

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: 11-W-00030/1 and 21-00071/1
TITLE: MassHealth Medicaid and CHIP Section 1115 Demonstration
AWARDEE: Massachusetts Executive Office of Health and Human Services
(EOHHS)

Under the authority of Section 1115(a)(1) of the Social Security Act (“the Act”), the following waivers are granted to enable the Commonwealth of Massachusetts (referred to herein as the state, State, or Commonwealth) to operate the MassHealth Medicaid and CHIP Section 1115 Demonstration. These waivers are effective beginning October 1, 2022 through December 31, 2027 and are limited to the extent necessary to achieve the objectives below. These waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in the accompanying document. The following waivers are also applicable to Medicaid Expansion CHIP populations unless otherwise specified.

As discussed in the Centers for Medicare & Medicaid Services’ (CMS) approval letter, the Secretary of Health and Human Services has determined that the MassHealth Medicaid and CHIP Section 1115 Demonstration, including the granting of the waivers described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

Except as provided below with respect to expenditure authority, all requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived in this list, shall apply to the demonstration project for the period beginning October 1, 2022 through December 31, 2027.

1. Statewide Operation **Section 1902(a)(1)**

To enable Massachusetts to provide managed care plans or certain types of managed care plans, only in certain geographical areas of the Commonwealth.

To enable Massachusetts to provide health-related social needs (HRSN) services or certain types of HRSN services, only in certain geographical areas of the Commonwealth.

2. Comparability/Amount, Duration, and Scope **Sections 1902(a)(10)(B), 1902(a)(17)**

To enable Massachusetts to implement premiums and copayments that vary by eligibility group, income level and service, and delivery system as described in Attachment C.

To the extent necessary to enable the Commonwealth to provide benefits that vary from those specified in the State plan, as specified in Table 4, and which may not be available to any categorically needy individuals under the Medicaid state plan, or to any individuals in a statutory eligibility group.

To the extent necessary to enable the Commonwealth to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs identified through assessment, and/or their Medicaid delivery system.

3. Eligibility Procedures and Standards

**Section 1902(a)(10)(A),
Section 1902(a)(10)(C)(i)-(iii),
and Section 1902(a)(17)**

To enable Massachusetts to use streamlined eligibility procedures including simplified eligibility redeterminations for certain individuals who attest to no change in circumstances and streamlined redeterminations for children, parents, caretaker relatives, and childless adults.

4. Disproportionate Share Hospital (DSH)

**Section 1902(a)(13) insofar
as it incorporates
Section 1923**

To exempt Massachusetts from making DSH payments to hospitals which qualify as a Disproportionate Share Hospital in any fiscal year or part of a fiscal year in which Massachusetts is authorized to make provider payments from the Safety Net Care Pool (the amount of any DSH payments made during a partial fiscal year must be prorated if necessary so that DSH payments will not exceed the percentage of the DSH allotment corresponding to the percentage of the federal fiscal year for which payment of DSH payments is required).

5. Financial Responsibility/Deeming/Comparability

Section 1902(a)(17)

To enable Massachusetts to use family income and resources to determine an applicant's eligibility even if that income and resources are not actually made available to the applicant, and to enable Massachusetts to deem income from any member of the family unit (including any Medicaid-eligible member) for purposes of determining income.

To enable Massachusetts to use MAGI-like financial eligibility determination methodologies for disabled adults in determining eligibility for MassHealth Standard and CommonHealth.

To enable Massachusetts to treat the state veteran annuity as non-countable income in making any calculations related to the post-eligibility treatment of income (PETI) rules and other forms of cost sharing.

6. Freedom of Choice

Section 1902(a)(23)(A)

To enable Massachusetts to restrict freedom of choice of provider for individuals in the demonstration, including to require managed care enrollment for certain populations exempt from mandatory managed care under section 1932(a)(2). Freedom of choice of family planning provider will not be restricted.

To limit primary care clinician plan (PCC) plan and Primary Care Accountable Care Organization (PCACO) enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services, to limit enrollees who are clients of the Departments of Children

and Families or Youth Services and who do not choose a managed care option to the single PIHP for behavioral health services, requiring children with third party insurance to enroll into a single PIHP for behavioral health services; in addition to limiting the number of providers within any provider type as needed to support improved care integration for MassHealth enrollees, and to permit the state to limit the number of providers who provide Anti-Hemophilia Factor drugs.

