. Federally Mandated Disproportionate Share Adjustments

A. Data Sources. The Commonwealth shall determine for each fiscal year a federally mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The prior year DHCFP-403 report shall be used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient Charges and free care charge-off. If said DHCFP-403 report is not available prior year DHCFP-403 report to estimate these variables.

B. Determination of Eligibility under the Medicaid Utilization Method. The Commonwealth shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of all non-acute care hospitals for the federally mandated disproportionate share adjustment. The Commonwealth shall determine such threshold as follows:

1. First, calculate the statewide weighted average Medicaid inpatient utilization rate by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total inpatient days for all non-acute care hospitals in the state.

2. Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

3. Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted averaged Medicaid inpatient utilization rate. The sum of these two numbers shall be the threshold Medicaid inpatient utilization rate.

4. The Commonwealth shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to Section VIII.B.1, then the hospital shall be eligible for the federally mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

C. Determination of Eligibility Under the Low-Income Utilization Rate Method

The Commonwealth shall then calculate each hospital's low-income utilization rate. The Commonwealth shall make such determination as follows:

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

1. First, calculate the Medicaid and subsidy share of net revenues by dividing the sum of Medicaid net revenues plus state and local government subsidies by the sum of total net revenues plus state and local government subsidies.

2. Second, calculate the free care percentage of total inpatient Charges by dividing the inpatient share of audited free care Charge-off by total inpatient Charges.

3. Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of net revenues calculated pursuant to Section VIII.C.1 to the free care percentage of total inpatient Charges calculated pursuant to Section VIII.C.2. If the low-income utilization rate exceeds 25%, the hospital shall be eligible for the federally mandated Medicaid disproportionate share adjustment under the low-income utilization rate method.

D. Determination of Payment. The payment under the federally mandated disproportionate share adjustment shall be calculated as follows:

1. For each hospital determined eligible for the federally mandated disproportionate share adjustment under the Medicaid utilization method established in Section VIII.B, the Commonwealth shall divide the hospital's Medicaid utilization rate calculated pursuant to Section VIII.B.4 by the threshold Medicaid utilization rate calculated pursuant to Section VIII.B.3. The ratio resulting from such division shall be the federally mandated disproportionate share ratio.

2. For each hospital determined eligible for the federally mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally mandated Medicaid utilization method, the Commonwealth shall set the hospital's federally mandated disproportionate share ratio equal to one.

3. The Commonwealth shall then determine, for the group of all eligible hospitals, the sum of federally mandated disproportionate share ratios calculated pursuant to Section VIII.D.1 and Section VIII.D.2.

4. The Commonwealth shall then calculate a minimum payment under the federally mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to Section VIII.E for payments under the federally mandated disproportionate share adjustment by the sum of the federally mandated disproportionate share ratios calculated pursuant to Section VIII.D.3.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

5. The Commonwealth shall then multiply the minimum payment under the federally mandated Medicaid disproportionate share adjustment by the federally mandated Medicaid disproportionate share ratio established for each hospital pursuant to Section VIII.D.1 and VIII.D.2. Subject to the limits herein, the product of such multiplication shall be payment under the federally mandated disproportionate share adjustment.

E. **Allocation of Funds**

The total amount of funds allocated for payment to non-acute hospitals under the federally mandated Medicaid disproportionate share adjustment is one hundred fifty thousand dollars annually. This amount is proportionately allocated among the eligible hospitals as determined pursuant to Section VIII.D.5.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

IX. Extraordinary Disproportionate Share Adjustment for Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health

The Commonwealth shall determine an extraordinary disproportionate share adjustment for all eligible Special Population State-Owned Non-Acute Hospitals, using the data and methodology described below.

A. Data Sources

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, Charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Commonwealth shall use the most recent available pervious DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Commonwealth shall determine and use the best alternative data source.

B. Determination of Eligibility

1. In order to qualify for the extraordinary disproportionate share payment adjustment, a State-Owned Non-Acute Hospital must:

   a. be owned or operated by the Massachusetts Department of Public Health;

   b. provide treatment to people with AIDS, tuberculosis patients, the medically needy homeless, multiply handicapped pediatric patients and patients with combined medical and psychiatric needs;

   c. participate as a Non-Acute Hospital provider in the MassHealth programs;

   d. meet the low-income standard as set forth in Section IX.B.2; and

   e. meet the unreimbursed cost standard as set forth in Section IX.B.3.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

2. Low-Income Standard

a. For each state-owned special population Non-Acute Hospital, the Commonwealth shall calculate the hospital-specific low-income utilization rate as follows:

(1) The Commonwealth shall divide each hospital's net Medicaid revenue by its total Gross Patient Service Revenue.

(2) The Commonwealth shall divide each hospital's free care Charges by its total Charges.

(3) The total of these percentages shall equal the hospital's low-income utilization rate.

b. If the hospital-specific low-income utilization rate exceeds 45%, then the state-owned special population Non-Acute Hospital meets the low-income standard.

3. Unreimbursed Cost Standard

a. For each state-owned special population Non-Acute Hospital, the Commonwealth shall calculate the hospital-specific unreimbursed cost percentage as follows:

(1) The Commonwealth shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid Charges plus self pay Charges plus free care Charges to total Charges.

(2) The Commonwealth shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in Section IX.B.3.a(1) to determine the amount of unreimbursed costs.

(3) The Commonwealth shall divide the amount of unreimbursed costs determined in Section IX.B.3.a(2) by the costs determined in Section IX.B.3.a(1) to determine the percentage of unreimbursed costs.

b. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the state-owned special population Non-Acute Hospital meets the unreimbursed cost standard.

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State: Massachusetts
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Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

C. Determination of Payment

Subject to the limits herein, for each state-owned special population Non-Acute Hospital that qualifies for the extraordinary disproportionate share adjustment under Section IX.B, the payment amount shall be calculated as follows:

1. first, determine the annual cost and revenue of providing hospital services to Medicaid-eligible and uninsured individuals using the data sources set forth in Section IX.A;

2. second, subtract the annual revenue from the annual costs to determine the uncompensated costs of providing services to Medicaid-eligible and uninsured individuals;

3. calculate adjustments to account for any significant changes in utilization, cost trends, or payment methods. Inflation will be considered by applying a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals;

4. for state fiscal years 2004 and 2005, the payment amount shall be computed up to 175% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

X. Extraordinary Disproportionate Share Adjustment for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health

The Commonwealth shall determine an extraordinary disproportionate share adjustment for all eligible State-Owned Non-Acute Hospitals operated by the Department of Mental Health, using the data and methodology described below.

A. Data Sources

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, Charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Commonwealth shall use the most recent available previous DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Commonwealth shall determine and use the best alternative source.

B. Determination of Eligibility

1. In order to be eligible for the extraordinary disproportionate share payment adjustment, a State-Owned Non-Acute Hospital operated by the Department of Mental Health must:

   a. be owned or operated by the Massachusetts Department of Mental Health;

   b. specialize in providing psychiatric/psychological care and treatment;

   c. participate as a psychiatric inpatient hospital provider in the MassHealth program;

   d. meet the low-income standard as set forth in Section X.B.2 below; and

   e. meet the unreimbursed cost standard as set forth in Section X.B.3.

2. Low-Income Standard

   a. For each state-owned non-acute hospital operated by the Department of Mental Health, the Commonwealth shall calculate the hospital-specific low-income utilization rate as follows:

      (1) The Commonwealth shall divide each hospital's net Medicaid revenue by its total Gross Patient Service Revenue.

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

(2). The Commonwealth shall divide each hospital's free care Charges by its total Charges.

(3) The total of these percentages shall equal the hospital's low-income utilization rate.

b. If the hospital-specific low-income utilization rate exceeds 45%, then the State-Owned Non-Acute Hospital meets the low-income standard.

3. Unreimbursed Cost Standard

a. For each State-Owned Non-Acute Hospital operated by the Department of Mental Health, the Commonwealth shall calculate the hospital-specific unreimbursed cost percentage as follows:

(1) The Commonwealth shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ration of Medicaid charges plus self pay charges plus free care Charges to total Charges.

(2) The Commonwealth shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in Section X.B.3.a(1), to determine the amount of unreimbursed costs.

(3) The Commonwealth shall divide the amount of unreimbursed costs determined in Section X.B.3.a(2) by the costs determined in Section X.B.3.a(1) to determine the percentage of unreimbursed costs.

b. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the State-Owned Non-Acute Hospital meets the unreimbursed cost standard.

C. Determination of Payment

Subject to the limits herein, for each State-Owned Non-Acute Hospital operated by the Department of Mental Health determined eligible for the extraordinary disproportionate share adjustment under Section X.B, the payment amount shall be equal to the estimated Rate Year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

Methods Used to Determine Rates of Payment for Services in State-Owned Non-Acute Hospitals (cont.)

1. first, determine the annual cost and revenue of providing hospital services to Medicaid-eligible and uninsured individuals using the data sources set forth in Section X.A;

2. second, subtract the annual revenue from the annual costs to determine the uncompensated costs of providing services to Medicaid-eligible and uninsured individuals;

3. calculate adjustments to account for any significant changes in utilization, cost trends, or payment methods. Inflation will be considered by applying a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals;

4. for state fiscal years 2004 and 2005, the payment amount shall be computed up to 175% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

D. Limits on Allocation of Funds

The total amount of funds allocated for payment to State-Owned Non-Acute Hospitals operated by the Department of Mental Health shall be proportionately reduced to stay within the limits for disproportionate share payments for institutions for mental diseases (IMDs) reported by the Commonwealth to Health Care Financing Administration in accordance with limits pursuant to 42 U.S.C. 1396r-4.

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XI. Provider Preventable Conditions

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Attachment 4.19-A(3) (State-Owned Non-Acute Hospitals) of this State plan where applicable.

☒Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-A(3) (State-Owned Non-Acute Hospitals) of this State plan, where applicable.

☒Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient

☒ Additional Other Provider-Preventable Conditions identified below
For State-owned Non-Acute Hospitals operated by the Department of Public Health only, where applicable:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

    1. Foreign object retained after surgery.
    2. Air Embolism
    3. Blood incompatibility
    4. Stage III and IV Pressure Ulcers
    5. Falls and Trauma, related to:
        - fractures
        - dislocations
        - intracranial injuries

- crushing injuries
- burns
- other injuries

- In addition, the following:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

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A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method

A. State-Owned Non-Acute Hospitals Operated by the Department of Mental Health

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

For inpatient services, provider preventable conditions ("PPCs") are defined as those conditions that are identified as Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs consist of the three National Coverage Determinations (the "NCDs") that are listed above.

For outpatient services, provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs consist of the three National Coverage Determinations (the "NCDs") that are listed above.

When a hospital reports a PPC that the hospital indicates was not present on admission, MassHealth will reduce payments to the hospital by not paying for services which the hospital indicates are PPC-related, excluding PPC-related costs/services during any retrospective reconciliation, and excluding any PPC-related costs /services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

B. State-Owned Non-Acute Hospitals Operated by the Department of Public Health

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

For inpatient services, provider preventable conditions ("PPCs") are defined as those conditions that are identified as Health Care-Acquired Conditions ("HCACs") and Other Provider-

Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above.

For outpatient services, provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above.

When a hospital reports a PPC that the hospital indicates was not present on admission, MassHealth will reduce payments to the hospital by not paying for services which the hospital indicates are PPC-related, excluding PPC-related costs/services during any retrospective reconciliation, and excluding any PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

If a hospital reports that it provided follow-up services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided during the follow-up stay or visit, payment will be made, but MassHealth will exclude PPC-related costs/services during any retrospective reconciliation and will exclude any PPC-related costs /services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for services, including co-payments and deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the commonwealth shall adjust reimbursements according to the methodology above.

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XII. Serious Reportable Events for State-Owned Non-Acute Hospitals Operated by the Department of Public Health

The non-payment provisions set forth in this Section XII apply to the following serious reportable events (SREs) only for state-owned non-acute hospitals operated by the Department of Public Health, where applicable:

1. Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person.

2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.

3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient / resident of any age.
5. Sexual abuse / assault on a patient or staff member within or on the grounds of a healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital services include:

1. All services provided during the inpatient stay during which a preventable SRE occurred, from the date the SRE occurred through discharge, not to exceed 60 days; and

2. All services provided during the outpatient visit during which a preventable SRE occurred; and

3. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

   a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

   b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

4. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

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Non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 3 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital services provided to the patient following a preventable SRE.

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Methods and Standards for Establishing Payment Rates – Other Types of Care

1. Below is a description of the policy and the methods to be used in establishing payment rates for each type of care or service listed in Section 1905(a) of the Social Security Act that is included in the state's medical assistance program.

2. Payments for care or service are not in excess of the upper limits described in 42 CFR Part 447, Subpart D.

3. The state agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or services or fee plus costs of materials.

4. The state agency has access to data identifying the maximum charges allowed; such data will be made available to the Secretary of Health and Human Services upon request.

5. Fee structures will be established that are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

6. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure. No supplementation exists with respect to payment for care furnished in skilled nursing homes.

7. Any increase in payment structure that applies to individual practitioner services will be documented in accordance with the requirements of 42 CFR 447.204.

8. The following is a description of the payment structures by practitioners of services:

   a. Outpatient hospital services — Percentage of charges or fee per visit. See relevant portions of Attachment 4.19-B(1) for a detailed explanation of how the percentage is determined.

   b. Laboratory and X-ray services — The fee-for-service rates for laboratory services are effective for services provided on or after August 1, 2015. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#114_3_20. To ensure compliance with 42 USC 1396b(i)(7), for laboratory tests for which Medicare rates are established, payment is the lowest of the provider's usual and customary charge, the Commonwealth's fee schedule, or the Medicare rate. For x-ray and other radiology services, see Attachment 4.19-B, section 8.d.3 (radiology provision within physician services reimbursement) for the fee-for-service rates. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

   c. Periodic screening and diagnosis of individuals who are eligible under the plan and are under the age of twenty-one to ascertain their physical or mental defects, and such health care, treatment and other measures to correct or ameliorate defects and chronic conditions discovered thereby, as may be provided in regulations of the Department of Health and Human Services.

d. Physician, Certified Nurse-Midwife, Certified Pediatric and Family Nurse Practitioner, and other Midlevel Practitioner services —

1. Medicine**:** The fee-for-service rates for physician, certified nurse-midwife, certified pediatric and family nurse practitioner, and other midlevel practitioner medicine services are effective for services provided on or after March 1, 2018. All rates are published on https://www.mass.gov/regulations/101-CMR-31700-medicine. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

2. Surgery and Anesthesia: The fee-for-service rates for physician, certified nurse-midwife, certified pediatric and family nurse practitioner, and other midlevel practitioner surgery and anesthesia services are effective for services provided on or after March 1, 2018. All rates are published on https://www.mass.gov/regulations/101-CMR-31600-surgery-and-anesthesia. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

3. Radiology: The fee-for-service rates for physician, certified nurse-midwife, certified pediatric and family nurse practitioner, and other midlevel practitioner radiology services are effective for services provided on or after January 1, 2019. All rates are published on https://www.mass.gov/regulations/101-CMR-31800-radiology. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

A physician, nurse practitioner, physician's assistant or certified registered nurse anesthetist employed by the non-profit UMass Memorial Medical Group practice established in accordance with St. 1997, c. 163 to support the purposes of a teaching hospital affiliated with a Commonwealth-owned medical school is eligible to receive an additional payment for physician services provided at such teaching hospital. Such payment will be a percentage, which shall not exceed 100%, of the difference between (1) payments to the eligible provider made pursuant to the fee schedule, and (2) the annually calculated average private commercial rate, where the average private commercial rate is derived using the ratio of commercial payments to commercial charges applied to paid Medicaid claims as reported to the MMIS. Such payment is made annually by the first quarter following the end of the preceding rate year. The payment made for rate year 2006 will take into account amounts attributable to rate years beginning with the effective date of this payment methodology (October 1, 2004).

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e. Medical or other type of remedial care recognized under the laws of the Commonwealth furnished by licensed practitioners within the scope of their practice as defined by the laws of the Commonwealth:

1. Audiological Services

The fee-for-service rates are effective for services provided on or after April 7, 2017. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#114_3_23. The published rates include a fee schedule for services provided from the effective date through April 6, 2018 and a fee schedule for services provided on or after April 7, 2018. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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e. Medical or other type of remedial care recognized under the laws of the Commonwealth furnished by licensed practitioners within the scope of their practice as defined by the laws of the Commonwealth:

2. Chiropractor Services

See Attachment 4.19-B, section 8.d for the fee-for-service rates for chiropractor services. This section of Attachment 4.19-B is the reimbursement method for physician services.

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e. Medical or other type of remedial care recognized under the laws of the Commonwealth furnished by licensed practitioners within the scope of their practice as defined by the laws of the Commonwealth:

3. Optometric Services (including professional fee and certain items dispensed)

The fee-for-service rates are effective for services provided on or after January 1, 2017. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#114_3_15. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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e. Medical or other type of remedial care recognized under the laws of the Commonwealth furnished by licensed practitioners within the scope of their practice as defined by the laws of the Commonwealth:

4. Psychologist Services

The fee-for-service rates are effective for services provided on or after January 1, 2017. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#114_3_29. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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e. Medical or other type of remedial care recognized under the laws of the Commonwealth furnished by licensed practitioners within the scope of their practice as defined by the laws of the Commonwealth:

5. Public Health Dental Hygienist

See Attachment 4.19-B, section 8.j for the fee-for-service rates for Public Health Dental Hygienists. This section of Attachment 4.19-B is the reimbursement methodology for dental services including dentures and prosthetic devices.

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e. Medical or other type of remedial care recognized under the laws of the Commonwealth furnished by licensed practitioners within the scope of their practice as defined by the laws of the Commonwealth:

6. Midlevel Practitioners

See Attachment 4.19-B, section 8.d. for the fee-for-service rates for midlevel practitioner services. This section of Attachment 4.19-B is the reimbursement methodology for physician and midlevel practitioner services.

f. Home health care services — see Attachment 4.19-B pages 2a-1 through 2a-7.

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g. The fee-for-service rates for private duty nursing services are effective for services provided on or after February 23, 2018. All rates are subject to a public notice and hearing process and published on www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-350.pdf. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

h. Clinic services — Payments under this section are described below, and comply with the Federal upper payment limits (UPL) established under 42 CFR 447.321.

1. Designated Emergency Mental Health Providers (DEP/ESP)
   Attachment 4.19-B, section 8.s. describes payments to designated emergency mental health provider/emergency service programs.

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(Item h. Clinic Services, continued)

2. Freestanding Ambulatory Surgical Centers:
The fee-for-service rates are effective for services provided on or after November 30, 2018. All rates are published on https://www.mass.gov/regulations/101-CMR-34700-freestanding-ambulatory-surgery-centers. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

(Item h. Clinic Services, continued)

3. Family Planning Clinics

The fee-for-service rates are effective for services provided on or after January 25, 2019. All rates are published on https://www.mass.gov/regulations/101-CMR-31200-family-planning-services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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4. Sterilization Clinics

The fee-for-service rates are effective for services provided on or after February 22, 2019. All rates are published on https://www.mass.gov/regulations/101-CMR-31300-rates-for-freestanding-clinics-providing-abortion-and-sterilization. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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5. Radiation Oncology Centers

See Attachment 4.19-B, sections 8.b and 8.d. for the fee-for-service rates for Radiation Oncology Centers. These sections of Attachment 4.19-B are reimbursement methodologies for x-ray and physician services, respectively.

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6. Renal Dialysis Clinics

The fee-for-service rates are effective for services provided on or after January 1, 2017. All rates are published on http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-337.pdf. The published rates include a fee schedule for services provided from the effective date through December 15, 2017 and a fee schedule for services provided on or after December 16, 2017. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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7. Rehabilitation Centers

See Attachment 4.19-B, section 8.k for the fee-for-service rates for Rehabilitation Centers. Section 8.k of Attachment 4.19-B is the reimbursement methodology for therapies and related services.

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8. Speech and Hearing Centers

See Attachment 4.19-B, sections 8.e.1 and 8.k for the fee-for-service rates for Speech and Hearing Centers. Section 8.e.1 of Attachment 4.19-B is the reimbursement methodologies for audiological services. Section 8.k of Attachment 4.19-B is the reimbursement methodologies for therapies and related services.

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9. Mental Health Centers

The fee-for-service rates are effective for service provided on or after January 26, 2019. All rates are published on https://www.mass.gov/ regulations/101-CMR-30600-rates-of-payment-for-mental-health-services-provided-in-community-health. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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10. Substance Use Disorder Treatment Clinics
The fee-for-service rates published https://www.mass.gov/files/documents/2019/07/01/jud-lib-101cmr346.pdf are effective for services provided on or after **July 1, 2019**.

The fee-for-service rates published on https://www.mass.gov/files/documents/2019/02/14/101-cmr-444.pdf are effective on **January 25, 2019** previous published rates for identical procedure codes billed by Substance Use Disorder Treatment Clinics are superseded by the rates displayed in this fee schedule.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

(Item h. Clinic Services, continued)

11. Indian Health Services (IHS) Facilities

Payment is made to Indian Health Services (IHS) facilities (including Section 638 tribal facilities) in accordance with the most recently published *Federal Register* notice addressing the I.H.S. encounter rate. Medicaid services covered by the all-inclusive rate include the following:

a. early and periodic screening, diagnosis and treatment services;
b. family planning services and supplies;
c. physicians' services;
d. medical care and any other remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law (i.e., podiatrist, optometrist, chiropractor, and audiologist services);
e. rural health clinic services;
f. home health services;
g. private duty nursing services;
h. clinic services;
i. dental services;
j. physical therapy and related services;
k. other diagnostic, screening, preventive, and rehabilitation services;
l. nurse-midwife services;
m. case management services;
n. extended services for pregnant women;
o. ambulatory prenatal care for pregnant women; and
p. pediatric or family nurse practitioners' services.

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(Item h. Clinic Services, continued)

12. Limited Services Clinic (LSC) - See Attachment 4.19-B, sections 8.b and 8.d for the fee-for-service rates for Limited Services Clinics. These sections of Attachment 4.19-B are reimbursement methodologies for laboratory and physician services, respectively.

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i. Rural health clinics: See Attachment 4.19-B, page 2 and 2i

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j. Dental services (including dentures and prosthetic devices) —

1. Fee-for-Service Rates

The fee-for-service rates for dental services, other than those provided by dentists who are also oral surgeons and use the Current Procedural Terminology (CPT) codes, are effective for services provided on or after October 1, 2018, and are published on https://www.mass.gov/regulations/101-CMR-31400-dental-services. For oral surgeons using CPT codes, see Attachment 4.19-B, section 8.d. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

2. High Medicaid Volume Intellectual/Developmental Disability Dental Provider Supplemental Payment

a. Eligibility

In order to qualify for this payment, a dental provider must have provided at least 70% of all MassHealth Behavioral Management visits in SFY18, and must enter into a separate payment agreement with EOHHS relating to payment as a High Medicaid Volume Intellectual/Developmental Disability Dental Provider. Based on these criteria, Tufts Dental Facilities is the only dental provider eligible for this payment.

b. Payment Methodology

Effective April 1, 2019, such payment will be the difference, not to exceed $3.0 million, between (1) annual (July 1 to June 30) payments to the eligible dental provider made pursuant to the fee schedule as reported to the MMIS, and (2) the annually calculated average private commercial rate, where the average private commercial rate is derived from commercial fee schedules applied to paid Medicaid claims as reported to the MMIS. Such payment is made as an annual lump sum by the first quarter following the end of the preceding rate year (September 30), and in equal quarterly installments thereafter.

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k. **Physical therapy and related services** —The fee-for-service rates are effective for services provided on or after April 7, 2017. All rates are published on https://www.mass.gov/regulations/101-CMR-33900-restorative-services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

This payment methodology for physical therapy and related services supersedes the payment methodology as described in section 8.k on page 1b of Attachment 4.19-B of TN 06-005.

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l. **Prescribed drugs, dentures, prosthetic devices, and eyeglasses** prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select — fee schedules established by EOHHS.

1. **Prescribed drugs**: The agency's rates were set by regulation as of April 1, 2017 and are effective for services on or after that date. All rates are published at http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr331. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

A. For multiple source drugs that are neither brand name drugs designated as Brand Name Preferred nor brand name drugs that have been certified by the prescriber as medically necessary on the prescription form, requiring a prescription and dispensed by community retail pharmacies, other than blood clotting factor and drugs obtained through the 340B pricing program or through the Federal Supply Schedule, payment shall not exceed the lowest of:

i. Federal Upper Limit (FUL), plus the professional dispensing fee;
ii. The lowest price for the drug available from one or more surveys of pharmacy costs designated by the agency, or, if no such surveys have been so designated, the drug's National Average Drug Acquisition Cost (NADAC), plus the professional dispensing fee;
iii. The drug's wholesale acquisition cost (WAC), if and only if no price determined in accordance with l(1)(A)(ii) above is available for the drug, plus the professional dispensing fee;
iv. The lowest price for a therapeutic equivalent of the drug available from one or more surveys of pharmacy costs designated by the agency, or, if no such surveys have been so designated, the lowest NADAC for a therapeutic equivalent of the drug, plus the professional dispensing fee; and
v. Usual and customary charge.

B. For single source drugs, and multiple source drugs that have been designated as Brand Name Preferred, and multiple source drugs that are brand name drugs that have been certified by the prescriber as medically necessary on the prescription form, requiring a prescription and dispensed by community retail pharmacies, other than blood clotting factor and drugs obtained through the 340B pricing program or through the Federal Supply Schedule, payment shall not exceed the lower of:

i. The lowest price for the drug available from one or more surveys of pharmacy costs designated by the agency, or, if no such surveys have been so designated, the drug's NADAC, plus the professional dispensing fee;
ii. The drug's WAC, if and only if no price determined in accordance with l(1)(B)(i) above is available for the drug, plus the professional dispensing fee; and
iii. Usual and customary charge.

C. For drugs dispensed by institutional or long term care pharmacies, drugs dispensed by specialty pharmacies, and drugs primarily dispensed through the mail (other than through the 340B pricing program and the Federal Supply Schedule), payment shall be determined in accordance with paragraphs A and B above.

D. For blood clotting factor not obtained through the 340B pricing program, payment shall not exceed the lowest of:

i. The lowest price for the drug available from one or more surveys of pharmacy costs designated by the agency, or, if no such surveys have been so designated, the drug's NADAC, plus the professional dispensing fee;
ii. The drug's WAC, if and only if no price determined in accordance with l(1)(D)(i) above is available for the drug, plus the professional dispensing fee;
iii. Average Sales Price (ASP) of the drug plus 6%, plus the professional dispensing fee; and
iv. Usual and customary charge.

E. For drugs other than blood clotting factor obtained through the 340B pricing program, whether dispensed by a 340B covered entity or a contract pharmacy under contract with a 340B covered entity, payment shall be the 340B Actual Acquisition Cost (AAC) of the drug, plus the professional dispensing fee.

F. For blood clotting factor obtained through the 340B pricing program, payment shall be the 340B Ceiling Price of the drug, plus the professional dispensing fee.

G. For drugs obtained at nominal prices and not obtained through the 340B pricing program or the Federal Supply Schedule, payment shall be the actual acquisition cost of the drug, plus the professional dispensing fee.

H. No Massachusetts providers obtain drugs for Medicaid members through the Federal Supply Schedule. Payment for such drugs will be defined in a state plan amendment if that circumstance changes.

I. No Indian Health Service, tribal, and urban Indian pharmacies are enrolled in Massachusetts at this time. Payment to such entities will be defined in a state plan amendment if that circumstance changes.

J. Investigational drugs are not covered.

K. Physician administered drugs.

i. For drugs administered at a physician's office that appear on the Medicare B fee schedule, payment shall not exceed ASP of the drug plus 6%.

ii. For other drugs administered at a physician's office, payment shall not exceed the provider's actual acquisition cost as determined from the provider's invoice.

iii. For drugs administered in the acute outpatient hospital setting for which direct reimbursement is made to the hospital, payment is as specified in Attachment 4.19-B(1), Section III of the State Plan, including for drugs that are defined as "APEC Carve-Out Drugs" under Section II of such Attachment 4.19-B(1).

iv. For drugs administered in the acute inpatient hospital setting for which direct reimbursement is made to the hospital, payment is as specified in Attachment 4.19-A(1), Section III of the State Plan, including for drugs that are defined as "APAD Carve-Out Drugs" under Section II of such Attachment 4.19-A(1).

L. Professional dispensing fees for prescribed drugs.

i. The professional dispensing fee for compounded drugs whose dispensing involves the mixing two or more commercially prepared products is $17.52.
ii. The professional dispensing fee for compounded drugs whose dispensing involves compounding lotions, shampoos, suspensions, or the mixing of powders or liquids into cream, ointment, or gel base is $20.02.
iii. The professional dispensing fee for compounded drugs whose dispensing involves compounding capsules, troches, suppositories, or pre-filled syringes $25.02.
iv. The professional dispensing fee for compounded drugs needing a sterile environment when mixing is $40.02.
v. The professional dispensing fee for blood clotting factor not obtained through the 340B program is $10.02.
vi. The professional dispensing fee for blood clotting factor obtained through the 340B program is 2.75 cents per unit.
vii. The professional dispensing fee for all other prescribed drugs is $10.02.

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- The dispensing fee for all other non-compounded drugs is $3.00 per prescription.
- The dispensing fee for compounded drugs is:
  - $3.00 per prescription, plus
  - an additional $1.00 for compounding ointments or solutions or preparing solutions that involves the weighing of ingredients ; or
  - an additional $2.00 for compounding suppositories or capsules, tablets, triturates or powders.

This payment methodology for prescribed drugs described in section 8.l on pages 1e and 1f of Attachment 4.19-B of TN-09-010(B) supersedes the payment methodology for prescribed drugs as described in section 8.l on page 1b of Attachment 4.19-B of TN 06-005.

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l. Prescribed drugs, dentures, prosthetic devices, and eyeglasses (continued)

2. Dentures: See Attachment 4.19-B, section 8.j on page 1c.

This payment method for dentures supersedes the payment methodology for dentures as described in sections 8.j and 8.l on page 1b of Attachment 4.19-B of TN 06-005.

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l. Prescribed drugs, dentures, prosthetic devices, and eyeglasses (continued)

3. Prosthetic Devices

The fee-for-service rates are effective for services provided on or after December 28, 2018. All rates are published on https://www.mass.gov/regulations/101-CMR-33400-prostheses-prosthetic-devices-and-orthotic-devices. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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l. Prescribed drugs, dentures, prosthetic devices, and eyeglasses (continued)

4. Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select – based on contract price established through competitive bidding or otherwise in accordance with section 1915(a)(1)(B) of the Social Security Act and regulations at 42 CFR 431.54(d). MassHealth has entered into a volume purchasing agreement with the Massachusetts Correctional Industries to supply providers of vision care services with certain ophthalmic materials (eyeglass frames and lenses) to eligible members. These eyeglasses are paid at rates specified in an interagency agreement between Massachusetts Correctional Industries and the MassHealth agency.

   See Attachment 4.19-B, section 8.3.e (optometric services) for ophthalmic materials and vision care services not covered by the volume purchasing agreement.

   The payment methodologies for these services supersede the payment methodology for eyeglasses as described in section 8.l on page 1b of Attachment 4.19-B of TN 06-005.

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l. Other diagnostic, screening, preventive, and rehabilitative services

1. Preventive Services

A. For vaccines and vaccine administration by clinicians within their scope of practice, see Attachment 4.19-B, section 8.d. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

This payment method for these services supersedes the payment methodology applicable to such services as described in section 8.m on page 1b of Attachment 4.19-B of TN 06-005.

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m. Other diagnostic, screening, preventive, and rehabilitative services (continued)

1. Preventive Services

B. The fee-for-service rates for psychiatric day treatment services are effective for services provided on or after January 25, 2019. All rates are published on https://www.mass.gov/regulations/101-CMR-30700-rates-for-psychiatric-day-treatment-center-services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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m. Other diagnostic, screening, preventive, and rehabilitative services (continued)

1. Preventive Services

C. The fee-for-service rates for adult day health services are effective for services provided on or after September 22, 2017. All rates are published on https://www.mass.gov/regulations/101-CMR-31000-adult-day-health-services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

This payment method for these services supersedes the payment methodology applicable to such services as described in section 8.m on page 1b of Attachment 4.19-B of TN 06-005.

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m. Other diagnostic, screening, preventive, and rehabilitative services (continued)

2. Rehabilitative Services

A. The fee-for-service rates for rehabilitative services provided in a day setting are effective for services provided on or after March 1, 2018. All rates are published on https://www.mass.gov/regulations/101-CMR-34800-day-habilitation-program-services Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

This payment method for these services supersedes the payment methodology applicable to such services as described in section 8.m on page 1b of Attachment 4.19-B of TN 06-005.

m. Other diagnostic, screening, preventive, and rehabilitative services (continued)

2. Rehabilitative Services

B. Reimbursement for rehabilitative services provided by the Department of Mental Health (DMH), the Department of Youth Services (DYS) and the Department of Children and Families (DCF) are claimed as certified public expenditures and reflect actual costs. Claims for rehabilitative services provided by DMH, DYS, and DCF are processed through MMIS using interim cost reimbursement rates that are based on the final cost reimbursement rates of the most recent rate period with established final cost reimbursement rates. Final cost reimbursement rates are calculated after state fiscal year-end and claims submitted during the rate period at the interim rates are reconciled with the final rates to determine a cost settlement for the rate period.

This payment method for these services supersedes the payment methodology applicable to such services as described in section 8.m on page 1b of Attachment 4.19-B of TN 06-005.

a. Definitions and Cost Reimbursement Methodology:

1. Rate Period
The state fiscal year beginning July 1 and ending June 30 of each year.

2. Interim Rate Methodology
The interim cost reimbursement rates are based on the final cost reimbursement rates of the most recent rate period with established final cost reimbursement rates.

3. Final Rate Methodology
The final cost reimbursement rates are determined each rate period based on rate petitions submitted by each agency that detail allowable actual expenditures multiplied by an aggregate treatment percentage, with that result divided by total units of service.

Agency Expenditures × Aggregate Treatment % ÷ Units of Service = Final Cost Reimbursement Rate

a. Agency Expenditures. Expenditures by DMH, DYS and DCF in the provision of rehabilitative services during the applicable rate period. Agency Expenditures include, as applicable:

i. **Direct costs:** actual payments to providers and those incurred by state operated programs for direct services. These expenditures are paid

through the state's accounting system. Providers are paid pursuant to state developed fee schedules.

ii. **Indirect costs**: For state operated programs, administrative costs allocated pursuant to an agency specific cost allocation plan.

iii. Room and board costs are excluded.

b. Aggregate Treatment Percentage. The portion of the delivered service that is reimbursable under Medicaid.

c. Units of Service. The total units of treatment service delivered during the rate period.

d. Rate Petition. Request for approval of rates submitted annually to EOHHS by DMH, DYS and DCF. Rate petitions include a certification of public expenditures using the CMS approved Certification Statement, and describe the agency's calculation of costs and the methodology used to determine the portion of a provider's time devoted to Medicaid reimbursable activities. Rate petitions are completed in accordance with the principles and standards for determining costs as described in 2 CFR 225 – Cost Principles for State, Local, and Indian Tribal Government (OMB circular A-87) . Rate petitions submitted are subject to desk review.

4. Cost Settlement
   a. During each rate period claims for reimbursement are processed through MMIS using provisional cost reimbursement rates.
   b. Final cost reimbursement rates are calculated after state fiscal year-end and claims submitted during the rate period at the provisional rates are reconciled with the final rates to determine a cost settlement for the rate period. This reconciliation is expected to occur by June 30th of the following fiscal year.
   c. If after cost settlement, an overpayment exists; EOHHS will return the federal share of the overpayment. If an underpayment exists, EOHHS will draw down additional FFP.

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n. Inpatient hospital services and skilled nursing home services for individuals 65 years of age or over in an institution for tubercular or mental diseases:

1. For inpatient hospital services — see **Attachment 4.19-A**.
2. For skilled nursing home services — see **Attachment 4.19-D**.[1]

This payment method for these services supersedes the payment methodology for such services as described in section 8.n on page 1b of Attachment 4.19-B of TN 06-005.

[1] Note: No skilled nursing facilities are IMDs.

o. **Any other medical care recognized under state law, including transportation services, oxygen, and podiatry:**

1. Medical Transportation – the fee-for-service rates for non-brokered transportation to MassHealth-covered medically necessary services that are claimed as medical assistance are effective for services on or after September 20, 2019. Those rates are published at https://www.mass.gov/regulations/101-CMR-32700-rates-of-payment-for-ambulance-and-wheelchair-van-services. Except as otherwise noted in subsection 2 of Attachment 4.19-B, section 8.o below, state developed fee schedule rates are the same for both governmental and private providers. Brokered transportation services that are claimed as medical assistance are described in subsection 1 of Attachment 3.1.D.

2. Governmental Ambulance Services Providers - EOHHS will recognize, on a voluntary basis, the allowable certified public expenditures of EOHHS-approved governmental ambulance service providers for providing services to MassHealth members as set forth below.

(1) "Governmental ambulance services provider" means a provider of ambulance services that is a unit of government as specified in 42 CFR 433.50.

(2) The allowable certified public expenditures of a participating governmental ambulance services provider who meets the required state enrollment criteria are eligible for federal reimbursement up to reconciled cost in accordance with (A) through (E) for services provided on or after April 1, 2013.

(A) The governmental ambulance services provider will be paid interim rates equal to the Medicaid reimbursement rates paid to other ambulance services providers in accordance with subsection 1 of Attachment 4.19-B, section 8.o above. The interim rates are provisional in nature, pending the submission of an annual cost report and the completion of cost reconciliation and a cost settlement for that period. Settlements are a separate transaction, occurring as an adjustment to prior year costs and are not to be used to offset future rates.

(B) The governmental ambulance services provider will submit a CMS approved cost report annually, on a form approved by EOHHS. The cost report will be completed on a state fiscal year basis and will be due to EOHHS no later than 120 days following the last day of the state fiscal year.

(C) Cost reconciliation and cost settlement processes will be completed within 24 months from the end of the cost reporting period.

(D) The provider's reported direct and indirect costs are allocated to the Medicaid program by applying a Medicaid utilization statistic ratio, to Medicaid charges associated with paid claims for the dates of service covered by the submitted cost report.

(E) A reconciliation will be computed by EOHHS based on the difference between the interim payments and total allowable Medicaid costs from the approved cost report.

State Plan under Title XIX of the Social Security Act
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Methods and Standards for Establishing Payment Rates – Other Types of Care

o. **Any other medical care recognized under state law, including transportation services, oxygen, and podiatry:** (continued)

3. Oxygen and durable medical equipment –The fee-for-service rates are effective for services provided on or after March 1, 2018. All rates are published on https://www.mass.gov/regulations/101-CMR-32200-durable-medical-equipment-oxygen-and-respiratory-therapy-equipment. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods and Standards for Establishing Payment Rates – Other Types of Care

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont.)

o. **Any other medical care recognized under state law, including transportation services, oxygen, and podiatry:** (continued)

4. Podiatry - See Attachment 4.19-B, item 8.d.

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont.)

FQHCs/RHCs

* ☒ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements Prospective Payment System (PPS).

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1. is agreed to by the state and the center or clinic; and
2. results in payment to the center or clinic of an amount that is at least equal to the PPS payment rate.

FQHCs and Community Health Centers that participate in MassHealth pursuant to 130 CMR 405 (FQHCs) are paid a per-visit class rate for medical services based on total costs for medical services, supporting services, and administration allocated to the medical cost center. The per-visit class rate is calculated as follows: A standardized per-visit rate is calculated for each FQHC. The administrative component of that rate is based on total administrative costs for medical services divided by total encounters. An efficiency standard for administrative costs is established at the 75th percentile of those costs. The rate is adjusted by a productivity factor based on a ratio of actual medical visits to full time equivalent (FTE) staff, and adjusted using the Medicare Economic Index (MEI) through the effective period. The 40th percentile of those individual FQHC rates is determined, and the class rate is established at 105% of that value. Payment for individual medical visits equals 102% of the per-visit class rate. Payment for obstetrical visits equals 100% of the per-visit class rate. Payment for medical visits for early and periodic screening, diagnosis and treatment services equals 105% of the per-visit class rate. Payment for group medical visits equals 20% of the per-visit class rate. Payment for urgent care visits occurring before 7:00 A.M. or after 4:59 P.M, Monday through Friday, and urgent care visits occurring at any time on Saturday or Sunday, equals 133% of the per-visit class rate. Payment for children's psychiatric mental health visits equals 102% of the class rate.

