DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

SEP 3 0 2010

Dr. Judy Ann Bigby, M.D.
Secretary
Massachusetts Executive Office of Health and Human Services
1 Ashburton Place, Room 1109
Boston, MA 02108

Dear Dr. Bigby:

We are pleased to inform you that certain elements of the Massachusetts demonstration amendment have been approved. The MassHealth demonstration continues as project #11-W-00030/1 through June 30, 2011. Upon this date, unless reauthorized, all waiver and expenditure authorities granted to operate this demonstration will expire. This approval is under the authority of section 1115(a) of the Social Security Act.

The State may deviate from Medicaid State plan requirements to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as inapplicable to expenditures for demonstration expansion populations and other services not covered under the State plan.

The approval is also conditioned upon continued compliance with the enclosed Special Terms and Conditions (STCs), defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs, waiver and expenditure authorities within 30 days of the date of this letter.

On March 1, 2010, the Commonwealth submitted a comprehensive request to amend its section 1115 demonstration. The Centers for Medicare & Medicaid Services (CMS) is able to approve the following amendments at this time:

1. An increase in the MassHealth pharmacy co-payments from $2 to $3 for generic prescription drugs.
2. Relief Payments to Cambridge Health Alliance (CHA) totaling approximately $216 million.
3. Relief Payments totaling approximately $270 million for private acute hospitals in the Commonwealth.

The approval of this Demonstration amendment does not include the other elements of the Commonwealth's proposal to 1) restore authorization for Designated State Health Programs to 2007 – 2009 levels; 2) increase authorization for expenses at Department of Public Health and Department of Mental Health facilities; 3) increase the safety net care pool cap; or, 4) authorize infrastructure payments. However, CMS is committed to working with the Commonwealth to resolve these outstanding items in an expeditious manner.

Your project officer is Ms. Julie Sharp. Ms. Sharp is available to answer any questions concerning this renewal of your section 1115 demonstration. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2292
Facsimile: (410) 786-5882
E-mail: Juliana.Sharp@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Sharp and to Mr. Richard McGreal, Associate Regional Administrator in our Boston Regional Office. Mr. McGreal's address is:

Centers for Medicare & Medicaid Services
JFK Federal Building
Rm 2275
Boston, MA 02203-0003

If you have additional questions, please contact Ms. VictoriaWachino, Director, Family and Children's Health Programs Group, Center for Medicaid, CHIP and Survey & Certification at (410) 786-5647. We look forward to continuing to work with you and your staff.

Sincerely,

Cindy Mann
Director

Cc:
Mr. Richard McGreal, ARA Boston Regional Office

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBER: **11-W-00030/1**

TITLE: **MassHealth Medicaid Section 1115 Demonstration**

AWARDEE: **Massachusetts Executive Office of Health and Human Services (EOHHS)**

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 beginning December 19, 2008 through June 30, 2011. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable Massachusetts to carry out the MassHealth Medicaid Section 1115 Demonstration.

1. **Amount, Duration, and Scope** — **Section 1902(a)(10)(B)**

   To enable the Commonwealth to provide benefits specified in Table B of Section VI, paragraph 41 of the STCs, which are not available to individuals under the Medicaid State plan.

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

2. **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 determining eligibility based on gross income levels.

3. **Disproportionate Share Hospital (DSH) Requirements** — **Section 1902(a)(13) insofar as it incorporates Section 1923**

   To exempt Massachusetts from making DSH payments to hospitals which qualify as a DSH.

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

To exempt Massachusetts from the eligibility standards and requirements in title XIX. Specifically, the Commonwealth may 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.

To enable Massachusetts to deem income from any member of the family unit (including any Medicaid-eligible member) for purposes of determining income.

5. **Freedom of Choice** **Section 1902(a)(23)**

To enable the Commonwealth to restrict freedom of choice of provider for individuals in the demonstration, including, but not limited to, requiring managed care enrollment for certain populations exempt from mandatory managed care under section 1932(a)(2); limiting primary care clinician (PCC) plan enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services; limiting enrollees who are clients of the Department of Children and Families and children with third-party insurance to a single contracted managed care entity, and limiting the number of providers who provide Anti-Hemophilia Factor drugs.

6. **Reimbursement** **Section 1902(a)(32)**

To enable Massachusetts to implement premium assistance for individuals enrolled in the Demonstration by making payments for health care-related services through direct subsidies or reimbursement:

a) to those 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 on their own; or
b) to insurers for the benefit of those individuals identified in subparagraph (a).