To permit the state to mandate that Medicaid eligibles with access to student health plans enroll into the plan, to the extent that it is determined to be cost effective, as a condition of eligibility as outlined in section 4 and Table 9. No waiver of freedom of choice is authorized for family planning providers.

7. Payment for Care and Services

Section 1902(a)(30)(A)

To permit the state to pay providers using rates that vary from those set forth under the approved state plan to the extent that the payment varies based on shared savings or shared losses in an incentive arrangement.

To allow the Commonwealth to establish primary care services payment rates for Primary Care ACO-participating primary care providers on an individual or class basis without regard to the rates set forth in the approved state plan. Such primary care services payment rates may vary based on factors such as provider class or clinical practice tier, or on the health status or rating category of the beneficiary served. Payments will not be reconciled to cost or utilization, however, the state will ensure that any Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) that participate in the primary care payment program with a Primary Care ACO are paid an amount at least equal to what they would be paid under their applicable PPS rates.

8. Direct Provider Reimbursement

Section 1902(a)(32)

To enable Massachusetts to make premium assistance payments directly to individuals who are low-income employees, self-employed, or unemployed and eligible for continuation of coverage under federal law, in order to help those individuals access qualified employer-sponsored insurance (where available) or to purchase health insurance (including student health insurance) on their own, instead of to insurers, schools or employers providing the health insurance coverage.

9. Retroactive Eligibility

Section 1902(a)(34)

To enable the Commonwealth not to provide retroactive eligibility for up to 3 months prior to the date that the application for assistance is made and instead provide retroactive eligibility as outlined in Table 9. Effective no later than July 1, 2023, this waiver does not apply to Medicaid-eligible pregnant individuals or to children up to age 19, as defined in the Medicaid and CHIP state plans. Effective no later than January 1, 2026, individuals of any eligible income level are eligible for retroactive coverage up to the first day of the third month prior to the date of application, and this waiver authority ends for the demonstration.

10. Extended Eligibility

Section 1902(a)(52)

To enable Massachusetts to not require families receiving Transitional Medical Assistance to report the information required by section 1925(b)(2)(B) absent a significant change in circumstances (i.e., members who are deceased, voluntarily withdraw, or moves out of state), and to not consider enrollment in a demonstration-only eligibility category or CHIP (title XXI) eligibility category in determining eligibility for Transitional Medical Assistance.

11. Comparability and Provision of Medical Assistance & Reasonable Promptness

**Sections 1902(a)(10)(B),
1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the Commonwealth to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 15 of the STCs, and to allow the state to limit the number of beneficiaries receiving HRSN services subject to the HRSN cap described in STCs 19.13-19.14.

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: 11-W-00030/1 and 21-00071/1
TITLE: MassHealth Medicaid and CHIP Section 1115 Demonstration
AWARDEE: Massachusetts Executive Office of Health and Human Services
(EOHHS)

Under the authority of section 1115(a)(2) of the Social Security Act (“the Act”), expenditures made by the Commonwealth of Massachusetts (referred to herein as the state, State, or Commonwealth) for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 1, 2022 through December 31, 2027, unless otherwise specified, be regarded as expenditures under the state’s title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services’ (CMS) approval letter, the Secretary of Health and Human Services has determined that the MassHealth Medicaid and CHIP Section 1115 Demonstration, including the granting of the expenditure authorities described below, is likely to assist in promoting the objectives of title XIX and XXI of the Act.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable the Commonwealth to operate the above-identified section 1115(a) demonstration.