FQHCs are paid a per-visit class rate for adult psychiatric mental health visits services based on total costs for mental health services. The per-visit class rate for adult psychiatric mental health visits is calculated as follows: The direct care expenses for psychiatrist services is divided by the total direct care costs for all mental health services, and then multiplied by overall mental health administrative and operating costs, adjusted by an efficiency standard. A retrospective cost adjustment factor based on the MEI is then added to determine the overall costs related to psychiatrist services. The resulting total is divided by the number of psychiatrist visits, adjusted by a productivity factor, to calculate the per-visit cost for each FQHC. The 75th percentile of those individual FQHC costs is determined, and the class rate is established at 100% of that value.

The rate of payment for other FQHC services is that applicable to each discrete service including, for example, dental, pharmacy, clinical laboratory, vision care, and radiology. In addition, a per-visit dental enhancement is paid to FQHCs.

Supplemental payments are made to FQHCs for which the calendar year 2016 gross margin

earned on drugs purchased through the 340B Drug Pricing Program ("340B drugs") is greater than the projected annual impact of the increased per-visit class rate effective October 20, 2017. In total, supplemental payments to each eligible FQHC for the 12-month period beginning with October 2017 will equal the difference between the FQHC's 2016 gross margin earned on 340b drugs and the projected annual impact on the FQHC of the increased per-visit class rate effective October 20, 2017, less any gross margin earned on 340B drugs between October 1, 2017 and February 28, 2018. In total, supplemental payments to each eligible FQHC for the 15-month period beginning with October 2018, and the 12-month periods beginning with January 2019, January 2020, and January 2021 will equal, respectively, 100%, 75%, 50%, and 25% of the FQHC's supplemental payment amount for the 12-month period beginning with October 2017 prior to the reduction based on gross margin earned on 340B drugs between October 1, 2017 and February 28, 2018.

Individual FQHCs may apply for an adjustment to the per-visit rate described above or the establishment of a rate separate from the per-visit rate described above for special and/or innovative programs to meet special needs of certain patients, which are not ordinarily met by existing services in FQHCs, or to ensure appropriate access to and quality of services.

Payment to each FQHC resulting from the alternative payment methodology described above is at least equal to the payment to the FQHC that would result from the PPS payment rate.

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont.)

q. Case Management Services

I. Reimbursement for Targeted Case Management services provided by the Department of Mental Health (DMH) for Medicaid enrolled members are claimed as certified public expenditures (CPE) and reflect actual costs. Claims are processed through MMIS using interim cost reimbursement rates that are based on the final cost reimbursement rates of the most recent rate period with established final cost reimbursement rates. Consistent with 45 CFR 95.4 once final cost reimbursement rates are calculated after state fiscal year-end, the claims submitted during the rate period at the interim rates are reconciled with the final rates to determine a cost settlement for the rate period.

a) Definitions and Cost Reimbursement Methodology:

1. Rate Period - The state fiscal year beginning July 1 and ending June 30 of each year.

2. Interim Rate Methodology - The interim cost reimbursement rate is based on the final cost reimbursement rate of the most recent rate period with established final cost reimbursement rate.

3. Final Rate Methodology - The final cost reimbursement rate is determined each rate period based on allowable actual expenditures divided by total units of service.

$$\left[\begin{matrix}\textit{Agency Expenditures} \div \textit{Units of Service} = \\ \textit{Final Reimbursement Rate}\end{matrix}\right]$$

a. Agency Expenditures include, as applicable:

i. **Direct costs:** Expenditures paid through the state's accounting system (MMARS) for salary, fringe and other expenses to support case management services provided by state employed case managers.

ii. **Indirect costs**: Administrative costs allocated pursuant to an agency specific cost allocation plan.

iii. Room and board costs are excluded.

b. Units of Service - The total units of case management service delivered during the rate period.

c. Rate Petition. Request for approval of rates submitted annually to EOHHS by DMH. Rate petition includes a certification of public expenditures using the CMS approved Certification Statement, and describes the agency's calculation of costs, and are completed in accordance with the principles and standards for determining costs as described in 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Rate petitions submitted are subject to desk review.

4. Cost Settlement

a. During each rate period claims for reimbursement are processed through MMIS using the interim cost reimbursement rate.

b. The final cost reimbursement rate is calculated after state fiscal year-end and claims submitted during the rate period at the interim rate are reconciled with the final rate to determine a cost settlement for the rate period. This reconciliation occurs by June 30th of the following fiscal year.

c. If after cost settlement, an overpayment exists; EOHHS will return the federal share of the overpayment. If an underpayment exists, EOHHS will draw down additional FFP.

II. Reimbursement for Targeted Case Management Services provided by the Department of Developmental Services (DDS) for Medicaid enrolled members are claimed as certified public expenditures (CPE) and reflect actual costs. Claims are processed through MMIS using interim cost reimbursement rates that are based on the final cost reimbursement rates of the most recent rate period with established final cost reimbursement rates. Consistent with 45 CFR 95.4 once final cost reimbursement rates are calculated after state fiscal year-end, the claims submitted during the rate period at the interim rates are reconciled with the final rates to determine a cost settlement for the rate period.

a) Definitions and Cost Reimbursement Methodology:

1. Rate Period - The state fiscal year beginning July 1 and ending June 30 of each year.

2. Interim Rate Methodology - The interim cost reimbursement rate is based on the final cost reimbursement rate of the most recent rate period with established final cost reimbursement rate.

3. Final Rate Methodology - The final cost reimbursement rate is determined each rate period based on allowable actual expenditures divided by total units of service.

$$\left[\begin{matrix}\textit{Agency Expenditures} \div \textit{Units of Service} = \\ \textit{Final Reimbursement Rate}\end{matrix}\right]$$

a. Agency Expenditures include, as applicable:

iv. **Direct costs:** Expenditures paid through the state's accounting system (MMARS) for salary, fringe and other expenses to support case management services provided by state employed case managers.

v. **Indirect costs**: Administrative costs allocated pursuant to an agency specific cost allocation plan.

vi. Room and board costs are excluded.

b. Units of Service - The total units of case management service delivered during the rate period.

c. Rate Petition. Request for approval of rates submitted annually to EOHHS by DDS. Rate petition includes a certification of public expenditures using the CMS approved Certification Statement, and describes the agency's calculation of costs, and are completed in accordance with the principles and standards for determining costs as described in 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Rate petitions submitted are subject to desk review.

4. Cost Settlement

a. During each rate period claims for reimbursement are processed through MMIS using the interim cost reimbursement rate.

b. The final cost reimbursement rate is calculated after state fiscal year-end and claims submitted during the rate period at the interim rate are reconciled with the final rate to determine a cost settlement for the rate period. This reconciliation occurs by June 30th of the following fiscal year.

c. If after cost settlement, an overpayment exists; EOHHS will return the federal share of the overpayment. If an underpayment exists, EOHHS will draw down additional FFP.

II. Case management for children served by the Department of Social Services — the reimbursement method will be similar to that used for reimbursement under the DMR Home and Community-Based Services Waiver (0064.92). The rate for case management reimbursement will be established on a statewide average based on retrospective costs.

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont.)

VIII. Case management for Medicaid recipients Diagnosed with AIDS living in congregate housing (TCM AIDS). The reimbursement method for TCM AIDS is a provider specific 15 minute unit rate that reflects the reasonable and necessary costs for required staff including salaries, taxes, and benefits, and the associated overhead costs. The unit rate is established by the Executive Office of Health and Human Services utilizing the methodology established in regulation at 130 CMR 114.5.4: Rates for Certain Social, Rehabilitation and other Health Care Services. This regulation is published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-5-4.pdf.

Each TCM AIDS provider's rate is based on an annual program budget, and delineates costs for services and necessary administrative activities. Rate development for TCM AIDS services includes the collection and review of service data maintained by the provider. Costs for room and board and other unallowable costs are excluded from the rate.

The table below contains the rate used for each provider and the effective dates of the rate.

Provider	Per Unit (15 Minutes)	Effective date
Pine Street Inn	$2.51	November 1, 2002

Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers.

IX. Case management for Medicaid recipients who are juveniles committed to the custody of the Department of Youth Services. The reimbursement method will be a monthly rate that reflects the reasonable and necessary costs for required staff including salaries, taxes, and benefits, and the associated overhead costs. The monthly rate is fixed, negotiated, provider specific, and established by contract. The monthly rate is prorated on a daily basis for services provided for less than a month.

XI. Case Management for individuals under age 21 with a serious emotional disturbance – This service is reimbursed using per diem rate. The rate methodology is based on a model budget that assumes program costs (direct and indirect) and maximum productivity time specific for the provision of each service. The data sources for program costs include cost reports and salary data from providers of these and other similar behavioral health services. . The model budget assumes a maximum productivity time for each service based on an estimated time available for the direct contacts by eligible direct care staff.

The fixed fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods and Standards for Establishing Payment Rates – Other Types of Care

I. Definitions

The following definitions are used in defining and calculating home health agency rates.

Complex-Care Member A MassHealth member, whose medical needs, as determined by the Division or its designee, are such that he or she requires a nurse encounter typically of more than two continuous hours of nursing services to remain in the community.

Eligible Provider Any organization certified as a provider of services under the Medicare Health Insurance Program for the Aged (Title XVIII) and meeting the Medicare and Medicaid Conditions of Participation for home health agencies in Massachusetts, or other requirements set forth by EOHHS.

Home Health Agency An agency that provides health services in a home setting. These services include nursing, physical therapy, occupational therapy, speech therapy, and home health aide services.

Home Health Aide Service The provision of personal care in the home, under the supervision of a registered nurse or, if appropriate, a physical, speech, or occupational therapist. Home Health Aide Services are performed by trained personnel who assist clients in following physicians' instructions and established plans of care. Additional services include, assisting the patient with activities of daily living, exercising, taking medications ordered by a physician which are ordinarily self-administered, assisting the patient with necessary self-help skills, and reporting to the professional supervisor any changes in the patient's condition or family situation.

Home Health Aide Units Fifteen minute increments.

Home Visit A morbidity visit rendered in the home by a qualified employee such as a licensed nurse, a licensed physical therapist or supervised licensed physical therapy assistant a licensed occupational therapist or a supervised licensed certified occupational therapy assistant a licensed speech therapist, or home health aide.

Household Place of residence where two or more people are living: (A) in a group home, a residential care home, or other group living situation; (B) at the same street address if it is a single-family house that is not divided into apartments or units; or (C) at the same apartment number or unit number if the members live in a building that is divided into apartments or units.

Methods Used to Determine Rates of Payment for Services Provided by Home Health Agencies (cont.)

Interpreter Costs. The necessary costs associated with providing translation services to non-English-speaking patients.

Medication Administration. A skilled nursing service solely for the purpose for administration of medications when the member is unable to perform the task due to impaired physical, cognitive, behavioral and/or emotional issues, no able caregiver is present, the member has a history of failed medication compliance resulting in a documented exacerbation of the member's condition, and/or the task including the route of administration or medication requires a licensed nurse to provide the service. A medication administration visit may include administration of oral, intramuscular, and/or subcutaneous medication or administration of medications other than oral, intramuscular and/or subcutaneous medication, but does not includes intravenous administration.

Minor Medical Supplies. Items which are either frequently furnished to patients or are utilized individually in small quantities. Such items would not be expected to be specifically identified in the physician's plan of treatment and no separate charge is made for them. Examples of minor medical supplies include cotton balls, alcohol prep, bandages, and surgical sponges. Documentation for the cost of these supplies must be maintained separately from billable supplies.

Non-Reimbursable Costs. Costs associated with programs not covered for reimbursement under the Medicare Health Insurance Program for the Aged (Title XVIII) and Title XIX of the Social Security Act or under other agreements by the purchasing agency. These services may be reimbursable by other programs.

Normal Work Day. The number of hours in the average home health agency employees' normal work week reported on the most recent cost report divided by five work days. (This is necessary because each agency has a different number of hours in its workday).

Nursing Service. Service provided to a patient by a professional registered nurse, licensed practical nurse, or a nursing student under the supervision of a registered nurse, including: evaluating nursing care needs; developing and implementing a nursing care plan; providing services that require specialized skills; observing signs and symptoms, reporting to the physician; initiating nursing procedures; giving treatments and medications ordered by the physician; teaching the patient and family.

Occupational Therapy. Service provided by a registered occupational therapist (OTR), a certified occupational therapy assistant (COTA) or an occupational therapy student supervised by a registered occupational therapist, including; evaluating patient's level of function; applying diagnostic and prognostic procedures; teaching activities of daily living; observing and reporting to the physician; instructing the patient, family and health team personnel.

Office Visit. A health promotion or therapeutic visit rendered in the home health agency's office.

Methods Used to Determine Rates of Payment for Services Provided by Home Health Agencies (cont.)

Physical Therapy. Service provided by a licensed physical therapist , a physical therapy assistant (PTA) or a physical therapy student supervised by a licensed physical therapist, including: evaluating patient care needs; treating patient with active and passive exercises; using specialized equipment such as packs, vibrators, etc.; observing signs and reporting symptoms to the physician; instructing patient, family and health team personnel in the use of braces, other equipment and modalities.

Prudent Buyer Concept. The assumption that any amount paid by a provider above the market price for a supply or service is an unreasonable cost and shall be excluded from reimbursable costs.

Reasonable Costs. Those reasonable and necessary reimbursable costs incurred by an eligible provider in provision of home health services to publicly aided individuals subject to efficiency measures, staffing requirement, and the costs of providing comparable service.

Speech Therapy. Service provided by a qualified speech therapist, a speech therapy assistant or a speech therapy student supervised by a qualified speech therapist including: evaluating patient care needs; providing rehabilitating services for speech and language disorder; observing and reporting to the physician; instructing patient, family and health care team personnel.

Security/Escorts. The necessary costs of providing security services to ensure the safety of direct care personnel in the performance of a reimbursable home health service to a client in his/her residence.

Therapeutic or Morbidity Home Visit. A home visit rendered by an eligible provider to an individual and/or family for the purpose of treating one or more diagnosed illnesses or disabilities.

Total Home Health Aide Hours. Total number of hours spent in therapeutic and morbidity home visits by all home health aides, but not including visits associated with nonreimbursable costs and visits termed “not home, not found.”

Total Nursing Visits. All therapeutic and morbidity home visits provided by all nurses, licensed practical nurses, and nursing students but not including visits associated with nonreimbursable costs, visits termed “not home, not found,” supervisory observation in the home, and office visits.

Total Occupational Therapy Visits. All therapeutic and morbidity home visits rendered by all licensed occupational therapists and licensed occupational therapy assistants, but not including visits associated with nonreimbursable costs, visits termed "not home, not found," supervisory observation in the home and office visits.

Total Physical Therapy Visits. All therapeutic and morbidity home visits rendered by all licensed physical therapists and licensed physical therapy assistants, , but not including visits associated with nonreimbursable cost, visits termed "not home, not found," supervisory observation in the home, and office visits.

Total Speech Therapy Visits. All therapeutic and morbidity home visits rendered by all licensed speech therapists, but not including visits associated with nonreimbursable cost, visits termed "not home, not found," supervisory observation in the home, and office visits.

Transportation Costs. Costs associated with travel by Home Health Agency employees on Home Health Agency business.

II. General Discussion of Reimbursement Methodologies

A. Background

As part of its community-based service offerings, the Massachusetts Medicaid program provides Home Health Services to eligible clients. These services include Nursing, Physical Therapy, Speech Therapy, Occupational Therapy, and Home Health Aide Services.

Historically, a home health based agency rate of payment was determined prospectively on the basis of unit costs. Various measures have been implemented over the years to keep cost growth within reasonable limits and promote efficiency among providers.

Methods Used to Determine Rates of Payment for Services Provided by Home Health Agencies (cont.)

These measures include, among others, productivity standards, capping rates and limits on reimbursement for overhead costs. The continued excessive variance among providers in costs for identical services indicated the need for a more effective reimbursement methodology.

This rate methodology establishes one rate for all providers in each service category with possible administrative adjustments. The class rate assures that payment rates reward efficient providers. Providers who provide services at costs below the class rate will be reimbursed at the class rate and benefit accordingly. The class rate also creates incentives for those providers with costs above the efficient level to reduce them to a level at or below the class rate.

B. Cost Finding and Reporting

1. Required Reports. Each eligible provider must file the following information no later than 90 days after the close of each fiscal period.

   a. A home health agency (HCFA 1728) cost report and any supplemental schedules as required by the Commonwealth.

   b. Financial statements (for the same fiscal period) certified by a certified public accountant. In the absence of certified statements, the agency may submit uncertified statements or a Balance Sheet and Operating Statement prepared by the agency.

   c. A home health agency may request to submit a home health agency cost report using an alternative allocation methodology for administrative costs if the alternative methodology allows for a more accurate allocation of costs. Supporting documentation must accompany such a report. A home health agency which files an alternative report must also file a copy of the cost report filed with the Medicare fiscal intermediary, if the cost reports differ. In requesting an alternative method, the agency must submit a letter demonstrating the rationale for the method by the due date of the cost report.

2. Examination of Records. Upon request, each participating home health agency shall make available all records relating to its operation for audit by EOHHS or its designee.

III. Class Rate Methodology

A. Cost Components

Statewide class rates are set for these home health services: skilled nursing visits, medication administration visits, continuous skilled nursing services, home health aide services, speech therapy visits, physical therapy visits, and occupational therapy visits. Current rates are determined as the sum of direct and indirect components, using data derived from annual cost report submissions with an adjustment for inflation and benchmarked to the rates paid to other community providers. A skilled nursing service, typically less than two hours in duration, and physical, occupational and speech therapy services are paid on a per visit basis. Continuous skilled nursing services are paid in 15 minute increments. Payments for these services are in accordance to the fee schedules that are determined based on cost elements described below. All private and governmental providers are reimbursed according to the same fee schedule.

1. Direct: The direct portion is the compensation paid by the agency to the nurse, aide or therapist.

2. Indirect: The indirect portion includes agency overhead expenses, such as administrative and general expenses, compensation of support staff, occupancy expenses, taxes, interest and depreciation, and outside services.

3. Nursing Services Provided for Multiple Members: When two or more members in the same household are receiving nursing services during the same time period, the rates for subsequent member or members is paid at a lower rate per visit/unit to reflect lower indirect costs incurred.

4. Skilled Nursing Services (excluding visits for Medication Administration) Provided on or after 31 Consecutive Calendar Days of Home Health Services: When skilled nursing services are provided to a member on or after the 31st calendar day of the member's first home health service, even if some or all of those services were provided by a different home health agency or paid by a third-party insurer other than MassHealth, skilled nursing services are paid at a lower rate per visit/unit than the standard per visit/unit rate for nursing services. If a member receives home health services after a discharge from an inpatient hospitalization of at least one night or nursing facility stay of at least three nights, admission to a crisis stabilization unit of at least one overnight, or after a break in home health services of 60 days or more, then nursing services provided during the 30 consecutive calendar days following discharge are paid at the higher rate per visit/unit applicable to services for 1-30 calendar days for skilled nursing services, and only after 30 days of skilled nursing services have been provided are skilled nursing services again paid at the reduced rate per visit/unit applicable to skilled nursing services provided on or after 31 days of skilled nursing services.

5. Nursing Services Provided for Medication Administration: When home health skilled nursing services are provided to a member solely for medication administration, such skilled nursing services are paid at a lower rate per visit/unit than the standard per visit/unit rate for nursing services.

6. Administrative Add-on: Providers that incur interpreter or security escort costs receive an add-on to their rates to reimburse for these expenses. These adjustments are made upon request and rates are set using cost report data and are paid through the normal claims process. EOHHS calculates the administrative per visit rate for interpreter/ or security escort services as reported on the individual home health agency cost report and adds that per visit calculation to the rate paid to the requesting provider.

7. The agency's fee-for-service rates are effective for services provided on or after April 1, 2018. The fee schedule is subject to a public notice and hearing process and published at https://www.mass.gov/regulations/101-CMR-350-home-health-services.

B. Alternative Prospective Payment System

In accordance with Chapter 236 of the Act of 2000, which authorizes the Division of Medical Assistance (the Division) to enter into contracts with certain home health agencies to provide prospective payments for services. The payment structure is a 30-day episodic all-inclusive fee for all home health services provided to an eligible MassHealth member, which includes skilled nursing, home health aide, physical therapy, occupational therapy and speech/language therapy. The rate per episode is based on applicable class rates applied to the provider's average course of treatment provided to members over the course of 30-day initial and subsequent episodes. EOHHS, having subsumed the Division's authority, will pay providers under this alternative system if:

1. they are organized as a not-for-profit entity;
2. in fiscal year 1999, they delivered more than 10% of all Massachusetts Medicaid reimbursed skilled nursing visits and more than 15% of all such home health aide services; and
3. in the determination of EOHHS, provide services that are essential to ensure access to home health services for medical assistance recipients.

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School-Based Services

School-Based Services (SBS) are provided by School-Based Service Providers, which are school districts and other educational entities that are enrolled with the MassHealth program as providers of School-Based Services. School-Based Services are provided pursuant to an Individualized Service Plan (IEP), a section 504 accommodation plan pursuant to 34 C.F.R. § 104.36, an Individualized Health Care Plan, an Individualized Family Service Plan, or are otherwise medically necessary, and include medical services as described under Item 4.b. EPSDT in Supplement to Attachment 3.1-A/B. School-Based Services include physical therapy, occupational therapy and other services, including services provided by audiologists and services for individuals with speech, hearing and language disorders, performed by, or under the direction of, providers who meet the qualifications set forth at 42 CFR § 440.110; physician services under 42 CFR § 440.50(a); optometry services provided by a qualified professional under 42 CFR § 440.60; respiratory therapy provided by a qualified professional under 42 CFR § 440.60;nursing services coverable under 42 CFR § 440.80 and 42 CFR § 440.60 ordered by a licensed physician and performed by a registered nurse or licensed practical nurse; nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated to individuals who receive appropriate teaching, direction, and supervision from a Registered Nurse or Practical Nurse; fluoride varnish performed by a dental hygienist under 130 CMR § 420.424(b) in accordance with 42 CFR § 440.100; personal care services coverable and performed by individuals qualified under 42 CFR § 440.167; services performed by licensed practitioners within the scope of their practice for individuals with behavioral health (mental health and substance abuse) disorders, as defined under state law, and coverable as medical or other remedial care under 42 CFR § 440.60; diagnostic, screening, preventive, and rehabilitative services covered under 42 CFR § 440.130; medical nutritional services provided by a qualified professional under 42 CFR § 440.60; and sports related or other injury assessment and therapy provided by a qualified professional under 42 CFR § 440.60. Assessments and independent evaluations are covered as necessary to assess or reassess the need for medical services in a child's treatment plan and must be performed by any of the above licensed practitioners within the scope of practice.

A. Cost Reimbursement Methodology for School-Based Services

Final reimbursement is based on the certified reports that are submitted using the methodology allowed under the Massachusetts School-Based Cost Report approved by the Centers for Medicare and Medicaid Services (CMS).

To determine the Medicaid-allowable costs of providing School-Based Services to MassHealth members, the following steps are performed:

(1) Direct costs of providing School-Based Services include payroll costs and other costs that can be directly charged to School-Based Services, including costs that are integral to School-Based Services. Direct costs are recorded on a modified accrual basis consistent with the Massachusetts Department of Education chart of accounts, and the

source data is the School-Based Service Providers' accounting and payroll systems. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by School-Based Services providers under Item 4.b. EPSDT in Supplement to Attachment 3.1-A/B. Direct costs do not include salaries for staff who do not meet the qualifications required under item 4.b.EPSDT in Supplement to Attachment 3.1-A/B.

Other direct costs include costs directly attributed to activities performed by the personnel who are approved to deliver School-Based Services, such as, travel, materials and supplies. Additional direct costs include purchased services. These direct costs are accumulated on the annual CMS-approved Massachusetts School-Based Cost Report. .

Direct costs do not include room and board.

(2) Direct costs for School-Based Services from Item 1 above are reduced by any federal payments for those costs, resulting in adjusted direct costs for School-Based Services.

(3) Adjusted direct costs from Item 2 above are then allocated to identify Medicaid-reimbursable costs for School-Based Services according to the Random Moment Time Study (RMTS) results that are identified according to the process described in the Massachusetts RMTS Implementation Plan, approved by CMS.

(4) Indirect costs are calculated using the unrestricted indirect cost rate set by the Massachusetts Department of Education as the cognizant agency or other allowable rates per OMB 2 CFR Part 225: Cost Principles for State, Local, and Indian Tribal Governments (OMB Circular A-87). Indirect costs are equal to adjusted direct costs multiplied by the unrestricted indirect costs rate. These indirect costs are the added to the adjusted direct costs to determine the total direct costs.

(5) Medicaid-allowable costs are identified by applying the applicable Medicaid penetration rate to the total direct costs. For those costs allocated by the RMTS as being covered services pursuant to an IEP, the Medicaid penetration rate is the number of Medicaid-enrolled students with an IEP divided by the total number of students with an IEP on the same day. For covered services not related to an IEP, the Medicaid penetration rate is the number of Medicaid-enrolled students divided by the total number of students on the same day.

B. Interim Rates

The School-Based Services Providers' specific interim rate is the rate for a specific service that is provisional in nature, pending the completion of a cost reconciliation and a cost settlement for that period. This rate is for direct medical services, per unit of service, on a per visit basis. Claims filed by School-Based Services Providers to Medicaid Management Information System (MMIS) as part of this process are to be used for interim rates and cost settlement purposes only.

C. Certification of Funds Process

Each School-Based Services Provider certifies on an annual basis through its completed School-Based Cost Report its total actual, incurred Medicaid-allowable costs, including the federal share and the nonfederal share. These costs do not include any indirect costs that are not included in the unrestricted indirect cost rate set by the Massachusetts Department of Education as the cognizant agency.

D. Annual Cost Report Process

Each School-Based Services Provider annually will complete a School-Based Cost Report for all services delivered during the previous state fiscal year covering July 1 through June 30. Cost reports are due to the State no later than June 30th of the year following the close of the year during which the costs included in the Cost Report were accrued. The annual cost report includes the certification of funds, as described in Section C above. Submitted cost reports are subject to desk review by the single state agency or its designee.

E. The Cost Reconciliation Process

The total Medicaid allowable costs based on the CMS-approved School-Based Cost Report are compared to the School-Based Services Provider's Medicaid interim rate claims for services delivered during the reporting period, as documented in MMIS. Each School-Based Services Provider's interim rate claims are adjusted to reflect, in aggregate, the total Medicaid-allowable costs based on the certified cost report identified in Section C. This results in a cost reconciliation.

Reconciliation will take place within 24 months of the end of the reporting period contained in the School-Based Services Providers' submitted cost report. Massachusetts may not modify the CMS-approved scope of costs, the CMS-approved RMTS Implementation Plan, which includes time study information, or the CMS-approved Massachusetts School Based Cost Report without CMS approval.

F. The Cost Settlement Process

If the Commonwealth determines that an overpayment has been made, EOHHS will return the federal share of the overpayment.

If the actual, certified Medicaid-allowable costs of a School-Based Services Provider exceed the interim Medicaid rates, EOHHS will submit claims to CMS for the underpayment.

Cost settlement will occur within the timelines set forth in 42 CFR § 433, Subpart F.

s. Designated Emergency Mental Health Provider (DEP) is also known as an Emergency Service Program (ESP). To qualify as a DEP/ESP, a provider must be designated as such by the Massachusetts Executive Office of Health and Human Services (EOHHS).

DEPs/ESPs will be paid on a fee-for-service basis at the rate of $488.00 per encounter for providing emergency mental health services delineated by the Commonwealth to eligible MassHealth members.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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Methods and Standards for Establishing Payment Rates -- Other Types of Care

t. Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found.

The rate methodology used to create the following fee schedules for are based on a model budget that accounts for program costs (direct and indirect) and maximum productive time specific for the provision of each service. The data sources for program costs include cost reports and salary data from providers of these and other similar behavioral health services. Maximum productive time for each service was derived by assessing the time available for direct billable contacts by eligible direct care staff.

Mobile Crisis Intervention – The fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Behavioral Management Therapy – The fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Behavioral Management Monitoring - The fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

In-Home Therapy –The fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Therapeutic training and support –The fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published onhttp://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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Therapeutic Mentoring Services –The fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Family Support and Training Services - The current fee-for-service rates are effective for service provided on or after August 1, 2018. All rates are published on http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html#101cmr352. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Applied Behavior Analyst Services – The current fee-for-service rates are effective for service provided on or after September 1, 2019. All rates are published on https://www.mass.gov/regulations/101-CMR-35800-rates-of-payment-for-applied-behavior-analysis. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

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Methods and Standards for Establishing Payment Rates – Other Types of Care

t. Early and Periodic Screening, Diagnostic and Treatment services for individuals under 21 years of age, and treatment of conditions found (continued)

Early Intervention - The fee-for-service rates for Early Intervention Services are effective for services provided on or after March 1, 2016. All rates are published on https://www.mass.gov/regulations/101-CMR-34900-rates-for-early-intervention-program-services. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

This payment method for these services supersedes the payment methodology for such services as described in section 8.m on page 1b of Attachment 4.19-B of TN 06-005.

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Reserved

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p. **Hospice Services:**

Massachusetts pays for hospice services using the CMS annually published Medicaid hospice rates that are effective from October 1 of each year through September 30 of the following year. Except as otherwise noted in the plan, fee schedule rates are the same for both governmental and private providers. With the exception of payment for physician services Medicaid reimbursement for hospice care will be made at one of the following five predetermined rates for each day in which an individual receives the respective type, duration and intensity of the services furnished under the care of the hospice.

1. Routine Home Care (RHC): Hospice providers are paid one of two levels of RHC for dates of service on or after 1/1/2016. This two-rate payment methodology will result in a higher RHC rate based on payment for days one (1) through sixty (60) of hospice care and a lower RHC rate for days sixty-one (61) or later. A minimum of sixty (60) days gap in hospice services is required to reset the counter which determines which payment category a participant is qualified for.
2. Continuous Home Care
3. Inpatient Respite Care
4. General Inpatient Care
5. Service Intensity Add-On

Effective January 1, 2016, hospice providers that are not in compliance with Medicare quality reporting requirements established under section 1814(i)(5)(A)(i) of the Social Security Act are subject to a 2% reduction to the market basket percentage increase.

u. **Personal Care Services:**

I. General Description of Payment Methodology

The following section describes the methods and standards utilized by the Executive Office of Health and Human Services (EOHHS) to establish rates of payment for personal care attendant (PCA) services. These services are described under Supplements to Attachments 3.1-A and 3.1-B. Fee schedules are established as follows:

II. Fee Schedules

The fee schedules for Personal Care Attendant Services are established by the Executive Office of Health and Human Services. The regulation, administrative bulletins, and fee schedules are published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-5-4.pdf and http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-309.pdf. http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html.

Effective July1, 2019, the fee schedule used to pay for personal care services provided by Personal Care Attendant providers is $4.36 per 15 minute unit or $17.45 per hour, inclusive of the PCA wage, employer required taxes, and workers' compensation insurance for PCA services provided during the day or night. Personal care attendants who are authorized by MassHealth to work emergency overtime or work on one of four holidays (New Year's Day, July 4, Thanksgiving Day or Christmas) receive premium pay in addition to regular pay, equal to $2.18 per 15 minute unit, or $8.725 per hour, inclusive of employer required taxes and workers' compensation insurance.

Effective July 1, 2014, EOHHS will provide a 3 hour paid Orientation for newly hired PCAs. The fee schedule for the 3 hour Orientation is based on the hourly PCA rate in effect on the date the newly hired PCA receives orientation.

Effective January 1, 2016, through June 30, 2019, PCAs are eligible to accrue earned sick time from the first date of work and can begin using earned sick time 90 days after the first date of work at a rate of one hour per 30 hours worked, including overtime hours, up to 40 hours per benefit year. PCAs may use up to 40 hours of earned sick time per 12-month period as designated by EOHHS. The fee schedule is based on the hourly PCA rate in effect at the time the earned sick time is used.

Effective July 1, 2019, PCAs are eligible to accrue earned paid time off from the first date of work. PCAs accrue earned paid time off at a rate of one hour per 30 hours worked, including overtime hours, up to 50 hours per benefit year, and may carry over up to 50 hours to a new benefit year. A benefit year runs from July 1 to June 30. Upon termination of PCA employment, a PCA's remaining accrued paid earned time will be paid to the PCA. The fee schedule is based on the hourly PCA rate in effect at the time the earned paid time off is used, or, for purposes of payout at termination of all PCA employment, on the hourly PCA rate in effect on the date of the PCA's termination of all PCA employment.

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Effective January 1, 2016, PCAs are eligible to receive overtime pay in accordance with the requirements of the Fair Labor Standards Act. Effective July 1, 2019, PCA overtime pay is equal to $0.15 per 1 minute unit, or $8.725 per hour, inclusive of employer required taxes and workers' compensation insurance. Effective July 1, 2019, PCA travel time pay is equal to $0.29 per 1 minute unit, or $17.45 per hour, inclusive of employer required taxes and workers' compensation insurance.

The fee used for Transitional Living providers of personal care services is a provider specific rate established by the Executive Office of Health and Human Services. Such regulations are entitled: Rates for Certain Social, Rehabilitation and other Health Care Services. The regulation is published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-5-4.pdf.

Each Transitional Living provider's rate is an all-inclusive per diem rate for the provision of personal care services and is based on an annual program budget, and delineates costs for direct care services and necessary administrative activities. Rate development for transitional living services includes the collection and review of service data maintained by the transitional living provider. Costs for room and board and other unallowable costs are excluded from the rate.

The table below contains the rates used for Transitional Living providers and the effective dates of the rates.

Provider	Per diem rate	Effective date
Advocates, Inc., Douglas House	$207.53	July 1, 2016
Advocates, Inc., McLaughlin House	$288.29	July 1, 2016
Advocates, Inc., Warren House	$247.60	July 1, 2016
CCHIP House	$206.73	July 1, 2016

Except as otherwise noted in the plan, state developed fee schedules are the same for both governmental and private providers.

v. **Licensed Freestanding Birth Centers**

Freestanding Birth Center (FBC) Facility Rate: Fee schedules established by DHCFP and published at http://www.mass.gov/dhcfp/regs. The link to the FBC fee schedule as of October 5, 2011, is http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_3_55.pdf. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

For physician, certified nurse midwife, and nurse practitioner services provided by FBC employees or contractors paid by the FBC, the FBC will be paid for the professional component of such services in accordance with Section 8.d. of Attachment 4.19-B of the State Plan. Other clinician services are included in the FBC Facility Rate.

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Reserved

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont.)

The mechanisms through which rates are established are: (1) determination of costs and charges prepared in accordance with Commission rules and regulations; (2) annual field audit of filed statements of reimbursement together with supporting data; (3) establishing of rates or reimbursement based on reasonable and necessary services in accordance with Commission criteria and in conjunction with public hearings with interested professional organizations. (Every rate established by the Rate Settling Commission is consistent, where applicable, with principles of reimbursement for provider cost in effect under regulations prescribed by Titles XVIII and XIX of the Social Security Act.)

Appeals to the Commission, as provided by statute, are heard by Commission appointed officers; findings of the appeal officers may be taken to the courts.

b. The Single State Agency will insure that payments for care or services are not in excess of the upper limits described in the federal regulations.

c. The Single State agency will take whatever measures are necessary to assure appropriate audit of records whenever reimbursement is based on costs of providing care or service, or fee plus costs of material.

State/Territory: Massachusetts

PAYMENT TO PACE PROVIDERS

I. PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible Medicare and Medicaid enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing. PACE providers assume full financial risk for providing member's care as required under the Agreement.

II. Rates and Payments

A. The State assures HCFA that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

___ 1. Rates are set at a percent of fee-for-service costs
___ 2. Experience-based (contractors/State's cost experience or encounter date)(please describe)
___ 3. Adjusted Community Rate (please describe)
_X_ 4. Other (please describe)

Description of the Upper Payment Limit Methodology for PACE providers

Transition Plan from Demonstration Status to Provider Status for PACE providers:

The Division of Medical Assistance has contracted with its actuaries, William M. Mercer, to develop the Upper Payment Limits (UPLs) for PACE providers. The Division has tasked William M. Mercer to develop actuarially sound UPLs which, by definition, cannot exceed what the Division would have otherwise spent on providing the State plan approved services on a FFS basis to an actuarially equivalent non-enrolled population. Our actuaries will develop two UPLs to reflect the enrollment profile of PACE enrollees into two separate Rating Categories: (1) the first is the Medicaid only; and (2) the second is the Medicaid-Medicare (dually eligible). Based upon the calculated UPLs, the Division will establish Capitation Rates for the PACE providers. The Division will then set the Capitation Rates as a percentage of the UPLs for both Rating Categories, based upon several factors, including the expected casemix of the population to be enrolled in the PACE provider networks. In this way, the Division will ensure CMS that Capitation Rates are less than the cost of providing the same services to an actuarially equivalent non-enrolled population group.

The Division intends to develop UPLs and Capitation Rates for the contract period November 1, 2002 through June 30, 2004, covering the State's Fiscal Years 2003 and 2004. The Division's decision to develop UPLs that cover this contract period is consistent with its desire to keep consistent with the similar contract period for the Senior Care Options Program currently under development.

Outline of the Upper Payment Limit Methodology:

The Division's actuaries will follow a two-step process in developing the UPLs.

1. Calculate Baseline Fee-For-Service Data:
   - Collect and analyze claims and eligibility data for Fiscal Years 1998 and 1999 for the Medicaid only and the Medicaid-Medicare rating categories. The baseline data includes data for: (1) all Home and Community Based Waiver members; and (2) all Nursing Facility members. Data on these two groups were found by our actuaries to reflect the clinical profiles of an actuarially equivalent non-enrolled population. The baseline data consists of only costs and utilization incurred by Medicaid for the Fee-For-Service population eligible for PACE.
     i. Medicaid members under the age of 55 are excluded from the baseline data; only members over the age of 54 are included in the baseline data.
     ii. All Medicaid buy-in premiums (the cost of purchasing Medicare coverage) for dual eligibles are excluded from the baseline data.
     iii. Persons with only Medicare coverage (that is, they have no Medicaid coverage) may enroll in PACE, but are excluded from the baseline data and consideration in the development of the UPL, because they do not qualify for Medicaid coverage.
   - Apply completion factors to the data for each SFY to account for incurred by not reported claims.
   - Analyze data to ensure that data are both accurate and reasonable.
   - Develop Per Member Per Month costs by Rating Category and by geographic area of the state.

2. Calculate FY 03/FY04 the service component of the UPLs:
   - Our actuaries will adjust the baseline FFS data to ensure actuarially sound UPLs by applying the following factors:
     i. Apply adjustments to the baseline data to account for nursing facility and home health expenditures.
     ii. Exclude pharmacy rebates.
     iii. Incorporate any program changes between the base years and the contract period.
     iv. Apply trend factors that are used to adjust for the costs of providing services between the base years and the contract period.
     v. Certify actuarial equivalence of the populations.

3. Administrative Percentage: The Division is also considering adding an administrative component to the UPL for the PACE Program to reflect what the Division would have otherwise spent on a Fee-For-Service basis for administration. Adding administration to the UPL is consistent with the approach that the Division has taken with all of its managed-care programs.

Capitation Rate-Setting Process

A. The Division will set a Capitation Rate for PACE providers for both Rating Categories through the contract process. Capitation rates will be equal to a certain percentage of the UPLs; the same methodology will be applied to all PACE providers.

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

William M. Mercer

C. The State will submit all capitated rates to the HCFA Regional Office for prior approval.

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B (Other Types of Care) of this State plan, for these services, where applicable:

X-ray services
Physician services
Optometric services
Clinic services**
Dental services
Podiatry services
FQHC /RHC services
Licensed Freestanding Birth Center services

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

___ Additional Other Provider-Preventable Conditions identified below: - None.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reduction in provider payment may be limited to the extent that the following apply: (i) the identified provider preventable conditions would otherwise result in an increase in payment; (ii) the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method: Effective for dates of service on or after July 1, 2012, MassHealth will not pay for OPPC-related services if the provider reports an Other Provider Preventable Condition (OPPC). If a provider's future year payment rate is calculated using a data source that would otherwise include the OPPC, all reported OPPC-related costs/services will be excluded from the calculation.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursement according to the methodology above.

** See Attachment 4.19-B, page 10 for Payment Adjustments for Provider Preventable Conditions for Freestanding Ambulatory Surgery Center services.

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Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions – Freestanding Ambulatory Surgery Center (FASC) Services

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B of this State Plan (Other Types of Care), for Freestanding Ambulatory Surgery Center (FASC) services, where applicable:

☒Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒Additional Other Provider-Preventable Conditions identified below:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

    1. Foreign object retained after surgery
    2. Air Embolism
    3. Blood incompatibility
    4. Stage III and IV Pressure Ulcers
    5. Falls and Trauma, related to:
        - fractures
        - dislocations
        - intracranial injuries
        - crushing injuries
        - burns
        - other injuries

- In addition, the following:

    1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
    2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
    3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
    4. Patient death or serious injury associated with patient elopement (disappearance)
    5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.