7. **Retroactive Eligibility** **Section 1902(a)(34)**

To enable the State to exclude individuals in the demonstration from being eligible for up to 3 months prior to the date that the application for assistance is made.

8. **Extended Eligibility** **Section 1902(a)(52)**

To enable the Commonwealth to provide up to a full year of continued State plan eligibility for individuals in the Demonstration receiving Transitional Medical Assistance when income from earnings or child support payments during that 1-year period would otherwise discontinue the individuals' eligibility.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00030/1**

TITLE: **MassHealth Medicaid Section 1115 Demonstration**

AWARDEE: **Massachusetts Executive Office of Health and Human Services**

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 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable Massachusetts to operate its MassHealth section 1115 Medicaid Demonstration.

I. Demonstration Population Expenditures

1. **Premium Assistance.** Expenditures for premium assistance payments to enable individuals enrolled in the following coverage types to enroll in employer-sponsored or other group health insurance to the extent the Commonwealth determines that insurance to be cost effective:

    a. Common Health;

    b. Family Assistance;

    c. Basic; and

    d. Essential.

2. **CommonHealth Adults**. Expenditures for health care-related costs for adults aged 19 through 64 who are totally and permanently disabled and not eligible for Standard coverage, but who are:

    a. Employed; or

    b. Not employed and meet a one-time only deductible.

3. **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 Standard coverage.

4. **Family Assistance [e-Family Assistance and e-HIV/FA]**. Expenditures for health care-related costs for the following individuals with incomes at or below 200 percent of the FPL:

    a. Individuals who are HIV-positive, if they are age 64 or younger, are not institutionalized, and are not otherwise eligible under the Massachusetts State Plan. These expenditures include the 60-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 who are not otherwise eligible under the Massachusetts State Plan due to family income.

5. **Breast and Cervical Cancer Treatment Program [BCCTP]**. Expenditures for health care-related costs for uninsured women under the age of 65 with breast or cervical cancer, who are not otherwise eligible under the Massachusetts State Plan, have income at or below 250 percent of the FPL, and have been screened through the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program administered by the Massachusetts' Department of Public Health.

6. **Insurance Partnership [IRP]**. Expenditures to provide subsidies for the cost of employer-sponsored insurance (ESI) for persons under the age of 65 as follows:

    a. **Employee Subsidy**. Expenditures for a portion of the employee cost for an ESI plan which meets the basic benefit levels and where the employer contributes at least 50 percent of the cost of health insurance benefits, for individuals (including employees, sole proprietors, and self-employed persons) whose gross family income is no more than 300 percent of the FPL.

    b. **Employer Subsidy**. Expenditures for a portion of employer costs of qualified new employer-provided health insurance (insurance not offered prior to January 1, 1999) except that such subsidies are not authorized for sole proprietors and self-employed individuals.

7. **Basic.** Expenditures for health-care related costs for long-term unemployed childless adults ages 19 through 64 with income at or below 100 percent of the FPL who are receiving Emergency Aid to Elders, Disabled, and Children or services from the Department of Mental Health.

8. **Essential.** Expenditures for health-care related costs for long-term unemployed childless adults ages 19 through 64 with income at or below 100 percent of the FPL who are not eligible for Basic coverage.

9. **Medical Security Plan.** Expenditures for health-care related costs for individuals with incomes at or below 400 percent of the FPL receiving unemployment benefits from the Division of Unemployment Assistance.

10. **Commonwealth Care**. Expenditures for premium assistance for the purchase of commercial health insurance products for uninsured individuals with income at or below 300 percent of the FPL who are not otherwise eligible under the Massachusetts State plan or any other eligibility category.

II. Medicaid Eligibility Quality Control. Expenditures that would have been disallowed under section 1903(u) of the Act based on Medicaid Eligibility Quality Control findings.