1. **CommonHealth Adults.** Expenditures for health care-related costs for:
 - a. Adults aged 19 through 64 who are totally and permanently disabled and not eligible for comprehensive coverage under the Massachusetts state plan.
 - b. Adults aged 65 and over who are not eligible for comprehensive coverage under the Massachusetts state plan, with disabilities that would meet the federal definition of “permanent and total disability” if these adults were under the age of 65.
2. **CommonHealth Children.** Expenditures for health care-related costs for children from birth through age 18 who are totally and permanently disabled with incomes greater than 150 percent of the Federal poverty level (FPL) and who are not eligible for comprehensive coverage under the Massachusetts state plans, or, for otherwise Title XXI eligible children, if the Title XXI allotment is exhausted.
3. **Family Assistance (e-Family Assistance and e-HIV/FA).** Expenditures for health care-related costs for the following individuals:
 - a. Individuals who would be eligible for the New Adult Group (MassHealth CarePlus) but for the income limit, are HIV-positive, are not institutionalized, with incomes above 133 through 200 percent of the FPL and are not otherwise eligible under the Massachusetts Medicaid state plan. These expenditures include expenditures for

health care services furnished during the 90-day period between the time an individual submits an application and the time that the individual provides to the Commonwealth proof of his or her HIV-positive health status.

- b. Non-disabled children with incomes above 150 through 300 percent of the FPL who are not otherwise eligible under the Massachusetts Medicaid state plan due to family income or the CHIP state plan due to having insurance at application, or if the CHIP allotment is exhausted.
4. **Breast and Cervical Cancer Demonstration Program (BCCDP).** Expenditures for health care-related costs for uninsured individuals under the age of 65 with breast or cervical cancer, who are not otherwise eligible under the Massachusetts state plan and have income above 133 percent but no higher than 250 percent of the FPL.
5. **TANF and EAEDC Recipients.** Expenditures for health care related costs for individuals receiving Temporary Assistance for Needy Families and Emergency Aid to Elders, Disabled and Children. Individuals in this eligibility group are eligible for MassHealth based on receipt of TANF and/or EAEDC benefits, not based on an income determination.
6. **End of Month Coverage.** End of Month Coverage for Members Determined Eligible for Subsidized Qualified Health Plan (QHP) Coverage through the Massachusetts Health Connector but not enrolled in a QHP. Expenditures for individuals who would otherwise lose MassHealth coverage because they are eligible for coverage in a QHP during the period.
7. **Provisional Coverage Beneficiaries.** Expenditures for MassHealth Coverage for individuals who self-attest to any eligibility factor, except disability, immigration and citizenship; provided that expenditures for MassHealth Coverage for individuals who self-attest to income not otherwise verified through data hubs are limited to the following populations:
 - a. Pregnant women with attested modified adjusted gross income (MAGI) at or below 200% of the FPL;
 - b. Adults 21 through 64 years of age who are HIV positive and have attested MAGI income at or below 200% FPL;
 - c. Individuals with breast and cervical cancer who are under 65 years of age and have attested MAGI income at or below 250% FPL; and
 - d. Children under age 21.
8. **Presumptively Eligible Beneficiaries.** Expenditures for individuals determined presumptively eligible for HIV-Family Assistance or the Breast and Cervical Cancer Treatment Program under the demonstration by qualified hospitals that elect to do so.
9. **Out-of-state Former Foster Care Youth.** Expenditures to extend eligibility for full Medicaid State Plan benefits (MassHealth Standard) to former foster care youth who are under age 26, were in foster care under the responsibility of a state other than Massachusetts or a Tribe in such a state when they turned 18 or a higher age at which the state's or Tribe's

foster care assistance ends, and were enrolled in Medicaid under that state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they aged out.