6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reduction in provider payment may be limited to the extent that the following apply: (i) the identified provider preventable conditions would otherwise result in an increase in payment; (ii) the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:
MassHealth will not pay the FASC for OPPC-related services if the FASC reports an Other Provider Preventable Condition (OPPC). If a future year FASC payment rate is calculated using a data source that would otherwise include the OPPC, all reported OPPC-related costs/services will be excluded from the calculation.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for services, including co-payments or deductibles deemed non-billable to MassHelath are not billable to the member.
In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursement according to the methodology above.

Payment Adjustment for Serious Reportable Events – Freestanding Ambulatory Surgery Center (FASC) services[**]

Serious Reportable Events (SREs)

The State identifies the following serious reportable events for which it applies the following non-payment method for Freestanding Ambulatory Surgery Center (FASC) services under Attachment 4.19-B, where applicable:

1. Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.
3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
4. Abduction of a patient / resident of any age
5. Sexual abuse/ assault on a patient or staff member within or on the grounds of a health care setting.

Non-Payment Method:
MassHealth will not pay the FASC for the facility component if an SRE listed above occurs on premises covered by the FASC license that was preventable, within the FASC's control, and unambiguously the result of a system failure, as described in applicable Massachusetts Department of Public Health regulations as in effect on the date of the service. MassHealth will also not pay the FASC the facility component for FASC services that are made necessary by, or are provided as a result of such an SRE.

Nonpayment provisions also apply to third-party liability and crossover payments by MassHealth. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

[**] These Serious Reportable Events are not Provider Preventable Conditions.

Increased Primary Care Service Payment 42 CFR 447.400, 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☒ The rates reflect all Medicare site of service adjustments and the mean value over all counties for each of the specified evaluation and management and vaccine administration codes.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code:

To determine the mean rate over all counties, the state utilized the Medicare Physician Fee Schedule RVUs November 2012 release with the 2009 conversion factor.

The state will make changes to the fee schedule annually to reflect Medicare updates.

The rates initially paid were developed using the initial Deloitte fee schedule distributed in January, 2013. Starting April 12, 2013 for non-vaccine codes and May 4, 2013 for vaccine codes, the rates paid were developed using the revised Deloitte fee schedule distributed in March, 2013.

Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

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Methods and Standards for Establishing Payment Rates – Other Types of Care

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes). _99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99288, 99315, 99316, 99339, 99340, 99354, 99355, 99356, 99357, 99358, 99359, 99360, 99363, 99364, 99366, 99367, 99368, 99374, 99375, 99377, 99378, 99379, 99380, 99401, 99402, 99403, 99404, 99406, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99485-99489, 99495, and 99496

(Primary Care Services Affected by this Payment Methodology – continued)

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, for vaccines provided under the Vaccines for Children program, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 (or, if higher, the rate using the CY 2009 conversion factor and the 2013 and 2014 RVUs) for code 90460.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is:_$16.19_____.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____
_____
_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

The rates for 90465 and 90471 were calculated using CMS's 2009 relative value units adjusted by an average statewide geographic pricing cost index (GPCI). After multiplying a state conversion factor by the adjusted RVUs, the final rate for both codes came out to $16.19. After weighting both rates by claim volume, the final imputed rate for 90460 in effect on 7/1/09 is $16.19.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on _12/31/14_____. All rates are published at (*insert agency website*).
http://www.mass.gov/eohhs/gov/laws-regs/hhs/regs.html

Vaccine Administration

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods and Standards for Establishing Payment Rates – Other Types of Care

This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on _12/31/14_____. All rates are published at (*insert agency website*).
http://www.mass.gov/eohhs/gov/laws-regs/hhs/regs.html

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 48 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to :CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Overview

In accordance with Section 6402 of the Omnibus Budget Reconciliation Act of 1989, the Massachusetts Department of Public Welfare submits the attached Medicaid payment and provider participation data. These data show that Massachusetts is in full compliance with the Health Care Financing Administration's Region I guidelines.

Medicaid Payment Rates for Pediatric and Obstetric Services

Attachment I reports maximum payment rates for all CPT codes requested in the instructions. Each CPT code has been listed along with the CPT procedure description and the applicable Medicaid rate. All rates are currently in effect and are subject to review by the state's Rate Settling Commission.

Data in this report can be found on the enclosed diskette under the file name /STATPLN.WK1.

Adequacy of Access

Based on the data supplied in Attachment II, Massachusetts asserts that both pediatric and obstetrical services are available to Massachusetts Medicaid recipients at least to the extent that such services are available to the general population. Our comparisons rely on statewide data, because no reliable regional breakdowns are available from the Massachusetts Board of Registration.

Data in this report can be found on the enclosed diskette under the file name /STATPLN2.WK1.

HMO Pediatric and Obstetrical Services

All Medicaid/HMO contractors are required to adhere to the pediatric and obstetrical service standard outlined in the Department of Public Welfare's Medicaid program regulations. Because HMO capitation rates are based on each HMO's community specific rate, they are by definition competitive with other carriers in the service area.

Medicaid Pediatric and Obstetric Participation Standards

I. Pediatric Standards

Total number of physicians enrolled and providing pediatric services and actively billing Medicaid*	2096
Total number of physicians providing pediatric services licensed and actively practicing in Massachusetts**	2576
Percent participating in Medicaid versus standard set by HCFA	81% 50%

II. Obstetric Standards

Total number of obstetric-related physicians enrolled and actively billing Medicaid*	1486
Total number of obstetric-related physicians licensed and actively practicing in Massachusetts**	1999
Percent participating in Medicaid versus standard set by HCFA	74% 50%

* As reflected in paid Medicaid claims to physicians for dates of service CY96 (unduplicated count of physicians billing)

** As measured by the Massachusetts Medical Society for 1996

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP."

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ____ of this attachment (see 3. Below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR."

4. Any exception to the general methods used for a particular group or payment are specified on Page 3 in item _ of this attachment (see 3. Above).

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A **SP** Deductibles	**SP**	Coinsurance
	Part B **SP** Deductibles	**SP**	Coinsurance
Other Medicaid Recipients	Part A **SP** Deductibles	**SP**	Coinsurance
	Part B **SP** Deductibles	**SP**	Coinsurance
Dual Eligible (QMB Plus)	Part A **SP** Deductibles	**SP**	Coinsurance
	Part B **SP** Deductibles	**SP**	Coinsurance

SP – State Plan – Medicaid
MR – Medicare rates

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Exceptions:

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute outpatient hospital services for RY19.

1. Except as provided in subsection 2, below, for dates of service in RY19 (October 1, 2018 through September 30, 2019), in-state Hospitals will be paid in accordance with this Attachment for Outpatient Services provided at Hospital Outpatient Departments, and at those Hospital-Licensed Health Centers (HLHCs) and other Satellite Clinics that are provider-based in accordance with 42 CFR 413.65.

2. In-state Critical Access Hospitals will be paid in accordance with the methods set forth in **Exhibit 1**, which is attached hereto and incorporated by reference into this Attachment, for dates of service in RY19 beginning October 1, 2018 through September 30, 2019.

3. The supplemental payments specified in **Section III.F** apply to dates of service from October 1, 2018 through September 30, 2019.

4. In-state Acute Hospitals are defined in **Section II**.

5. This **Section I.A.5** describes the payment methods to out-of-state acute outpatient hospitals for acute outpatient hospital services.

a. Except as provided in **subsections 5.c** and **5.d**, below, all out-of-state acute outpatient hospitals are paid utilizing an adjudicated payment per episode of care (APEC) payment methodology ("Out-of-State APEC") as described in **subsection 5.b,** below, for APEC-covered services, and in accordance with the applicable MassHealth fee schedule for services for which in-state acute hospitals are not paid the APEC. "APEC-covered services" are outpatient services for which in-state acute hospitals are paid the APEC.

b. The Out-of-State APEC for each payable episode will equal the sum of (i) the episode-specific total EAPG payment and (ii) the APEC outlier component (if applicable), as further described in **subsections 5.b.(1) and (2)**, below. Components of the Out-of-State APEC that are based on the in-state method will simultaneously adjust effective with the 2nd RY19 Period (as defined in **Section II**) to reflect updates being implemented effective with the 2nd RY19 Period to the in-state method, as applicable.

(1) The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC Outpatient Statewide Standard in effect for in-state acute hospitals, and the claim detail line's Adjusted EAPG Weight. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line's MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight for this purpose.

(2) The "APEC outlier component" is equal to the Marginal Cost Factor in effect for in-state acute hospitals multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold. If the episode-specific case cost is less than the episode-specific outlier threshold, the APEC outlier component is $0.

(i) The "episode-specific case cost" is determined by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the applicable outpatient cost-to-charge ratio. For High MassHealth Volume Hospitals (as defined in **subsection 5.d**, below), the outpatient cost-to-charge ratio is hospital-specific. For all other out-of-state acute hospitals, the median in-state acute outpatient hospital cost-to-charge ratio in effect based on MassHealth episode volume is used.

(ii) The "episode-specific outlier threshold" is equal to the sum of the episode-specific total EAPG payment corresponding to the episode, and the Fixed Outpatient Outlier Threshold in effect for in-state acute hospitals.

(iii) An APEC outlier component is not payable if the episode-specific total EAPG payment is $0.

c. Out-of-state acute hospitals will be paid for APEC Carve-Out Drugs (as defined in **Section II**) in accordance with the payment method applicable to such drug as in effect for in-state acute hospitals on the date of service.

d. If an inpatient service payable by MassHealth is not available in-state, payment for the related acute hospital outpatient services will be made at the rate of payment established for the medical service under the other state's Medicaid program (or equivalent), or such other rate as MassHealth determines necessary to ensure member access to services. This provision does not apply to "High MassHealth Volume Hospitals", which are defined (i) for purposes of the 1st RY19 Period as any out-of-state acute hospital that, during the most recent federal fiscal year for which complete data is available, had at least 150 MassHealth discharges, and (ii) for purposes of the 2nd RY19 Period as any out-of-state acute hospital that, during the most recent federal fiscal year for which complete data is available, had at least 100 MassHealth discharges.

e. The payment methods in this **Section I.A.5** are the same for private and governmental providers.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

B. Non-Covered Services

The payment methods specified in this Attachment do not apply to the following Outpatient Hospital Services:

1. Behavioral Health Services for Members Enrolled with the Behavioral Health Contractor

MassHealth contracts with a Behavioral Health (BH) Contractor to provide Behavioral Health Services to Members enrolled with the BH Contractor.

Hospitals are not entitled to, and may not claim for, any payment from EOHHS for any services that are BH Contractor-covered services or are otherwise payable by the BH Contractor.

2. MCO Services

MassHealth contracts with Managed Care Organizations (MCOs) to provide medical services, including Behavioral Health Services, to Members enrolled with the MCO. Hospitals are not entitled to, and may not claim for, any payment from EOHHS for any services that are MCO-covered services or are otherwise payable by the MCO.

3. Air Ambulance Services

In order to receive payment for air ambulance services, providers must have a separate contract with EOHHS for such services.

4. Ambulatory Services Not Governed by this Attachment

The following services provided by Hospitals to MassHealth Members on an outpatient basis are not paid pursuant to this Attachment: audiology dispensing, vision care dispensing, ambulance services, psychiatric day treatment, dental, early intervention, home health, adult day health and adult foster care, outpatient covered drugs processed through the MassHealth Pharmacy On-Line Processing System (POPS), and services of designated emergency mental health providers / emergency services programs (DEPs/ESPs).

II. Definitions

The definitions set forth in the "**1st RY19 Period**" column, below, apply during the **1st RY19 Period** (as defined below). The definitions set forth in the **"2nd RY19 Period**" column, below, apply during the **2nd RY19 Period** (as defined below), unless (i) that column specifies that there is no change to the definition, or (ii) for purposes of the APEC payment methodology set forth in **Section III.B**, the Episode's first date of service for Emergency Department or Observation Services that extend past midnight occurred in the 1st RY19 Period, in which case, the definitions set forth in the **1st RY19 Period** column continue to apply.

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
1st RY19 Period	The "1st RY19 Period" is the portion of RY19 from October 1, 2018 through October 31, 2018.	No change to definition.
2nd RY19 Period	The "2nd RY19 Period" is the portion of RY19 from November 1, 2018 through the end of RY19.	No change to definition.
3M EAPG Grouper	The 3M Corporation's EAPG Grouper version 3.10, configured for the MassHealth APEC payment method.	The 3M Corporation's EAPG Grouper version 3.12, configured for the MassHealth APEC payment method.
Accountable Care Organization (ACO)	An entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans (ACPPs), Primary Care ACOs, and MCO-Administered ACOs.	No change to definition.
Accountable Care Partnership Plan (ACPP)	A type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is approved by the Massachusetts Division of Insurance as a health-	No change to definition.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	maintenance organization (HMO), and which is organized primarily for the purpose of providing health care services.	
Acute Hospital	See Hospital.	No change to definition.
Actual Acquisition Cost	For purposes of **Section III.E-1**, the Hospital's "actual acquisition cost" of the Drug is the Hospital's invoice price for the Drug, net of all on- or off- invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member during an Acute Outpatient Hospital visit, including any efficacy-, outcome-, or performance-based guarantee (or similar arrangements), whether received pre- or post-payment.	No change to definition.
Adjudicated Payment per Episode of Care (APEC)	A Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in **Sections I.B, III.C through III.E, and III.E-1**. The APEC is calculated as set forth in **Section III.B**, utilizing the methodology applicable to the 1st RY19 Period**.**	A Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in **Sections I.B, III.C through III.E, and III.E-1**. The APEC is calculated as set forth in **Section III.B**, utilizing the methodology applicable to the 2nd RY19 Period**.**
Adjusted EAPG Weight	The EAPG weight that is multiplied by the APEC Outpatient Statewide Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating the Episode-Specific	The EAPG weight that is multiplied by the Hospital's Wage Adjusted APEC Outpatient Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	Total EAPG Payment, utilizing the methodology applicable to the 1st RY19 Period. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight, including as follows: • **consolidation** is the collapsing of multiple identical or related significant procedure EAPGs into a single EAPG for payment purposes, with the additional procedures weighted at zero percent; • **packaging** applies to ancillary service EAPGs present with a significant procedure EAPG or medical visit EAPG, with the ancillary service EAPGs weighted at zero percent; • **discounting** applies to multiple unrelated significant procedures, repeat ancillary procedures, terminated procedures, and bilateral procedures. All discounting rates are 50%, with the exception of terminated procedures (75% of full weight) and the third and subsequent ancillary procedures (25% of full weight).	the Episode-Specific Total EAPG Payment, utilizing the methodology applicable to the 2nd RY19 Period. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight, including as follows: • **consolidation** is the collapsing of multiple identical or related significant procedure EAPGs into a single EAPG for payment purposes, with the additional procedures weighted at zero percent; • **packaging** applies to ancillary service EAPGs present with a significant procedure EAPG or medical visit EAPG, with the ancillary service EAPGs weighted at zero percent; • **discounting** applies to multiple unrelated significant procedures, repeat ancillary procedures, terminated procedures, and bilateral procedures. All discounting rates are 50%, with the exception of terminated procedures (75% of full weight) and the third and subsequent ancillary procedures (25% of full weight).
APEC Base Year	The APEC Base Year is FY14.	No change to definition.
APEC Carve-Out Drugs	Drugs that are carved out of the APEC payment and separately paid	No change to definition.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	pursuant to **Section III.E-1**. APEC Carve-Out Drugs are identified on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List.	
APEC-Covered Services	MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, except those services described in **Sections I.B, III.C through III.E and III.E-1.**	No change to definition.
APEC Outlier Component	A Hospital-specific, Episode-specific component of the APEC which is calculated by EOHHS as described in **Section III.B.2.b**, utilizing the methodology applicable to the 1st RY19 Period, and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.	A Hospital-specific, Episode-specific component of the APEC which is calculated by EOHHS as described in **Section III.B.2.b**, utilizing the methodology applicable to the 2nd RY19 Period, and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.
APEC Outpatient Statewide Standard	The APEC outpatient statewide standard determined by EOHHS as described in **Section III.B.2.a(1)** and applicable to the 1st RY19 Period.	The APEC outpatient statewide standard determined by EOHHS as described in **Section III.B.2.a(1)(a)** and applicable to the 2nd RY19 Period.
Behavioral Health (BH) Contractor	The entity with which EOHHS contracts to provide, arrange for and coordinate Behavioral Health Services to enrolled Members on a capitated basis, and which meets the definition of prepaid inpatient health plan at 42 C.F.R. §438.2.	No change to definition.
Behavioral Health Services (or Behavioral Health)	Services provided to Members who are being treated for psychiatric disorders or substance use disorders.	No change to definition.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Casemix	The description and categorization of a hospital's patient population including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.	No change to definition.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.	No change to definition.
Community-Based Physician	Any physician or physician group practice, excluding interns, residents, fellows, and house officers, who is not a Hospital-Based Physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths.	No change to definition.
Contract	see RFA and Contract.	No change to definition.
Critical Access Hospital	An acute hospital that, prior to October 1, 2017, was designated by CMS as a Critical Access Hospital and that continues to maintain that status.	An acute hospital that, prior to October 1, 2018, was designated by CMS as a Critical Access Hospital and that continues to maintain that status.
Drugs	Drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified form and strength. Each dosage form and strength is a separate Drug.	No change to definition.
Emergency Department	A Hospital's emergency room or level I trauma center which is located at the same site as the Hospital's inpatient facility.	No change to definition.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Enhanced Ambulatory Patient Group (EAPG)	A group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M EAPG Grouper.	No change to definition.
Episode	All MassHealth-covered Outpatient Services, except those set forth in **Sections I.B, III.C through III.E and III.E-1,** delivered to a MassHealth Member on a single calendar day, or if the services extend past midnight in the case of Emergency Department or Observation Services, on consecutive days. Additionally, in limited circumstances, APEC-Covered Services delivered to a MassHealth Member during a second distinct and independent visit on the same calendar day may be considered a separate Episode for payment purposes if the services are for unrelated purposes and conditions as determined by EOHHS.	No change to definition.
Episode's Total Allowed Charges	the sum of the MassHealth allowed charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.	the sum of the MassHealth allowed charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.
Episode-Specific Case Cost	The product of the Episode's Total Allowed Charges, and the Hospital's FY16 outpatient cost-to-charge ratio as calculated by EOHHS using the Hospital's FY16 Massachusetts Hospital cost report.	The product of the Episode's Total Allowed Charges, and the Hospital's FY17 outpatient cost-to-charge ratio as calculated by EOHHS using the Hospital's FY17 Massachusetts Hospital cost report.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Episode-Specific Outlier Threshold	the sum of the Episode-Specific Total EAPG Payment, as determined by EOHHS, and the Fixed Outpatient Outlier Threshold.	the sum of the Episode-Specific Total EAPG Payment, as determined by EOHHS, and the Fixed Outpatient Outlier Threshold.
Episode-Specific Total EAPG Payment	An Episode-specific payment amount, which summed with the APEC Outlier Component (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in **Section III.B.2.a**, utilizing the methodology applicable to the 1st RY19 Period.	An Episode-specific payment amount, which summed with the APEC Outlier omponent (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in **Section III.B.2.a**, utilizing the methodology applicable to the 2nd RY19 Period..
Executive Office of Health and Human Services (EOHHS)	The single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.	No change to definition.
Fiscal Year (FY)	The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. This period coincides with the federal fiscal year (FFY). FY19 begins on October 1, 2018 and ends on September 30, 2019.	No change to definition.
Fixed Outpatient Outlier Threshold	For the 1st RY19 Period, the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $2,750.	For the 2nd RY19 Period, the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $3,600.
Hospital	Any health care facility which: a. operates under a hospital license issued by the Massachusetts Department of Public Health (DPH) pursuant	No change to definition.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	to M.G.L. c. 111 § 51; b. is Medicare certified and participates in the Medicare program; and c. has more than fifty percent (50%) of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds, as determined by DPH and currently utilizes more than fifty percent (50%) of its beds exclusively as such, as determined by EOHHS.	
Hospital-Based Physician	Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Outpatient Hospital Services to Members at a site for which the Hospital is otherwise eligible for payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.	No change to definition.
Hospital-Licensed Health Center (HLHC)	A Satellite Clinic that (1) meets MassHealth requirements for payment as a HLHC as provided at 130 CMR 410.413; and (2) is	No change to definition.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	approved by and enrolled with MassHealth as a HLHC.	
Inflation Factors for Operating Costs	For price changes between RY14 and RY18, a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factors for Operating Costs between RY14 and RY18 are as follows: • 1.611% reflects the price changes between RY14 and RY15. • 1.573% reflects the price changes between RY15 and RY16. • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18.	For price changes between RY14 and RY19, a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factors for Operating Costs between RY14 and RY19 are as follows: • 1.611% reflects the price changes between RY14 and RY15. • 1.573% reflects the price changes between RY15 and RY16. • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18. • 2.183% reflects the price changes between RY18 and RY19.
Managed Care Organization (MCO)	Any entity with which EOHHS contracts to provide primary care and certain other medical services, including Behavioral Health Services, to Members on a capitated basis, and which meets the definition of an MCO at 42 CFR § 438.2. For clarity purposes, MCOs also include Accountable Care Partnership Plans (ACPPs).	No change to definition.
Marginal Cost Factor	As used in the calculation of the APEC Outlier Component, the percentage of payment made for the difference between the Episode-Specific Case Cost and the Episode-	As used in the calculation of the APEC Outlier Component, the percentage of payment made for the difference between the Episode-Specific Case Cost and the Episode-

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	Specific Outlier Threshold. For the 1st RY19 Period, the Marginal Cost Factor is 80%.	Specific Outlier Threshold. For the 2nd RY19 Period, the Marginal Cost Factor is 50%.
Massachusetts-specific Wage Area Index	Not applicable.	Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage. Massachusetts Hospitals' wages and hours were determined based on CMS's FY2019-April-27-2018-Wage-Index-PUF zip file, downloaded May 1, 2018 (the "CMS File"). Wage areas were assigned according to the same CMS File, except that BayState Franklin Medical Center was assigned to (and its wages and hours included in) the Springfield wage area, and PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined from their hospital's license. The area's Wage Index is the Massachusetts-specific Wage Area Index for each Hospital assigned to the area, except for any Hospital that was re-designated in a written decision from CMS to the Hospital provided to EOHHS by March 30, 2018. For any such redesignated Hospital, its Massachusetts-specific Wage Area Index was calculated based on the wages and hours, determined from the CMS File, of (i) the redesignated Hospital, (ii) all other Hospitals redesidgnated to that same area, and (iii) all Hospitals assigned to that area, combined.
MassHealth (also referred to as Medicaid)	The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E, Titles	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	XIX and XXI of the Social Security Act, and any approved waivers of such provisions.	
MassHealth EAPG Weight	The MassHealth relative weight developed by EOHHS for each unique EAPG, as applicable to the 1st RY19 Period.	The MassHealth relative weight developed by EOHHS for each unique EAPG, as applicable to the 2nd RY19 Period.
Member	A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.	No change to definition.
Observation Services	Outpatient Hospital Services provided anywhere in an Acute Hospital to evaluate a Member's condition and determine the need for admission to an Acute Hospital. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.	No change to definition.
Outpatient Department (also referred to as **Hospital Outpatient Department**)	A department or unit located at the same site as the Hospital's inpatient facility, or a School-Based Health Center that operates under the Hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, primary care clinics, specialty clinics and Emergency Departments.	No change to definition.
Outpatient Services (also **Outpatient Hospital**	Preventive, diagnostic, therapeutic or palliative services provided to a Member on an outpatient basis, by or	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Services)	under the direction of a physician or dentist, in a Hospital Outpatient Department, Hospital-Licensed Health Center or other Satellite Clinic. Such services include, but are not limited to, emergency services, primary care services, Observation Services, ancillary services, day surgery services, and recovery room services. Payment rules regarding Outpatient Services are found in 130 CMR Parts 410 and 450, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions and the RFA.	
PAPE Covered Services	MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics that were paid utilizing the PAPE payment methodology under prior Acute Outpatient Hospital SPAs (including SPA 016-016 for the period up through December 29, 2016).	No change to definition.
Payment Amount Per Episode (PAPE)	An outpatient payment methodology that was utilized in prior Acute Outpatient Hospital SPAs. The PAPE was a fixed Hospital-specific all-inclusive facility payment that was made for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode (as defined in prior Acute Outpatient Hospital SPAs, including SPA 016-016 for the RY17 period up through December 29, 2016), with the exception of those services that were excluded from the PAPE payment methodology as described in those prior SPAs. The PAPE methodology	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	was replaced by the APEC payment methodology during RY17, effective with dates of service on or after December 30, 2016.	
Primary Care ACO	A type of ACO with which the MassHealth agency contracts under its ACO program.	No change to definition.
Primary Care Clinician Plan (PCC Plan)	A comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive primary care, behavioral health, and other medical services.	No change to definition.
Rate Year (RY)	Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table: Rate Year* / Dates RY04 10/1/2003 – 9/30/2004 RY05 10/1/2004 – 9/30/2005 RY06 10/1/2005 – 9/30/2006 RY07 10/1/2006 – 10/31/2007 RY08 11/1/2007 – 9/30/2008 RY09 10/1/2008 – 10/31/2009 RY10 11/1/2009 – 11/30/2010 RY11 12/01/2010–09/30/2011 RY12 10/01/2011 --9/30/2012 RY13 10/01/2012 –09/30/2013 RY14 10/1/2013 – 09/30/2014 RY15 10/1/2014 – 9/30/2015 RY16 10/1/2015 – 9/30/2016 RY17 10/1/2016 – 9/30/2017 RY18 10/1/2017 – 9/30/2018 RY19 10/1/2018 - 9/30/2019 *In future rate years, Hospitals will be paid in in accordance with this Attachment (until amended).	No change to definition.

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RFA and Contract	The Request for Applications and the agreement executed between each selected Hospital and EOHHS that incorporates all of the provisions of the RFA.	No change to definition.
Satellite Clinic	A facility that operates under a Hospital's license, is subject to the fiscal, administrative, and clinical management of the Hospital, provides services to Members solely on an outpatient basis, is not located at the same site as the Hospital's inpatient facility, and demonstrates to EOHHS's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.	No change to definition.
School-Based Health Center (SBHC)	A center located in a school setting which: (1) provides health services to MassHealth Members under the age of 21; (2) operates under a Hospital's license; (3) is subject to the fiscal, administrative, and clinical management of a Hospital Outpatient Department or HLHC; and (4) provides services to Members solely on an outpatient basis.	No change to definition.
Usual and Customary Charges	Routine fees that Hospitals charge for Outpatient Services rendered to patients regardless of payer sources.	No change to definition.
Wholesale Acquisition Cost (WAC)	The wholesale acquisition cost (WAC) of the Drug as published by First Data Bank or other national price compendium designated by EOHHS.	No change to definition.

III. Payment for Outpatient Services

A. Overview

Except as otherwise provided for Outpatient Services specified in S**ections I.B, III.C through III.E,** and **III.E-1,** and in **Exhibit 1**, Hospitals will receive a Hospital-specific, Episode-specific payment for each Episode known as the Adjudicated Payment per Episode of Care (APEC), calculated as set forth in **Section III.B**, below. This payment methodology is applicable to all public and private providers.

Except as otherwise provided for medically necessary services to a MassHealth Standard or CommonHealth member under 21, hospitals will not be paid for Outpatient Hospital Services specified as non-payable in Subchapter 6 of the MassHealth Acute Outpatient Hospital Manual.

For dates of service in RY19 beginning October 1, 2018 through September 30, 2019, Critical Access Hospitals are paid in accordance with **Exhibit 1**.

B. Adjudicated Payment per Episode of Care (APEC)

1. Rate Year 2019 APEC Payment Methodology

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the APEC payment methodology. The APEC methodology is set forth in **Section III.B.2**, below. The **"1st RY19 Period'** column applies to dates of service in the 1st RY19 Period, and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The "**2nd RY19 Period"** column applies to dates of service in the 2nd RY19 Period, and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. As an exception, for Episodes that extend past midnight in the case of Emergency Department or Observation Services, if the Episodes' first date of service occurs in the 1st RY19 Period, then the 1st RY19 Period APEC methodology applies to the entire Episode. The 1st RY19 Period APEC methodology is the same methodology that applied during the 2nd RY18 Period effective beginning March 1, 2018, under approved SPA TN-017-016, as amended by approved SPA TN-018-002.

1st RY19 Period (for dates of service in the 1st RY19 Period)	**2nd RY19 Period (for dates of service in the 2nd RY198 Period)**
2. Description of APEC payment method Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for each payable Episode known as the APEC. The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus (2), if applicable, an APEC Outlier Component, as further described below.	**2. Description of APEC payment method** Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for each payable Episode known as the APEC. The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus (2), if applicable, an APEC Outlier Component, as further described below.

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1st RY19 Period (for dates of service in the 1st RY19 Period)	2nd RY19 Period (for dates of service in the 2nd RY198 Period)
a. Episode-Specific Total EAPG Payment. For each claim detail line containing APEC-Covered Services in the Episode, the APEC Outpatient Statewide Standard (as described below) is multiplied by the claim detail line's Adjusted EAPG Weight (as described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.	**a. Episode-Specific Total EAPG Payment.** For each claim detail line containing APEC-Covered Services in the Episode, the Hospital's Wage Adjusted APEC Outpatient Standard (as described below) is multiplied by the claim detail line's Adjusted EAPG Weight (as described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.
(1) **APEC Outpatient Statewide Standard.** The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described below. For each Hospital, an average outpatient cost per Episode for the APEC Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all PAPE paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. The Hospital's CCR was calculated based on the Hospital's FY14 - 403 cost report, and Hospital-specific Episodes and charges were based on paid claims for Episodes residing in MMIS for the APEC Base Year, for which MassHealth was primary payer. Each Hospital's average outpatient cost	(1) **Wage Adjusted APEC Outpatient Standard.** The Wage Adjusted APEC Outpatient Standard is the APEC Outpatient Statewide Standard, adjusted by the Hospital's Massachusetts-specific Wage Area Index, as further described below. (a) **APEC Outpatient Statewide Standard.** The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for wage area index, casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described below. For each Hospital, an average outpatient cost per Episode for the APEC Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all PAPE paid

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1st RY19 Period (for dates of service in the 1st RY19 Period)	2nd RY19 Period (for dates of service in the 2nd RY198 Period)
per Episode was then divided by the Hospital-Specific Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific Outpatient CMI was determined based on PAPE paid claims residing in MMIS for the APEC Base Year for which MassHealth was primary payer. For each Hospital and month of the APEC Base Year, an average EAPG weight per Episode was determined by assigning individual EAPGs and associated MassHealth-developed weights to the Hospital's PAPE paid claims for the month (using the 3M EAPG Grouper), summing the individual EAPG weights together, and dividing that sum by the number of Episodes. The sum of the Hospital's twelve monthly average EAPG weights per Episode for the APEC Base Year, divided by 12 is the Hospital-Specific Outpatient CMI. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY16 MassHealth Episodes for the Hospitals was produced from paid claims in MMIS for which MassHealth was primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 67% of the total number of statewide Episodes in MMIS. The APEC efficiency standard applicable to the 1st RY19 Period is $291.36. The APEC Outpatient Statewide Standard was then determined by multiplying (a) the weighted mean of the standardized	Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. The Hospital's CCR was calculated based on the Hospital's FY14 -403 cost report, and Hospital-specific Episodes and charges were based on paid claims for Episodes residing in MMIS for the APEC Base Year, for which MassHealth was primary payer. The labor portion of the average outpatient cost per Episode for each Hospital was adjusted by the Hospital's Massachusetts-specific Wage Area Index, as defined in **Section II**, and the labor and non-labor portions were then adjusted by the Hospital-Specific Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific Outpatient CMI was determined based on PAPE paid claims residing in MMIS for the APEC Base Year for which MassHealth was primary payer. For each Hospital and month of the APEC Base Year, an average EAPG weight per Episode was determined by assigning individual EAPGs and associated MassHealth-developed weights, as adjusted by EOHHS, to the Hospital's PAPE paid claims for the month (using the 3M EAPG Grouper), summing the individual EAPG weights together, and dividing that sum by the number of Episodes. The sum of the Hospital's twelve monthly average EAPG weights per Episode for the APEC Base Year,

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1st RY19 Period (for dates of service in the 1st RY19 Period)	2nd RY19 Period (for dates of service in the 2nd RY198 Period)
costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 93%; and by (c) the Inflation Factors for Operating Costs between RY14 and RY18, and then dividing that result by a conversion factor of 1.057. The APEC Outpatient Statewide Standard applicable to the 1st RY19 Period is $258.43. For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's APEC Outpatient Statewide Standard is instead $323.43.	divided by 12 is the Hospital-Specific Outpatient CMI. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY17 MassHealth Episodes for the Hospitals was produced from paid claims in MMIS for which MassHealth was primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 60% of the total number of statewide Episodes in MMIS. The APEC efficiency standard applicable to the 2nd RY19 Period is $702.87. The APEC Outpatient Statewide Standard was then determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 95%; and by (c) the Inflation Factors for Operating Costs between RY14 and RY19, and then dividing that result by a conversion factor of 1.078. The APEC Outpatient Statewide Standard applicable to the 2nd RY19 Period is $638.49. For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's APEC Outpatient Statewide Standard is instead $768.49.

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1st RY19 Period (for dates of service in the 1st RY19 Period)	2nd RY19 Period (for dates of service in the 2nd RY198 Period)
	(b) **Wage Adjusted APEC Outpatient Standard** The Hospital's Wage Adjusted APEC Outpatient Standard is determined by (1) multiplying the labor portion of the APEC Outpatient Statewide Standard by the Hospital's Massachusetts-specific Wage Area Index (as defined in **Section II**), and (2) adding this amount to the non-labor portion of the APEC Outpatient Statewide Standard.
(2) **Claim Detail Line's "Adjusted EAPG Weight**." EAPGs are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted Hospital claim, utilizing the 3M EAPG Grouper. EAPGs are assigned at the claim detail line level. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights (as defined in **Section II**) to produce that claim detail line's Adjusted EAPG Weight.	(2) **Claim Detail Line's "Adjusted EAPG Weight**." EAPGs are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted Hospital claim, utilizing the 3M EAPG Grouper. EAPGs are assigned at the claim detail line level. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights (as defined in **Section II**) to produce that claim detail line's Adjusted EAPG Weight.
b. APEC Outlier Component. The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then multiplied by the 1st RY19 Period Marginal Cost Factor. The Episode-Specific Case Cost is the product of the Episode's Total Allowed Charges and the Hospital's FY16 Outpatient CCR (which is based on the Hospital's FY16 Massachusetts Hospital cost report). The	**b. APEC Outlier Component.** The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then multiplied by the 2nd RY19 Period Marginal Cost Factor. The Episode-Specific Case Cost is the product of the Episode's Total Allowed Charges and the Hospital's FY17 Outpatient CCR (which is based on the Hospital's FY17 Massachusetts Hospital cost report). The

1st RY19 Period (for dates of service in the 1st RY19 Period)	2nd RY19 Period (for dates of service in the 2nd RY198 Period)
Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section III.B.2.a,** above), and the 1st RY19 Period Fixed Outpatient Outlier Threshold of $2,750. If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor for the 1st RY19 Period set at 80%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.	Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section III.B.2.a,** above), and the 2nd RY19 Period Fixed Outpatient Outlier Threshold of $3,600, If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor for the 2nd RY19 Period set at 50%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.
c. Calculation of the APEC. The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section III.B.2.a**, above) and the APEC Outlier Component (calculated as set forth in **Section III.B.2.b**., above).	**c. Calculation of the APEC.** The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section III.B.2.a**, above) and the APEC Outlier Component (calculated as set forth in **Section III.B.2.b**., above).

See **Tables 1, 1.1 and 1.2**, below, for an illustrative example of the calculation of a Hospital's APEC for Episode claim with multiple EAPGs. The example assumes the 2nd RY19 Period applies.

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Table 1 -- Example of Hospital's APEC Calculation for a Single Episode -- 2nd RY19 Period			
(Values are for demonstration purposes only)			
Line	**Description**	**Value**	**Calculation or Source**
Calculation of Episode-Specific Total EAPG Payment			
1	Episode-Specific Total EAPG Payment	$1,593.35	Sum of Episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #s 1 through 5 from Table 1.2 below)
Calculation of APEC Outlier Component (only calculated if Line 1 > $0)			
2	Episode's Total Allowed Charges	$13,700.00	Sum of Episode's claim detail line MassHealth allowed charges (sum of Line 2 from claim detail lines #s 1 through 5, from Table 1.2, below)
3	Hospital's Outpatient Cost-to-Charge Ratio	37.65%	Hospital's FY17 Massachusetts Hospital Cost Report
4	Episode-Specific Case Cost	$5,158.15	Line 2 * Line 3
5	Fixed Outpatient Outlier Threshold	$3,600	Section II Definition (2nd RY19 Period)
6	Episode-Specific Outlier Threshold	$5,193.35	Line 1 + Line 5
7	Does Episode-Specific Cost exceed Episode-Specific Outlier Threshold?	FALSE	Is Line 4 > Line 6 ? If TRUE, then APEC Outlier Component is due
8	Marginal Cost Factor	50%	Determined annually
9	APEC Outlier Component	$0.00	(Line 4 - Line 6) * Line 8
APEC for the Episode			
10	APEC	$1,593.35	Line 1 + Line 9

Table 1.1 Hospital's Wage Adjusted APEC Outpatient Standard (Example)			
(Values are for demonstration purposes only)			
Line	**Description**	**Value**	**Calculation or Source**
1	APEC Outpatient Statewide Standard	$638.49	Section III.B.2.a(1)(a) (2nd RY19 Period)
2	Hospital's Massachusetts-specific wage area index	1.0728	Varies by Hospital
3	Labor factor	0.6000	Determined annually
4	Hospital's Wage Adjusted APEC Outpatient Standard	$666.38	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3))

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Table 1.2 -- Claim Detail Line EAPG Payment Amounts (Example)			
(Values are for demonstration purposes only)			
Claim Detail Line #1 EAPG Payment Amount Calculation			
299	**EAPG 299 (CAT SCAN - BRAIN)**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$666.38	Table 1.1, Line 4
2	Claim detail line allowed charges	$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	0.1973	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	0.1973	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$131.48	Line 1 * Line 4
Claim Detail Line #2 EAPG Payment Amount Calculation			
220	**EAPG 220 (LEVEL II NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP)**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$666.38	Table 1.1, Line 4
2	Claim detail line allowed charges	$3,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	1.4625	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	1.4625	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$974.58	Line 1 * Line 4
Claim Detail Line #3 EAPG Payment Amount Calculation - DISCOUNTED			
220	**EAPG 220 (LEVEL II NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP)**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$666.38	Table 1.1, Line 4
2	Claim detail line allowed charges	$3,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	1.4625	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	0.7313	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$487.29	Line 1 * Line 4
Claim Detail Line #4 EAPG Payment Amount Calculation - CONSOLIDATED			
298	**EAPG 298 (CAT SCAN BACK)**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$666.38	Table 1.1, Line 4
2	Claim detail line allowed charges	$3,500.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	0.2074	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	0.0000	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	Line 1 * Line 4
Claim Detail Line #5 EAPG Payment Amount Calculation - PACKAGED			
400	**EAPG 400 (LEVEL I CHEMISTRY TESTS)**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$666.38	Table 1.1, Line 4
2	Claim detail line allowed charges	$200.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	0.0560	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	0.0000	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	Line 1 * Line 4

C. Physician Payments

1. A Hospital may receive payment for the professional component of physician services provided by Hospital-Based Physicians to MassHealth members.

2. Such payment shall be as specified in Attachment 4.19B, section 8.d. of the State Plan. Hospitals will not be paid separately for professional fees for practitioners other than Hospital-Based Physicians as defined in **Section II**.

3. Hospitals will be paid for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

4. Physician services provided by residents and interns are not payable separately.

5. Hospitals will not be paid for physician services if those services are (1) provided by a Community-Based Physician; or (2) as further described herein.

6. In order to qualify for payment for Hospital-Based Physician services provided during the provision of Observation Services, the reasons for the Observation Services, the start and stop time of the Observation Services, and the name of the physician ordering the Observation Services, must be documented in the Member's medical record.

D. Outpatient Hospital Services Payment Limitations

1. Payment Limitations on Hospital Outpatient Services Preceding an Admission

Hospitals will not be separately paid for Outpatient Hospital Services when an inpatient admission to the same Hospital, on the same date of service, occurs following the Outpatient Hospital Services.

2. Payment Limitations on Outpatient Services to Inpatients

Hospitals will not be paid for Outpatient Services provided to any Member who is concurrently an inpatient of any Hospital. The Hospital is responsible for payment to any other provider of services delivered to a Member while an inpatient of that Hospital.