III. Safety Net Care Pool. The Commonwealth is authorized to claim Federal reimbursement under the SNCP for the following categories of payments and expenditures.

a) Commonwealth Care. The Commonwealth may claim Federal reimbursement under the SNCP for premium assistance under the Commonwealth Care health insurance program, as specified in paragraph I.10 above.

b) Designated State Health Programs (DSHP). The Commonwealth may claim Federal reimbursement under the SNCP for DSHP, which are otherwise state-funded programs that provide health services, as specified in Attachment E of the Special Terms and Conditions.

c) Providers. As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the Demonstration to the extent permitted under the SNCP limits under STC 46, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, Medicaid managed care, Commonwealth Care, and low-income uninsured individuals. The Commonwealth may also claim as an allowable expenditure payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).

d) Infrastructure and capacity-building. The Commonwealth may claim Federal reimbursement under the SNCP for expenditures that support the improvement or continuation of health care services that benefit the uninsured, underinsured, and SNCP populations, such as capacity-building and infrastructure. The Commonwealth may expend an amount equal to no more than ten percent of the aggregate SNCP cap over the SNCP extension period for infrastructure and capacity-building.

IV. Diversionary Behavioral Health Services. Expenditures for benefits specified in Table B of Section VI, paragraph 41 of the Special Terms and Conditions to the extent not available in the Medicaid State plan that are provided to the following Demonstration populations:

a. Enrollees in a managed care organization (MCO) (for which the MCO will provide the services);
b. Enrollees in the Primary Care Clinician (PCC) plan (for which the services will be provided by the behavioral health contractor);

c. Children under the supervision of the Department of Children and Families (DCF) or the Department of Youth Services, and children with third party insurance, even if those children are not otherwise enrolled in an MCO or PCC Plan (for which the services will be provided by the behavioral health contractor); and
d. Adolescents who age out of DCF care or custody, even if those children are not otherwise enrolled in an MCO or PCC plan (for which the services will be provided by the behavioral health contractor).

All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable in the lists below, shall apply to expenditures authorized herein.

The Following Title XIX Requirements Do Not Apply to Any Expenditures Authorized Herein.

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 determining eligibility based on gross income levels.

Amount, Duration, and Scope of Services — **Section 1902(a)(10)(B)**

To enable Massachusetts to provide different benefit packages to individuals enrolled in these demonstration programs.

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

Cost Sharing — **Section 1902(a)(14) insofar as it incorporates Section 1916**

To enable Massachusetts to impose premiums and cost-sharing in excess of statutory limits.

Out-of-State Services — **Section 1902(a)(16)**

To exempt the State from making payments for otherwise covered services rendered to individuals enrolled in these demonstration programs when such benefits are rendered out-of-State.

Financial Responsibility/Deeming — **Section 1902(a)(17)**

To exempt Massachusetts from the eligibility standards and requirements in title XIX. Specifically, the Commonwealth may 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.

To enable Massachusetts to deem income from any member of the family unit (including any Medicaid-eligible member) for purposes of determining income.

Freedom of Choice **Section 1902(a)(23)**

To enable Massachusetts to restrict freedom of choice of provider for individuals in the demonstration, including but not limited to requiring managed care enrollment for certain populations exempt from mandatory managed care under section 1932(a)(2); limiting primary care clinician (PCC) plan enrollees to a single Prepaid Insurance Health Plan (PIHP) for behavioral health services; limiting enrollees who are clients of the Department of Children and Families and children with third-party insurance to a single contracted managed care entity and limiting the number of providers who provide Anti-Hemophilia Factor drugs.

Reimbursement **Section 1902(a)(32)**

To enable Massachusetts to implement premium assistance for individuals enrolled in these demonstration programs by making payments for health care-related services through direct subsidies or reimbursement:

a) to those 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 on their own; or

b) to insurers for the benefit of those individuals identified in subparagraph (a).

Retroactive Eligibility **Section 1902(a)(34)**

To enable Massachusetts to exclude individuals enrolled in these demonstration programs from being eligible for up to 3 months prior to the date that an application for assistance is made.

Extended Eligibility **Section 1902(a)(52)**

To enable Massachusetts to exclude individuals from extended eligibility.

Disproportionate Share Hospital (DSH) Requirements **Section 1902(a)(13) insofar as it incorporates Section 1923**

To exempt Massachusetts from making DSH payments to hospitals which qualify as a DSH.

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance, IRP, Basic, and Essential, the Medical Security Plan and the Safety Net Care pool, including Commonwealth Care

Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) — **Section 1902(a)(43)**

To exempt Massachusetts from furnishing or arranging for EPSDT services for individuals enrolled in these demonstration programs.

Assurance of Transportation — **Section 1902(a)(4) insofar as it incorporates 42 CFR 431.53**

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

In Addition to the Above, the Following Title XIX Requirements Do Not Apply to Expenditures for Family Assistance, IRP, Basic, and Essential (non-hypothetical[1] Essential population), the Medical Security Plan and the Safety Net Care pool, including Commonwealth Care (non-hypotheticals Commonwealth Care population).