10. **Recipients of State Veteran Annuities.** Expenditures to extend eligibility for the populations of individuals specified below.
 - a. **Recipients of State Veteran Annuities.** Except as described in 10(b), expenditures to extend eligibility for MassHealth Standard, MassHealth CarePlus, MassHealth Family Assistance and MassHealth Limited benefits for individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income, provided that individuals described above are not otherwise eligible to receive comparable coverage on the state exchange.
 - b. Expenditures to extend eligibility for MassHealth Standard and CommonHealth benefits for disabled individuals who would be eligible for such benefits but for the receipt of a state veteran annuity or the inclusion of such annuity in the household income.
 - c. Expenditures to extend eligibility for individuals who would be eligible to enroll in PACE but for the receipt of a state veteran annuity or but for the inclusion of such annuity in the household income
11. **Continuous Eligibility.** Expenditures for health care related costs for individuals who have been determined eligible under groups specified in STC 4.10 for continued benefits during any periods within the continuous eligibility period when these individuals would otherwise lose coverage during an eligibility redetermination, except as noted in STC 4.10(b). Along with other populations, this authority includes providing continuous eligibility for certain individuals in the Adult Group.
 - a. For expenditures related to 1905(z)(2) expansion state individuals in the Adult Group who are eligible for continuous eligibility based on their release from a correctional institution, the state shall make a downward adjustment by claiming 2.6 percent of expenditures at the state's regular Federal Medical Assistance Percentage (FMAP) instead of at the 1905(z)(2) expansion state increased FMAP.
 - b. For expenditures related to 1905(z)(2) expansion state individuals in the Adult Group who are eligible for continuous eligibility because they are experiencing homelessness as defined in STC 4.10, no downward adjustment of the 1905(z)(2) expansion state increased FMAP will be required.
 - c. For expenditures related to 1905(z)(2) expansion state individuals in the Adult Group aged 19 and over who are eligible for continuous eligibility based on both MAGI and non-MAGI eligibility criteria, the state shall make a downward adjustment by claiming 2.6 percent of expenditures at the state's regular FMAP instead of at the 1905(z)(2) expansion state increased FMAP.

12. **Premium Assistance.** Expenditures for premium assistance payments to enable individuals enrolled in CommonHealth (Adults and Children) and Family Assistance to enroll in private health insurance in accordance with STC 8.13 and Table 9.
13. **Diversionsary Behavioral Health Services.** Expenditures for benefits specified in Table 5 to the extent not available under the Medicaid state plan.
14. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services and benefits specified in Table 6 to the extent not available under the Medicaid state plan, furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). Expenditures for benefits specified in Table 6 to the extent coverable under the Medicaid state plan that are delivered in non-IMD settings.
15. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED).** Expenditures for otherwise covered Medicaid services, including inpatient psychiatric hospital services, and benefits specified in STC 7.1 furnished to otherwise eligible individuals who are primarily receiving treatment for a serious mental illness (SMI) or serious emotional disturbance (SED) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). And expenditures for benefits specified in STC 7.1 to the extent coverable under the Medicaid state plan that are delivered in non-IMD settings.
16. **Full Medicaid Benefits for Presumptively Eligible Pregnant Individuals.** Expenditures to provide full MassHealth Standard plan benefits to presumptively eligible pregnant individuals (including Hospital Presumptive Eligibility) with incomes at or below 200 percent of the FPL.
17. **Medicare Cost Sharing Assistance.** Expenditures for monthly Medicare Part A and Part B premiums and for deductibles and coinsurance under Part A and Part B for MassHealth Standard members with incomes not more than the limits established under the state plan for Medicare Savings Programs, and for monthly Medicare Part B premiums, including through the Qualifying Individual program, for MassHealth Standard members with incomes less than those established under the state plan for Medicare Savings Programs, who are also eligible for Medicare.

Effective through June 30, 2026, expenditures to cover the costs of monthly Medicare Part B premiums for CommonHealth members who are also eligible for Medicare with gross income up to 135 percent FPL .
18. **Enhanced Case Management Payment.** Expenditures for the Commonwealth to directly pay providers participating in either the PCC Plan or a Primary Care ACO an additional case management fee, which does not duplicate payment the PCC Plan or Primary Care ACO makes to the providers.