E. Laboratory Services

1. Payment for Laboratory Services

a. Hospitals will be paid for laboratory services as specified in Attachment 4.19-B, section 8.b. of the State Plan.

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2. Physician Services

No additional payment shall be made for any physician service provided in connection with a laboratory service, except for surgical pathology services. The maximum allowable payment is payment in full for the laboratory service.

E-1. Payment for APEC Carve-Out Drugs

Payment to Hospitals for APEC Carve-Out Drugs administered to Members during an outpatient hospital visit will be the lowest of (1) the Hospital's Actual Acquisition Cost of the Drug; (2) the Wholesale Acquisition Cost (WAC) of the Drug; and (3) if available, the Medicare Part B rate for the Drug, each as determined by EOHHS.

F. Payment for Unique Circumstances

1. High Public Payer Hospital Supplemental Payment

a. Eligibility

In order to qualify for this supplemental payment, a Hospital must have received greater than 63% of its Gross Patient Service Revenue (GPSR) in FY17 from government payers and uncompensated care as determined by the Hospital's FY17 Massachusetts Hospital Cost Report.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to qualifying Hospitals.

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of $6.5 million to qualifying hospitals on a pro rata basis according to each qualifying hospital's number of MCO, Primary Care ACO and PCC Plan outpatient episodes in FY19, with each qualifying hospital's FY19 MCO and Primary Care ACO episode volume weighted at 60% and each qualifying hospital's FY19 PCC Plan episode volume weighted at 40%.

For purposes of this calculation, "MCO, Primary Care ACO and PCC Plan outpatient episodes in FY19" refer to paid outpatient episodes of care delivered by the qualifying hospital to MassHealth Members enrolled in an MCO, a Primary Care ACO or the PCC Plan, as determined by EOHHS utilizing, for the MCO episode volume, MCO encounter data submitted by each MCO for FY19 and residing in the MassHealth data warehouse as of March 31, 2020, and for the PCC Plan and Primary Care ACO episode volume, Medicaid paid claims data for FY19 residing in MMIS as of March 31, 2020, for which MassHealth is primary payer. "MCO" for purposes of this **Section III.F.1** refers to all MCOs as defined in **Section II**, except for Senior Care Organizations and One Care plans. Only MCO encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section III.F.1.a**) is considered in determining the pro rata share.

2. Essential MassHealth Hospitals

a. Eligibility

In order to qualify for payment as an Essential MassHealth Hospital, a Hospital must itself meet, or be within a system of Hospitals, any one of which meets, at least four of the following criteria, as determined by EOHHS, provided that all Hospitals within such system are owned or controlled, directly or indirectly, by a single entity that (i) was created by state legislation prior to 1999; and (ii) is mandated to pursue or further a public mission:

(1) The Hospital is a non-state-owned public Acute Hospital.

(2) The Hospital meets the current MassHealth definition of a non-profit teaching Hospital affiliated with a Commonwealth-owned medical school.

(3) The Hospital has at least 7% of its total patient days as Medicaid days.

(4) The Hospital is an acute care general Hospital located in Massachusetts which provides medical, surgical, emergency and obstetrical services.

(5) The Hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

Based on these criteria, Cambridge Health Alliance (CHA) and the UMass Memorial Health Care, Inc. Hospitals (UMass Hospitals) are the only Hospitals eligible for this payment.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Essential MassHealth Hospitals.

This payment is based on approval by EOHHS of the Hospital's accurately submitted and certified EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report (UCCR) for the hospital fiscal year corresponding with the payment.

For the UMass hospitals, the Federal Fiscal Year 2019 (FFY19) outpatient payment amount will be $1,200 times the total number of Episodes with dates of service during FFY19, not to exceed $7.816 million. Notwithstanding such maximum outpatient amount, EOHHS may make outpatient payments to the UMass Hospitals of up to an additional 10% of the UMass Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with all applicable federal rules and payment limits, and satisfying all other conditions of this **Section III.F.2** as it applies to the UMass Hospitals, so long as the total FFY19 inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to the UMass Hospitals under this paragraph and under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-018-017) do not, in the aggregate, exceed the UMass Total Maximum Essential Amount. The UMass Total Maximum Essential Amount is $26.696 million.

For CHA, the Federal Fiscal Year outpatient payment amount will be the difference between the non-state-owned public hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $12.5 million. Notwithstanding such maximum outpatient amount, EOHHS may make outpatient payments to CHA of up to an additional 10% of the CHA Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with

all applicable federal rules and payment limits, and satisfying all other conditions of this **Section III.F.2** as it applies to CHA, so long as the total inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to CHA for the Federal Fiscal Year under this paragraph and under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-018-017) do not, in the aggregate, exceed the CHA Total Maximum Essential Amount. The CHA Total Maximum Essential Amount is $20.0 million.

The 10% provisions referenced above in this section may be invoked if, upon reconciliation, an applicable inpatient hospital limit would be exceeded if the UMass Hospitals or CHA (as applicable) were paid their maximum FFY19 inpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-018-017), or if the UMass Hospitals or CHA (as applicable) have insufficient inpatient utilization or otherwise to support such maximum inpatient payment amount.

Essential MassHealth Hospital payments will be made after EOHHS' receipt of the hospital's certified UCCR, finalization of payment data and applicable payment amounts, and receipt of any necessary approvals, but no later than 1 year after receipt of the hospital's final reconciliation UCCR (which must be submitted by 45 days after the Hospital's Medicare 2552 Report for the payment year has been finalized by Medicare's Fiscal Intermediary).

3. Acute Hospitals with High Medicaid Discharges

a. Eligibility

In order to qualify for payment as an Acute Hospital with High Medicaid Discharges, a Hospital must be an Acute Hospital that has more than 2.7% of the statewide share of Medicaid discharges, determined by dividing each Hospital's total Medicaid discharges as reported on the Hospital's Massachusetts hospital cost report by the total statewide Medicaid discharges for all Hospitals.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Acute Hospitals that have higher Medicaid discharges when compared with other participating MassHealth Hospitals.

The payment amount is based on Medicaid payment, cost and charge data for the federal fiscal year. The payment equals the variance between the Hospital's outpatient Medicaid payment and outpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Acute Hospital with High Medicaid Discharges payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

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IV. [Reserved]

V. Other Provisions

A. Federal Limits

If any portion of the payment methodology is not approved by CMS or is in excess of applicable federal limits, EOHHS may recoup any payment made to a Hospital in excess of the approved methodology. Any such recovery shall be proportionately allocated among affected hospitals. Any FFP associated with such overpayments will be returned to CMS.

B. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital RFA and Contract in effect on that date.

C. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital during the effective period of the state plan, EOHHS, in its sole discretion, shall determine, on a case-by-case basis (1) whether the Hospital qualifies for payment under the state plan, and, if so, (2) the appropriate rates of payment. Such rates of payment shall be determined in accordance with the provisions of the state plan to the extent EOHHS deems possible. EOHHS's determination shall be based on the totality of the circumstances. Any such rate may, in EOHHS's sole discretion, affect computation of the statewide average or statewide standard payment amount and/or any efficiency standard.

D. Data Sources

If data sources specified in this Attachment are not available, or if other factors do not permit precise conformity with the provisions of this Attachment, EOHHS shall select such substitute data sources or other methodology(ies) that EOHHS deems appropriate in determining Hospitals' rates. .

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VI. Other Quality and Performance Based Payment Methods

A. Provider Preventable Conditions

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B (1), (Acute Outpatient Hospital Services) of this State plan, where applicable.

☒Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
☒Additional Other Provider-Preventable Conditions identified below:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

1. Foreign object retained after surgery.
2. Air Embolism
3. Blood incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma, related to:
    - fractures
    - dislocations
    - intracranial injuries
    - crushing injuries
    - burns
    - other injuries

- In addition, the following:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.

3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reduction in provider payment may be limited to the extent that the following apply: (i) the identified provider preventable conditions would otherwise result in an increase in payment; (ii) the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:
EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above.

When a Hospital reports a PPC, MassHealth will reduce payments to the Hospital as follows:

1. APEC:
    a. MassHealth will not pay the APEC if the Hospital reports that only-PPC-related services were delivered during the episode of care, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
    b. MassHealth will pay the APEC, as adjusted to exclude PPC-related costs/services, if the Hospital reports that non-PPC related services were also delivered during the same episode of care, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Outpatient Hospital Payments for Hospital-Based Physician Services: MassHealth will not pay for outpatient Hospital-based physician services reported as PPC-related services.

3. Follow-Up Care in Same Hospital: If a Hospital reports that it provided follow-up outpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license., MassHealth will not pay for the reported follow-up services. If the hospital reports that non–PPC-related services were provided during the follow-up episode of care, payment will be made, but adjusted in the case of an APEC payment to exclude PPC-related costs/services, and MassHealth will exclude all PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third party liability and crossover payments by MassHealth.

Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursement according to the methodology above.

B. Serious Reportable Events

The non-payment provisions set forth in this Section VI.B. apply to the following serious reportable events (SREs), where applicable:

1. Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person.
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances
3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient / resident of any age.
5. Sexual abuse / assault on a patient or staff member within or on the grounds of the healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital and Hospital-Based Physician services include:

1. All services provided during the outpatient visit during which a preventable SRE occurred; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

    a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

    b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

The non-payment provision also applies to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital and Hospital-Based Physician services provided to the patient following a preventable SRE. .

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Exhibit 1: RY19 Payment Method for Critical Access Hospitals
Effective October 1, 2018 through September 30, 2019

EXHIBIT 1
RY19 Payment Method Applicable to Critical Access Hospitals
Effective October 1, 2018 through September 30, 2019

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY19 (October 1, 2018 through September 30, 2019).

Section II. Payment Method - General

EOHHS will pay Critical Access Hospitals an amount equal to 101 percent of the Hospital's allowable costs as determined by EOHHS utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services in RY19, as more fully described below. Interim payments will be made to Critical Access Hospitals based on the rates and methods set forth in this **Exhibit 1**, which payments are provisional in nature and subject to the completion of a cost review and settlement for the time period beginning October 1, 2018 through September 30, 2019, as described in **Section II(B)** of this **Exhibit 1**. The interim payments made for Outpatient Services to Critical Access Hospitals will be made on the same basis as payment would be made for those same Outpatient Services to all other Hospitals (e.g., per Episode for Outpatient Services paid by the APEC), and the timing of the interim payments will not differ from the timing that Outpatient Services are paid to all other Hospitals. Subject to this **Exhibit 1**, **Attachment 4.19-B(1**) otherwise applies to Critical Access Hospitals. If a Hospital loses its designation as a Critical Access Hospital, the payment methods for such hospital shall revert to the standard acute hospital rate methodologies, and payments may be adjusted accordingly. Reversion to any such rate methodologies shall not affect the payment rates to other participating acute hospitals for the applicable rate year.

(A) Payment for Outpatient Services

Critical Access Hospitals will be paid for Outpatient Services in accordance with **Attachment 4.19-B(1)** with the following changes.

For dates of service in RY19, Critical Access Hospitals will be paid a Hospital-specific, Episode-specific Adjudicated Payment per Episode of Care (APEC) for those Outpatient Services for which all other in-state Hospitals are paid an APEC.

Notwithstanding **Section III.B** of this **Attachment 4.19-B(1)**, for dates of service in the 1st RY19 Period, the hospital-specific, episode-specific APEC for each Critical Access Hospital was calculated as follows:

(1) EOHHS calculated a cost per Episode for outpatient services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 21 of the Hospital's FY16 CMS-2552-10 cost report, by the Hospital's number of FY16 Medicaid (MassHealth) Episodes. Episode volume was derived from FY16 paid claims data residing in MMIS for which MassHealth was primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY16 and RY18, as defined in **Section II** of **Attachment 4.19-B(1)**, to derive the Critical Access Hospital's 1st RY19 Period inflation-adjusted cost per Episode.

(3) EOHHS then divided each Critical Access Hospital's 1st RY19 Period inflation-adjusted cost per Episode by each Hospital's FY16 outpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 1st RY19 Period CAH-specific Outpatient Standard Rate per Episode.

(5) The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the 1st RY19 Period CAH-specific Outpatient Standard Rate per Episode for the APEC Outpatient Statewide Standard and calculating a CAH APEC payment as otherwise described in **Section III.B.2** of this Attachment 4.19-B(1), utilizing the methodology applicable to the 1st RY19 Period.

Notwithstanding **Section III.B** of this **Attachment 4.19-B(1)**, for dates of service in the 2nd RY19 Period, the hospital-specific, episode-specific APEC for each Critical Access Hospital was calculated as follows:

(1) EOHHS calculated a cost per Episode for outpatient services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 21 of the Hospital's FY17 CMS-2552-10 cost report, by the Hospital's number of FY17 Medicaid (MassHealth) Episodes. Episode volume was derived from FY17 paid claims data residing in MMIS for which MassHealth was primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY17 and RY19, as defined in **Section II** of **Attachment 4.19-B(1)**, to derive the Critical Access Hospital's 2nd RY19 Period inflation-adjusted cost per Episode.

(3) EOHHS then divided each Critical Access Hospital's 2nd RY19 Period inflation-adjusted cost per Episode by each Hospital's FY17 outpatient casemix index (CMI), as determined by EOHHS.

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Exhibit 1: RY19 Payment Method for Critical Access Hospitals
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(4) That result is the 2nd RY19 Period CAH-specific Outpatient Standard Rate per Episode.

(5) The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the 2nd RY19 Period CAH-specific Outpatient Standard Rate per Episode in place of the Wage Adjusted APEC Outpatient Standard and calculating a CAH APEC payment as otherwise described in **Section III.B.2** of this Attachment 4.19-B(1), utilizing the methodology applicable to the 2nd RY19 Period.

(B) Post RY19 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2019 review to determine whether the Critical Access Hospital received aggregate interim payments in an amount equal to 101% of allowable costs utilizing the Medicare cost-based reimbursement methodology for both inpatient and outpatient services for FY19, as such amount is determined by EOHHS ("101% of allowable costs"). See also Exhibit 1 to Attachment 4.19-A(1). EOHHS will utilize the Critical Access Hospital's FY19 CMS-2552-10 cost reports, including completed Medicaid (Title XIX) data worksheets, and such other information that EOHHS determines is necessary, to perform this post RY19 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for FY19, but excluding, if applicable, any state plan supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in **Section III.F.1 o**f **Attachment 4.19-B(1)**.

If the Critical Access Hospital was paid less than 101% of allowable costs, EOHHS will pay the Critical Access Hospital the difference between 101% of allowable costs and the aggregate interim payments. If the Critical Access Hospital was paid more than 101% of allowable costs, the Critical Access Hospital shall pay to EOHHS, or EOHHS may recoup the amount that equals the difference between the aggregate interim payments and 101% of allowable costs.

This post RY19 review and settlement will take place within twelve (12) months after EOHHS has obtained all accurate and complete data needed to perform the review and settlement calculation. EOHHS estimates that it will have accurate and complete data by September 30, 2020. Assuming this date, the settlement will be complete by September 30, 2021.

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Methods used to Determine Rates of Payment for Chronic Disease and Rehabilitation Hospital Outpatient Services

Methods Used to Determine Rates of Payment for Chronic Disease and Rehabilitation Hospital Outpatient Services

I. Overview

The following sections describe the methods and standards utilized by the Commonwealth of Massachusetts, acting by and through its Executive Office of Health and Human Services (EOHHS) to establish rates of payment by contract for Outpatient Services rendered by Chronic Disease and Rehabilitation Hospitals to MassHealth Members.

II. Definitions

Charge -- The standard fee that a Hospital charges for a Hospital service rendered to a patient, regardless of payer source, and which is required be filed with the Division of Health Care Finance and Policy.

Chronic Disease and Rehabilitation Hospital (Hospital) – A non-acute hospital licensed by the Massachusetts Department of Public Health under M.G.L. c. 111, §51, with a majority of its beds providing chronic disease services and/or comprehensive rehabilitation services to patients with appropriate medical needs. This definition includes such a facility licensed with a pediatric specialty.

Division of Health Care Finance and Policy (DHCFP) -- An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services, established under M.G.L. c. 118G from 2003 until the passage of Chapter 224 of the Acts for 2012. EOHHS is DHCFP's successor agency for rate setting functions, and the Center for Health Information and Analysis is DHCFP's successor agency for certain other functions. All references to DHCFP or DHCFP regulations also refer to the applicable successor.

Hospital Outpatient Department -- A department or unit that operates under the Hospital's license and provides services to Members on an ambulatory basis provided that the hospital adheres to the applicable guidelines established in 42 CFR 413.65

MassHealth Program (MassHealth) -- The medical assistance benefit plans operated and administered by EOHHS pursuant to M.G.L. c. 118E, §1 *et seq.* and 42 U.S.C. §1396 *et seq.* (Medicaid).

Member -- A person determined by the MassHealth Program to be eligible for medical assistance benefits under M.G.L. c. 118E, §1 *et seq.*

Outpatient Cost to Charge Ratio -- A percentage applied to the Charges for Outpatient Services of a Hospital to calculate payment for Outpatient Services provided to Members under the MassHealth Program.

Outpatient Services – Rehabilitative and medical services provided to Members in a hospital Outpatient department. Such services include, but are not limited to, Radiology, Laboratory,

Diagnostic Testing, Therapy Services, (i.e., physical, speech, occupational and respiratory) and Day surgery services.

Usual and Customary Charges — Routine fees that Hospitals charge for outpatient services rendered to patients regardless of payer source.

III. Payment Methodology

A. Data Sources.

1. The base year for setting payment rates for Outpatient Services is the Hospital fiscal year (HFY) 2003, except that the base year for a Hospital with no fewer than 500 licensed beds as of June 30, 2007 is the HFY 2006. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2003 HCFP-403 cost report, except for a Hospital with no fewer than 500 licensed beds as of June 30, 2007, which uses the HFY 2006 HCFP-403. All references to specific schedules, columns and lines refer to the HCFP-403 report filed with and reviewed by the Division of Health Care Finance and Policy (DHCFP). Except where noted, all references are to the HFY 2003 version of the HCFP-403.

2. The calculations use each Hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by DHCFP.

3. If the specified data source is unavailable or inadequate, The MassHealth program will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data. If required information is not furnished by a Hospital within the applicable time period, it may not receive any increase to its rate.

B. Rates for Outpatient Services.

1. A Chronic Disease and Rehabilitation Hospital will be paid for Outpatient Services using a Hospital-specific Outpatient Cost-to-Charge Ratio. The Outpatient Cost-to-Charge Ratio is a fixed percentage that is applied to a Hospital's Usual and Customary Charges for Outpatient Services, based on Charges filed with the Division of Health Care Finance and Policy. Payment for a particular Outpatient Service shall be equal to the product of the Cost-to-Charge Ratio times the Hospital's Usual and Customary Charge for the Outpatient Service, on file as of the previous July 1.. Any such payment shall not exceed the Hospital's Usual and Customary Charge.

2. The Cost-to-Charge Ratio for an individual Hospital is calculated by dividing its outpatient costs (Schedule XVIII) by its outpatient service revenue (schedule XI), as derived from the DHCFP-403 cost report.

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and Rehabilitation Hospital Outpatient Services

3. MassHealth payment for a new Outpatient Service is based upon the Charge that is filed with the DHCFPand is equal to the product of the Cost-to Charge Ratio times such Charge. A new Outpatient Service is a service that is instituted after July 1 of each year. A Hospital must provide written notification to the DHCFP at least thirty (30) days in advance of implementation of any Charge for a new Outpatient Service.

4. For laboratory services in a Hospital Outpatient Department, the maximum allowable payment shall be at the lowest of the following:

   a. Rates under the agency's fee schedules for applicable Clinical Laboratory Services, which were set as of August 1, 2014 and published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-320.pdf; or rates under the agency's fee schedule for applicable Surgery & Anesthesia Services, which were set as of August 31, 2012 and published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-3-16.pdf. These fee schedules apply only to private payers; or
   b. The Hospital's Usual and Customary Charge; or
   c. The amount that would be recognized under 42 U.S.C. §1395l(h) for tests performed for a person with Medicare Part B benefits.

5. All claims for Outpatient Services are required to itemize services. MassHealth Transmittal Letter OPD-52, dated January 2004, requires hospitals to use HCPCS codes when submitting claims. Claims for any outpatient service without a HCPCS/CPT code will be denied.

6. In accordance with the General Appropriation Act for fiscal year 2006, any hospital whose outpatient rate of payment, under the payment methodology for hospital fiscal year 2006, would be less than the rate in effect during hospital fiscal year 2005, the MassHealth program will continue to pay at the applicable outpatient rate of payment in effect during hospital fiscal year 2005.

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and Rehabilitation Hospital Outpatient Services

C. **Provider Preventable Conditions**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B(2) (Chronic Disease and Rehabilitation Hospital Outpatient Services) of this State plan where applicable.

☒Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒Additional Other Provider-Preventable Conditions identified below:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

    1. Foreign object retained after surgery.
    2. Air Embolism
    3. Blood incompatibility
    4. Stage III and IV Pressure Ulcers
    5. Falls and Trauma, related to:
        - fractures
        - dislocations
        - intracranial injuries
        - crushing injuries
        - burns
        - other injuries

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- In addition, the following:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above

When a hospital reports a PCC, MassHealth will reduce payments to the Hospital as follows:

1. Payments for Outpatient Services: MassHealth will not pay for services which the hospital indicates are PPC-related and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Follow-Up Care in Same Hospital: If a hospital reports that it provided follow-up outpatient services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license. MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided during the follow-up visit, payment will be made, but MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth

Charges for services, including co-payments or deductions, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

D. Serious Reportable Events

The non-payment provisions set forth in this Section III.D. apply to the following serious reportable events (SREs), where applicable:

1. Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person.
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.

3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient / resident of any age.
5. Sexual abuse / assault on a patient or staff member within or on the grounds of the healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital services include:

1. All services provided during the outpatient visit during which a preventable SRE occurred; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

    a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

    b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

Non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital services provided to the patient following a preventable SRE.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods for Establishing Payment Rates Chronic Disease and Rehabilitation Outpatient Hospital Services

7. This **Section III.B.7** describes the outpatient payment methods for payments made to out-of-state chronic disease or rehabilitation hospitals and to such hospitals with both out-of-state inpatient facilities and in-state outpatient facilities.

    a. Except as described below in **b.**, payment to an out-of-state chronic disease or rehabilitation hospital for any Outpatient Service payable by the MassHealth agency is the lowest of:
        i. The rate of payment established for the medical service under the other state's Medicaid program;
        ii. The MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
        iii. The MassHealth rate of payment established for a comparable provider in Massachusetts.
    b. Payment to a chronic disease or rehabilitation hospital with both out-of-state inpatient facilities and in-state outpatient facilities, for any Outpatient Service payable by MassHealth is made:
        i. For Outpatient Services provided out-of-state, in accordance with the methodology set forth at **Section III.B.7.a**.
        ii. For Outpatient Services provided in-state, the median of the in-state Outpatient Cost-to-Charge Ratio for comparable Hospitals.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods used to Determine Rates of Payment for Chronic Disease and Rehabilitation Hospital Outpatient Services

C. **Provider Preventable Conditions**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B(2) (Chronic Disease and Rehabilitation Hospital Outpatient Services) of this State plan where applicable.

☒Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒Additional Other Provider-Preventable Conditions identified below:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

    1. Foreign object retained after surgery.
    2. Air Embolism
    3. Blood incompatibility
    4. Stage III and IV Pressure Ulcers
    5. Falls and Trauma, related to:
        - fractures
        - dislocations
        - intracranial injuries
        - crushing injuries
        - burns
        - other injuries

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods used to Determine Rates of Payment for Chronic Disease and Rehabilitation Hospital Outpatient Services

- In addition, the following:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above

When a hospital reports a PCC, MassHealth will reduce payments to the Hospital as follows:

1. Payments for Outpatient Services: MassHealth will not pay for services which the hospital indicates are PPC-related and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Follow-Up Care in Same Hospital: If a hospital reports that it provided follow-up outpatient services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license. MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided during the follow-up visit, payment will be made, but MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth

Charges for services, including co-payments or deductions, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

D. Serious Reportable Events

The non-payment provisions set forth in this Section III.D. apply to the following serious reportable events (SREs), where applicable:

1. Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person.
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.

3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient / resident of any age.
5. Sexual abuse / assault on a patient or staff member within or on the grounds of the healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital services include:

1. All services provided during the outpatient visit during which a preventable SRE occurred; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

   a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

   b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

Non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital services provided to the patient following a preventable SRE.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Private Psychiatric Hospital Outpatient Services

1. Outpatient private psychiatric hospital services are services provided to members on an ambulatory basis when rendered on-site in a private psychiatric Hospital Outpatient Department, licensed by the Department of Mental Health (DMH), pursuant to M.G.L.c. 19, §19.

   Outpatient services are paid utilizing a hospital specific outpatient cost-to-charge ratio for outpatient services, derived from the FY 2008 HCF-403 cost reports filed with the Division of Health Care Finance and Policy ("DHCFP"). The outpatient Cost-to-Charge Ratio is a fixed percentage that is applied to a Hospital's Usual and Customary Charges for Outpatient Services based on charges filed with the Center for Health Information and Analysis as of July 1, 2014. Payment for a particular Outpatient Service shall be equal to the product of the Cost-to-Charge Ratio times the Hospital's Usual and Customary Charge. Any such payment shall not exceed the Hospital's Usual and Customary Charge.

   For any newly operating psychiatric hospital outpatient department for which historical cost and charge information used to establish standard MassHealth outpatient psychiatric hospital rates is not available, MassHealth pays using the median of the cost-to-charge ratios for the other private psychiatric hospitals in Massachusetts that provide outpatient care. The median cost-to-charge ratio is derived by calculating the midpoint of the hospitals that provide outpatient services.

2. Outpatient substance abuse hospital services are services provided to members on an ambulatory basis when rendered on-site in a substance abuse hospital's outpatient department, licensed by the Department of Public Health (DPH), Division of Health Care Quality, pursuant to regulations at 105 CMR 130.00 and M.G.L. c. 111, §§ 51-56.

   The substance abuse treatment hospital will be paid for outpatient substance abuse services using the hospital outpatient Cost-To-Charge Ratio for outpatient services, derived from the FY 2008 HCF-403 cost reports filed with the Division of Health Care Finance and Policy. The outpatient Cost-To-Charge Ratio is 66.58%.

Citation
42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B(3) of this State plan, where applicable:

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional Other Provider-Preventable Conditions identified below: - None.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reduction in provider payment may be limited to the extent that the following apply: (i) the identified provider preventable conditions would otherwise result in an increase in payment; (ii) the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions, effective for dates of service on or after July 1, 2012.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") listed above

When a hospital reports a PCC, MassHealth will not pay for services which the hospital indicates are PPC-related and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth

Charges for services, including co-payments or deductions, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts

Payments for Reserved Beds

☒ Payment is made for reserving beds in long-term-care facilities for members during their temporary absence for the purposes indicated below.

☒ For medical leaves of absence (MLOA) for purposes of hospital care:

MassHealth will pay the nursing facility for up to 20 medical leave-of-absence days at the rate specified in Attachment 4.19-D (4).

☒ For medical leaves of absence (MLOA) for purposes of stays in acute, chronic disease and rehabilitation, and psychiatric hospitals:

MassHealth will pay the nursing facility for up to 20 medical leave-of-absence days at the rate specified in Attachment 4.19-D (4).

☒ For non-medical leaves of absence:

MassHealth will pay the nursing facility for up to 10 non-medical leave-of-absence days per twelve month period beginning with the first non-medical leave of absence day at the rate specified in Attachment 4.19-D (4).

State Plan under Title XIX of the Social Security Act
State. Massachusetts
Methods for Establishing Payment Rates - Nursing Facilities

I. General Description of Payment Methodology

A. Overview. Nursing facility payments for services provided to MassHealth members are governed by the Executive Office of Health and Human Services (EOHHS) regulation,101 CMR 206.00: Standard Payments to Nursing Facilities as of January 25, 2019. This attachment describes the methods and standards used to establish payment rates for nursing facilities effective January 1, 2019.

B. Chief Components. The payment method describes standard payments for nursing facility services. Standard payments are derived from reported median base-year costs for Nursing and Other Operating Costs as well as a capital payment component. Nursing and Other Operating Standard Payment rates were calculated using Calendar Year (CY) 2007 costs The allowable basis for capital was updated using CY 2007 data. .

II. Cost Reporting Requirements and Cost Finding

A. Required Reports. Except as provided below, each provider of long-term care facility services under the State Plan must complete an annual Cost Report.

1. For each cost reporting year, the Cost Report must contain detailed cost information based on generally accepted accounting principles and the accrual method of accounting that meets the requirements of 101 CMR 206.08 as of January 25, 2019.

2. There are five types of cost reports: a) Nursing Facility Cost Report; b) Realty Company Cost Report (if the facility is leased from another entity); c) Management Company Cost Report (if the facility reports management expenses paid to another entity); d) Financial Statements, and e) Clinical Data.

3. A facility that closes prior to November 1 is not required to submit a cost report for the following calendar year.

4. There are special cost reporting requirements outlined in 101 CMR 206.08(2)(g) as of January 25, 2019 for hospital-based nursing facilities, state-operated nursing facilities, and facilities that operate other programs such as Adult Day Health, Assisted Living or Outpatient Services.

5. A facility may be subject to penalties in accordance with 101 CMR 206.08(7) as of January 25, 2019 if a facility does not file the required cost reports by the due date.

B. General Cost Principles. In order to report a cost as related to MassHealth patient care, a cost must satisfy the following criteria:

1. the cost is ordinary, necessary, and directly related to the care of publicly aided patients;

2. the cost is for goods or services actually provided in the nursing facility;

3. the cost must be reasonable; and

4. the provider must actually pay the cost.

Costs that are not considered related to the care of MassHealth patients include, but are not limited to: costs that are discharged in bankruptcy; costs that are forgiven; costs that are converted to a promissory note; and accruals of self-insured costs that are based on actuarial estimates.

A provider may not report any of the costs that are listed in 101 CMR 206.08(3)(h) as of January 25, 2019 as related to MassHealth patient care.

III. Methods and Standards Used to Determine Payment Rates

A. Prospective Per Diem Rates. The prospective per diem payment rates for nursing facilities are derived from the Nursing, Other Operating, and Capital payment components. Each of these components is described in detail in the following sections.

B. Nursing Cost. The following Nursing Standard Payments (per diem) comprise the Nursing Cost component of the prospective per diem payment rates for nursing facilities.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 – 30	$14. 58
JK	30.1 – 110	$39. 91
LM	110.1 – 170	$69.01
NP	170.1 – 225	$97.23
RS	225.1 – 270	$118.75
T	270.1 & above	$147.65

The base year used to develop the Nursing Standard Payments is 2007. Nursing costs reported in CY 2007 in the following categories are included in the calculation: Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Director of Nurses and Nursing Workers' Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense. The Nursing Standard Payments are derived from the product of the industry CY 2007 median nursing costs times the CY 2007 industry median management minutes for each of six payment groups listed in 101 CMR 206.04(1) as of January 25, 2019. The base year amounts for each group are updated to rate year 2008 by a cost adjustment factor of 3.79%. This cost adjustment factor is based on Massachusetts-specific consumer price index (CPI) forecasts as well as national and regional indices supplied by Global Insight, Inc.

C. Other Operating Cost. The Other Operating Cost Standard Payment (per diem) comprises the other operating component of the prospective per diem payment rates for nursing facilities. The Other Operating Standard Payment, effective January 1, 2019, is $76.96.

The base year used to develop the Other Operating Standard Payment of $76.96 is CY 2007. Other operating costs reported in CY 2007 in the following categories are included

in the calculation: variable, administrative and general, and motor vehicle costs. The Other Operating Standard Payment is set equal to the CY 2007 industry median of these cost amounts, except for administrative and general costs, which are subject to a ceiling of $18.45 before combining with other cost components. The calculation of the Other Operating Standard Payment is reduced by 2.95% to exclude non-allowable reported costs. The allowable base-year amount is updated to rate year 2008 by a CAF of 3.79%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by Global Insight, Inc.

D. Capital. The Capital component is computed in accordance with 101 CMR 206.05 as of January 25, 2019.

1. Capital Payments. Capital payments for all facilities except for those identified in D.2 below, shall be based on the facility's allowable capital costs, including allowable depreciation, financing contribution and other fixed costs.

(a) If a facility's capital payment effective September 30, 2014 is less than $17.29, its capital payment will be the greater of its September 30, 2014 capital payment or the payment determined as follows:

2007 Base Year Capital Cost Per Day (101 CMR 206.05 (1))	Capital Payment
$ 0.00 - $4.00	$4.45
$ 4.01 - $ 6.00	$6.18
$ 6.01 - $ 8.00	$8.15
$ 8.01 - $10.00	$10.13
$10.01 - $12.00	$12.11
$12.01 - $14.00	$14.08
$14.01 - $16.00	$16.06
$16.01 - $17.29	$17.29
$17.30 - $18.24	$18.24
$18.25 - $20.25	$20.25
$20.26 to $22.56	$22.56
$22.57 to $25.82	$25.82
>$25.83	$27.30

(b) If a facility's revised capital payment effective September 30, 2014 is greater than or equal to $17.29, the facility's revised capital payment will equal its September 30, 2014 capital payment.

(c) If a provider re-licensed beds during the rate period that were out of service, its capital payment will be the lower of (1) the capital payment rate established under D.1.(a) or (2) the facility's most recent capital payment rates.

(d) If a provider's capital payment is based on a Determination of Need (DON)

approved prior to March 7, 1996 and the provider receives a temporary capital payment in accordance with 101 CMR 206.05(4)(b)(3), the provider's capital payment will be revised in accordance with 101 CMR 206.05(4)(b)(4) as of January 25, 2019.

2. **Capital Payments Exceptions**. The capital payment for new facilities constructed pursuant to a DON approved after March 7, 1996; replacement facilities that open pursuant to a DON approved after March 7, 1996; new facilities in urban under bedded areas that are exempt from the DON process; new beds that are licensed pursuant to a DON approved after March 7, 1996; new beds in twelve-bed expansion projects not associated with an approved DON project; beds acquired from another facility that are not subject to a DON, to the extent that the additional beds increase the facility's licensed bed capacity; and private nursing facilities that sign their first provider agreement on or after October 1, 2008 shall be as follows:

Date that New Facilities & Licensed Beds became Operational	Payment Amount
02/01/1998 - 12/31/2000	$ 17.29
01/01/2001 - 06/30/2002	$ 18.24
07/01/2002 - 12/31/2002	$ 20.25
01/01/2003 - 08/31/2004	$ 20.25
09/01/2004 - 06/30/2006	$ 22.56
07/01/2006 - 07/31/2007	$ 25.82
08/01/2007 - 07/31/2008	$ 27.30
08/01/2008 – 09/30/2016	$ 28.06
10/01/2016- forward	$37.60

3. **Notification of Substantial Capital Expenditures**. Any nursing facility that opens, adds new beds, adds substantial renovations, or re-opens beds after September 1, 2004, is required to notify EOHHS in accordance with 101 CMR 206.05(4)(a) as of January 25, 2019. At that time, the Capital component may be recomputed in accordance with 101 CMR 206.05(4)(b) as of January 25, 2019.

E. Retroactive Adjustments. EOHHS will retroactively adjust the Capital Payment component of the rates if it learns that there was a material error in the rate calculation or if a nursing facility made a material error in its cost report. A material error is any error that would result in a change to a provider's rate.

IV. Special Conditions

A. Innovative and Special Programs. The MassHealth program may contract for special and/or innovative programs to meet special needs of certain patients, which are not ordinarily met by existing services in nursing facilities or which can only be met by existing services in nursing facilities at substantially higher cost. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as programs for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e., Management Minute Category T), nursing facilities that have a substantial concentration of patients with multiple sclerosis or multiple sclerosis and amyotrophic lateral sclerosis, nursing facilities that have a substantial concentration of deaf patients, and nursing facilities with substantially higher costs due to island location.

B. Rate for Innovative and Special Programs. A provider who seeks to participate in an innovative and special program must contract with the MassHealth program to provide special care and services to distinct categories of patients designated by the MassHealth program. This is usually done through a Request for Responses by the MassHealth program for special or innovative programs to address special needs of certain patients that are not ordinarily met by existing services in nursing facilities. Payment under the innovative and special programs may be calculated based on the added reasonable and necessary costs and expenses that must be incurred (as determined by the MassHealth program) by a provider in connection with that program. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the MassHealth Program, and that such items or services are reasonable and appropriate in the efficient delivery of necessary health care. The rate for an innovative and special program may be established as an add-on to a rate established by EOHHS under 101 CMR 206.00 as of January 25, 2019 or as a stand-alone rate established by contract under M.G.L. c. 118E, s.12 that is not subject to the provisions of 101 CMR 206.00 as of January 25, 2019. In either instance, the rate must be consistent with the payment methodology established herein for long-term care facilities. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

C. Facilities with High-Acuity High-Nursing Need Residents. A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board;

2. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to qualify for MM category 10; and

3. the facility must be a geriatric nursing facility.

D. Pediatric Nursing Facilities. EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and other operating costs, excluding administration and general costs, from the facility's 2007 Cost Report. EOHHS will include an administration and general payment based on 85% of 2007 median statewide administration and general costs. EOHHS will apply an appropriate cost adjustment factor to nursing, other operating, and administration and general costs.

The nursing and other operating component of the rate is increased by a cost adjustment factor of 3.79%. This factor is derived from a composite market basket. The labor component on the market basket is the Massachusetts Consumer Price Index, optimistic forecast, as provided by Global Insight. The non-labor component is based on the CMS Skilled Nursing Facility without capital market basket, except for the Food and Health Care Services subcomponents, which are based on the Regional CPI for New England, as published by Global Insight.

E. Beds Out of Service. Facilities with licensed beds that were out of service prior to 2001 that re-open in 2001 will receive the lower of the Standard Payment rates or the most recent prior payment rates adjusted by the applicable CAF for Nursing and Other Operating Costs.

F. Receivership under M.G.L. c.111, s.72N *et seq.* In accordance with 101 CMR 206.06(10) as of January 25, 2019, provider rates of a nursing facility in receivership may be adjusted by EOHHS to reflect the reasonable and necessary costs associated with the court-approved closure of the facility.

G. Review and Approval of Rates and Rate Methodology by the MassHealth Program. Pursuant to M.G.L c 118E, s.13, the MassHealth program shall review and approve or disapprove any change in rates or in rate methodology proposed by EOHHS. The MassHealth program shall review such proposed rate changes for consistency with federal and state policy and budget requirements prior to certification of such rates by EOHHS. The MassHealth program shall, whenever it disapproves a rate increase, submit the reasons for disapproval to EOHHS together with such recommendations for changes. Such disapproval and recommendations for changes, if any, are submitted to EOHHS after the MassHealth program is notified that EOHHS intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing

held by EOHHS regarding such rate change; provided that no rates shall take effect without the approval of the MassHealth program. EOHHS and the MassHealth program shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the CPI to the Massachusetts House and Senate Committees on Ways and Means.

H. Supplemental Funding. If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the MassHealth program to exceed the amount of funding appropriated for such purpose in the budget for the fiscal year, the MassHealth program and EOHHS shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the MassHealth program under Title XIX of the federal Social Security Act.

I. Appeals. A provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 101 CMR 206.00 as of January 25, 2019 within 30 calendar days after EOHHS files the rate with the Secretary of the Commonwealth. EOHHS may amend a rate or request additional information from the provider even if the provider has filed a pending appeal.

J. Department of Developmental Services (DDS) Requirements. As part of the per diem rate calculation, an adjustment to the per diem rate will be calculated under 101 CMR 206.06(2) as of January 25, 2019 for nursing facilities that serve persons with intellectual disabilities and developmental disabilities and that maintain clinical and administrative procedures in a manner that complements DDS interdisciplinary service planning activities.

1. **Eligibility.** Eligible facilities are those identified by DDS as providers of care to nursing facility residents with intellectual disabilities or developmental disabilities as of July 28, 2016. A facility may become ineligible for the allowance and its calculated per diem add-on may be rescinded if the facility fails to comply with DDS interdisciplinary service planning requirements.

2. **Total Add-On Allowance Amount.** The total allowance amount to be allocated to all eligible facilities be equal to the number of Medicaid eligible residents identified by DDS as of July 28, 2016 as having intellectual disabilities or developmental disabilities, times $3.00, times 365 days.

3. **Add-On Calculation.** The per diem amount to be included in the payment rate for an eligible facility is calculated by dividing the total add-on allowance amount calculated above by the product of:
   a. Current licensed bed capacity for the rate period, times 365,
   b. Reported 2014 actual utilization percentage, times
   c. Reported 2014 Medicaid utilization percentage.

K. Kosher Kitchens. Nursing facilities with kosher kitchen and food service operations shall receive an add-on of up to $5.00 per day to reflect any additional cost of these operations. Eligibility requirements and determination of payment amounts are described in 101 CMR 206.06(3) as of January 25, 2019.

L. Quality Achievement and Improvement Payments and Large Medicaid Provider Payment

1. **Quality Achievement and Improvement Payments.** Effective January 1, 2019, a nursing facility may be eligible for one of two quality achievement and improvement payments as follows. A nursing facility may receive either the Quality Achievement and Improvement Add-on or the High Medicaid Quality Achievement and Improvement Add-on, but may not receive both add-ons concurrently.
   a. Quality Achievement and Improvement Add-on
      i. Eligibility. A nursing facility will be eligible for a quality achievement and improvement payment if at least one of the following criteria is met:
         (a) the nursing facility received a score of at least 124 on the Department's Nursing Facility Survey Performance Tool as of November 27, 2017 and at least 4 stars in the overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of November 1, 2017;
         (b) the nursing facility received a score of at least 124 on the Department's Nursing Facility Survey Performance Tool as of November 27, 2017 and at least 4 stars in the staffing rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of November 1, 2017; or
         (c) the nursing facility's score on the Department's Nursing Facility Survey Performance Tool increased by at least 3 points between November 27, 2016 and November 27, 2017 or the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool increased by at least 1 star between November 1, 2016 and November 1, 2017.
      ii. Calculation of Add-on. EOHHS will calculate the amount of the add-on received by each eligible facility as follows.
         (a) EOHHS will divide $4.4 million by the number of Massachusetts Medicaid non-managed care days, as the term is used in the Nursing Facility Cost Report, projected for FY2019.

b. High Medicaid Quality Achievement and Improvement Add-on

i. Eligibility. A nursing facility will be eligible for a high Medicaid quality achievement and improvement payment if:

(a) the nursing facility meets one of the criteria in IV.L.1.a.i.(a) – (c); and

(b) the nursing facility's combined Massachusetts Medicaid managed care days, Massachusetts Medicaid and non-managed care days, and Senior Care Options (SCO) and Program of All-Inclusive Care for the Elderly (PACE) days, as reported in its 2016 Nursing Facility Cost Report, divided by total patient days excluding residential care days, as reported in its 2016 Nursing Facility Cost Report, is equal to or greater than 75%.

ii. Calculation of Add-on. EOHHS will calculate the amount of the add-on received by each eligible facility as follows.

(a) EOHHS will divide $5.78 million by the number of Massachusetts Medicaid non-managed care days, as the term is used in the Nursing Facility Cost Report, projected for FY2019.

2. **Large Medicaid Provider Payment**. Effective until January 25, 2019, a facility will be eligible for a Large Medicaid Provider Payment as follows.

a. Eligibility. A facility will be eligible for payment if:

i. The facility had at least 188 licensed beds in 2015

ii. the facility's 2015 Medicaid days divided by total patient days, as report in its 2015 HCF-1, was equal to or greater than 70% and

iii. the facility received a score of at least 122 on the Department of Public Health's Nursing Facility Survey Performance Tool or at least 3 stars on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as received by the Division on August 29, 2017.

b. Calculation of Payment. The EOHHS will calculate the amount of the payment received by each eligible facility as follows:

i. EOHHS will divide the number of reported 2015 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities

ii. EOHHS will multiply the resulting percentage by $1,670,572

iii. EOHHS will divide the amount calculated above by the product of:

(a) current licensed bed capacity for the rate period, times 365, times

(b) reported 2015 Actual Utilization, time

(c) reported 2015 Medicaid Utilization

c. The amount will be included as an add-on to each Provider's rate.

M. State-Operated Nursing Facilities. A Facility operated by the Commonwealth will be paid at the Facility's reasonable cost of providing covered Medicaid services to eligible Medicaid recipients.

1. EOHHS will establish an interim per diem rate using a FY2014 base year CMS-2540 cost report inflated to the rate year using the cost adjustment factor calculated pursuant to (2) below and a final rate using the final CMS-2540 cost report from the rate year.

2. EOHHS will use a 2.96% cost adjustment factor for the period FY2016 through FY2018 using a composite index using price level data from the CMS Nursing Home without capital forecast, and regional health care consumer price indices, and the Massachusetts-specific consumer price index (CPI), optimistic forecast. EOHHS will use the Massachusetts CPI as proxy for wages and salaries.

3. EOHHS will retroactively adjust the final settled amount when the Medicare CMS-2540 cost report is re-opened or for audit adjustments. Adjustments will be made on an annual basis to update the base year and cost adjustment factor with the most recent data.

N. Publicly-Operated Nursing Facilities. Certain publicly operated nursing facilities will receive an add-on payment of $3.80 per day. Nursing facilities will be eligible for an add-on if they are owned and operated by a town, city or state government entity or transferred from municipal ownership since 2001, in which the municipality retains the power to appoint at least one member of the board, and is operating on land owned by the municipality. This amount will be included as an add-on to the rates established by EOHHS under 101 CMR 206.06(8) as of January 25, 2019.

O. PASRR Level II Add-on. Effective January 1, 2019, a nursing facility will be able to receive this member-based add-on for providing services to certain MassHealth members as follows.

1. Eligibility for the add-on. In order to receive the add-on for a MassHealth member, all of the following criteria must be met:
   a. The member is eligible for nursing facility services in accordance with 130 CMR 456.403 and 456.409;
   b. The conditions in 130 CMR 456.407 and 456.408 are met;
   c. The facility completed an initial Preadmission Screening and Resident Review (PASRR) on the member in accordance with 130 CMR 456.410 and applicable subregulatory guidance;
   d. The facility received a Level II Determination Notice for the member from the Department of Developmental Services and/or the Department of Mental Health stating that the member meets PASRR criteria for Intellectual Disability,

e. Developmental Disability or Serious Mental Illness and that the nursing facility is an appropriate setting to meet the member's needs;
f. The facility complied with applicable subregulatory guidance on PASRR with regard to resident reviews after it received the Level II Determination Notice; and
g. The facility has not received a subsequent Level II Determination Notice stating that the nursing facility is not an appropriate setting to meet the member's needs.

2. Add-on amount: A nursing facility will receive a per diem of $5.38 for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.
3. Payment of the add-on. Nursing facilities must comply with all EOHHS billing instructions in order to receive a PASRR Level II Add-on payment for an eligible MassHealth member.

P. Certification of Public Expenditures of a Nursing Facility Owned and Operated by a Municipality.

1. Within 60 days after the filing of its Medicare CMS-2540 cost report, a nursing facility, which is owned and operated by a municipality, may submit a request for Certified Public Expenditures (CPE) to EOHHS. This CPE will account for its public expenditures of providing Medicaid services to eligible Medicaid recipients. The submission shall be based on the inpatient routine service cost reported on the 2540 Medicare cost report.

2. Following review of the facility's submission, EOHHS within 60 days of the submission, will approve, deny, or revise the amount of the Certified Public Expenditure request based upon its evaluation of the reported costs and payments. The final approved amount will be equal to the difference between the Medicaid interim payments and the total allowable Medicaid costs as determined by EOHHS and this final determined amount will be certified by the municipality as eligible for federal match.

3. Interim Payments are based on the reimbursement methodology contained in Section III of the State Plan Attachment 4.19-D(4).

4. The determination of allowable (CPE) Medicaid costs will be based on the Medicare CMS - 2540 Cost Report and will be determined on a per diem rate calculated as follows:

I. Skilled Nursing Facility Inpatient Routine Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *30*, Column 18
(B) Total Days - Worksheet *S*-3, Line 1, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line 1, Column 5
(E) Medicaid Allowable *Skilled Nursing Facility* Costs - (C) X (D)

II. Nursing Facility Inpatient Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *31*, Column 18
(B) Total Days - Worksheet *S*-3, Line *3*, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line *3*, Column 5
(E) Medicaid Allowable *Nursing Facility* Costs - (C) X (D)

III. Total Allowable Medicaid Costs

I (E) Skilled Nursing Facility Inpatient Costs + II (E) Nursing Facility Inpatient Costs

5. EOHHS will calculate an interim reconciliation based on the difference between the interim payments and total allowable Medicaid costs from the as filed CMS - 2540 Cost Report. When the CMS-2540 is reopened the facility must immediately notify EOHHS. Within 60 days after receiving notification of the final Medicare settlement EOHHS will retroactively adjust the final settlement amount.

Q. Leaves of Absence.

The current payment rate for medical or non-medical leave of absence is $80.10 per day.

State Plan under Title XIX of the Social Security Act
State. Massachusetts
Methods for Establishing Payment Rates - Nursing Facilities

V. State Legislative Changes

A. Nursing Facility Assessments. An adjustment to nursing facility payment rates is established, effective January 25, 2019, to reimburse participating MassHealth nursing facilities for the providers' assessment costs that are incurred for the care of MassHealth members only, reflecting a portion of the providers' total assessment costs. No reimbursement is made for the providers' assessment costs that are incurred for the care of privately paying residents or others who are not MassHealth members.

1. The rate adjustments for the Nursing Facility Assessment (User Fee) reflect Medicaid's partial share of the tax costs as an allowable cost for purposes of developing Medicaid payment rates and do not provide for a hold harmless arrangement with providers.

(a) Except as provided in section V.A.1.(b) and (c) below, each nursing facility's user fee adjustment will be based on the facility's Nursing Facility Group under 101 CMR 512.04 as follows:

Nursing Facility Group under 101 CMR 512.04 as of October 6, 2016	Adjustment Amount
1	$15.47
2	$1.55
3	$1.55
4	$0.00

(b) For the period from October 1, 2018 through September 30, 2019, the user fee adjustment will be as follows:

Nursing Facility Group under 101 CMR 512.04 as of October 6, 2016	Adjustment Amount
1	$18.98
2	$1.90
3	$1.90
4	$0.00

(c) FY2019 Annualization. For the period from October 1, 2018 through April 30, 2019, there will be an additional user fee adjustment as follows:

Nursing Facility Group under 101 CMR 512.04 as of October 6, 2016	Adjustment Amount
1	$0.57
2	$0.06
3	$0.06
4	$0.00

d) A prior rate period may be recertified to exclude these add-ons if the Nursing Facility fails to incur the cost of the Nursing Facility user fee assessment within 120 days of the assessment due date.

e) The add-on amount may be adjusted to reflect a change in the amount of the Nursing Facility user fee assessment under 101 CMR 512.04.

B. Multiple Sclerosis Primary Diagnosis. In accordance with the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, and Chapter 151 of the Acts of 1996, a rate add-on is computed, for eligible nursing facilities that serve a patient population of which more than 75% of the residents have a primary diagnosis of multiple sclerosis to reflect the difference between the standard payment amounts for nursing and the actual base year nursing costs of the eligible nursing facility. Therefore, an eligible nursing facility would get full recognition of its actual base year nursing costs in its rates.

C. Payments for Direct Care Workers. For the period from October 1, 2018 through June 30, 2019, providers will receive periodic lump sum installment payments for wages, benefits, and related employee costs of direct care workers totaling $38.3 million to be distributed.

a) Calculation of Payments. EOHHS will:
   1. Sum the total FY2018 direct care staff payments for all providers.
   2. Calculate the difference between $38.3 million and the total FY2018 direct care staff payments for all providers included in V.C.(a)(1).
   3. Divide the FY2018 total direct care staff payments for each provider by the FY2018 total direct care staff payments for all providers and multiply the quotient by the difference calculated under V.C.(a)(2).
   4. For each provider, sum the provider's total FY2018 total direct care staff payment and share of the difference for the provider calculated under V.C.(a)(3).

b) Distribution of Payments. The total FY2019 direct care staff payment calculated pursuant to V.C.(a) for each provider will be paid to each provider in three periodic installment payments in October 2018, January 2019 and April 2019. Any FY2019 direct care staff payment allocated to a provider that closes during FY2019 shall not be paid to the closing provider following the date of closure and shall be redistributed among all remaining eligible providers.

VI. Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID)

Payments for services provided by Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID) to publicly assisted residents are governed by EOHHS regulation, 101 CMR 129: Rate and Charge Determination for Certain Intermediate Care Facilities Operated by the Department of Developmental Services (formerly 114.1 CMR 29.00) as of July 1, 2013.

The per diem payment rates for ICFs/ID are provider-specific and are established using Center for Health Information and Analysis (CHIA) ICF Cost Reports (403A). ICFs/ID rates are interim in nature and final rates are determined based on the final cost reports for the rate year. The initial inpatient per diem rate is calculated by dividing the allowable total patient care costs by total patient days using data from the fiscal year two years prior to the rate year and then adding inflation up to the rate year. The final inpatient per diem is calculated by dividing the allowable total patient care costs by total patient days using the data from the rate year. The final rate then replaces the initial per diem for the rate year.

The inflation factor for the initial per diem rates consists of a composite index comprised of two cost categories: labor and non-labor. The Massachusetts CPI is used as a proxy for the labor cost categories and the CMS Market Basket for Prospective Payment System-exempt hospitals is used for the non-labor cost category.

Payment rates include all allowable costs that are reasonable and directly related to health care and services provided in the ICFs/ID. Allowable total patient care costs are the sum of the ICF/ID's total inpatient routine and ancillary costs plus overhead costs associated with ICFs/ID health care and services, as reviewed and adjusted pursuant to regulation 101 CMR 129.04.

An ICF/ID may apply for an administrative adjustment to its inpatient per diem rate.

VII. Reimbursement for Individuals in a Disaster Struck Nursing Facility

A. Reimbursement to a Disaster Struck Nursing Facility for individuals that must be temporarily evacuated to another facility (Resident Accepting Nursing Facility) may continue for up to 30 days after the disaster event. Reimbursement will be the same as if the individual was residing in the Disaster Struck Nursing Facility. No other reimbursement will be made to either the Disaster Struck Nursing Facility or the Resident Accepting Nursing Facility for evacuated individuals. The Disaster Struck Nursing Facility must meet the following conditions in order to receive reimbursement for evacuated individuals:

a) The Disaster Struck Nursing Facility must have a contract with the Resident Accepting Nursing Facility. The contract must include: (i) terms of reimbursement and mechanisms to resolve any contract disputes; (ii) protocols for sharing care and treatment information between the two facilities; and (iii) requirements that both facilities meet all conditions of Medicaid participation, as determined by MassHealth.

b) The Disaster Struck Nursing Facility must notify MassHealth of the disaster event, maintain records of all evacuated individuals that include each individual's name, date of evacuation, and Resident Accepting Nursing Facility, and update MassHealth on the status of any necessary repairs.

c) The Disaster Struck Nursing Facility must determine within 15 days of the disaster event whether evacuated individuals will be able to return to the facility within 30 days of the disaster event. If the Disaster Struck Nursing Facility determines that it is not able to reopen within 30 days, it must discharge all evacuated individuals and work with them to choose admission to other facilities or alternative placements. Nothing shall preclude an evacuated individual from asking to be discharged and admitted to another facility or alternative placement. Reimbursement to the Disaster Struck Nursing Facility shall cease when an individual is discharged from the facility.

R. Certification of Public Expenditures of a Nursing Facility Owned and Operated by a Municipality.

1. Within 60 days after the filing of its Medicare CMS-2540 cost report, a nursing facility, which is owned and operated by a municipality, may submit a request for Certified Public Expenditures (CPE) to EOHHS. This CPE will account for its public expenditures of providing Medicaid services to eligible Medicaid recipients. The submission shall be based on the inpatient routine service cost reported on the 2540 Medicare cost report.

2. Following review of the facility's submission, EOHHS within 60 days of the submission, will approve, deny, or revise the amount of the Certified Public Expenditure request based upon its evaluation of the reported costs and payments. The final approved amount will be equal to the difference between the Medicaid interim payments and the total allowable Medicaid costs as determined by EOHHS and this final determined amount will be certified by the municipality as eligible for federal match.

3. Interim Payments are based on the reimbursement methodology contained in Section III of the State plan Attachment 4.19 - D (4).

4. The determination of allowable (CPE) Medicaid costs will be based on the Medicare CMS - 2540 Cost Report and will be determined on a per diem rate calculated as follows:

I. Skilled Nursing Facility Inpatient Routine Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *30*, Column 18
(B) Total Days - Worksheet *S*-3, Line 1, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line 1, Column 5
(E) Medicaid Allowable *Skilled Nursing Facility* Costs - (C) X (D)

II. Nursing Facility Inpatient Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *31*, Column 18
(B) Total Days - Worksheet *S*-3, Line *3*, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line *3*, Column 5
(E) Medicaid Allowable *Nursing Facility* Costs - (C) X (D)

III. Total Allowable Medicaid Costs

I (E) Skilled Nursing Facility Inpatient Costs + II (E) Nursing Facility Inpatient Costs

5. EOHHS will calculate an interim reconciliation based on the difference between the interim payments and total allowable Medicaid costs from the as filed CMS - 2540 Cost Report. When the CMS-2540 is reopened the facility must immediately notify EOHHS. Within 60 days after receiving notification of the final Medicare settlement EOHHS will retroactively adjust the final settlement amount.

S. Leaves of Absence.

1. For the purposes of a medical leave of absence for Medicaid eligible residents, a facility must ensure that the bed in the facility occupied by said resident before the hospitalization will be available upon the return of said resident from an inpatient acute hospital stay for a period of up to ten (10) days.

2. The current payment rate for medical or non-medical leave of absence is $80.10 per day.

State Plan under Title XIX of the Social Security Act
State. Massachusetts
Methods for Establishing Payment Rates - Nursing Facilities

V. State Legislative Changes

A. Nursing Facility Assessments. An adjustment to nursing facility payment rates is established, effective October 1, 2002, to reimburse participating MassHealth nursing facilities for the providers' assessment costs that are incurred for the care of MassHealth members only, reflecting a portion of the providers' total assessment costs. No reimbursement is made for the providers' assessment costs that are incurred for the care of privately paying residents or others who are not MassHealth members.

1. The rate adjustments for the Nursing Facility Assessment (User Fee) reflect Medicaid's partial share of the tax costs as an allowable cost for purposes of developing Medicaid payment rates and do not provide for a hold harmless arrangement with providers.

(a) Except as provided in section V.A.1. (b) and (c) below, the user fee adjustment will be based on the Nursing Facility Class under 114.5 CMR 12.04 as follows:

Nursing Facility Class	Adjustment Amount
1	$15.47
2	$1.55
3	$1.55
4	$0.00

(b) In accordance with the provisions of Chapter 38 of the Acts of 2013, section 2, line 4000-0640, for the period from October 1, 2013 through June 30, 2014, the user fee adjustment will be as follows:

Nursing Facility Class	Adjustment Amount
1	$18.41
2	$1.84
3	$1.84
4	$0.00

(c) FY2014 Annualization. In accordance with the provisions of Chapter 38 of the Acts of 2013, section 2, line 4000-0640, for the period from October 1, 2013 through June 30, 2014, there will be an additional user fee adjustment as follows:

Nursing Facility Class	Adjustment Amount
1	$0.98
2	$0.10
3	$0.10
4	$0.00

d) A prior rate period may be recertified to exclude these add-ons if the Nursing Facility fails to incur the cost of the Nursing Facility user fee assessment within 120 days of the assessment due date.

e) The add-on amount may be adjusted to reflect a change in the amount of the Nursing Facility user fee assessment under 114.5 CMR 12.04

B. Multiple Sclerosis Primary Diagnosis. In accordance with the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, and Chapter 151 of the Acts of 1996, a rate add-on is computed, for eligible nursing facilities that serve a patient population of which more than 75% of the residents have a primary diagnosis of multiple sclerosis to reflect the difference between the standard payment amounts for nursing and the actual base year nursing costs of the eligible nursing facility. Therefore, an eligible nursing facility would get full recognition of its actual base year nursing costs in its rates.

VI. Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID)

Payments for services provided by Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID) to publicly assisted residents are governed by EOHHS regulation, 101 CMR 129: Rate and Charge Determination for Certain Intermediate Care Facilities Operated by the Department of Developmental Services (formerly 114.1 CMR 29.00) as of July 1, 2013.

The per diem payment rates for ICFs/ID are provider-specific and are established using Center for Health Information and Analysis (CHIA) ICF Cost Reports (403A). ICFs/ID rates are interim in nature and final rates are determined based on the final cost reports for the rate year. The initial inpatient per diem rate is calculated by dividing the allowable total patient care costs by total patient days using data from the fiscal year two years prior to the rate year and then adding inflation up to the rate year. The final inpatient per diem is calculated by dividing the allowable total patient care costs by total patient days using the data from the rate year. The final rate then replaces the initial per diem for the rate year.

The inflation factor for the initial per diem rates consists of a composite index comprised of two cost categories: labor and non-labor. The Massachusetts CPI is used as a proxy for the labor cost categories and the CMS Market Basket for Prospective Payment System-exempt hospitals is used for the non-labor cost category.

Payment rates include all allowable costs that are reasonable and directly related to health care and services provided in the ICFs/ID. Allowable total patient care costs are the sum of the ICF/ID's total inpatient routine and ancillary costs plus overhead costs associated with ICFs/ID health care and services, as reviewed and adjusted pursuant to regulation 101 CMR 129.04.

An ICF/ID may apply for an administrative adjustment to its inpatient per diem rate.

114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00: STANDARD PAYMENTS TO NURSING FACILITIES

6.01: General Provisions

(1) Scope and Purpose. 114.2 CMR 6.00 governs the payments effective December 1, 2007 for services rendered to Publicly Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility. 114.2 CMR 6.00 does not govern nursing facility payments pursuant to a contract with the Office of Medicaid.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units that may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Base Year. The calendar year used to compute the standard payments.

Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use,

such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Financing Contribution, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of six categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

CMS. The federal Centers for Medicare and Medicaid Services.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g., drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs.

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Generally Available Employee Benefits. Employee benefits that are nondiscriminatory and available to all full-time employees.

Hospital-Based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was

before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity, or longer life.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility that increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the MassHealth Agency.

Massachusetts Corporate Excise Tax. Those taxes that have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) necessary to obtain long-term financing through a mortgage, bond or other long-term debt instrument.

New Facility. A facility that opens after the effective date of the regulation. A Replacement Facility is not a New Facility.

Nursing Costs. Nursing costs include the Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment, the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the MassHealth Agency. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

Private Nursing Facility. A Nursing Facility that formerly served only non-Medicaid residents and does not have a Provider agreement with the MassHealth Agency to provide services to public Residents.

Provider. A Nursing Facility providing care to Publicly Aided Residents or Industrial Accident Residents.

Prudent Buyer Concept. The assumption that a purchase price that exceeds the market price for a supply or service is an unreasonable cost.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Related Party. An individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility licensed prior to January 1, 2002 that replaces its entire building with a newly-constructed facility pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6). A facility that renovates a building previously licensed as a nursing facility is not a Replacement Facility.

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the HCF-1.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility licensed by the Department to provide residential care.

State Fiscal Year (SFY). The twelve month period from July 1 through June 30.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: General Payment Provisions

(1) Nursing Facility Payments are prospective rates based on reported costs for a prior Base Year. The Base Year for the standard payments effective August 1, 2007 is 2005.

(2) Nursing Facility Payments include the Nursing Standard Payments and Other Operating Cost Standard Payment established in 114.2 CMR 6.04 and the Capital Payment established in 114.2 CMR 6.05. Payments are adjusted to include additional payments in accordance with 114.2 CMR 6.06.
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(3) Disclaimer of Authorization of Services. 114.2 CMR 6.00 is not authorization for or approval of the substantive services, or lengths of time, for which rates are determined pursuant to 114.2 CMR 6.00. Governmental units that purchase services from eligible providers are responsible for the definition, authorization, and approval of services and lengths of time provided to publicly-aided individuals. Information concerning substantive program requirements must be obtained from purchasing governmental units.

6.04 Nursing and Other Operating Costs

(1) Nursing Standard Payments. Facilities will be paid at the following Nursing Standard Payments:

Payment Group	Management Minute Range	Standard Payment
H	0 - 30	$14.08

JK	30.1 – 110	$37.55
LM	110.1 – 170	$65.72
NP	170.1 – 225	$95.76
RS	225.1 – 270	$116.69
T	270.1 and above	$137.60

(2) For all payment groups, the Other Operating Cost Standard Payment is $71.73.

6.05 Capital

(1) Allowable Basis of Fixed Assets and Capital Cost

(a) Allowable Basis of Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.

2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council and used for Nursing Facility services. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, the allowable amount will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's Allowable Basis.

b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June 30, 1976 and 1993 forward.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.

5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The

Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership, increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Capital Costs. The Division will calculate the Provider's Capital Costs including depreciation, Financing Contribution, and Other Capital Costs as defined below.

1. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets as of December 31, 2005. Depreciation of Buildings, Building Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Building Improvements	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

2. Financing Contribution. The Division will calculate a Financing Contribution by multiplying 7.625% by the Allowable Net Book Value as of December 31, 2005. The Allowable Net Book Value is the allowable basis less all accumulated depreciation calculated for the period through December 31, 2005, except allowed Building depreciation expense that occurred between January 1, 1983 and December 31, 1992.

3. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.

4. Capital Costs. The Division will calculate the Provider's Capital Costs by adding allowable 2005 depreciation and Other Fixed Costs and the Financing Contribution.

5. 2005 Capital Cost Per Day. The Division will calculate the Provider's 2005 Capital Cost per day by dividing 2005 Capital Costs by the greater of: (a) 96% or (b) the Actual Utilization Rate times the Constructed Bed Capacity times 366.

(2) Capital Payment. The Division will include capital payments listed in 114.2 CMR 6.05(2)(d) for the following facilities:

(a) New Facilities and Licensed Beds that become operational on or after February 1, 1998 and are:

1. New or Replacement Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;

2. New Facilities constructed in Urban Underbedded areas exempt from the Determination of Need process;

3. New beds licensed pursuant to a Determination of Need approved after March 7, 1996; and
4. New beds in twelve-bed expansion projects not associated with an approved Determination of Need project.

(b) Private Nursing Facilities that sign a Provider Agreement with the MassHealth Agency after August 1, 2007.

(c) The capital payment will be as follows:

Date that New Facilities and Licensed Beds Became Operational	Payment Amount
February 1, 1998 – December 31, 2000	$17.29
January 1, 2001 – June 30, 2002	$18.24
July 1, 2002 – December 31, 2002	$20.25
January 1, 2003 – August 31, 2004	$20.25
September 1, 2004 – June 30, 2006	$22.56
July 1, 2006 – July 31, 2007	$25.82
August 1, 2007 - Forward	$27.30

(3) Capital Payment – Other Facilities. For all other facilities, the Capital Payment is based on the facility's Capital Costs, including allowable depreciation, Financing Contribution, and Other Fixed Costs.

(a) If a facility's capital payment effective July 31, 2007 is less than $17.29, its capital payment will be the greater of its July 31, 2007 capital payment or the payment determined as follows:

2005 Capital Costs Per Day (114.2 CMR 6.05(1))	Capital Payment Effective August 1, 2007
$0.00 to $4.00	$4.45
$4.01 to $6.00	$6.18
$6.01 to $8.00	$8.15
$8.01 to $10.00	$10.13
$10.01 to $12.00	$12.11
$12.01 to $14.00	$14.08
$14.01 to $16.00	$16.06
$16.01 to $17.29	$17.29
$17.30 to $18.24	$18.24
$18.25 to $20.25	$20.25
>$20.25	$22.56

2. If a facility's capital payment effective July 31, 2007 is greater than or equal to $17.29, the facility's revised capital payment will equal its July 31, 2007 capital payment.
3. If a Provider relicensed beds that were out of service during the rate period, its Capital Payment will be the lower of (1) the capital payment rate established under 114.2 CMR 6.05(2)(c) or (2) the facility's most recent capital payment rates.
4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, and the Provider receives a temporary Capital Payment in accordance with 6.05(4)(b)(3), then the Division will revise the Provider's Capital Payment in accordance with 6.05(4)(b)(4).

(4) Revised Capital Payment for Substantial Capital Expenditure.

(a) General Notification Requirements. All Providers must notify the Division when they open, add new beds, renovate or re-open beds. The notification must contain the Provider's name, address and vendor payment number, date of bed change, type of change and description of project.
(b) Request for Revised Capital Payment. Eligible Providers may request a revised Capital Payment for capital costs associated with the change or renovation of licensed beds.

1. Facilities that may request a revised Capital Payment include:
   a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need;
   b. Replacement Facilities that open on or after September 1, 2005 pursuant to a Determination of Need;
   c. Facilities with Renovations made pursuant to a Determination of Need;
   d. Facilities with twelve bed additions; and
   e. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).
2. If a Provider listed in 114.2 CMR 6.05(4)(b)1 requests a revised Capital Payment to reflect a change in beds, it must submit the following:
   a. a description of the project;
   b. a copy of the construction contract;
   c. copies of invoices and cancelled checks for construction costs;
   d. a copy of the Department's licensure notification associated with the new beds; and
   e. a copy of the mortgage.

The Division may request further information it determines necessary to calculate a revised Capital Payment.
3. The Division will certify a temporary Capital Payment of $25.82 upon receipt of the notification of the change in beds, rate adjustment request, and required supporting documentation.
4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, in order to calculate the final revised Capital Payment the Division will determine the amount of new allowable assets and apply the Financing Factor in 114.2 CMR 6.05(1)(b)2.

(c) Revised Capital Payment.

1. For the Providers specified in 114.2 CMR 6.05(2)(a), the Division will certify a Capital Payment of $27.30.

2. For the following facilities, the final revised Capital Payment will be the greater of 90% of the amount calculated under 114.2 CMR 6.05(4)(b)4 or $27.30:

a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need approved on or before March 7, 1996;

b. Replacement Facilities that open on or after July 1, 2002 pursuant to a Determination of Need approved on or before March 7, 1996;

c. Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and

d. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

3. For the following facilities, the revised Capital Payment will be the lower of the amount calculated under 114.2 CMR 6.05(4)(b)4 or $27.30:

a. facilities that renovate pursuant to a Determination of Need approved after March 7, 1996;

b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the revised Capital Payment will be determined under 114.2 CMR 6.05(3)(c)1; and

c. facilities with a twelve-bed addition and simultaneously renovate pursuant to a Determination of Need approved after March 7, 1996.

4. For Facilities with Renovations made pursuant to a Determination of Need approved before March 7, 1996, if the revised amount calculated under 114.2 CMR 6.05(4)(b)4 is greater than $27.30, the Capital Payment will be 90% of the amount calculated under 114.2 CMR 6.05(4)(b)4. If the calculated amount is lower than $27.30, the Capital Payment will be the amount calculated under 114.2 CMR 6.05(4)(b)4.

(d) Effective Date. The effective date of the revised Capital Payment will be the date upon which the Provider submits the notification and all information and documentation required in 114.2 CMR 6.05(4)(b)2.

(e) Weighted Capital Payment. If a Provider receives a revised capital payment for new beds and also has beds for which payment is determined under 114.2 CMR 6.05(3)(a), the Division will calculate a weighted capital payment. The provider's capital payment will be determined in accordance with the schedule in 114.2 CMR 6.05(3)(a). The payment rate will be the next highest payment rate from the weighted rate as calculated by the Division.

6.06 Other Payment Provisions

(1) Residential Care Beds. Effective August 1, 2007, the total payment Nursing and Other Operating costs for Residential Care Beds in a dually-licensed facility is $76.60.

(2) Retroactive Adjustments. The Division may retroactively adjust capital payments if it learns there was a material error in the rate calculation or if the Provider made a material error in the cost report.

(3) Pediatric Nursing Facilities. The Division will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and other operating costs, excluding administration and general costs, from the facility's most recently filed Cost Report. The Division will include an administration and general payment based on 85% of 2005 median statewide

administration and general costs. The Division will apply an appropriate cost adjustment factor to nursing, other operating, and administration and general costs.

(4) Receiverships. The Division may adjust the rate of a receiver appointed under M.G.L. c. 111, § 72N solely to reflect the reasonable costs, as determined by the Division and the MassHealth Agency, associated with the court-approved closure of the facility.

(5) Other Payment Provisions.

(a) Nursing Facility payments will include an add-on for the Medicaid portion of the nursing facility user fee assessment. The add-on will be equal to the user fee assessed pursuant to 114.5 CMR 12.00. The Division may recertify a prior period rate to exclude this add-on if the Facility fails to incur the cost of the nursing facility user fee assessment within 120 days of the assessment due date.

(b) Eligible facilities will receive an add-on to reflect the difference between the standard payment amounts and actual Base Year nursing spending. To be eligible for such payment, the Department must certify to the Division that over 75% of the facility's residents have a primary diagnosis of multiple sclerosis.

(c) Facilities with kosher kitchen and food service operations may receive an add-on of up to $5 per day to reflect the additional costs of these operations.

1. Eligibility. To be eligible for this add-on, the facility must:

a. maintain a fully kosher kitchen and food service operation that is, at least annually, rabbinically approved or certified; and in accordance with all applicable requirements of law related to kosher food and food products, including but not limited to, M.G.L. c. 94, §156;

b. provide to the Division a written certification from a certifying authority, including the complete name, address and phone number of the certifying authority, that the applicant's nursing facility maintains a fully kosher kitchen and food service operation in accordance with Jewish religious standards. For purpose of this paragraph, the phrase "certifying authority" shall mean a recognized Kosher certifying organization or rabbi who has received Orthodox rabbinical ordination and is educated in matters of Orthodox Jewish law;

c. provide a written certification from the Administrator of the nursing facility that the percentage of the nursing facility's residents requesting kosher foods or products prepared in accordance with Jewish religious dietary requirements is at least fifty percent (50%); and

d. upon request, provide the Division with documentation of expenses related to the provision of kosher food services, including but not limited to, invoices and payroll records.

2. Payment Amounts. To determine the add-on amount, the Division will

a. determine the statewide median dietary expense per day for all facilities. The add-on equals the difference between the eligible facility's dietary expense per day and the statewide median dietary expense per day, not to exceed $5 per day. In calculating the per day amount, the Division will include allowable expenses for dietary and dietician salaries, payroll taxes and related benefits, food, dietary purchased service expense, dietician purchased service expense, and dietary supplies and expenses. The days used in the denominator of the calculation will be the higher of the facility's actual days or 96% of available bed days.

b. The Division will compare the sum of the add-on amounts multiplied by each facility's projected annual rate period Medicaid days to the state appropriation. In the event that the sum exceeds the state appropriation, each facility's add-on shall be proportionally adjusted.

(d) Subject to available funding, a facility will be eligible for a Large Medicaid Provider Supplemental Payment as follows.

1. Eligibility. A facility will be eligible for the payment if:
   a. The facility had at least 188 licensed beds in 2002.
   b. The facility had Medicaid occupancy of 70% or higher in 2002. For purposes of this section, Medicaid occupancy is defined as annual Medicaid days divided by total patient days as reported in the 2002 HCF-1.
   c. The facility has a score of at least 123 on the Department's Nursing Facility Survey Performance Tool as received by the Division on March 25, 2005.
2. Calculation of Supplemental Payment. The Division will calculate the amount of the supplemental payment received by each eligible facility as follows:
   a. The Division will divide the number of reported 2002 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities.
   b. The Division will multiply the resulting percentage by the amount of the surplus.
   c. The Division will divide the amount calculated above by the product of:
      1. current licensed bed capacity for the rate period , times 365, times
      2. reported 2002 Actual Utilization, times
      3. reported 2002 Medicaid Utilization.
      4. This amount will be included as an add-on to each Provider's rate.

(e) Subject to available funding, there will be a supplemental payment to certain publicly-operated nursing facilities owned and operated by a town, city, or state government entity. The payments will be allocated as follows:

1. The Division will divide the number of reported 2002 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities.
2. The Division will multiply the resulting percentage by the sum of total supplemental payments.
3. The Division will divide the amount calculated above by the product of:
   1. current licensed bed capacity for the rate period , times 365, times
   2. reported 2002 Actual Utilization, times
   3. reported 2002 Medicaid Utilization.
   d. This amount will be included as an add-on to each Provider's rate.
4. Effective Dates. This supplemental payment will be effective August 31, 2007.

(6) Allowance for Department of Mental Retardation (DMR) Requirements. Eligible nursing facilities will receive a one-time allowance to establish and maintain clinical and administrative procedures in a manner that complements DMR interdisciplinary service planning activities under the "Active Treatment Policy" for nursing facility residents with mental retardation and developmental disabilities, which was issued by the Executive Office of Health and Human Services in December 2002.

(a) Eligibility. Eligible nursing facilities are identified by the Department of Mental Retardation as nursing facility providers of care to nursing facility residents with mental retardation or development disabilities as of July 25, 2003.

(b) Calculation of Allowance. For each eligible nursing facility identified by DMR, the number of residents identified by DMR as having mental retardation or developmental disabilities and

communicated to the Division as of June 14, 2007 times $3.00, times 366 days, will equal the total allowance amount. To calculate a per day amount to be included in the payment rates, the Division will divide the allowance amount calculated above by the product of items 1 through 3 below:

1. current licensed bed capacity for the rate period , times 366,
2. reported 2005 Actual Utilization percentage, times
3. reported 2005 Medicaid Utilization percentage.

(c) If the DMR notifies the Division that a facility has failed to comply with its requirements or failed to cooperate with the planning activities under the Active Treatment Policy, the Division may deem the facility to be ineligible for this adjustment and rescind this allowance for a provider.

(7) Annualization Adjustment. Nursing facilities will receive an additional, one-time adjustment to annualize rate increases effective August 1, 2007. This adjustment will expire on July 1, 2008. The Division may recertify payment rates effective July 1, 2008 to eliminate the adjustment in rates effective on or after July 1, 2008. The adjustment will be comprised of the following:

Nursing Standard H	$0.05
Nursing Standard JK	$0.14
Nursing Standard LM	$0.25
Nursing Standard NP	$0.43
Nursing Standard RS	$0.45
Nursing Standard T	$0.50
Other Operating Standard	$0.70

The Division will include an additional annualization adjustment for the following add-ons by multiplying the difference between the SFY 2006 and SFY 2007 per day add-ons by 9.254%:

Kosher Kitchen
Capital
DMR Add-on

The Division will make an additional annualization adjustment to reflect the elimination of the following add-ons calculated by multiplying the SFY 2006 per day add-on by -9.254%:

Direct Care Add-on
SFY 2007 Annualization Adjustments

(8) Leave of Absences.

(a) For the purposes of a medical leave of absence for Medicaid eligible residents, a facility must ensure that the bed in the facility occupied by said resident before the hospitalization will be available upon the return of said resident from an inpatient acute hospital stay for a period of not less than ten (10) days. If a facility fails to hold this bed open, it will be ineligible to receive payments pursuant to 114.2 CMR 6.06(5), or allowances for DMR requirements pursuant to 114.2 CMR 6.06(6). The Division may make further adjustment to the facility's rate to comply with the provisions of Chapter 42 of the Acts of 2003.

(b) The payment rate for a medical or non-medical leave of absence day is $80.10 per day.

(9) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the MassHealth Agency, or a Provider's payments include Ancillary Services pursuant to the regulations or written

policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(10) State-operated Nursing Facilities. A Facility operated by the Commonwealth that meets the definition in 42 CFR 443.50(a)(1) will be paid at the Facility's reasonable cost of providing covered Medicaid services to eligible Medicaid recipients.

(a) The Division will establish an Interim per diem rate using a base year CMS-2540 cost report inflated to the rate year using the cost adjustment factor calculated pursuant to 114.6 CMR 6.06(10)(b).and a final rate using the finalized rate year CMS-2540 cost report.
(b) The Division will determine a cost adjustment factor using a composite index using price level data from the CMS Nursing Home without capital forecast, and regional health care consumer price indices, and the Massachusetts-specific consumer price index (CPI), optimistic forecast. The Division will use the Massachusetts CPI as proxy for wages and salaries.
(c) The Division may retroactively adjust the final settled amount when the Medicare CMS-2540 cost report is re-opened or for audit adjustments.

6.07 Reporting Requirements

(1) Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses. If a Provider has closed on or before November 30, the Provider is not required to file an HCF-1 report.
(b) Realty Company Cost Report. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.
(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.
(d) Financial Statements. If a Provider or its parent organization is required or elects to obtain independent audited financial statements for purposes other than 114.2 CMR 6.00, the Provider must file a complete copy of its audited Financial Statements that most closely correspond to the provider's Nursing Facility Cost Report fiscal period. If the Provider or its parent organization does not obtain audited Financial Statements but is required or elects to obtain reviewed or compiled Financial Statements for purposes other than 114.2 CMR 6.00, the Provider must file a complete copy of its Financial Statements that most closely correspond to the Nursing Facility Cost Report fiscal period. Financial Statements must accompany the provider's Nursing Facility Cost Report filing. Nothing in this section shall be construed as an additional requirement that nursing homes complete audited, reviewed, or compiled Financial Statements solely to comply with the Division's reporting requirements.
(e) Clinical Data. The Division may require Providers to submit patient level data for the purpose of measuring clinical performance in a format specified by the Division. The Division may designate required data, data specifications and other data collection requirements by Administrative Bulletin.
(f) CMS-2540 Reports. State operated Nursing Facilities that meet the definition in 42 CFR 443.50(a)(1) must file a CMS-2540 report with the Division annually. The State operated Nursing Facility must report the final disposition made by the Medicare intermediary.