19. **PCCM Entities.** Expenditures for shared savings payments to participating Primary Care ACOs that include risk-based (upside and downside) payments to these Primary Care ACOs, and that may allow or require the Primary Care ACOs to distribute some portion of shared savings to or collect shared losses from select direct service providers, that are outside of the ranges for Integrated Care Models (ICMs) provisions and/or are not otherwise authorized under 42 CFR §438.
 - a. **Primary Care Payment.** Expenditures for primary care payments to Primary Care ACOs. These payments will be prospective PMPM rates that vary from state plan rates, set using actuarial principles, and will not be reconciled to cost or utilization.
20. **Safety Net Care Pool (SNCP).** Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.
 - a. **DSRIP and Related Initiatives.** Expenditures for incentive payments and state infrastructure payments for the DSRIP program specified in Section 12 of the STCs, and for flexible services provided to Primary Care ACO, Accountable Care Partnership Plan, and MCO-contracted ACO enrolled beneficiaries, to the extent not otherwise available under the Medicaid state plan, under other state or federal programs, or under this demonstration. The only expenditures permitted after April 1, 2023, are incentive payments for prior periods of performance and administrative activities to close out the DSRIP program.
 - b. **Public Hospital Transformation and Incentive Initiatives (PHTII).** Expenditure authority for close-out activities of the Public Hospital Transformation and Incentive Initiatives program from previous demonstration period that ended June 30, 2022, for up to two years following the conclusion of the demonstration.
 - c. **Disproportionate Share Hospital-like (DSH-like) Pool.** As described in Attachment E, limited to the extent set forth under the SNCP limits, expenditures for payments to providers, including: acute hospitals and health systems, non- acute hospitals, and other providers of medical services to support uncompensated care for Medicaid eligible individuals (Medicaid shortfall), and low-income uninsured individuals, in accordance with the Massachusetts' Uncompensated Cost Limit Protocol approved December 17, 2013 (including any subsequent amendments), and expenditures for payments for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD). Expenditure authority to make Safety Net Provider Payments tied to contractual withholds to providers, per STC 11.2(b), for up to two years following the conclusion of the demonstration. Expenditure authority for close-out activities for Safety Net Provider payments associated with the previous demonstration period.
 - d. **Uncompensated Care Pool.** As described in Attachment E, expenditures for supplemental payments to hospitals to reflect uncompensated charity care costs beyond the expenditure limits of the DSH Pool. Specifically, expenditures for additional Health Safety Net payments to hospitals that reflect care provided to certain low-income, uninsured patients; and Department of Public Health (DPH) and

Department of Mental Health (DMH) hospital expenditures for care provided to uninsured patients. This expenditure authority does not entitle low-income or uninsured individuals to coverage under the demonstration.

21. **Marketplace Subsidies.** Expenditures for the payments made through the Commonwealth's state-operated program to:
 - a. Provide premium subsidies for individuals with incomes at or below 500 percent of the FPL who purchase health insurance through the Massachusetts Health Insurance Connector Authority (Health Connector). Subsidies will be provided on behalf of individuals who: (A) are not Medicaid eligible; and (B) whose income, as determined by the state, is at or below 500 percent of the FPL. The income ceiling for eligibility may be reduced to a threshold no lower than 300 percent of the FPL subject to the terms in STC 10.1.
 - b. Provide cost-sharing subsidies for individuals who purchase health insurance through the Health Connector. Subsidies will be provided on behalf of individuals who: (A) are not Medicaid eligible; and (B) whose income, as determined by the Health Connector, is at or below 500 percent of the FPL. The income ceiling for eligibility may be reduced to a threshold no lower than 300 percent of the FPL subject to the terms in STC 10.1.
 - c. **Health Connector Gap Coverage.** Expenditures for individuals as defined in STC 10.1 who are determined eligible QHP coverage, for up to 100 days while they select, pay and enroll into a health plan.
22. **Health- Related Social Needs (HRSN) Services.** Expenditures for health-related social needs services not otherwise covered furnished to individuals who meet the qualifying criteria as described in Section 15 of the STCs. This authority is contingent upon adherence to the requirements within Section 21 of the STC, as well as all other applicable STCs.
 - a. Time-limited authority for the Commonwealth to continue providing Flexible Services under its existing Flexible Services program without adherence to the delivery system expectations within Section 15, STC 15.7 through 15.9, as well as 15.15(b), of the STC for both managed care and, if applicable, fee-for-service delivery systems, until January 1, 2025, as described in STC 15.7. Delivery of Flexible Services must fully comply with Section 15 of the STCs and applicable regulations for managed care and, if applicable, fee-for-service delivery systems no later than January 1, 2025.
23. **Expenditures for HRSN Services Infrastructure.** Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized in Section 15 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 21 of the STCs, as well as all other applicable STCs.