(2) General Cost Reporting Requirements

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions that the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:

a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;

b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and

c. Expenses related to policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.

d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.
3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.
4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.
b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.
c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.
d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment, accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.
e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.
6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.
7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.
8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.

b. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.
c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.
b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, that clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first Notification of Change in Beds.
2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will allocate fixed Equipment on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The Division will allocate capital expenditures that relate to the total plant on a square footage basis.
d. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics used in preparing the Nursing Provider Cost Report.

(3) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;
(b) The cost adheres to the Prudent Buyer Concept;
(c) Payments to related parties: Expenses otherwise allowable shall not be included for purposes of determining rates under 114.2 CMR 6.00 where such expenses are paid to a Related Party unless the Provider identifies any such Related party and expenses attributable to it in the Reports submitted under 114.2 CMR 6.00 and demonstrates that such expenses do not exceed the lower of the cost to the Related Party or the price of

comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the Provider or the Related Party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

(d) Employee Benefits: Only the provider's contribution of Generally Available Employee Benefits shall be deemed an allowable cost. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer. To qualify as a Generally Available Employee Benefit, the Provider must establish and maintain evidence of its nondiscriminatory nature. Generally Available Employee Benefits shall include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. Bonuses related to profit, private occupancy, or directly or indirectly to rates of reimbursement shall not be included for calculation of prospective rates. Benefits which are related to salaries shall be limited to allowable salaries. Benefits, including pensions, related to non-administrative and non-nursing personnel will be part of the other operating cost center. Benefits that are related to the Director of Nurses, including pensions and education, shall be part of the Nursing Cost Center. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken, provided that these benefits are both stated in the written policy and are the actual practice of the Provider and that such benefits are guaranteed to the employee even upon death or termination of employment. Such expenses may be recorded and claimed for reimbursement purposes only as of the date that a legal liability has been established.

(e) The cost must be for goods or services actually provided in the nursing facility; and

(f) The cost must be reasonable; and

(g) The cost must actually be paid by the Provider. Costs not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs discharged in bankruptcy; costs forgiven; costs converted to a promissory note; and accruals of self-insured costs based on actuarial estimates;

(h) A Provider may not report the following costs as related to the care of Massachusetts publicly-aided Residents:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;

2 Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;

3. Expenses not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;

4. Compensation and fringe benefits of residents on a Provider's payroll;

5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;

6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;

7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies not registered with the Department under regulation 105 CMR 157.000 or paid for at rates greater than the rates established by the Division pursuant to 114.3 CMR 45.00;

8. Any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the facility;

9. All legal expenses, including those accounting expenses and filing fees associated with any appeal process;
10. Prescribed legend drugs for individual patients;
11. Recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than residents, telephone income, vending machine income and medical records income. Vending machine income shall be recovered against Other Operating Costs. Other recoverable income shall be recovered against an account in the appropriate cost group category, such as Administrative and General Costs, Other Operating Costs, Nursing Costs, and Capital Costs. The cost associated with laundry income which is generated from special services rendered to private patients shall be identified and eliminated from claims for reimbursement. Special services are those services not rendered to all patients (e.g., dry cleaning, etc.). In the event that the cost of special services cannot be determined, laundry income shall be recovered against laundry expense.
12. Costs of ancillary services required by 114.2 CMR 6.00 or by a governmental unit to be billed on a direct basis to the purchasing government unit;
13. Accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, shall not be included in the prospective rates. When the Division receives satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates.

(4) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
2. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Division may grant a request for an extension of the filing due date for a maximum of 30 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances that prevent the Provider from meeting the deadline; and
3. file the request with the Health Data Policy Group at the Division of Health Care Finance and Policy no later than 30 calendar days before the due date.

(c) Administrative Bulletin. The Division may modify the Filing Deadlines by issuing an administrative bulletin 30 days prior to any proposed change.

(5) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information that the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Audits. The Division and the MassHealth Agency may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(7) Penalties. If a Provider does not file the required Cost Reports by the due date, the Division may reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

6.08 Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) Appeals. A Provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after the Division files the rate with the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

(3) Administrative Bulletins. The Division may issue administrative bulletins to clarify provisions of 114.2 CMR 6.00 or to specify data collection requirements. Such bulletins shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

REGULATORY AUTHORITY

114.2 CMR 6.00: M.G.L. c. 118G.

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

MassHealth
Nursing Facility Bulletin 115
August 1998

TO: Nursing Facilities Participating in MassHealth

FROM: Bruce M. Bullen, Commissioner

RE: **Voluntary Ancillary Pilot Project**

Introduction

The Division is conducting a voluntary pilot project. The project will study the inclusion of ancillary goods and services in nursing-facility per diem rates. The purpose of this bulletin is to describe how the voluntary ancillary pilot will be conducted.

Informational Sessions

The Division of Medical Assistance, in collaboration with the Division of Health Care Finance and Policy and the Massachusetts Extended Care Federation (MECF), will be holding three statewide informational meetings. **Please contact MECF at (617) 558-0202 to register for one of the following sessions and for directions.**

Tuesday, August 25, 1998 *10:00 a.m. to 12:00 p.m.*	*Willows at Westborough,* *1 Lyman St.* *Westborough, MA*
Wednesday, August 26, 1998 *10:00 a.m. to 12:00 p.m.*	*Mass. Extended Care Federation* *2310 Washington St.* *Newton Lower Falls, MA*
Thursday, August 27, 1998 *10:00 a.m. to 12:00 p.m.*	*Elihu White Nursing and Rehab. Ctr.* *95 Commercial St.* *Braintree, MA.*

Objectives

The main objectives of the voluntary pilot project are to:

1. collect information to enhance the Division's understanding of how best to include ancillary goods and services into fully bundled nursing facility rates; and
2. assess what accommodations may be needed to ensure access to adequate and appropriate service levels for MassHealth members.

Overview

The ancillary pilot project will:

1. determine for each participating facility a per diem Medicaid ancillary cost per day based on state fiscal year (SFY) 1996 ancillary claims payments, inflated for the pilot period during SFY 1999. Throughout the remainder of this bulletin this amount will be referred to as the facility specific rate (FSR);
2. utilize a statewide standard payment per day for ancillary goods and services. The statewide standard payment per day (SSPD) equals $5.85;
3. pay a participating facility based on a risk/return model (Risk/return sharing between the facility and the Division will be in the form of a retrospective settlement considering the prospective ancillary allowance and the actual amount expended by the Division in payments to ancillary vendors.);
4. exclude from retrospective settlement calculation any patient with ancillary spending per patient day in excess of 500% of the statewide-average ancillary-per-diem payment for the period of the pilot project;
5. reconcile each facility's final payments at the end of the pilot project;
6. allow ancillary vendors to continue to bill the Division directly; and
7. make available for each participating facility monthly updates on ancillary spending.

Payment

A facility chosen to participate in the pilot project will be assigned to one of two payment groups depending on their FSR. (Please refer to Attachment A to determine the payment model for your facility) The groups are as follows:

1. Group I, Standard Payment Model: A facility will be assigned to this group if their FSR falls between the statewide standard of $5.85 and $7.02 (120% of $5.85).
2. Group II, Outlier Payment Model: A facility will be assigned to this group if their FSR falls either between $1.17 (20% of $5.85) and $5.85 or between $7.02 (120% of $5.85) and $11.70 (200% of $ 5.85). Facilities with spending levels less than $1.17 or greater than $11.70 are excluded from participation in the pilot project.

Billing

For administrative simplicity, vendors of ancillary goods and services will continue to submit claims to the Division directly, and the Division will continue to process these claims for payment.

Final Settlement, Group I

There is no financial risk for facilities participating in this group. The baseline amount for this group is the statewide standard per diem of $5.85. Settlements at the end of the pilot period will be based on: payments to vendors during the pilot; the statewide standard per diem ($5.85); and the facility specific rate (FSR). The methods for settlement will be:

1. if vendor payments are less than the FSR but are greater than $5.85 (SSPD), the Division will pay the facility 25% of the difference between their FSR and actual vendor payments; or
2. if vendor payments are less than $5.85 (SSPD), the Division will pay:
   a. the amount calculated in (1) above, plus 50% of the difference between $5.85 and the actual vendor payments up to $2.93 (50% of $5.85); or
   b. if vendor payments exceed the FSR there will be no settlement with the facility.

Final Settlement, Group II

The baseline amount for this group is the amount equal to the facility specific rate (FSR). Final settlement will be based on the difference between vendor payments and the baseline amount (FSR). The methods for settlements will be:

1. if vendor payments are less than the FSR, down to and including 50% of that amount, the Division will pay the facility an amount equal to 50% of the difference; or
2. if vendor payments exceed the FSR, up to and including 150% of that amount, then the facility will reimburse the Division for 25% of the difference between that amount and the actual vendor payments.

Reconciliation and settlement through this approach effectively cap both the downside and upside financial exposure for facilities. Risk is capped at 12.5% of the FSR. Return is capped at 25% of the FSR.

Special Conditions

For ancillaries that are provided by the facility itself there will be no payment to the facility or to special vendors. These are services the facility decides to make rather than buy or to make special contracts with vendors for fees below levels in the MassHealth rate schedule. These amounts will not be considered part of the incurred vendor payments. This means that the facility and the Division will share in the reduction of vendor payments that may result from such arrangements. For these situations the facility will:

1. notify the Division (Lisa McDowell) in writing of the changes being made and the affected services; and
2. segregate the costs incurred in providing the goods and services.

Settlement examples and grids for both groups can be found in Attachments B and B1.

Timing and Duration

The pilot project will run from October 1, 1998, through June 30, 1999. The project sample will constitute those residents in the facility on October 1, 1998, and those admitted to the facility between October 1, 1998, and March 31, 1999. The data collection period will run from October 1, 1998, through June 30, 1999, allowing all residents to be tracked for the duration of their stay or for three months, whichever is shorter. The final evaluation activity will occur from July 1, 1999, to September 30, 1999.

Evaluation Protocols

The evaluation will rely on facility pre- and post-pilot comparisons and comparisons with all nonparticipating facilities. The intent is to describe outcomes and issues of the administrative feasibility of bundled payment. The issues that will be examined include changes and/or differences in:

1. MassHealth payments for ancillaries, and for all health care taken together for patients served under the participating groups;
2. prescribing patterns and frequency of key, necessary therapies and pharmaceuticals, and the appropriateness of this care (including treatment for secondary conditions);
3. frequency and patterns of admission for persons with high ancillary costs or heavy care needs; and
4. corroborating evidence of changes in clinical and administrative decision making.

Evaluation Data Needs

Several types of data will be needed to answer the evaluation questions. These data include the following.

1. Medical records data.
2. MDS/MMQ data.
3. Claims and payment data for study patients. (Claims data in the baseline and post period will be provided by the Division.)
4. Qualitative management information — intensive case studies at 10-12 facilities. (These administrative studies will require two or three site visits each in order to document the changes in clinical and administrative decision making regarding ancillaries and the nature of in-house controls and physician interactions. It is also likely that the qualitative data collection will include focus groups or direct interviewing of persons conducting discharge planning in selected hospitals to determine if there are patterns of restricted access (difficult placement) for certain types patients in pilot facilities.)
5. Tracer conditions – selected conditions where pilot effects are expected to be most pronounced or most interesting.

Selection Criteria

The selection of facilities to participate in the pilot project will be determined by the Division. At a minimum, facilities must meet the following criteria in order to be considered for participation in the pilot project.

1. Capacity of 60 or greater beds.
2. Facility-specific ancillary costs per patient day between $1.17 and $11.70 (See Attachment C).
3. No significant changes in facility operations since 1996 including, but not limited to: mission, licensure, and casemix.
4. No substandard quality of care issues identified by the Department of Public Health that may impact participation and/or outcomes of the study.

Obligations of Participants

Facilities that are selected to participate will agree to:

1. remain in the pilot for the duration of the project;
2. provide all necessary data including MDS on patients;
3. provide access for medical-record reviews;
4. allow interviews and observation by evaluators;
5. notify the Division of special arrangements for ancillaries; and
6. retain associated cost information.

Applications

Facilities that meet the minimum participation requirements and that are interested in applying should complete the Application Form found in Attachment D. The deadline for the receipt of applications is August 31, 1998. Send your applications to:

Lisa McDowell
Division of Medical Assistance
600 Washington St.
Boston, MA 02111

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Timely Claims Payment: Definition of Claim

For the purposes of meeting the requirements of 42 CFR 447.45 for timely payment of claims, a claim is defined as the following:

1. for services by an acute hospital, a claim is all services for one recipient within a bill; and

2. for all other services, a claim is a line item of service.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Conditions for Direct Payment for Dentists' and Physicians' Services
Direct Reimbursement for Certain Medical Expenses

Individuals who have applied for benefits under SSI or AFDC Programs, have had the applications denied by the Social Security Administration or the Department of Public Welfare, and have had the application denial overturned are entitled to reimbursement for certain medical expenses paid by them. In order to be eligible for reimbursement, the initial decision must be overturned through the reconsideration process, administrative hearing, Appeals Council review, or reopening under the Social Security Administration rules on administrative finality or through the Department of Public Welfare's appeal process, including judicial review. Reimbursement is limited to bills that are incurred on or after the date of initial Medicaid eligibility and that are paid between the date of the erroneous application decision and the date on which the recipient is notified of Medicaid eligibility. The bill must have been paid by the recipient or spouse, or the parent of a minor recipient, or a legal guardian.

Reimbursement is limited to amounts actually paid for care or services that would have been covered under the Medical Assistance Program had eligibility been determined correctly. Prior to reimbursing a recipient for care or services that would have required prior authorization, the Department may require submission of medical evidence for consideration under the prior authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in the Medical Assistance Program.

Requirements for Third Party Liability: Identifying Liable Resources (cont.)

A. The State Medicaid Agency meets the requirements of 42 CFR 433.138 and 433.139.

B. The State Medicaid Agency meets the requirements for identifying liable third party resources in the following way(s):

1. For the data exchanges required in 42 CFR 433.138(d)(1), (d)(3), (d)(4) and (f) and the diagnosis and trauma code edits required in §433.138(e):

   a. The State Medicaid Agency obtains wage and earning information through a monthly data exchange with the Massachusetts Department of Revenue (DOR), and a bi-weekly data exchange with the Social Security Administration (SSA). See 42 CFR 433.138(d)(1).

   b. EOHHS, the State Medicaid Agency, is the state Title IV-A agency and continually reviews information concerning employment obtained during the intake and redetermination processes. See 42 CFR 433.138(d)(3).

   c. MassHealth receives a data match on a monthly basis from the Massachusetts Department of Industrial Accidents (DIA) and compares this list to a list of MassHealth members in the MMIS system. If a match occurs, then MassHealth creates a pending case in the Case Tracking System.

      EOHHS uses a comprehensive Payment Intercept Program (PIP), which identifies non-recurring settlement payments for injury or trauma cases, inclusive of motor vehicle accidents, in the amount of $500 or more. All insurance companies must report through this system, allowing the state an opportunity to intervene and follow-up with liable third parties. See 42 CFR 433.138(d)(4).

   d. The State Medicaid Agency monitors diagnosis and trauma codes through internal reports. See 42 CFR 433.138(e). These reports determine which codes yield the highest return on TPL payments. Moreover, the State Medicaid Agency has developed the PIP process, which identifies insurance settlement payments for injury/trauma cases. This process is undertaken on a daily basis.

2. For the follow-up measures for identifying third party liability resources required in 42 CFR 433.138(g)(1) and (g)(2), the State Medicaid Agency implements these follow-up mechanisms to identify legally liable third party resources:

   a. The State Medicaid agency requests that members provide TPL information when applying for Medicaid. The Medicaid agency accepts TPL information directly from members, providers, MassHealth Enrollment Centers (MECs), Social Security Administration (SSA) local offices, Department of Transitional Assistance local offices, managed care providers and others. The Medicaid agency conducts matches

with the Massachusetts DOR to obtain information about new employment for its members and to identify legally liable non-custodial parents. See 42 CFR 433.138(g)(1)).

b. The State Medicaid Agency conducts a daily, weekly and monthly match to identify members who also have commercial insurance. The State Medicaid Agency conducts regular matches with CMS's Medicare Enrollment Database (EDB) and SSA's State Verification and Exchange System (SVES) files to identify members who eligible for Medicare. The State Medicaid Agency conducts regular matches with the Defense Enrollment Eligibility Reporting System (DEERS) to identify members who are eligible for Tricare. The State Medicaid agency uses the Public Assistance Reporting Information Systems (PARIS) to identify individuals who may be enrolled in another state Medicaid program. See 42 CFR 433.138(g)(2).

3. The State Medicaid Agency has implemented the PIP process, which is used to identify non-recurring settlement payments for injury or trauma cases in the amount of $500 or more. All insurance companies must report through this system, allowing the State an opportunity to intervene and follow-up with liable third parties. This process is discussed in greater detail below. See 42 CFR 433.138(d)(4)(ii).

4. The State Medicaid Agency monitors diagnosis and trauma codes through internal reports. These reports determine which codes yield the highest return on TPL payments. Moreover, the State Medicaid Agency uses the PIP process for detailed case development within the Casualty Recovery Unit (CRU).

   PIP was created by the Massachusetts Department of Revenue (DOR) Child Support Enforcement Division. In July 2003, M.G.L. c. 175, §24E was enacted, authorizing MassHealth and the Department of Transitional Assistance (DTA) to identify insurance payments for the purpose of recovering public assistance benefits. The PIP is a DOR interactive web-based application that licensed insurers to exchange settlement information with MassHealth, DOR Child Support, and DOR Tax Division.

   Once an insurer makes an inquiry into the PIP, a request comes to CRU, the medical claims records are ordered from MMIS. The records, which include the trauma codes, are uploaded into the case-tracking system. Subject Matter Experts (SMEs) undertake a detailed review of all paid claims.

   Starting October 1, 2015, when ICD-10 Codes were implemented, the State Medicaid Agency identifies adjudicated claims that contain ICD-10 diagnosis codes that reflect an injury or trauma for which there may be a liable third party. ICD-9 is still valid for services prior to October 1, 2015 for claims submitted within one year of the date of service, and for historic claims records. The SMEs have received training on ICD-10 codes and review those identified claims.

   The State Medicaid Agency may only recover from the amount that is designated in the settlement for payment of medical expenses related to the cause of action; this may result in a recovery amount that is less than the amount Medicaid expended.

The SME:

- obtains information concerning the client's attorney such as name, address, and telephone number. The SME contacts the attorney for case status, date of accident, and all insurance information.
- processes information received from insurance carriers to obtain policy and coverage information. If the SME determines that there is third party liability, then a notice of lien is sent to the carrier to remain on file against future settlement monies in accordance with Massachusetts General Laws Chapter 118E, §22; and
- reviews financial and medical assistance relating to the accident and provides the attorney with the amount of the lien.

If and when the case settles, the State Medicaid Agency recovers the amount it is owed and discharges the lien.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Requirements for Third Party Liability Payment of Claims

(d)

1. The method to determine compliance with requirements of 42 CFR 433.139(b)(3)(ii)(C) is as follows: The State Plan as referenced herein requires providers to bill third parties. In a case where medical support is being enforced by the state Title IV-D Agency, the provider will be required to submit documentation that the provider has billed the third party and has not received payment from the third party.

   The same method is used to meet the requirements contained in 42 CFR 433.139(b)(3)(i).

   State laws are in effect that require third parties to comply with the provisions of 1902(a)(25)(I) of the Social Security Act, including those which require third parties to provide the state with coverage, eligibility, and claims data.

2. Recovery from Health Insurers

   The State Medicaid Agency will seek reimbursement from a liable health insurer when the State Medicaid Agency determines that the potential accumulated recovery will amount to at least $250, or will otherwise be cost effective.

3. Recovery from Liability Insurers or Other Third Parties for Benefits Provided for Accidents, Injuries, Illnesses and Other Losses. See **42 CFR 433.139(f)(2) and (3).**

   Threshold Amount: The State Medicaid Agency will seek reimbursement from a liable third party for benefits provided on account of accidents, injuries, illnesses or other losses suffered by recipients when the State Medicaid Agency determines that the potential recovery, as evidenced by accumulated billings, will amount to at least $250, or otherwise will be cost-effective.

   Cost-Effectiveness: At times the State Medicaid Agency may determine that it is more cost-effective to pursue a lesser amount than the full cost of care in order to avoid litigation. Cost-effectiveness must be determined on a case-by-case basis. For example, the State Medicaid Agency may reduce the amount of its claim, which becomes the amount of reimbursement that the State Medicaid Agency can reasonably expect to recover. The State Medicaid Agency will use cost-effective criteria such as the following:

   1. Factual and legal issues of liability that may exist concerning the MassHealth recipient and the liable party; and
   2. Total funds, e.g. policy limits available for settlement; and
   3. An estimate of the cost to the MassHealth program to pursue the claim including attorney fees and costs.

   After considering the above factors, the State Medicaid Agency may pursue a lesser recovery

amount to the extent that the MassHealth agency determines it to be cost-effective. Total funds available for settlement of a casualty/tort claim are the funds designated for payment of medical expenses only.

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

1. Cost Effectiveness based on Expenditure Projection

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

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

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

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

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

2. **Cost Effectiveness based on Actual Expenditures or Client Diagnosis**

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

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

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

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

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

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

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

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

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

6. Benefit Wrap and Cost Sharing

Individuals enrolled in the state's premium assistance program must be afforded the member protections available to all other Medicaid enrollees.

(a) The state will provide a benefits wrap to all services and benefits available under the Medicaid State plan that are not provided through the premium assistance group health plans and student health plans available in the individual market.

(b) The state will ensure that individuals enrolled in the premium assistance program will not incur cost sharing amounts that exceed the cost sharing limits described in the state plan for a Medicaid covered service. To effectuate this policy, the state has elected to limit the providers from whom premium assistance beneficiaries can receive services to ones that are contracted with both the private insurer and the Medicaid state agency. These dually contracted providers will limit cost-sharing charges to the amounts allowed under the state plan. The State will submit to CMS an analysis demonstrating the overlap of providers participating in both Medicaid and group/individual health insurance plans is adequate to meet the health needs of premium assistance beneficiaries.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
State Laws Requiring Third Parties to Provide
Coverage, Eligibility and Claims Data

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

Income and Eligibility Verification System Procedures
Requests to Other State Agencies

Pursuant to 42 CFR 435.948 (a) (6), the Massachusetts Department of Public Welfare conducts matches with

- banks, credit unions, and other financial institutions within the state for all active Medicaid recipients. A tape match is generated giving the account number and account balance when the balance exceeds the Medicaid asset limit; and

- the Registry of Motor Vehicles whenever the Department questions the impact of vehicular ownership on an applicant's or recipient's eligibility. The Registry provides verification of ownership of both disclosed and undisclosed vehicles as well as verification of the address at which the vehicle is registered.

Method for Issuance of Medicaid Eligibility Cards to Homeless Individuals

Homeless individuals may have their Medicaid eligibility cards sent to the post office box or Local Welfare office covering the area in which they reside.

Requirements for Advance Directives under State Plans for Medical Assistance

The following is a written description of the law of the state (whether statutory or as recognized by the courts of the state) concerning advance directives. If applicable states should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special state limitations on living will declarations, proxy designation, process information and state forms, and identify whether state law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

In 1990, the Massachusetts Legislature enacted Chapter 201D of the General Laws, the Health Care Proxy Act. This Act provides every competent adult (at least eighteen years of age) the right to appoint a health care agent by executing a health care proxy. The health care proxy must be in writing signed by the adult or at the direction of such adult in the presence of two other adults. No person named as a health care agent may act as a witness to the execution of the proxy.

The health care agent has the authority to make any and all health care decisions on the principal's behalf that the principal could make, including decision about life-sustaining treatment, subject to the express limitations in the health care proxy. The authority of the health care agent begins after a determination is made by the attending physician that the principal lacks the capacity to make or communicate health care decisions. The authority of the health care agent ceases upon the physician's determination that the principal has regained capacity.

The state law permits physicians to refuse to honor an agent's health care decision because the decision is contrary to the moral or religious views of the physician; provided that the patient is transferred to another physician in the same facility, or in an equivalent facility that is reasonably accessible the patient's family, who is willing to honor the agent's decision. If the physician or agent is unable to arrange such a transfer, the physician shall seek judicial relief or honor the agent's decision.

Similarly, a private facility is not required to honor an agent's decision that is contrary to a formally adopted policy of the facility that is expressly based on religious beliefs, provided: a) the facility has informed the patient or health care agent of such policy prior to or/upon admission, if reasonably possible; and b) the patient is transferred to another equivalent facility that is reasonably accessible to the patient's family and willing to honor the decision. If the facility or agent is unable to arrange a transfer, the facility shall seek judicial guidance or honor the agent's decision.

Requirements for Advance Directives under State Plans for Medical Assistance (cont.)

Where no health care proxy has been executed, the Act does not preclude a health care provider from relying upon the informed consent of responsible parties on behalf of incompetent or incapacitated patients to the extent permitted by the law. Further, the Act does not invalidate a power of attorney delegating authority to make health care decisions executed prior to enactment of the Act.

Finally, the Act provides for the commencement of special court proceedings to: determine the validity of the health care proxy; have the health care agent removed under certain circumstances; or to override the agent's decision on specified grounds.

Eligibility Conditions and Requirements: Enforcement of Compliance for Nursing Facilities

The state uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

None

Eligibility Conditions and Requirements: Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Eligibility Conditions and Requirements: Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at §1919 (h) (2) (A)) for applying the remedy.

☐ Specified Remedy

(Will use the criteria and notice specified in the regulation)

☒ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring noncompliance. Notice requirements are as specified in the regulation.)

Receiver in lieu of temporary management

Pursuant to M.G.L. Chapter 111, §§72M through 72T, the Massachusetts Patient Care Receivership Statute, the Department may have a receiver appointed for any facility in cases where an emergency exists. An emergency means a situation or condition which presents imminent danger of death or serious physical harm to residents. Such a situation is analogous to the "immediate jeopardy" definition found in federal regulations at 42 CFR 488. 301.

The state remedy is similar to and as effective as the imposition of temporary management on a facility, since the individual appointed will have had experience in the filed of long term care and will have complete management control over the facility. The condition under which a receivership or temporary management may be imposed are the same under both state and federal law since both rules call for this penalty to be imposed in cases of immediate jeopardy to resident health or safety.

Eligibility Conditions and Requirements: Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919 (h) (2)(A)) for applying the remedy.

☐ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☒ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Denial of Admission in lieu of denial of payment

Under 105 CMR 153.016, the state may limit or cease all admissions to facilities following the initiation of a Medicaid decertification action. The Department of Public Health has consistently imposed a total freeze on admissions to facilities in situations when we initiate a Medicaid termination action. The Department has the authority to impose the freeze in cases specified by the federal regulations.

This state remedy is as effective as the federal remedy of denial of payment for new admissions. In fact, it is more stringent than the federal penalty because state law allows the Department to cease all admissions to a facility, including the admission of new private-pay residents as well as readmission of residents who have been temporarily hospitalized.

Eligibility Conditions and Requirements:
Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919 (h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Eligibility Conditions and Requirements:
Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919*h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulation.)

Eligibility Conditions and Requirements:
Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents §1919 (h)(2)(A)) for with closure of facility:

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Describe the criteria (as required at applying the remedy.

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

Eligibility Conditions and Requirements: Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at §1919 (h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

None.

Definition of Specialized Services

Specialized services for individuals with mental retardation and related conditions are programs that include aggressive, consistent implementation of a program of specialized and generic training, treatment and related services that when combined with the services provided by the nursing facility result in a continuous active treatment program that meets the definition of 42 CFR § 483.440 (a) 1.

Categorical Determinations

PASRR Level II Preadmission Screening by Categorical Determination

The following categories developed by the State mental health authority and approved by the State Medicaid Agency may be made applicable to individuals identified by PASRR Level I as possibly having serious mental illness when existing data on the individual appear to be current and accurate and are sufficient to allow the reviewer readily to determine that the individual fits the category. The data available includes physical, mental, and functional assessments as required by 42 CFR 483.132(c).

An adequate inspection of records for a categorical determination takes the place of the NF individualized Level II evaluation and/or the Specialized Services individualized Level II evaluation as indicated below. Categorical evaluation and determination reports as required by 42 CFR 483.128 and .130, are produced, prior to admission, for all categorical determinations.

When existing data is not adequate, or any judgment is required about the presence of serious mental illness, the individual is referred for individualized Level II evaluation. The State mental health authority is responsible for: 1. assuring that the categorical determinations meet requirements; 2. assuring that the determinations are in the best interests of the residents; 3. retaining copies of the categorical evaluation and determination reports, and 4. maintaining a tracking system for all categorical determinations.

For time limited categories — individuals are either discharged, or evaluated by individualized Level II Resident Review, within the specified time limits. FFP is not available for days of NF care after the time limit expires and before a Level II Resident Review is completed according to requirements.

The state intellectual disability authority has elected not to allow the application of categorical determinations to individuals who screen positive for intellectual or developmental disability, whether alone or in combination with serious mental illness

(Check each that applies, and supply definitions and time limits as required.)

I. Categorical Determination that NF placement is appropriate. (Level II Specialized Services evaluation and determination by the appropriate Level II authority is individualized. A new, individualized, Level II Resident Review is required if at any time the resident experiences a qualifying significant change in physical or mental condition, or the admission exceeds the specified time limit.)

☒ NF services are needed for convalescent care from an acute physical illness which

required hospitalization, and does not meet all the criteria for an exempt hospital discharge as defined in 42 CFR 483.106(b)(2).

Definition	Time limit
A time-limited categorical determination that applies to an individual who will be directly admitted to a nursing facility after being hospitalized to treat a medical condition (excluding psychiatric care) and the individual's admission does not meet all of the requirements of an Exempted Hospital Discharge (EHD).	75 calendar days

☒ Terminal illness (as defined for hospice purposes at 42 CFR 418.3: a life expectancy of 6 months or less if the illness runs its normal course), unless the Level II authority determines that this category does not apply to the individual. NF admission is not approved to a facility without a hospice contract unless terminal illness is documented and the individual waives a hospice contract.

Additional Definition *(optional)*
A categorical determination that applies when a clinician has certified that an individual seeking admission to a nursing facility has a life expectancy of 6 months or less if the illness runs its normal course.

□ Other category(s) defined by the State.

Definition	Time limit

II. Categorical Determination that NF placement is appropriate, and that Specialized Services are not needed. (Determination that Specialized Services <u>are</u> needed is individualized, not categorical.)

☒ Severe physical illness which results in a level of impairment documented to be so severe that the individual could not be expected to benefit from Specialized Services, such as coma, or functioning at or near a brain stem level. The end stages of other conditions may, on an individual basis, be documented to cause such impairment, such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure.

Definition
A categorical determination that applies if: 1. An individual seeking admission to a nursing facility has at least one of the following conditions: coma, persistent vegetative state, end-stage Parkinson's disease, end-stage Huntington's chorea, end-stage congestive heart failure, end-stage chronic obstructive pulmonary disease, end-stage amyotrophic lateral sclerosis, and chronic respiratory failure (ventilator dependent); and 2. Due to the severity of the illness or condition, the individual would not be expected to benefit from specialized services.

□ Other category(s) defined by the State, in which a level of impairment is documented to be so severe that the individual could not be expected to benefit from Specialized Services.

Definition	Time limit *(optional)*

III. Provisional admissions. Categorical Determination that NF placement is appropriate for a brief period. Option to also categorically determine by the Level II authority (not Level I screeners) that Specialized Services are not needed because stay is expected to be brief and the individual does not have a history of need for intensive services related to the individual's PASRR disability. (Determination that Specialized Services are needed is individualized, not categorical.)

□ Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.

Additional Definition *(optional)*	SS Not Needed Categorical	Time limit (≤7 days)
	□	

☒ Provisional admission pending further assessment in emergency situations requiring protective services, with placement in the nursing facility not to exceed 7 days.

Additional Definition *(optional)*	SS Not Needed Categorical	Time limit (≤7 days)
A time-limited categorical determination that applies when an individual seeking admission to a nursing facility requires protective services or seeks admission during an emergency situation on a night, weekend, or holiday.	☒	7 calendar days

☒ Very brief and finite stays of up to a fixed number of days to provide respite to in-home caregivers to whom the individual is expected to return following the brief NF stay.

Additional Definition *(optional)*	SS Not Needed Categorical	Time limit
A time-limited categorical determination that applies when an individual is admitted to a nursing facility to provide relief to the family and/or in-home caregiver.	☒	15 calendar days

IV. Categorical determination that Specialized Services are not needed.
(Determination that Specialized Services are needed is individualized, not categorical. Determination that NF placement is appropriate is individualized.)

□ Dementia and I/DD. The State intellectual disability authority (not Level I screeners) makes categorical determinations that an individual with dementia in combination with intellectual disability or a related condition, does not need Specialized Services. The dementia is of a severity to affect the individual's need for or ability to make use of Specialized Services.

Additional Definition *(optional)*

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Section 6032 Compliance Plan
Section 1902(a) (68) Employee Education About False Claims Recovery

The state Medicaid agency will perform compliance oversight through the methodology described below.

1. Require all covered entities to provide annual written certification of compliance. Such entities include any governmental agency, organization, unit, corporation, partnership or other business arrangement as well as any Medicaid managed care organization, that received or made payments for health care items or services under the State Plan or any waiver, totaling at least $5,000,000 during the prior Federal fiscal year. Such entities include both for profit and non profit organizations. Such entities also include any entity with aggregate payments of more than $5,000,000 if payments were made to multiple locations within the same entity as well as one entity with multiple provider or tax identification numbers.

2. Require a covered entity, upon request, to make available to the state Medicaid agency a copy of its written policies and such other information deemed necessary by the Medicaid agency to demonstrate compliance.

3. Perform on an annual basis, an audit of a sample of covered entities to assess compliance. The state Medicaid agency will review the covered entity's policies either through electronic viewing, examination of written policies, and/or physical review to assure the following:

    a. Policies are easily accessible and allow for full disclosure of all details of section 1902(a)(68) of the Social Security Act and specifically address:
        i. Entity's policies and procedures for detecting and preventing fraud, waste and abuse
        ii. Detailed information about federal and state false claims laws including penalties for submitting false claims and statements
        iii. Specific discussion in such policies relative to the protection and rights associated with whistleblowers.
        iv. Roles of the laws in preventing and detecting fraud, waste and abuse
    b. If an employee manual exists, assure the inclusion of information contained in 3(a) into said manual

4. When noncompliance is identified, initiate such action as the state Medicaid agency determines appropriate, including but not limited to requiring corrective action, recovering payments and imposing sanctions such as fines and termination or suspension from participation in its program.

SECTION 5: PERSONNEL ADMINISTRATION

Citation

5.1 Standards of Personnel Administration

42 CFR 432.10 (a)
AT-78-90
AT-79-23
AT-80-34

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Services Commission in accordance with Section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

☐ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all requirements of 5 CFR Part 900, Subpart F.

Citation 5.2 Reserved

Citation	5.3 Training Programs; Subprofessional and Volunteer Programs
42 CFR Part 432 Subpart B AT-78-90	The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of subprofessional staff and volunteers.

SECTION 6: FINANCIAL ADMINISTRATION

Citation	6.1 Fiscal Policies and Accountability
42 CFR 433.32 AT-79-29	The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure what claims for federal funds are in accord with applicable federal requirements. The requirements of 42 CFR 433.32 are met.

Citation	6.2 Cost Allocation
42 CFR 433.34 47 FR 17490	There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Citation

6.3 State Financial Participation

42 CFR 433.33
AT-79-29
AT-80-34

(a) State funds are used in both assistance and administration.

☒ State funds are used to pay all of the non-federal share of total expenditures under the plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-federal share of the total expenditures under the plan. There is a method of apportioning federal and state funds among the political subdivisions of the state on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the state.

(b) State and federal funds are apportioned among the political subdivisions of the state on a basis consistent with equitable treatment of individuals in similar circumstances throughout the state.

SECTION 7: GENERAL PROVISIONS

Citation	7.1 Plan Amendments
42 CFR 430.12 (c)	The plan will be amended whenever necessary to reflect new or revised federal statutes or regulations or material change in state law, organization, policy or state agency operation.

Citation

45 CFR Parts 80 and 84

7.2 Nondiscrimination

In accordance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et. seq*.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), and the regulations at 45 CFR Parts 80 and 84, the Medicaid agency assures that no individual shall be subject to discrimination under this plan on the grounds of race, color, national origin, or handicap.

The Medicaid agency has methods of administering to assure that each program or activity for which it receives federal financial assistance will be operated in accordance with title VI regulations. These methods for title VI are described in **Attachment 7.2-A**.

RESERVED

OFFICIAL

Citation

7.4 State Governor's Review

42 CFR 430.12 (b)

The Medicaid agencies will provide opportunity for the Office of the Governor to review State Plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Centers for Medicare and Medicaid Services with such documents.

☒ Not applicable. The Governor —

☒ Does not wish to review any plan material.

☐ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of the

Executive Office of Health and Human Services
Designated Single State Agency

Marylou Sudders

Secretary
Title

State Plan under Title XIX of the Social Security Act
State: Massachusetts

December 30, 1969

Appendix B

Mr. Neil Fallon
Regional Representative
Bureau of Family Services
Department of Health, Education, and Welfare
John F. Kennedy Federal Building
Boston, Massachusetts 02203

Dear Mr. Fallon:

I hereby certify that the **statement of compliance pursuant to title VI of the Civil Rights Act of 1964**, Form CB-PS 5002 signed and dated March 3, 1965 and the statements of the implementing methods of administration with amendments as approved on July 23, 1965 and April 12, 1966 and found acceptable for incorporation in the medical assistance title XIX program as of October 17, 1966 are also applicable to the administration of the Medical Assistance Title XIX program resubmitted on December 30, 1969.

The information pamphlet regarding the Medical Assistance title XIX program to be given to each applicant for medical assistance will carry the Civil Rights legend regarding the right to appeal any alleged discrimination. No other additional methods will be needed to assure compliance in the organization of the Medical Assistance title XIX program.

Robert F. Ott
_____
Commissioner
Massachusetts Department of
Public Welfare

TO: BOARDS OF PUBLIC WELFARE

FROM: STATE DEPARTMENT OF PUBLIC WELFARE

RE: **The Civil Rights Act**

In accordance with Title VI of the Civil Rights Act of 1964 and the Department of Health, Education, and Welfare Regulation set forth in Title 45, Part 80 of the Code of Federal Regulations, all Boards of Public Welfare must immediately put into effect the following procedures related to non-discrimination in regard to race, color, or national origin in the federally aided public assistance program.

Written Statement

Attached is a written statement entitled "The Civil Rights Act of 1964" which includes information about the purpose of the Act, the protections afforded individuals by the Act, the rights of individuals under the Act, and the complaint procedure to be followed in the event of discrimination and non-compliance. This shall be referred to hereinafter as the Statement. All employees of the local agency are to be given a copy of the Statement.

Assurance of Compliance by Boards of Public Welfare

Enclosed is a statement entitled "Statement to Assure Compliance with the Civil Rights Act" which must be signed by the local Director of Public Assistance acting as the duly authorized agent of the Board of Public Welfare and returned to the Department. A copy of this statement shall be retained by the local agency.

Dissemination of Information to Applicants, Recipients and Others

A copy of the Statement must be mailed to every recipient of OAA, MAA, AFDC and DA immediately.

Each applicant for any of the federally aided categories must also be provided with a copy of the Statement. Usually this will be given with the Information Pamphlet.

The Statement must also be made available to any other persons who request information on the Civil Rights Act.

Sufficient copies of the Statement are being sent to Boards of Public Welfare. Additional copies, as needed, are to be obtained from the District Office.

Other Agencies, Institutions, Organizations and Individuals

The Department is directly contacting by mail all vendors who are currently doing business with Boards of Public Welfare; or who are likely to be doing such business, informing them of the provisions of the Civil Rights Act. The Statement together with a transmittal letter is being sent to all vendors and they are required to sign and return to the Department an Assurance of Compliance with the Act in order to be eligible for payment for any aid, care, goods or services rendered to public assistance recipients of OAA, MAA, AFDC, or DA.

As soon as possible the Department will compile an approved master list of vendors who have given assurance of compliance and this list shall be made available to Boards of Public Welfare. Until such a list is available all vendors doing business with Boards of Public Welfare shall be presumed to be in compliance with the Act.

Complaint Procedures

As explained in the Statement any person aggrieved because of discrimination on the ground of race, color, or national origin or his representative may file a written complaint with the Board of Public Welfare, State Department of Public Welfare or the U.S. Department of Health, Education, and Welfare.

In addition when a complaint is made to the Board of Public Welfare and the complaintant is not satisfied that proper action has been taken to correct conditions which are believed to be discriminatory, he is advised in the Statement to bring his complaint to the attention of the State Department of Public Welfare. In such instances the State Department will be ready to hear, investigate and act upon the complaint.

The State Department will review, supervise and give final approval to local agency methods of handling complaints and their actions to modify any areas of discrimination.

All complaints must be made in writing and signed by the complaintant or his representative. If not so stated in the written complaint, the Board of Public Welfare must determine the type of alleged discrimination, the time and place, and all other pertinent facts related to the complaint. In addition, the Board of Public Welfare must indicate to whom and where the complaint was sent, what investigation was undertaken, what determination was made and by whom, whether written advice of the decision was given to the complaintant and the type of corrective action that was taken.

A record of all of the foregoing information on each complaint must be kept by the Board of Public Welfare and made available to State and Federal personnel for review. Also, Boards of Public Welfare must keep confidential the identity of the complaintant except to the extent necessary to carry out complaint procedures, and all complaints must be finalized as soon as possible but no later than ninety (90) days from the date the written complaint was received.

Complaints to Boards of Public Welfare or the State Department of Public Welfare will be processed in accordance with the procedures described in Chapter VI, Section A, page 1 of the Policy Manual.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

Each of the Department's invoices contains the following certification which must be signed by the provider of service.

"I hereby certify that the above services were rendered personally by me or under my direction, that I have not previously billed the Department of Public Welfare for any of the above services, and that services were not provided in compliance with Title VI of the Civil Rights Act of 1964. I hereby agree to keep such records as are necessary to fully disclose the extent of the service provided under the State's Title XIX Plan and to furnish such information regarding any payments claimed above as the state agency may request. Signed under the pains and penalties of perjury".

In addition, the Department has recently initiated an extensive sanction mechanism. (see attached sheets). Failure to comply with the Civil Rights Act is thus a sanctionable offense subject to those mechanisms.

State Plan under Title XIX of the Social Security Act
State: Massachusetts

TO: MASSACHUSETTS DEPARTMENT OF PUBLIC WELFARE

RE: **STATEMENT TO ASSURE COMPLIANCE WITH THE CIVIL RIGHTS ACT**

In accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations, policies, procedures and standards established by the Massachusetts Department of Public Welfare relative thereto, the Board of Public Welfare named below will provide all public assistance applicants, recipients, and other interested persons with information concerning the provisions of the Act and will cooperate in carrying out complaint procedures established for the protection of individuals thereunder. In addition, all records and reports deemed necessary to assure compliance with provisions of the Act and rules, regulations, policies, procedures and standards relative thereto shall be maintained and submitted as required.

Distinction on the ground of race, color, or national origin will not be permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, the amount and type of aid, care, services, and other benefits under the public assistance programs and use thereof.

These prohibited discriminatory practices will extend also to services purchased or otherwise obtained by the Board of Public Welfare named below from other agencies, organizations, institutions and individuals for beneficiaries of the public assistance program, and to treatment of clients in facilities in which services are provided, except in case of medical emergencies.

In the operation of any community work and training program or work-experience program under Title V of the Economic Opportunity Act, requirements regarding non-discrimination will include selection of participants for the program, assignment and reassignment to projects, promotions, demotions, rates and form of compensation, separate use of facilities and other treatment of participants.

All non-employees of the Board of Public Welfare who are participating in a public assistance program as trainees, observers, participants in institutes, consulting and members in advisory groups shall likewise be subject to these provisions.

Signature	Title	Board of Public Welfare	Date Signed

Return to:

Civil Rights Unit, Mass. Dept. of Public Welfare, 600 Washington St., Boston, 02111

Commonwealth of Massachusetts
Department of Public Welfare

In **conformity with the provisions of Title VI of the Civil Rights Act of 1964**, you are hereby advised of the purpose of the Act and the rights and protection it affords as well as the procedures for filing any complaints in connection with discriminatory conditions or practices.

Purpose of the Civil Rights Act

Under the Civil Rights Act no person shall, on the ground of race, color, or national origin be excluded from participation in, be denied any aid, care, service, or other benefits of, or be otherwise subjected to discrimination in the programs of Old Age Assistance, Medical Assistance for the Aged, Disability Assistance, Aid to Families with Dependent Children, or the program administered by the Division of Child Guardianship, either directly by the agencies administering these programs or by those through whom they provide care or service through contracts or other arrangements.

Protection of Rights

In order to protect the rights of all applicants for or recipients of assistance under the above programs against discrimination on the ground of race, color, or national origin, the following discriminatory practices are prohibited:

1. denying any individual or family any aid, care, services, or other benefits under those programs
2. providing any aid, care, services, or other benefits to an individual which is different, or is provided in a different manner, from that provided to others under these programs;
3. subjecting an individual or family to segregate or separate treatment in any matter related to his receipt of any aid, care, services, or other benefits provided under these programs;

4. restricting an individual in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any aid, care, services, or other benefits provided under these programs;
5. treating an individual or family differently from others in determining whether he satisfies any eligibility or other requirement or condition which individuals or families must meet in order to receive any aid, care, services, or other benefits provided under these programs;
6. denying any individual or family an opportunity to participate in these programs through the provision of services or otherwise or afford him an opportunity to do so which is different from that afforded others under these programs (including the opportunity to participate in the programs as an employee where the primary objective of the program is to provide employment, including a program under which the employment is provided to reduce employment).

Method of Filing Complaints

Any individual aggrieved because of discrimination on the ground of race, color, or national origin by any of the above individuals, agencies, institutions or organizations such as hospitals, nursing homes, physicians, druggists, etc., may file a written complaint either through his representative or directly with the Board of Public Welfare, the State Department of Public Welfare, or the U.S. Department of Health, Education, and Welfare. If a complaint is made to a Board of Public Welfare and the complaintant is not satisfied that proper action has been taken to correct the conditions which are believed to be discriminatory, he should forward his written complaint to the State Department of Public Welfare. In such instances the State Department of Public Welfare will be ready to hear, investigate, and act on the complaint.

Methods of Administration

Chapter 118E, Section 1B of the General Laws requires that the Department establish administrative sanctions against provisions for any violation of the rules, regulations, standards or laws governing the Medical Assistance program.

As used in this section, the following terms and phrases shall, unless the context clearly requires otherwise, have the following meanings:

1. Department — the Department of Public Welfare.
2. Commissioner — the Commissioner of Public Welfare.
3. Assistant Commissioner — the Assistant Commissioner for Medical Assistance.
4. Division — the Division of Medical Assistance.
5. Medical Assistance Program — the program operated by the Department to provide medical services and care to individuals and to make payment to providers for such medical services and care. This includes all medical services purchased by the Department.
6. Provider — any institution, agency, person, or group qualified under the laws of the Commonwealth to perform or provide the medical care or services enumerated in Chapter 118E, Section 6, and who seeks payment therefore from the Department under Massachusetts General Laws, Chapter 117 or Massachusetts General Laws, Chapter 118E.
7. Statutory Prerequisites — any license, certificate, or other requirement of Massachusetts law which a provider must have in full force and effect in order to qualify under the laws of the Commonwealth to perform or provide the medical care or services enumerated in Chapter 118E, including but not limited to certificates required by the Department of Public Safety, licenses required by the Departments of Public Health or Mental Health, and certificates issued by the applicable Board of Registration.

Violations

All providers are subject to the laws and rules and regulations governing the Medical Assistance program. Following are examples of the violations of these laws, rules, or regulations that may result in the imposition of sanction.

1. Charges in excess of the fee schedule.
2. Charges for services not rendered.
3. Overutilization of goods and services.
4. Any practice, act, or condition that violates the conditions of participation or the rules and regulations of the Department.
5. Any practice or act which constitutes false representation.
6. Services not meeting professional standards.
7. Violation of state or federal law.
8. Failure to have a statutory prerequisite.

If the provider wished to have the imposition of the sanction stayed pending appeal, he may request in his claim of appeal and shall give his reasons why the Commissioner should grant a stay. The Commissioner shall grant a stay for good cause shown and not otherwise. In no event shall a stay be granted unless the Commissioner is satisfied that the granting of a stay will not adversely affect the health or safety of any person receiving

assistance under the Medical Assistance program.

Every appeal shall be conducted on the record, except that, where there is a genuine dispute as to material focus, the Commissioner shall afford the provider a hearing at which time he may contest each disputed finding of violation. Such hearing shall be before the Commissioner or his designee and shall be conducted in accordance with the rules of evidence

and procedure applicable to hearings held under General laws, Chapter 30A, Sections 10 and 11.

If the Division has information that a provider has committed a violation, the Assistant Commissioner may impose such sanction under this regulation as he considers appropriate. Before imposing a sanction, he shall mail written notice to the provider, which notice shall include:

1. A statement of the alleged violation.
2. A statement of the proposed sanction and effective date thereof, except, however, that, in the case of violation under 8 above, the sanction shall take effect immediately upon receipt of this notice.
3. A copy of this regulation.

Except as provided herein, no sanction shall be imposed until after the affected provider has had an opportunity to petition the Assistant Commissioner.

Any provider in receipt of a notice of proposed sanction may petition the Assistant Commissioner in writing not to impose such sanction. Such written petition shall be filed, within ten (10) days of the date of the notice, with the Assistant Commissioner at the offices of the Division in Boston.

Said written petition shall state the provider's objections to the statement of violation, if any, or to the proposed sanction or effective date thereof. The provider shall set forth with specificity any allegation of fact or argument of law which he wishes the Assistant Commissioner to take into consideration and shall attach to the written petition any documentary evidence he wishes considered.

A conference before the Assistant Commissioner or his designee shall be permitted within the discretion of the Assistant Commissioner. If the provider wishes to have a conference either in person or through counsel, he shall so request in his written petition. The Division shall notify the provider in writing of the action of the Assistant Commissioner upon his written petition not less than fifteen (15) days after the filing of such petition in accordance with this regulation. Whenever the Assistant Commissioner imposes a sanction, or whenever he continues a sanction already imposed for violation 8 above, the notice to the provider shall set forth findings of fact and rulings of law in support of such action and the basis for rejecting any allegation or argument presented in the provider's written petition.

Appeal

Any provider dissatisfied by the action of the Assistant Commissioner, in whole or in part may appeal to the Commissioner; provided, that he files a chain of appeal with the Commissioner not later than thirty (30) days after notification of such action. Such claim of appeal shall set forth with specificity each respect in which the provider is dissatisfied with the final action of the Assistant Commissioner. The claim of appeal may be accompanied by written argument.

An appeal shall be concluded by a decision of the Commissioner, which shall include a determination of each material issue of fact or law in dispute. The Department shall promptly notify the affected provider in writing of the Commissioner's decision. Where a stay has been granted, it shall terminate upon notification of said decision.

Sanctions

Sanctions may include, but shall not be limited to, any one or more of the following:

1. An order to make restitution as a condition of continued participation in the Medical Assistance program.
2. Suspension from participation in the Medical Assistance program for a period of

Notice of Sanction

The Department shall, in an appropriate case, notify the appropriate professional society, Board of Registration, Federal or State agency, or other law enforcement agency of the Department's finding and decision.

Section	Contents
0	Introduction
1	General Description and Purpose of the Children's Health Insurance Plans and the Requirements
2	General Background and Description of Approach to Children's Health Insurance Coverage and Coordination
3	Delivery Standards
4	Eligibility Standards and Methodology
5	Outreach and Coordination
6	Coverage Requirements for Children's Health Insurance
7	Quality and Appropriateness of Care
8	Cost Sharing and Payment
9	Strategic Objectives and Performance Goals and Plan Administration
10	Annual Reports and Evaluations
11	Program Integrity (section2101 (a))
12	Applicant and Enrollee Protections (Section 2101 (a))

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts
Introduction

(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))

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

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved 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: Daniel Tsai Position/Title: Assistant Secretary for MassHealth
Name: Matthew Klitus Position/Title: Chief Financial and Strategy Officer
Name: Robin Callahan Position/Title: Deputy Medicaid Director and CHIP Director

***Disclosure. 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 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.**

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act of 2010 further modified the program.

This template outlines the information that must be included in the state plans and the state plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
  - Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
  - Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
  - Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
  - Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
  - Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
  - Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
  - Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.

The Centers for Medicare & Medicaid Services (CMS) is developing regulations to implement the CHIPRA requirements. When final regulations are published in the Federal Register, this template will be modified to reflect those rules and States will be required to submit SPAs illustrating compliance with the new regulations. States are not required to resubmit their State plans based on the updated template. However, States must use the updated template when submitting a State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP

SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires a description that must include both proposed methods of delivery and proposed utilization control systems. This section should fully describe the delivery system of the Title XXI program including the proposed contracting standards, the proposed delivery systems and the plans for enrolling providers. (Section 2103); (42 CFR 457.410(A))
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)

5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42CFR, 457.90)
6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretary-approved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment**- This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of pre-existing medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)

11. **Program Integrity**- In this section, 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. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State Plan Amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections) indicating State

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address:

Name of Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid, CHIP and Survey & Certification
Mail Stop - S2-01-16

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

Guidance: Check below if child health assistance shall be provided primarily through the development of a separate program that meets the requirements of Section 2101, which details coverage requirements and the other applicable requirements of Title XXI.

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

Guidance: Check below if child health assistance shall be provided primarily through providing expanded eligibility under the State's Medicaid program (Title XIX). Note that if this is selected the State must also submit a corresponding Medicaid SPA to CMS for review and approval.

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

Guidance: Check below if child health assistance shall be provided through a combination of both 1.1. and 1.2. (Coverage that meets the requirements of Title XXI, in conjunction with an expansion in the State's Medicaid program). Note that if this is selected the state must also submit a corresponding Medicaid state plan amendment to CMS for review and approval.

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 ☒ Check to 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))

1.3 ☒ Check to 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)

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Effective date: October 1, 1997
Implementation date: August 24, 1998

SPA #1 (Benchmark Change)
Submission date: October 12, 2001
Approval date: March 22, 2002
Effective date: January 1, 2002
Implementation date: January 1, 2002

SPA #2 (Compliance)
Submission date: June 28, 2002
Approval date: September 19, 2002
Effective date: August 24, 2001
Implementation date: August 24, 2001

SPA #3 (Cost Sharing)
Submission date: April 8, 2003
Approval date: June 23, 2003
Effective date: March 1, 2003
Implementation date: March 1, 2003

SPA # 4 (Healthy Start)
Submission date: April 24, 2003
Approval date: September 15, 2003
Effective date: November 1, 2002
Implementation date: November 1, 2002

SPA #5 (Family Assistance Expansion)
Submission date: May 2, 2006
Approval date July 20, 2006
Effective date: July 1, 2006
Implementation date: July 1, 2006

SPA #6 (CHIPRA Legally Residing Immigrants)
Submission date: March 12, 2010
Approval date: February 9, 2012
Effective date: August 29, 2009
Implementation date: August 29, 2009

SPA #6 (CHIPRA Dental Requirement)
Submission date: March 12, 2010
Approval date: February 9, 2012
Effective date: August 29, 2009
Implementation date: October 1, 2009

SPA #6 (RWJ Grant and State Share)
Submission date: March 12, 2010
Approval date: February 9, 2012
Effective date: August 29, 2009
Implementation date: March 12, 2010

SPA #7 (Health Services Initiative)
Submission date: June 28, 2010
Approval date: August 29, 2011
Effective date: July 1, 2009
Implementation date: July 1, 2009

SPA #8 (Express Lane Renewal)
Submission date: January 27, 2012
Approval date: November 9, 2012
Effective date: January 23, 2012
Implementation date: January 23, 2012

SPA#9 (Health Services Initiative)
Submission date: June 26, 2012
Approval date: October 16, 2012
Effective date: October 1, 2011
Implementation dates:
October 1, 2011 for the following provisions: Child At-Risk Hotline; Teen Pregnancy Prevention Program; Youth Violence Prevention Program; Youth Parents Support Program; and Safe and Successful Youth Program.
January 1, 2014 for the following provisions: Children's Medical Security Plan; Failure to Thrive Program; Pediatric Sexual Assault Nurse Examiner (SANE) Program; and Pediatric Palliative Care.

SPA #10 (in MMDL as TN-13-026) (CS24, CHIP Application)
Submission date: December 30, 2013 through the MMDL
Approval date: May 5, 2014
Effective date: October 1, 2013
Implementation date: October 1, 2013

SPA #11 (in MMDL as TN-14-003) (CS3, CHIP Medicaid Expansion) Pending
Submission Date: January 16, 2014 through the MMDL
Approval date: December 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #12 (in MMDL as TN-14-005) (CS14, CHIP 2101(f))
Submission date: February 11, 2014 through the MMDL
Approval date: April 15, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #13 (in MMDL as TN-14-013) (CS15, 17-21, CHIP MAGI Eligibility and Income)
Submission date: March 28, 2014 through the MMDL
Approval date; September 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #14 (in MMDL as TN-14-006) (CS7,9,13, CHIP non-financial eligibility)
Submission date: March 28, 2014 through the MMDL
Approval date: September 22, 2014
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #15 (Unborn child option benefits) (TN-14-014)
Submission date: June 27, 2014
Approval date: March 11, 2015
Effective date: January 1, 2014
Implementation date: January 1, 2014

SPA #16 (Health Services Initiative) (TN-014-015)
Submission date: June 27, 2014
Approval date: December 8, 2014
Effective date: July 1, 2013
Implementation date: July 1 2013 for the following H.S.I provision: "Services for Homeless Youth"

SPA #17 (Applied Behavior Analysis) (TN-016-004)
Submission date: March 31, 2016
Approval date: May 18, 2016
Effective date: July 1, 2015
Implementation date: July 1, 2015

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

Verification of Tribal Consultation is attached.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

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 Commonwealth 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.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
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Section 2. General Background and Description of State Approach to Child Health

Table 2a.

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

Uninsured Children					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18 (2)	Total
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
Total	**55,281**	**32,753**	**47,210**	**10,814**	**146,058**
Insured Children					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18	Total
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
Total	**552,013**	**449,080**	**352,482**	**59,674**	**1,413,249**

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

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 2. General Background and Description of State Approach to Child Health

Table 2b

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

Insured Children					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18 (2)	Total
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
Total	**552,013**	**449,080**	**352,482**	**59,674**	**1,413,249**
Children Covered by Employer Related Group Health Insurance					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18	Total
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	162,714	139,641	107,194	29,539	439,088
Total	**372,539**	**314,899**	**259,003**	**48,516**	**994,957**
Children Covered by Other Health Insurance (3)					
Federal Poverty Level	Age 0 - 6	Age 7 - 12	Age 13 - 17	Age 18	Total
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	15,661	11,414	15,500	2,526	45,101
Total	**179,475**	**134,180**	**93,479**	**11,158**	**418,292**

(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.

Updated children's uninsurance data for the State Plan Amendment submitted on April 28, 2006:

The information in the table below is the Unduplicated Number of Children Ever Enrolled in SCHIP in Massachusetts for the two most recent reporting periods.

Program	FFY 2004	FFY 2005	Percent change FFY 2004-2005
SCHIP Medicaid Expansion Program	119,377	115,858	(3.0%)
Separate Child Health Program	47,131	42,715	(9.3%)

Three-year averages in the number and/or rate of uninsured children Massachusetts based on the Current Population Survey (CPS) are shown in the table below, along with the percent change between 1996-1998 and 2001-2004.

	Uninsured Children Under Age 19 Below 200 Percent of Poverty		Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19	
Period	Number	Std. Error	Rate	Std. Error
1996-1998	70	15.5	4.6	1.0
1998-2000	68	15.5	4.2	0.9
2000-2002	40	9.9	2.6	0.7
2002-2004	53	11.7	3.4	0.7
Percent change 1996-1998 vs. 2002-2004	-24.3	NA	-26.1	NA

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. These efforts are described below.

MassHealth
MassHealth has made significant strides in outreach, application processing and enrollment of eligible children with the development of the EOHHS Virtual Gateway. The goal of the Virtual Gateway (VG) is to provide a single point of intake, eligibility screening, and referral services for applicants. This allows potential applicants of health and human services in the Commonwealth, either directly through the web or with assistance from a health and human services agency or a patient-accounts staff person, to obtain information and to gain access to available HHS programs. In addition, providers are also able to track electronically submitted applications.

Application volume through the VG for MassHealth and Uncompensated Care Pool (UCP) determinations increased steadily since implementation. By the end of FY 2005, the VG deployment had reached provider sites constituting 80% of UCP volume. There are currently 120 MassHealth providers using the VG, made up of 72 hospitals and 48 community health centers.

The Virtual Gateway has been pivotal in improving access to MassHealth since its implementation in October 2004. Access improvements have resulted in an 8.4% increase in family enrollment and a 6.7% increase in children's enrollment in MassHealth in the period October 2004 to November 2005.

In the last quarter of FFY05, MassHealth awarded $500,000 in mini-grants to 22 community-based organizations across the state to increase MassHealth enrollment. These grants will help provide critical access to people who are already eligible for MassHealth but not enrolled. MassHealth is working closely with these grantees to give them the knowledge and tools to enroll new MassHealth members. One component of this effort is training those grantees who are not already doing so to submit electronic applications for MassHealth. Each of the grantees has tailored programs specific to the people and regions they serve. To buttress training provided by MassHealth, grantees will use novel approaches for outreach, including health fairs, public notices, multi-lingual

collaborations with YMCAs, YWCAs, hospitals, community service organizations, soup kitchens, homeless shelters, clinics, schools, and businesses, as well print, radio, and television marketing campaigns.

Massachusetts continues as a Robert Wood Johnson Foundation Covering Kids' site, collaborating with Health Care for All. MassHealth also continues to work with the medical community including the Massachusetts Hospital Association, the Massachusetts Medical Society, and the American Academy of Pediatrics to promote the MassHealth program. Providers are encouraged to participate in training sessions on MassHealth and are supplied with enrollment kits titled "What to do when an Uninsured Child Shows up at your Door".

Additionally, to support member education efforts, MassHealth continues to provide funding for the Health Access Networks (HANs). HANs were developed in partnership with the University of Massachusetts Medical School's Area Health Education Center (AHEC) as a forum to share information, strategies, and experiences on effective member education practices. HANs have been established in each of the six regional areas and continued to meet monthly during SFY05. MassHealth Operations continues to fund this effort as MassHealth Technical Forums. The meetings currently promote information dissemination, sharing of best practices, and building of community/public sector linkages to increase targeted outreach and member education information about MassHealth.

MassHealth has also elected the Express Lane Renewal option to provide a simplified renewal process for eligible Medicaid Expansion CHIP children (133% to at or below 150% of the federal poverty level for children aged 1 to 5 years old; 114% to at or below 150% of the federal poverty level for children aged 6 to 17 years old; and 0% to at or below 150% of the federal poverty level for children aged 18 years old). This option is also provided for unborn-CHIP children from 0% to at or below 150% of the federal poverty level. Gross income is used for all income calculations. The Express Lane renewal process allows Medicaid Expansion CHIP and CHIP children who are also receiving Supplemental Nutrition Assistance Program (SNAP) benefits to have their eligibility renewed through an automatic process that will not require a paper renewal form. This process promotes retention of children in health benefits

Children's Medical Security Plan (CMSP)

CMSP is a state-funded program that provides coverage for certain preventive and ambulatory medical services for children of any income who are not eligible for MassHealth. EOHHS has 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, an eligibility determination is automatically made for CMSP.

Other EOHHS Programs

There are several other programs operated by EOHHS 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 provides 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 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 encourages uninsured pregnant women and parents and guardians of uninsured children to apply for MassHealth. Staff also refers 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 is able to assist uninsured patients in applying for CMSP and MassHealth benefits.

- 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.

- Early Intervention Partnerships 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: MassHealth contracts with 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 increase coordination with the MassHealth managed care system.

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:

MassHealth continues to form public/private partnerships with Massachusetts employers through its premium assistance programs.

MassHealth encourages employer-sponsored coverage for low-income employees and their families through a combination of the SCHIP program and its 1115 Waiver. MassHealth provides premium assistance payments on behalf of eligible children with family income at or below 300% FPL (before disregards). In addition, under the 1115 Waiver, MassHealth provides premium assistance to eligible adults who work for a qualified small employer and makes an incentive payment to the small employer.

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))

EOHHS will assess children's eligibility for both Title XIX and Title XXI programs. EOHHS 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 (Title XIX and Title XXI), 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 MassHealth's eligibility system (MA21) to invoke an eligibility

determination. MA21 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 300% of the FPL (before disregards) appears to have access to health insurance through an employer, MassHealth will conduct a health insurance investigation to determine if the insurance meets MassHealth 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. Children between 200 and 300% of the FPL may be subject to a waiting period of up to six months for coverage if they are found to have dropped employer-sponsored insurance within the previous six months (see section 4.4.4.2).

The MBRs of children who are ineligible for MassHealth are automatically processed for CMSP and Safety Net Care.

MassHealth notices include information regarding the WIC program if a family member is pregnant or under age five.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 3. Methods of Delivery and Utilization Controls

☐ 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.

Guidance: In Section 3.1., discussion may include, but is not limited to: contracts with managed health care plans (including fully and partially capitated plans); contracts with indemnity health insurance plans; and other arrangements for health care delivery. The State should describe any variations based upon geography, as well as the State methods for establishing and defining the delivery systems.

Should the State choose to cover unborn children under the Title XXI State plan, the State must describe how services are paid. For example, some states make a global payment for all unborn children while other states pay for services on fee-for-services basis. The State's payment mechanism and delivery mechanism should be briefly described here.

Section 2103(f)(3) of the Act, as amended by section 403 of CHIPRA, requires separate or combination CHIP programs that operate a managed care delivery system to apply several provisions of section 1932 of the Act in the same manner as these provisions apply under title XIX of the Act. Specific provisions include: section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. If the State CHIP program operates a managed care delivery system, provide an assurance that the State CHIP managed care contract(s) complies with the relevant sections of section 1932 of the Act. States must submit the managed care contract(s) to CMS' Regional Office servicing them for review and approval.

In addition, states may use up to 10 percent of actual or estimated Federal expenditures for targeted low-income children to fund other forms of child health assistance, including contracts with providers for a limited range of direct services; other health services initiatives to improve children's health; outreach expenditures; and administrative costs (See 2105(c)(2)(A)). Describe which, if any, of these methods will be used.

Examples of the above may include, but are not limited to: direct contracting with school-based health services; direct contracting to provide enabling services; contracts with health centers receiving funds under section 330 of the Public Health Service Act; contracts with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Act; contracts with other

hospitals; and contracts with public health clinics receiving Title V funding.
If applicable, address how the new arrangements under Title XXI will work with existing service delivery methods, such as regional networks for chronic illness and disability; neonatal care units, or early-intervention programs for at-risk infants, in the delivery and utilization of services. (42CFR 457.490(a))

3.1. Delivery Standards 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))

☐ Check here if the State child health program delivers services using a managed care delivery model. The State provides an assurance that its managed care contract(s) complies with the relevant provisions of section 1932 of the Act, including section 1932(a)(4), Process for Enrollment and Termination and Change of Enrollment; section 1932(a)(5), Provision of Information; section 1932(b), Beneficiary Protections; section 1932(c), Quality Assurance Standards; section 1932(d), Protections Against Fraud and Abuse; and section 1932(e), Sanctions for Noncompliance. The State also assures that it will submit the contract(s) to the CMS' Regional Office for review and approval. (Section 2103(f)(3))

Guidance: In Section 3.2., note that utilization control systems are those administrative mechanisms that are 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.

Examples of utilization control systems include, but are not limited to: requirements for referrals to specialty care; requirements that clinicians use clinical practice guidelines; or demand management systems (e.g., use of an 800 number for after-hours and urgent care). In addition, the State should describe its plans for review, coordination, and implementation of utilization controls, addressing both procedures and State developed standards for review, in order to assure that necessary care is delivered in a cost-effective and efficient manner. (42CFR, 457.490(b))

MassHealth uses Title XXI funds to deliver child health assistance through the following MassHealth coverage types: MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance (including the Family Assistance Expansion for Children - FAEC), 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 comprehensive third-party health 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 obtain services on a fee-for-service basis. Uninsured CommonHealth members may, at their option, participate in the MassHealth managed care network.

MassHealth Standard and CommonHealth Premium Assistance Program (MSCPA)

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

MassHealth Family Assistance (including FAEC)

(A) Premium Assistance

Delivery system options: Premium Assistance payments are made to parents to subsidize the employee share of employer-sponsored insurance (ESI). All medical services are provided through the ESI. Dental services are provided directly by MassHealth on a fee-for-service basis. .

(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 MassHealth 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.

Primary Care Clinician (PCC) Plan Provider Network and the PCC Plan's Behavioral Health Program (BHP)

The PCC plan is a primary care case management program administered by MassHealth. In the PCC Plan, members enroll with a primary care clinician (PCC), who provides most primary and preventive care. There are currently approximately 1,100 PCC practices in the PCC Plan network, including individual physicians, group practices, community health center, independent nurse practitioners, and hospital outpatient departments. MassHealth monitors the performance of providers in the network, including developing and implementing quality improvement.

The BHP is a managed behavioral health care program that 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 in the PCC Network 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, as MassHealth MCOs are separately responsible for behavioral health services for their members.

MassHealth contracts with a vendor to administer and manage its BHP.

BHP 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.

Managed Care Organization (MCO) Provider Network

MassHealth currently contracts with MCOs that provide comprehensive health coverage, including medical, pharmacy, and behavioral health services, 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).

Fee-for-service

Members may receive certain services on a fee-for-service basis. Rates for these services are established either through contracts with MassHealth or regulations promulgated by the Massachusetts Executive Office of Health and Human Services. Any provider who meets program participation requirements set forth in the MassHealth regulations and provider agreements may participate in the MassHealth program.

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 MCO pays the SBHC from the MCO capitation paid by MassHealth. Where SBHCs do not have their own provider agreements, they cannot claim payment from MassHealth directly.

School Based Medicaid

School Based 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.

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 prior approval from MassHealth. 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 MassHealth. For Family Planning services provided by MassHealth providers not participating in the MCO network, MassHealth reimburses the provider on a fee-for-service basis.

Payment mechanisms

PCC Payment Mechanisms

Fee-for-service

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

Enhancement

MassHealth pays PCCs an enhancement for most office and home visits when they see one of its members. An enhanced fee is not paid for referrals. MassHealth 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 MassHealth's average monthly payment to the PCC for services to the PCC's plan members in the previous quarter. Reconciliations occur using subsequent claims submissions.

BHP Payment Mechanisms

Capitation and Risk Sharing Arrangements

MassHealth pays a different per member per day capitation rate for each rating category. A rating category groups members by eligibility status and reflects assumptions about projected service utilization and cost. MassHealth and the BHP vendor share the risk of over or underspending according to actuarially sound risk corridors.

MCO Payment Mechanisms

Capitation Payments

MassHealth 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 among groups of MassHealth members and differences in the covered services for which the MCOs are capitated. Capitation rates are established in accordance with regulations at 42 CFR 438.6 regarding actuarial soundness. The MCOs are at full risk for nearly all members, with the exception of certain small risk pools for high-needs children. In addition, MassHealth offers the MCOs the option to purchase stop-loss insurance coverage for persons with disabilities.

MassHealth reconciles estimated capitation payments with actual enrollment volume.

In addition, pursuant to Section 2105(a)(1)(D)(ii), Massachusetts will use administrative funds to offer "Health Services Initiatives" under the plan. Programs offered as part of these Health Services Initiatives with the overarching goal of improving the health of children (defined at 42 CFR 457.10 as "individual(s) under the age of 19 including the period from conception to birth"). Please note that, to the extent that any program does provide services to individuals age 19 or over, reimbursement will only be claimed for services or activities targeted towards children under age 19. The Health Services Initiatives will be activities funded by state appropriations to the Executive Office of Health and Human Services or the Executive Office of Education, and administered by related state departments or agencies, as described below. Specific Health Services Initiatives include the following programs:

- **Healthy Families**

  Healthy Families is a statewide neonatal and postnatal home parenting education and home visiting programs for at-risk newborns. This program is administered by the Massachusetts Children's Trust Fund (MCTF), a quasi-public agency that receives its state appropriation via the Department of Early Education and Care. MCTF provides funding through contracts with community-based human services organizations that furnishes the home visiting services to at-risk families. MCTF selects providers pursuant to Requests for Responses (RFR). The program is designed to prevent child abuse and neglect; achieve optimal health, growth and development in infancy and early childhood; and prevent repeat teen pregnancies. Specific services include home visits in which staff model and support positive parent-child interactions; teach about child development; help the family to

provide a safe and enriching environment for children; provide crisis intervention as needed; and connect the family with other services as needed.

- **School Based Health Programs**

School based health programs are sponsored by the Massachusetts Department of Public Health (DPH). School based health programs that are included as part of the Health Services Initiative are:

  - *"**Essential School Health Services,**"* which strengthens the infrastructure of school health services in the area of school nursing. The program provides funding to eligible school districts through RFRs with the goal of creating and expanding the Essential School Services structure and standards throughout the Commonwealth. This program provides school-age children access to a school health service program that includes nursing assessment/health education; medication management; and screenings with respect to postural, height/weight, hearing, oral health, and vision.

  - ***"Safe Spaces,"*** which provides suicide prevention and violence prevention programs for Gay, Lesbian, Bisexual and Transgender (GLBT) Youth. Through Safe Spaces, DPH funds youth development programs across Massachusetts; the programs are selected pursuant to an RFR issued by DPH. The programs are not necessarily based in schools and may provide services during after-school hours or weekends. The programs engage young people in shared decision-making, expanding life skills, leadership development, and affirming support around multidimensional GLBT identity development which includes successfully navigating race, ethnicity, gender expression, national origin, language, sexual orientation, socio-economic background, age, religion and ability.

- **Nutrition Programs for Children:**

  - ***"School Breakfast Programs,"*** which provide nutritious breakfasts to children on school days and during summer vacation. The program is funded with state appropriations that are supplemental to federal funding. All children may participate, but low income children are eligible for free or reduced price meals depending on family income. The Department of Elementary and Secondary Education (DESE) provides funding to school districts based on schools meeting the criteria of:
    - meeting the requirements of "Severe Need Schools" which are defined as schools where 40 percent or more of the lunches served to students at the

school in the second preceding year were served free or at a reduced prices; and

- having on file a combined total of fifty or more free and reduced price meal applications as of October of the preceding school year.

Expenditures claimed as part of this Health Services Initiative exclude expenditures used as "maintenance of effort" for other federal grants.

- o ***"State-Funded WIC"***, provides the following services through peer counseling and professional medical staff: breastfeeding support, dietary assessments, nutrition education and counseling, immunization screening and referrals to other health and social services. To administer this program, DPH uses an RFR process to select qualified community based organizations, such as community health centers and community action programs, which provide the services.

- **Smoking Prevention and Cessation Programs**

Through Smoking Prevention and Cessation Programs, DPH funds a wide range of activities to promote tobacco control and prevention. The activities serve a wide variety of populations, including children, adolescents, families, and adults. Only the expenditures associated with programs directed toward individuals below the age of 19 will be claimed under CHIP Health Services Initiative. DPH funding supports:

- o Production and dissemination of educational materials for youth and parents;
- o Funding to non-profit organizations (via an RFR process) to promote activities - such as interactive web sites and short-movie contests - to discourage youth from tobacco use.

- **Family Planning Programs**

Through Family Planning Programs, DPH provides the following services at family planning sites throughout the state.

- o Comprehensive family planning services, including complete gynecological and breast exams, cervical cancer screening, diagnosis and treatment of sexually transmitted diseases, contraceptive supplies including emergency contraception, pregnancy testing, follow-up and referral for identified medical problems, and other pre-conceptional care.
- o Individual health education and counseling on reproductive anatomy and physiology, all contraceptive methods, AIDS/HIV, sexually transmitted diseases, all options for positive pregnancy tests, infertility, and other related health concerns.

- Outreach and education to local communities and populations. These activities vary with each program but may include classes in schools and community organizations on reproductive health, sexuality, and HIV prevention; training and resources for teachers, health care providers and parents; peer education programs; participation in community coalitions; and collaboration with other organizations serving high risk populations.

- **DDS/DESE Project to Prevent Out of Home Residential Placements**

  This project provides services to youth with disabilities to enable the youth to live at home rather than in residential facilities. The project is sponsored by the Massachusetts Department of Developmental Services (DDS) and the Massachusetts Department of Elementary and Secondary Education (DESE). DDS receives funds from DESE to provide community based supports to students who a.) meet DDS eligibility criteria for services and b.) also receive special education services. The goal is to provide community based services to enable the youth to continue living with their families and prevent placement in a residential facility.

  Services are provided through this project are based on the individual needs of youth and are planned in conjunction with the families. Most services are provided in the child's home. Each child's needs and services are determined through an individualized plan reviewed with the DDS authorized case manager. The program empowers the youths' parents to arrange for the services needed for their children by providing the parents with funds to purchase necessary services. The range of services are diverse and may include behavioral intervention analysis and training, speech therapy, physical therapy, occupational therapy, adaptive equipment, specialized nutrition, and activities of daily living training.

- **The Children's Medical Security Plan to provide primary and preventive health services for uninsured children from birth through age 18.**

  The Children's Medical Security Plan (CMSP) provides coverage for primary and preventive health services for uninsured children from birth through age 18 who are not eligible for MassHealth. The CMSP is managed by the Executive Office of Health and Human Services (EOHHS). Eligibility for CMSP is determined by MassHealth, and re-determinations are conducted annually. CMSP covers medically necessary medical, behavioral-health, dental, and pharmacy services, but not inpatient services.

- **Child At-Risk Hotline for after hours reporting of suspected child abuse and neglect.**

  The Department of Children and Families engages a private social services agency to provide telephone coverage for reports of child abuse and neglect during nights and weekends. The staff triage reports and communicate information to the state agency.

- **Teen Pregnancy Prevention Program**

  The Department of Public Health engages community based agencies to provide science-based teen pregnancy prevention strategies to high-risk adolescents.

- **Failure to Thrive Program**

  The Department of Public Health oversees the Failure to Thrive Program which focuses on providing evaluation and treatment for infants or children who are exhibiting childhood malnutrition and growth failure known as Failure to Thrive. The overall goal of the program is to improve the growth and developmental outcome of the children. The Department of Public Health contracts with hospitals and community health centers to provide services by multidisciplinary teams.

- **Youth Violence Prevention Program**

  The Department of Public Health oversees the Youth Violence Prevention Program. Community based organizations provide comprehensive youth violence prevention programs to youth in at-risk communities.

- **Pediatric Sexual Assault Nurse Examiner (SANE) Program**

  The SANE program is administered by the Department of Public Health and provides direct patient care to adolescents and children who disclose sexual assault and who go to SANE designated Emergency Departments or Children's Advocacy Centers across Massachusetts. The nurses of the SANE program provide direct patient care to individuals who disclose sexual assault. This includes necessary medical exams, testing, and preventive treatment for HIV, STDs, and pregnancy. These services are the first step in psychological, physical, and emotional healing for the child.

- **Pediatric Palliative Care**

  The Department of Public Health funds the Pediatric Palliative Care Program which helps children with life-limiting illnesses and their families gain a sense of control in their lives. A network of licensed hospices helps children and their caregivers manage the pain and other symptoms brought on by illness.

- **Young Parents Support program**

  The Department of Children and Families funds this program whose goal is to strengthen parenting skills of low-income young mothers for the ultimate benefit of their children.

- **Safe and Successful Youth Program**

  The Executive Office of Health and Human Services oversees this program whose goal is to support a full continuum of services to support young men most likely to be victims or perpetrators of violence.

- **Services for Homeless Youth**

  Through Services for Homeless Youth, the Department of Early Education and Care (EEC) contracts with licensed organizations to provide a stable, nurturing environment that meets the individual, developmental, behavioral and emotional needs of homeless youth. Each family is assessed for their unique issues and needs and the provider develops a "Family Service Plan" to address the needs. Each child is assessed for developmental concerns and where developmental delays are identified, appropriate referrals are made. Parents are provided access to parenting programs, a variety of community resources (e.g., WIC), nutritional guidance, information on building positive parent-child interactions, and skills to help identify the best quality child care for their children. Based on the "Family Service Plan", when therapeutic supports are needed (medical, psychological, etc.), providers assist parents in accessing needed services.

  Expenditures claimed as part of this Health Services Initiative exclude costs for providing services to MassHealth covered members.

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 MassHealth PCC Provider Contract and meet the requirements specified in the Contract. 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/7-day/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 PCC 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 MassHealth 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

MassHealth's MCO contract details the MCOs' qualifications and responsibilities. MassHealth's decision to contract with an MCO is largely based on that organization's ability to meet MassHealth-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. MassHealth'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 MassHealth 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, MassHealth 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)

MassHealth'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

MassHealth 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 MassHealth, and 3) participation in and successful completion of performance evaluation activities related to the continuous quality improvement model of contract management utilized by MassHealth. MassHealth oversees compliance by the MCOs using a continuous quality improvement model.