24. **Workforce Initiatives.** Expenditures for behavioral health student loan repayment, primary care provider student loan repayment and family nurse practitioner residency programs that meet the criteria as specified in Section 13 of the STCs.
- a. Time limited expenditure authority is granted until four years following the conclusion of the Workforce Initiatives, in order for the Commonwealth to pay close-out administrative costs of operating the program and monitoring service commitments.
25. **Hospital Quality and Equity Initiative.** Expenditures for incentive payments to participating private acute hospitals and the Cambridge Health Alliance for meeting data collection requirements, reporting expectations, and demonstrating improvement in health care quality and equity, as specified in the STCs.
- a. Time limited expenditure authority is granted until two years following the conclusion of the approval period for the Hospital Quality and Equity Initiative, in order for the Commonwealth to pay close-out costs of operating the program, and incentive payments associated with periods of performance within the approval period for the Hospital Quality and Equity Initiative.

This expenditure authority does not entitle uninsured individuals to any benefits under the demonstration. This expenditure authority is contingent upon adherence to the requirements of Section 21 of the STCs.

26. **Community Partner Enhanced Care Coordination Funding.** Expenditures for payments to Long Term Services and Supports (LTSS) Community Partners (CPs) (paid directly by the state) to support LTSS CPs' enhanced care coordination responsibilities, as specified in STC 8.8(a).
27. **Streamlined Redeterminations for Adult Populations.** Expenditures for parents, caretaker relatives, and childless adults who would not be eligible under either the state plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.
28. **Streamlined Redeterminations for Children's Population.** Expenditures for children who would not be eligible under the Title XIX state plan, Title XXI state child health plan or other full-benefit demonstration populations, but for Streamlined Redeterminations.

All requirements of the Medicaid program expressed in law, regulation, and policy statements that are explicitly waived under the Waiver List herein shall similarly not apply to any other expenditures made by the state pursuant to its Expenditure Authority hereunder. In addition, none of the Medicaid program requirements as listed and described below shall apply to such other expenditures. All other requirements of the Medicaid program expressed in law, regulation, and policy statements shall apply to such other expenditures.

29. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid beneficiaries if not for their

incarceration status for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail or house of correction, or youth correctional facility.

30. **Expenditures for Pre-Release Administrative Costs.** Capped expenditures for payments for allowable administrative costs, services, supports, transitional non-service expenditures, infrastructure and interventions, which may not be recognized as medical assistance under Section 1905(a) or may not otherwise be reimbursable under Section 1903, to the extent such activities are authorized as part of the Reentry initiative.
31. **Designated State Health Programs (DSHP).** Expenditures for designated state health programs, described in these STCs (Section 23), which are otherwise state-funded, and not otherwise eligible for Medicaid payment. These expenditures are subject to the terms and limitations and not to exceed specified amounts as set forth in these STCs. This authority is contingent upon adherence to the requirements within Section 21 of the STC, as well as all other applicable STCs.

Medicaid Requirements Not Applicable to the Medicaid Expenditure Authority for Pre-Release Services

32. **Statewideness** **Section 1902(a)(1)**

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying beneficiaries on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

33. **Amount, Duration, and Scope of Services and Comparability** **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying beneficiaries that is different than the services available to all other beneficiaries outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration.

34. **Freedom of Choice** **Section 1902(a)(23)(A)**

To enable the state to require qualifying beneficiaries to receive pre-release services, as authorized under this demonstration, through only certain providers.

The Following Title XIX Requirements Do Not Apply to These Expenditure Authorities

35. **Premiums and Cost Sharing** **Section 1902(a)(14) insofar as it incorporates Section 1916 and 1916A**

To enable Massachusetts to impose premiums and cost-sharing in excess of statutory limits on individuals enrolled in the CommonHealth and Breast and Cervical Cancer Treatment programs.

36. Financial Responsibility/Deeming **Section 1902(a)(17)**

To enable Massachusetts to treat the state veteran annuity as non-countable income in making any calculations related to the post-eligibility treatment of income (PETI) rules.