MCO contracts substantially comply with the requirements of the Balanced Budget Act at 42 C.F.R. Part 438.

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 MassHealth 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, MassHealth 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.

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

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.
MassHealth 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 MassHealth for all diversionary services provided during the reporting period; these reports must be submitted monthly, quarterly, semiannually, and annually. MassHealth analyzes and monitors these reports to determine if the utilization of diversionary services is clinically appropriate;

- MassHealth requires the BHP vendor to submit provider profiles on a semiannual basis;

- On a regular basis, MassHealth 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, MassHealth requires the vendor to conduct provider site visits to review randomly selected medical records and participate in case conferences;

- MassHealth's BHP staff regularly join vendor staff supervision meetings and clinical management department meetings to monitor compliance with the administration of diversionary services; and

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

<u>BHP Network Management</u>

MassHealth requires the vendor to conduct network management functions. Network management includes:

development, maintenance, and management of the BHP provider network; and,
BHP provider contracting, and provider education.

Specifically, the Network Management service administered by the vendor and monitored by MassHealth 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 MassHealth 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 MassHealth approval, to terminate or take other appropriate management action with providers who may be insolvent or otherwise financially unsound.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

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))**

Pages CS7 and CS9 of TN-014-013 MMDL Supersed 4.1.1., 4.1.2 and income standards at 4.1.3

4.1.1. ☐ Geographic area served by the Plan:

MassHealth is available statewide.

4.1.2. ☒ Age:

In general, children under age 19 are eligible for Title XXI MassHealth. Eligibility for a coverage type is determined by a combination of age, family income, disability or pregnancy status, and the availability of health insurance. For specific eligibility guidelines, see Attachment 4.1 (d).

Language on income counting is superseded by TN-014-006 MMDL (CS15)

4.1.3. ☒ Income:

Title XXI MassHealth has a family income limit of 300% FPL (before disregards, see chart below) and who are not eligible for Medicaid under title XIX. For specific eligibility guidelines see Attachment 4.1 (d).

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.

MassHealth Standard through the CHIP unborn child option is available to uninsured pregnant women with family incomes from zero percent of the FPL up to and including 200 percent of the FPL who are not otherwise eligible for MassHealth Standard.

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) Earned Income

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

Earned income for the self-employed is the total amount of business income listed or allowable on a U.S. tax return, minus allowable business deductions.

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 MassHealth 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 MassHealth 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.

MassHealth 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.

Income Disregards

Gross Income as % of FPL	Income Disregards (as a % of FPL)
Below 200%	0
200	0
250	50
300	100

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

Section 4.1.5 Superseded by TN-014-006 MMDL

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 300% of the federal poverty level; and,
- Are permanently and totally disabled as defined below

Note: disabled children, regardless of income, are covered under CommonHealth through the Commonwealth's 1115 waiver.

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 MassHealth'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 MassHealth Standard and has family group gross income that is less than the standards described in **Attachment 4-1 (d)**; 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 MassHealth.

MassHealth 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 300% FPL (before disregards); and
- MassHealth has determined it is cost effective to purchase the insurance.

MassHealth will provide premium assistance toward the child's private health insurance premium payment through MassHealth Family Assistance.

4.1.8. ☒ Duration of eligibility:

A pregnant woman who has been determined eligible for MassHealth Standard, including under the unborn child option, 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 language superseded by TN-014-006 MMDL

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.

MassHealth 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 MassHealth, 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 MassHealth 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 MassHealth 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 or the mother of an unborn child eligible for MassHealth Healthy Start.

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 MassHealth 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:

- file a claim for compensation;
- assign to MassHealth 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 MassHealth's Post Payment Recovery Unit unless MassHealth 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 language superseded by TN-014-006 MMDL

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. Alternatively, a child must be otherwise eligible and lawfully residing in the United States as allowed for under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and as described in Section 4.1.10 below.

Verifications of Citizenship and 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. . An otherwise eligible lawfully residing individual as provided for in section 214 of CHIPRA will be verified to continue to lawfully reside in the United States using the documentation presented to the Commonwealth by the member on initial enrollment. If the Commonwealth cannot successfully verify that the member is lawfully residing in the United States in this manner, it shall require the member provide further documentation or other evidence.

For citizens, a determination of eligibility will be made once the application is complete except for documentation of citizenship and/or identity status. Citizens who have not submitted documentation of citizenship and identity status within sixty days of the date of the eligibility determination, shall subsequently be ineligible unless an extension is requested.

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.

Unborn Children
An unborn child is eligible if the gross income of the family group is less than or equal to 200% FPL and the unborn child's mother is otherwise ineligible for MassHealth Standard. The unborn child or children are counted as if born and living with the mother in determining family group size.

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 4-1 (d). 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.

(B) MassHealth Family Assistance (including FAEC) – 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 300% FPL (before disregards)
- the child is ineligible for MassHealth Standard and MassHealth CommonHealth; and
- the child is not insured, does not have access to health

insurance, as defined in Section 4.1.7., and, for children between 200 and 300% FPL, has not been insured in the previous six months, except as provided in section 4.4.4.2.

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.

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, MassHealth shall determine if the insurance meets HIPAA and basic benefit level requirements. If the insurance meets these requirements, MassHealth 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 300% FPL (before disregards) 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 using the schedule below.

%FPL	Per child	Family maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

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 MassHealth 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 MassHealth collects all premiums that MassHealth determines to be outstanding unless a hardship exemption or payment plan has been granted in accordance with MassHealth regulations.

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 MassHealth 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 (including FAEC)

Premium assistance under MassHealth Family Assistance is available to children aged one through eighteen between 150 and 200% FPL, and to children aged zero through eighteen between 200 and 300% FPL (before disregards), provided:

- 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;
- it is cost-effective to MassHealth to provide premium assistance; and,
- for children between 200 and 300% FPL, the child or children has been uninsured for a minimum of six months prior to application, except as specified in section 4.4.4.2.

In order to determine whether an employer –sponsored health plan meets the Basic Benefit Level, MassHealth 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 MassHealth's basic benefit requirements to ensure that the plan includes all state-mandated benefits.

MassHealth 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 MassHealth-calculated member share of the health insurance premium (if applicable). The member share is

%FPL	Per child	Family maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

. 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 MassHealth representative will contact the applicant's employer to collect the required data. Once the information is collected and verified, MassHealth will calculate a

premium assistance payment amount.

Estimated Premium Assistance Amount

The estimated premium assistance amount equals the total health insurance premium minus the employer share of the premium minus the MassHealth 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 MassHealth 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 MassHealth calculated member share is $24 (2 children X $12), then the MassHealth estimated premium assistance amount will be $126 per month.

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 MassHealth's MCO program, or $300 per month ($150 pmpm[1] x 2 children).

Actual Premium Assistance Amount

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

If the estimated premium assistance amount is less than the cost effective amount (as defined in #2 above), then MassHealth will set the actual premium assistance amount at the estimated premium assistance amount.

If the estimated premium assistance amount is higher than the cost effective amount (as defined in #2 above), then MassHealth

1 For demonstration purposes only, represents the average MCO pmpm.

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 MassHealth'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, MassHealth will pay copays, coinsurance, and deductibles for children eligible for premium assistance provided:

the copay, coinsurance or deductible was incurred as the result of a well baby/well-child care visit; or
the policyholder's annualized share of the employer-sponsored health insurance premiums, combined with copays, coinsurance, 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 MassHealth's policy on payment of copays, coinsurance and deductibles. Providers may bill MassHealth directly or members may seek reimbursement from MassHealth. MassHealth 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.

Express Lane Renewal Option

Certain children under the age of 19 eligible for Medicaid Expansion CHIP and CHIP

will meet the criteria for Express Lane Renewal at the time of their annual renewal. The MassHealth agency will identify Medicaid Expansion CHIP children and unborn-CHIP children who have income at or below gross 150% of the federal poverty level (FPL) and are also eligible for SNAP as shown from a data match with the Massachusetts Department of Transitional Assistance. The Massachusetts Department of Transitional Assistance oversees SNAP and will be the designated Express Lane Agency. Children's Medicaid Expansion CHIP benefits and CHIP benefits will be renewed based on the child's eligibility for SNAP. This process will be used for renewals only. All members eligible for this process have completed an initial application and have been approved for either Medicaid Expansion CHIP or CHIP and for SNAP. These members will also have their SNAP eligibility recertified on an annual basis.

4.1.10 ☒ Check if the State is electing the option under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) to provide coverage to the following otherwise eligible pregnant women and children as specified below who are lawfully residing in the United States including the following:

A child or pregnant woman shall be considered lawfully present if he or she is;

(1) A qualified alien as defined in section 431 of PRWORA (8 U.S.C. § 641);
(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;
(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. § 1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
(4) An alien who belongs to one of the following classes:

(i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);

(ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

(iii) Aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(iv) Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended;

(v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(vi) Aliens currently in deferred action status; or

(vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

(5) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(6) An alien who has been granted withholding of removal under the Convention Against Torture;

(7) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));

(8) An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or

(9) An alien who is lawfully present in American Samoa under the immigration laws of American Samoa. .

☒ The State elects the CHIPRA section 214 option for children up to age 19
☐ The State elects the CHIPRA section 214 option for pregnant women through the 60-day postpartum period

4.1.10.1 ☒ The State provides assurance that for individuals whom it enrolls in CHIP under the CHIPRA section 214 option that it has verified, both at the time of the individual's initial eligibility determination and at the time of the eligibility redetermination that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.

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)

Presumptive eligibility language superseded by TN-014-006 MMDL

Application and presumptive eligibility

To apply, a person must file a Medical Benefit Request (MBR).

MassHealth 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.

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 MassHealth's eligibility process of determining the appropriate coverage type providing the most comprehensive medical benefits.

If necessary information is received within the 60 calendar day period, the MBR is considered complete; if not received within the 60 calendar day period, MassHealth shall deactivate the MBR.

Reactivating the Medical Benefit Request
If all required information is submitted to MassHealth subsequent to the 60 calendar day period, MassHealth 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 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.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until MassHealth 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
MassHealth 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 Division of Unemployment Assistance (DUA), 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, MassHealth's eligibility system attempts data verification through automated matching with other MassHealth 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 MassHealth 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

MassHealth works with the following agencies to verify eligibility information.

- DUA

MassHealth processes matches with DUA for unemployment information. Recipients of unemployment insurance are identified for income matching purposes, and for determining eligibility for Basic. These individuals are paid by DUA 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 MassHealth 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 MassHealth'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 BENDEX 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 CMS 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

MassHealth shall review eligibility with respect to circumstances that may change. MassHealth 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

MassHealth uses an enrollment Broker (EB) to educate and enroll all managed care eligible MassHealth members in a health plan. Customer service representatives (CSRs) are employees of the EB. A CSR'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

MassHealth'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.

MassHealth 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 MassHealth and the Department of Public Health, the Division of Unemployment Assistance, 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.

<u>MassHealth Standard/MassHealth Family Assistance Members</u>
All MassHealth Standard/MassHealth Family Assistance members eligible to participate in managed care must enroll with either a MassHealth-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 services from any MassHealth provider.

Currently, MassHealth has no lock-in policy and members can transfer to another health care plan in their service area at any time.

<u>Description of Enrollment Process</u>
CSRs enroll MassHealth managed care eligible members into a health plan under either the PCC plan or an MCO according to MassHealth'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.

<u>Receipt of Member Data</u>
The EB receives data regarding managed care eligible members from MMIS. Eligibility workers at MassHealth 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 MassHealth.

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 MassHealth member enrollment data including: the members' names, addresses, recipient identification (RID) numbers, categories of assistance, and casehead RIDS and names.

The member has fourteen (14) calendar days to choose a health plan or MassHealth 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 MassHealth 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 MassHealth 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 as well as other factors such as quality performance and/or enrollment volume.

The assignment algorithm applies only to Standard, Family Assistance, and Basic members who have not been determined to be disabled. MassHealth does not assign members who have been determined disabled to MCOs, but assigns them to a PCC based on disabling condition, geographic location, and, where possible, provider experience.

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. Manual assignments, 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

MassHealth 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 are 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.

MassHealth-initiated Transfers

MassHealth may initiate the transfer of a member based on provider capacity, or if a health plan or primary care clinician terminates its agreement with MassHealth. When MassHealth-initiated transfers are required, MassHealth 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 MassHealth. 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, MassHealth requests that the PCC submit written notice to MassHealth at least thirty (30) days prior to the date of the intended termination. MassHealth 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

MassHealth'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, 6th 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 CSRs 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 MassHealth's approval, by which to determine when MassHealth 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 MassHealth 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.

New subsection (See CS15) per TN-014-013 MMDL

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 MassHealth's computerized MA21 eligibility system, which then invokes 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 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 mental diseases as defined 42.CFR 435.1009, at the time of initial application or any redetermination of eligibility.

The Express Lane Renewal process For Medicaid Expansion CHIP and CHIP children who have income at or below gross 150% of the federal poverty level utilizes the current screen and enroll process, which is described above. They will remain enrolled in the most comprehensive coverage type for which they are eligible.

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 MA21 system, MMIS is automatically updated to reflect the coverage type for which the child is eligible.

Since MassHealth offers a variety of programs to Massachusetts' residents, MA21 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 MassHealth'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, MassHealth 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.

Section 4.4.4. Superseded by TN-014-006 MMDL

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.

MassHealth's premium assistance program, which is based on the combined authority of MassHealth's 1115 Waiver Insurance Partnership Program and Title XXI, will prevent families from dropping their private health insurance coverage. MassHealth 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, MassHealth emphasizes in its marketing and outreach materials the availability of premium assistance benefits for insured families. Additionally, when the family applies for MassHealth benefits, MassHealth 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 MassHealth'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, MassHealth 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 MassHealth ensures that:

- Families with employer-sponsored coverage will be covered through premium assistance under MassHealth's 1115 Waiver.
- 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 Title XXI direct coverage.

MassHealth continuously monitors the effectiveness of these policies. MassHealth 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 conducted by the Division of Health Care Finance and Policy. Through these surveys, MassHealth 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.

Additionally, MassHealth regularly examines movement between direct coverage and premium assistance within the caseload to measure substitution and determine if current crowd-out prevention strategies are effective.

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.

MassHealth will continue current crowd-out monitoring activities, with a particular focus on the higher income population of FAEC,

including;

(a) Evaluating the biannual employer survey, which is conducted by the Division of Health Care Finance and Policy, and includes information on employer offer rates, contribution rates, and premiums, by size of employer;

(b) Regularly examining movement between direct coverage and premium assistance within the caseload;

(c) Evaluating annual CPS data; and,

(d) Utilizing MassHealth's health insurance carrier and employer databases to monitor changes in employer offers.

Crowd-out provisions for FAEC (200-300% FPL)

MassHealth will not provide direct coverage or premium assistance if the family had employer-sponsored group coverage for applying children within the previous six months. Families which had employer-sponsored group coverage within the previous six months will be subject to a six-month waiting period, from the date of loss of coverage, before being allowed to enroll in FAEC. Exceptions from this waiting period will be made for situations in which:

(a) A child or children has special or serious health care needs;

(b) The prior coverage was involuntarily terminated, including withdrawal of benefits by an employer, involuntary job loss, or COBRA expiration;

(c) A parent in the family group died in the previous six months;

(d) The prior coverage was lost due to domestic violence;

(e) The prior coverage was lost due to becoming self-employed; or

(f) The existing coverage's lifetime benefits were reduced substantially within the previous six months, or prior employer-sponsored health insurance was cancelled for this reason.

If MassHealth finds a significant level of crowd-out, it will reevaluate the exceptions to the waiting period to determine if they are contributing to crowd-out, and modify them as necessary.

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.
See 4.4.4.2

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 with income below 200% FPL 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. For children with income between 200 and 300% FPL who had employer-sponsored insurance in the previous six months, see section 4.4.4.2 for a description of the required waiting period and exceptions.

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 MassHealth to provide services to the member through the direct coverage option.

4.4.4.5 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))**

MassHealth 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. MassHealth 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, the Dukes County Health Commission was given a mini-grant to do general outreach, which would have included the AI/AN population on Martha's Vineyard.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

Section 5. Outreach and Coordination

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)**

MassHealth will accomplish outreach, 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) Periodically award mini-grants to community-based organizations to assist in enrollment of "hard-to-reach" uninsured individuals and families and support post enrollment education strategies. MassHealth and the 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. MassHealth will make regional outreach coordinators available at each of its four 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. MassHealth 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 MassHealth outreach efforts with the Massachusetts Hospital Association and 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. MassHealth 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 unborn child 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), Division of Unemployment Assistance (DUA), 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. MassHealth 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.

5. MassHealth will perform outreach and enrollment activities specifically related to the Express Lane Renewal option to rely on findings from SNAP to conduct simplified eligibility renewals. This will include the activities listed above as well as:

a. Providing detailed information about the Express Lane Renewal Process to stakeholders, including advocates, community outreach workers/grantees and providers to ensure education of the process to members.

b. Information sharing about Express Lane Renewal at Massachusetts Health Care Training Forums (MTFs)

c. Utilizing the Virtual Gateway listserv to update and educate providers about the Express Lane Renewal process

d. Coordinating with SNAP outreach programs and resources to promote Express Lane Renewal.

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

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

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

Our Title XXI Medicaid expansion group is newborns 185.1% FPL up to 200% FPL, children ages 1-5 133.1% FPL up to 150% FPL, children ages 6-17 114.1% FPL up to 150% FPL and children age 18 up to 150% FPL. These children are in MassHealth Standard and receive the Medicaid benefit package. **[See MMDL 014-003 approval for current percentages] and [MMDL 014-005 for language about 2101(f).**

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 and applicable additional coverage described in the Services Related Expenditures and related Special Terms and Conditions in the Massachusetts 1115 demonstration project (no. 11-w-00030) for Medicaid expansion children who are in MassHealth Standard and unborn CHIP children who are in MassHealth Standard, except that unborn CHIP children are not eligible for Premium Assistance.

6.1.4.2. ☒ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project for children in MassHealth Family Assistance and CommonHealth

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:

Covered services for MassHealth Family Assistance - Direct Coverage (including FAEC)

Non-disabled children who are not eligible for MassHealth Standard and who are in families with income up to 300% FPL are enrolled in MassHealth Family Assistance . Those who do not have cost effective Employer Sponsored Insurance (ESI) receive direct coverage. This coverage is equivalent to the MassHealth Standard (Medicaid benefit package) 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 include 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, 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 and 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
Applied Behavior Analysis services. .

Covered services for MassHealth Family Assistance- Premium Assistance

Children enrolled in Family Assistance who have access to cost effective Employer Sponsored Coverage (but are currently uninsured) receive Premium Assistance. In addition, if they do not have dental coverage through their ESI, they receive the Medicaid Standard dental benefit as a wrap service.

Covered services for MassHealth CommonHealth

Disabled children who do not qualify for MassHealth Standard are enrolled in CommonHealth. There is no income limit and premiums are based on income. MassHealth CommonHealth covered services are equivalent to MassHealth Standard (Medicaid benefit package) 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 include 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, orthotic 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.

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
Chapter 766: home assessment and participation in team meetings
Chiropractic services
Applied Behavior Analysis services

6.2 Covered services for Unborn Children

MassHealth provides coverage for "unborn children" in households with income up to 200% FPL whose mothers are not otherwise eligible for MassHealth Standard. Such unborn children are in MassHealth Standard and receive coverage that is the same as the Medicaid State Plan and the Massachusetts 1115 demonstration project for members in Standard. Benefits to unborn children are delivered through the same delivery and utilization control systems as those available to other Standard members under the 1115 waiver, except that unborn children are not eligible for Premium Assistance and are only eligible for direct coverage.

MassHealth uses a bundled payment methodology which pays for prenatal services, Labor and Delivery and one postpartum visit. The bundled payment is billed on the date

of birth of the baby so the postpartum visit is prepaid. If MassHealth is unable to use a bundled payment for any reason, the services are paid fee-for-service.

CHIP level FFP is available for all services provided during the pregnancy and for the bundled payment. 50% FFP under MassHealth Limited is available for emergency services provided during the postpartum period and no FFP is available for non-bundled non-emergency services provided during the postpartum period.

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))**

State Plan under title XXI of the Social Security Act
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Section 7. Quality and Appropriateness of Care

Guidance: **Methods for Evaluating and Monitoring Quality**- Methods to assure quality include the application of performance measures, quality standards consumer information strategies, and other quality improvement strategies.

Performance measurement strategies could include using measurements for external reporting either to the State or to consumers and for internal quality improvement purposes. They could be based on existing measurement sets that have undergone rigorous evaluation for their appropriateness (e.g., HEDIS). They may include the use of standardized member satisfaction surveys (e.g., CAHPS) to assess members' experience of care along key dimensions such as access, satisfaction, and system performance.

Quality standards are often used to assure the presence of structural and process measures that promote quality and could include such approaches as: the use of external and periodic review of health plans by groups such as the National Committee for Quality Assurance; the establishment of standards related to consumer protection and quality such as those developed by the National Association of Insurance Commissioners; and the formation of an advisory group to the State or plan to facilitate consumer and community participation in the plan.

Information strategies could include: the disclosure of information to beneficiaries about their benefits under the plan and their rights and responsibilities; the provision of comparative information to consumers on the performance of available health plans and providers; and consumer education strategies on how to access and effectively use health insurance coverage to maximize quality of care.

Quality improvement strategies should include the establishment of quantified quality improvement goals for the plan or the State and provider education. Other strategies include specific purchasing specifications, ongoing contract monitoring mechanisms, focus groups, etc.

Where States use managed care organizations to deliver CHIP care, recent legal changes require the State to use managed care quality standards and quality strategies similar to those used in Medicaid managed care.

Tools for Evaluating and Monitoring Quality- Tools and types of information available include, HEDIS (Health Employer Data Information Set) measures, CAHPS (Consumer Assessments of Health Plans Study) measures, vital statistics data, and

State health registries (e.g., immunization registries).

Quality monitoring may be done by external quality review organizations, or, if the State wishes, internally by a State board or agency independent of the State CHIP Agency. Establishing grievance measures is also an important aspect of monitoring.

☐ 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.

Guidance: The State must specify the qualifications of entities that will provide coverage and the conditions of participation. States should also define the quality standard they are using, for example, NCQA Standards or other professional standards. Any description of the information strategies used should be linked to Section 9. (Section 2102(a)(7)(A)) (42CFR, 457.495)

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. (Section 2102(a)(7)(A)) (42CFR 457.495(a))

MassHealth's MCO contract details the MCOs' qualifications and responsibilities. MassHealth's decision to contract with an MCO is largely based on that organization's ability to meet MassHealth-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. MassHealth'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 MassHealth 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

MassHealth currently coordinates quality assurance efforts through the following types of activities:

The Medicaid Director 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 MassHealth and identify and adopt quality improvement initiatives. In addition, MassHealth's Medical Director provides direction on all clinically-related quality initiatives, including;

- Regular meetings with sister agencies, conducted to develop interagency quality improvement projects in areas such as clinical practice and to share information; and

7.1.2. ☒ Performance measurement

7.1.2 (a) ☐ CHIPRA Quality Core Set
7.1.2 (b) ☐ Other

MCO Program

Each MCO must participate in regular (semi-annual) contract status meetings with MassHealth. 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 MassHealth with a written update, detailing progress toward meeting both MCO specific and standard Improvement Goals. MassHealth evaluates MCO performance on each goal and then produces an overall performance score for each MCO.

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

MassHealth conducts PCC Plan quality management and improvement activities by working collaboratively within PCC Plan functional areas and across other MassHealth programs and units. MassHealth 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

MassHealth 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 MassHealth 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 MassHealth.

HEDIS: on an annual basis, HEDIS data is collected by the PCC Plan and the MCO Program. MassHealth endorses a rotation of measures strategy whereby a subset of HEDIS measures is collected by each participating health plan. HEDIS behavioral health measures are included in the set of measures collected. The data is analyzed and the results used for quality improvements by MassHealth and the plans. A comprehensive HEDIS MassHealth Report, which includes plan-specific and MassHealth results, is produced each year.

Independent External Review: each year, MassHealth 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. MassHealth agrees to a focused consultant review in the following areas:

- Internal control and contract compliance;
- Prior year audit findings and corrective action plan;
- Claims administration;
- BHP financial reports and capitation rate payment reconciliation statement;
- Vendor's administrative functions and DSTRA activities;
- Vendor's contract performance standards; and,
- 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 MassHealth upon completion of the annual review.

7.1.3. ☒ Information strategies

MCO Program

In order to help MCOs meet the standard improvement goals, MassHealth conducts periodic workgroups related to each goal to assist the MCOs in developing strategies to attain the goals. Both MassHealth and MCO representatives participate in these workgroups. The workgroups maximize both MassHealth 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 Workgroup). 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 MassHealth contracts and other health care professionals. The Medical Directors' Workgroup advises and guides MassHealth and the PCC Plan on clinical and practice management issues that determine the quality of health care received by PCC Plan members.

MassHealth currently works with two contractors (MBHP and the Enrollment Broker) to provide member enrollment and education. In collaboration with MassHealth, MBHP 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 Enrollment Broker'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 MassHealth 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

MassHealth 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 MassHealth's quality improvement goals and are designed to ensure that MassHealth 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.

MassHealth uses this information to identify opportunities to improve compliance with the requirements in the contract and suggests improvement goals. MassHealth currently develops two 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 MassHealth and the MCO for noncapitated services.

(2) MCO-specific improvement goals. MassHealth negotiates the specific goal and measure language with each MCO based on the MCO's individual need for improvement.

MassHealth-sponsored workgroups

In order to help MCOs meet the standard improvement goals, MassHealth facilitates monthly workgroups related to each goal to assist the MCOs in developing strategies to attain the goals. Both MassHealth and MCO representatives participate in these workgroups. The workgroups maximize both MassHealth 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 Workgroup). 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 MassHealth. The primary purpose of these meetings is to review MCO progress towards the achievement of annual improvement goals. During this meeting, the MCO provides MassHealth with a written update, detailing progress toward meeting both MCO specific and standard improvement goals. MassHealth evaluates MCO performance on each goal annually; MassHealth produces an overall performance score for each MCO. This score includes the results of both the Quality Improvement goal process and the Contract Management 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
MassHealth 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. MassHealth'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 conducts educational sessions to share information. Outcomes are measured via project-specific clinical indicators gathered primarily from medical record review

Guidance: Provide a brief description of methods to be used to assure access to covered services, including a description of how the State will assure the quality and appropriateness of the care provided. The State should consider whether there are sufficient providers of care for the newly enrolled populations and whether there is reasonable access to care. (Section 2102(a)(7)(B))

7.2. Describe the methods used, including monitoring, to assure: (Section 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. MassHealth 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.

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))

MassHealth 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.

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

MassHealth currently has contracts with approximately 1,100 PCC practices, in the PCC Plan network. This network includes clinicians in various practice settings; individual physicians, group practices, community health canters, independent nurse practitioners, and hospital outpatient departments. The PCC Plan Provider Contract 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))

MassHealth has several methods in place to monitor and assure access to covered services, in addition to what is described above, MassHealth 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)) Exigent medical circumstances may require more rapid response according to the medical needs of the patient.

MassHealth assures that prior authorization of health services are completed in a timely manner and in accordance with State law. MassHealth takes into consideration the urgency of care in responding to prior authorization requests. Members may appeal any service denials to MassHealth's Board of Hearings

State Plan under title XXI of the Social Security Act
Children's Health Insurance Program
Commonwealth of Massachusetts

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 children under age one 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 and CommonHealth members is:

%FPL	Per child	Family maximum
150.1-200.0	$12	$36
200.1-250.0	$20	$60
250.1-300.0	$28	$84

For households with families enrolled in different coverage types, the family pays the highest of the premiums (rather than the sum of all the premiums).

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

8.2.2. Deductibles, Coinsurance or copayments:

Children under 19 years of age, including unborn children, are excluded from MassHealth copayment requirements.

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 MassHealth'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 300% FPL (before disregards). 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))**

Direct coverage
Premiums amounts never exceed 5% of family income. Copays are not required for children.

State Plan under title XXI of the Social Security Act
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Section 8. Cost Sharing and Payment (Section 2103 (e))

Premium assistance

As required by Title XXI, MassHealth will cover well-child care in full and set a family cap on the amount of total cost sharing for Title XXI children receiving premium assistance. MassHealth will cover cost sharing for well-baby and well-child care services by paying the provider or the family for any well-child or well-baby care co-payments and/or deductibles. Additionally, MassHealth 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, MassHealth 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-child care 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. MassHealth 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 MassHealth.

MassHealth will make every effort to generate manual payments directly to the providers. A 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, MassHealth 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 MassHealth will educate the provider community regarding the procedures for payment through bulletins and newsletters.

Consistent with MassHealth's policies, after MassHealth 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 MassHealth 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 MassHealth. 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 MassHealth for payment. MassHealth 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-child care bills to MassHealth for payment. Once MassHealth receives the bills for well-child care co-payments, payments will be generated to the provider or the member within one to two weeks.

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, MassHealth captures the self-declared ethnicity information provided on the MBRs and regularly runs a report identifying potential AI/AN. Then, those individuals are flagged by a manual process so that they will be excluded from cost-sharing.

Section 8.7 superseded by TN-014-006 MMDL

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 MassHealth 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.

8.8.4. ☒ **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))** Income and resource standards and methodologies for determining 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)**

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Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: States should consider aligning its strategic objectives with those discussed in Section II of the CHIP Annual Report.

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))

Guidance: Goals should be measurable, quantifiable and convey a target the State is working towards.

- Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children.
- Expand access to health coverage for low income uninsured children.
- Improve the efficiency of the eligibility determination process.
- Improve the health status and well-being of children enrolled in MassHealth direct coverage programs.
- 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))

Guidance: The State should include data sources to be used to assess each performance goal. In addition, check all appropriate measures from 9.3.1 to 9.3.8 that the State will be utilizing to measure performance, even if doing so duplicates what the State has already discussed in Section 9.

It is acceptable for the State to include performance measures for population subgroups chosen by the State for special emphasis, such as racial or ethnic minorities, particular high-risk or hard to reach populations, children with special needs, etc.

HEDIS (Health Employer Data and Information Set) 2008 contains performance measures relevant to children and adolescents younger than 19. In addition, HEDIS 3.0 contains measures for the general population, for which breakouts by children's age

bands (e.g., ages < 1, 1-9, 10-19) are required. Full definitions, explanations of data sources, and other important guidance on the use of HEDIS measures can be found in the HEDIS 2008 manual published by the National Committee on Quality Assurance. So that State HEDIS results are consistent and comparable with national and regional data, states should check the HEDIS 2008 manual for detailed definitions of each measure, including definitions of the numerator and denominator to be used. For states that do not plan to offer managed care plans, HEDIS measures may also be able to be adapted to organizations of care other than managed care.

- Develop programs to expand health coverage while maximizing employer-sponsored health insurance to low-income children.
  - Implement MassHealth Family Assistance Expansion for Children in SFY 2006.
- Expand access to health coverage for low-income children.
  - Reduce the number of uninsured children in the Commonwealth.
- Improve the efficiency of the eligibility determination process.
  - Develop a streamlined eligibility process by eliminating certain verifications.
  - Further enhance the fully automated eligibility determination system.
- 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.
- 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.
  - 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 (.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, 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 Expansion for Children in State Fiscal Year 2006.

MassHealth will measure the number of applicants with access to employer-sponsored health insurance that enrolled in their employer-sponsored health insurance plan. MassHealth will also measure the increase in children who are insured through employer-sponsored health insurance, and the reduction in the number of children in the free care pool.

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 enhancing matching activities.

Expand Virtual Gateway capabilities.

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.

MassHealth 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.
Automatically enroll all newly-eligible CMSP members eligible for MassHealth July-September 2006. Provide advance notice and information about new comprehensive benefits. Expedite enrollment into health plans.

MassHealth will measure the number of children who were enrolled in CMSP prior to July 1, 2006 to those who enroll with MassHealth after July 1, 2006.

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)

Guidance: The State should include an assurance of compliance with the annual reporting requirements, including an assessment of reducing the number of low-income uninsured children. The State should also discuss any annual activities to be undertaken that relate to assessment and evaluation of the program.

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)

MassHealth 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. MassHealth 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 coordinated 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 sections 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 MassHealth'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 MassHealth.

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)

Guidance: The State should verify that they will participate in the collection and evaluation of data as new measures are developed or existing measures are revised as deemed necessary by CMS, the states, advocates, and other interested parties.

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)

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

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(c)) (42CFR 457.120(a) and (b))

MassHealth 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 Massachusetts's Health Care Reform of 2006 included robust public exchange allowing various constituencies to voice their concerns.

To implement the 2006 changes MassHealth 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, Mass. Law Reform Legal Services, and other advocacy organizations;

- Health care providers such as: the Massachusetts Medical Society, the Massachusetts Hospital Association, and Primary Care Clinicians (PCCs) at various regional meetings;

- EOHHS's Child and Adolescent workgroup (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 Finance and Policy, the Executive Office of Health and Human Services, and the Executive Office of Administration and Finance.

Since implementing the CHIP program in August 1998, MassHealth has continued to involve the public in the program. MassHealth also holds a quarterly meeting of its Medical Care Advisory Committee to discuss pertinent issues regarding Medicaid and CHIP and hosts a monthly meeting of health care advocates. In addition, MassHealth continues to actively involve the provider community in the MassHealth program. For example, MassHealth is part of the Massachusetts Health Quality Partners, and meets as needed with the Massachusetts Medical Society and the Massachusetts Hospital Association. . MassHealth continues to sponsor and provide leadership for the Massachusetts Health Care Training Forum (MTF) program, which provides an opportunity to share information on MassHealth operations and policy changes and health care reform program and policy updates to health care organizations and community agencies that serve MassHealth members, the uninsured, and underinsured.

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. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

Mashpee Wampanoag Tribe: The MassHealth Director of Outreach and Education sent an email on 7/28/10 to the tribe's Health Director, MassHealth Insurance Coordinator and Outreach and Enrollment Specialist, suggesting a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Health Director, the Health and Human Services Liaison to the Tribal Council, the MassHealth Insurance Coordinator, and the Outreach and Enrollment Specialist, sent an email to the MassHealth Director of Outreach and Education on 8/2/10 confirming that the tribe agrees with this approach.

Wampanoag Tribe of Gay Head (Aquinnah): During a conference call on 9/15/10 with the Chairwoman and the Acting Health Director of the tribe, the MassHealth Director of Outreach and Education and the Member Education Clinical Coordinator suggested a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Chairwoman and the Acting Health Director confirmed on the call that they agreed with this approach.
During quarterly consultation calls on January 19, 2011, the representatives from the Mashpee Wampanoag Tribe, the Wampanoag Tribe of Gay Head (Aquinnah) and the Indian Health Programs confirmed that they considered any State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects to have a direct effect on Tribal members. The Commonwealth will therefore seek advice and feedback from the Tribes and Indian Health Program on all such changes to be submitted to CMS.

Native American Lifelines of Boston: During a conference call on 10/27/11 with the Acting Site Director, the MassHealth Director of Outreach and Education suggested a consultation policy consisting of quarterly meetings (both in-person and by conference call) with email contact between meetings as needed. The Acting Site Director confirmed on the call that he agreed with this approach.

During quarterly consultation calls on January 19, 2011, the representatives from the Mashpee Wampanoag Tribe, the Wampanoag Tribe of Gay Head (Aquinnah) and the Indian Health Programs confirmed that the Commonwealth will raise

issues identified as having a direct effect on the Tribes in the quarterly consultation calls or via email at least a month in advance of submission to CMS; and when notice is provided in calls or via email, the Tribes will have at least two weeks to respond with advice to the Commonwealth. For major initiatives the Commonwealth will notify the Tribes early in the process of development through the stakeholder processes associated with each initiative. These stakeholder processes ask stakeholders, including the Tribes, to give us their advice and feedback on the initiatives.

During the call on October 27, 2011 with Native American Lifelines of Boston, the Acting Site Director indicated he agreed with the approach and timeframes for consultation as described above.

In addition, MassHealth 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, MassHealth has a designated staff member in our Member Services Unit who deals with and is responsible for Indian and tribal issues.

MassHealth is also committed to consulting with the Tribes in Massachusetts to share its goals of increasing retention. MassHealth will solicit the Tribes' input on how to make their members aware of the Express Lane Renewal process. The Tribes will be provided with updates on Express Lane Renewal during quarterly conference calls. In addition, MassHealth will remain in full compliance with this State Plan Amendment by obtaining the Tribes' advice and responding to their concerns within the required timelines. MassHealth will work cooperatively with the Tribes on Express Lane Renewal.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

MassHealth provided talking points on applied behavior analysis (ABA) coverage to customer service staff, to Navigators and to advocates to help get notice out to parents that medically necessary ABA services were available to their children. MassHealth's managed care entities will begin coverage of ABA in October of 2015 and the plan materials will include information about ABA coverage.

9.10 Provide a 1-year projected budget.

A suggested financial form for the budget is below. 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 expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  - Total 1-year cost of adding prenatal coverage
  - Estimate of unborn children covered in year 1

Table 9-1 on page 11 provides projected CHIP expenditures for FFY 2012 The non-federal share of the funds is all state funds with one exception: The Commonwealth received a four year grant on February 17, 2009 from the Robert Wood Johnson (RWJ) Foundation to support MassHealth's increased enrollment and retention of children. The Commonwealth will use the RWJ grant as state matching funds. The state funds are appropriated annually from the Commonwealth's General Fund.

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CHIP Amendment #17	CHIP ABA	Cost Projections of Approved CHIP Plan	Total
	FFY2016	FFY 2016	FFY 2016
State's enhanced FMAP rate	88.00%	88.00%	88.00%
Benefit Costs			
Insurance payments	$421,060	$8,982,350	$9,403,409
Managed Care	$10,105,428	$284,042,058	$294,147,486
per member/per month rate @ # of eligible	$9	$338	$347
Fee for Service	$0	$207,276,783	$207,276,783
Total Benefit Costs	$10,526,488	$500,301,191	$510,827,679
(offsetting beneficiary cost sharing payments)	$0	$0	$0
Net Benefit Costs	$10,526,488	$500,301,191	$510,827,679
Administrative Costs			
Personnel	$0	$0	$0
General Administration	$0	$10,007,508	$10,007,508
Contractors/Brokers	$0	$0	$0
Claims Processing	$0	$0	$0
Outreach/marketing costs	$0	$0	$0
Other (H.S.I.)	$0	$43,000,000	$43,000,000
Total Administrative Costs	$0	$53,007,508	$53,007,508
10% Administrative Cap	$1,169,610	$55,589,021	$56,758,631
Federal Share	$9,263,309	$486,911,655	$496,174,965
State Share	$1,263,179	$66,397,044	$67,660,222
TOTAL COSTS OF APPROVED CHIP PLAN	$10,526,488	$553,308,699	$563,835,187

Note: MassHealth will not claim administrative costs for approved Health Service Initiative programs in excess of the 10% cap. The H.S.I. expenditures are direct services and the administrative costs directly related to provision of services.

As with all collections, MassHealth will reduce the expenditures by the amount collected for premiums by returning to CMS the FFP associated with the premiums for children in Family Assistance direct coverage.

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Section 10. Annual Reports and Evaluations

Guidance: The National Academy for State Health Policy (NASHP), CMS and the states developed framework for the annual report that states have the option to use to complete the required evaluation report. The framework recognizes the diversity in State approaches to implementing CHIP and provides consistency across states in the structure, content, and format of the evaluation report. Use of the framework and submission of this information will allow comparisons to be made between states and on a nationwide basis. The framework for the annual report can be obtained from NASHP's website at http://www.nashp.org. Per the title XXI statute at Section 2108(a), states must submit reports by January 1st to be compliant with requirements.

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 uninsured 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.

10.3-DC ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly current and accurate information on enrolled dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Please update Sections 6.2-DC and 9.10 when electing this option.

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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)

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Section 12. Applicant and Enrollee Protections (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.

12.1. Eligibility and Enrollment Matters- Describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Describe any special processes and procedures that are unique to the applicant's rights when the State is using the Express Lane option when determining eligibility.

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

Medicaid Expansion CHIP children and unborn-CHIP children eligible for MassHealth Standard are not subject to premiums and will not be charged premiums as a result of Express Lane Renewal. They will remain eligible in their current benefit category.

Guidance: "Health services matters" refers to grievances relating to the provision of health care.

12.2. Health Services Matters- Describe the review process for health services matters that comply with 42 CFR 457.1120.

MassHealth's review process for health service matters is consistent with standard Medicaid procedures

12.3. Premium Assistance Programs- If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, 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.

MassHealth assures that is 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