37. Comparability/Amount, Duration, and Scope **Section 1902(a)(17)**

To enable Massachusetts to treat the state veteran annuity as non-countable income in making any calculations related to the post-eligibility treatment of income (PETI) rules and for any cost sharing calculations.

Effective no later than July 1, 2023, to enable Massachusetts to not apply a paid employment hours restriction to CommonHealth enrollees that have been enrolled in the program for at least 10 years.

38. Statewide Operation **Section 1902(a)(1)**

To the extent necessary to enable Massachusetts to provide health-related social needs (HRSN) services or certain types of HRSN services, only in certain geographical areas of the Commonwealth.

39. Comparability; Amount, Duration, and Scope **Section 1902(a)(10)(B),
Section 1902(a)(17)**

To the extent necessary to enable the Commonwealth to provide a varying amount, duration, and scope of HRSN services to a subset of beneficiaries, depending on beneficiary needs.

40. Comparability and Provision of Medical Assistance & Reasonable Promptness
**Sections 1902(a)(10)(B),
1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the Commonwealth to offer HRSN services to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 15 of the STCs.

To the extent necessary to allow the Commonwealth to delay the application review process for HRSN services in the event the Commonwealth does not have sufficient funding to support providing these services to eligible beneficiaries.

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance Coverage:

41. Early and Periodic Screening, Diagnostic and Treatment Services **Section 1902(a)(43)**

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) does not apply to individuals eligible for the Family Assistance program.

42. **Assurance of Transportation**

Section 1902(a)(4)

To enable Massachusetts to provide benefit packages to individuals enrolled in the Family Assistance demonstration programs that do not include transportation.

43. **Mandatory Services**

**Section 1902(a)(10)(A)
insofar as it incorporates
Section 1905(a)**

To exempt the state from providing all mandatory services to individuals enrolled in the Family Assistance demonstration programs.

The Following Title XIX Requirements Do Not Apply to Expenditures for Medicare Cost Sharing Assistance:

44. **Resource Limits**

Section 1902(a)(10)(E)

To enable Massachusetts to disregard all resources in determining eligibility for Medicare cost sharing assistance.

To enable Massachusetts to make monthly premium assistance payments for individuals who would otherwise not be eligible as Qualifying Individuals due to Medicaid State Plan eligibility.

No Title XIX Requirements are Applicable to Expenditures for the Safety Net Care Pool and Marketplace Subsidies.

The Following Title XIX Requirements are not Applicable to Expenditures for the CommonHealth program.

45. **Income Disregards under Section 1902(r)(2)(A)**

To enable Massachusetts to not apply financial eligibility determination methodologies required under section 1902(r)(2)(A) for CommonHealth adults eligible under expenditure authority #1.

Title XXI Expenditure Authorities

All requirements of the Children's Health Insurance Program (CHIP) shall apply to the demonstration populations and expenditures listed below, except those identified below as "not applicable." All CHIP rules not expressly waived or identified as not applicable in this document shall apply to the demonstration. These expenditure and "non-applicable" authorities, as well as the associated Special Terms and Conditions (STCs), are in effect as of October 1, 2022, through December 31, 2027, except where otherwise noted in these expenditure authorities.

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Massachusetts for the items identified below (which are not otherwise included as

expenditures under section 2107(e)(2)(A)) shall, for the period of this demonstration in accordance with the STCs, be regarded as matchable expenditures under Massachusetts' title XXI state plan:

46. **Continuous Eligibility.** Expenditures for health care related costs for individuals who have been determined eligible under groups specified in Table 1 of STC 4.10 for continued benefits during any periods within the continuous eligibility period when these individuals would be found ineligible if subject to redetermination in accordance with section 2102(b)(2) of the Act (regarding continuous eligibility). Along with other populations, this authority includes providing continuous eligibility for certain targeted low-income children enrolled in CHIP.
 - a. For expenditures related to 2110(b)(1) targeted low-income children who are eligible for continuous eligibility based on their release from a correctional institution.
 - b. For expenditures related to 2110(b)(1) targeted low-income children who are eligible for continuous eligibility because they are experiencing homelessness as defined in STC 4.10(b).
47. **Expenditures Related to Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying demonstration beneficiaries who would be eligible for the CHIP if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.