Reasonable Promptness — **Sections 1902(a)(3) and 1902(a)(8)**

To enable Massachusetts to cap enrollment and maintain waiting lists for these demonstration programs.

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 these demonstration programs.

In Addition to the Above, No Title XIX Requirements are Applicable to Expenditures for the Medical Security Plan, as described in 430 CMR 7.0 et seq., and the Safety Net Care Pool including Commonwealth Care, as described in 956 CMR 2.0 et seq. and 956 CMR 3.0 et seq., except the Following.

Actuarial Soundness — **42 U.S.C. 438.6(c)**

To enable Massachusetts to require Commonwealth Care providers to be subject to actuarially sound rates.

[1] See section IV, Eligibility and Enrollment, for an eligibility chart describing hypothetical populations.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00030/1**

TITLE: **MassHealth Medicaid Section 1115 Demonstration**

AWARDEE: **Massachusetts Executive Office of Health and Human Services (EOHHS)**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for the Massachusetts MassHealth section 1115(a) Medicaid demonstration (hereinafter "Demonstration"). The parties to this agreement are the Massachusetts Executive Office of Health and Human Services (State/Commonwealth) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the Commonwealth's obligations to CMS during the life of the Demonstration. The STCs are effective September 30, 2010, unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below for the State's expenditures relating to dates of service during this Demonstration extension. This Demonstration extension is approved through June 30, 2011.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility and Enrollment; Delivery System; Demonstration Programs and Benefits; Cost Sharing; The Safety Net Care Pool (SNCP); General Reporting Requirements; General Financial Requirements; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of State Deliverables for the Demonstration Extension Period. Additionally, 5 attachments are incorporated by reference in the STCs.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The MassHealth Demonstration is a statewide health reform effort encompassing multiple delivery systems, eligibility pathways, program types and benefit levels. The Demonstration was initially implemented in July 1997, and expanded Medicaid income eligibility for certain categorically eligible populations including pregnant women, parents or adult caretakers, infants, children and individuals with disabilities. Eligibility was also expanded to certain non-categorically eligible populations, including unemployed adults and non-disabled persons with HIV disease. Finally, the Demonstration also authorized the Insurance Partnership program which provides premium subsidies to both qualifying small employers and their low-income employees for the purchase of private health insurance. The Commonwealth was able to support these expansions by requiring certain beneficiaries to enroll in managed care delivery systems to generate savings. However, the Commonwealth's preferred mechanism for achieving coverage

has consistently been employer-sponsored insurance, whenever available and cost-effective.

The implementation of mandatory managed care enrollment under MassHealth changed the way health care was delivered resulting in a new focus on primary care, rather than institutional care. In order to aid this transition to managed care, the Demonstration authorized financial support in the form of supplemental payments for two managed care organizations (MCOs) operated by safety net hospital providers in the Commonwealth to ensure continued access to care for Medicaid enrollees. These payments ended in 2006.

In the 2005 extension of the Demonstration, CMS and the Commonwealth agreed to use Federal and State Medicaid dollars to further expand coverage directly to the uninsured, funded in part by redirecting certain public funds that were dedicated to institutional reimbursement for uncompensated care to coverage programs under an insurance-based model. This agreement led to the creation of the Safety Net Care Pool (SNCP). This restructuring laid the groundwork for health care reform in Massachusetts, because the SNCP allowed the Commonwealth to develop innovative Medicaid reform efforts by supporting a new insurance program.

Massachusetts' health care reform legislation passed in April 2006. On July 26, 2006 CMS approved an amendment to the MassHealth Demonstration to incorporate those health reform changes. This amendment included:

- the authority to establish the Commonwealth Care program under the SNCP to provide sliding scale premium subsidies for the purchase of commercial health plan coverage for uninsured persons at or below 300 percent of FPL;
- the development of payment methodologies for approved expenditures from the SNCP;
- an expansion of employee income eligibility to 300 percent of FPL under the Insurance Partnership; and
- increased enrollment caps for MassHealth Essential and the HIV/Family Assistance Program.

At this time there was also an eligibility expansion in the Commonwealth's separate title XXI program for optional targeted low-income children between 200 percent and 300 percent FPL, which enabled parallel coverage for children in households where adults are covered by Commonwealth Care. This expansion ensured that coverage is equally available to all members of low-income families. With the combination of previous expansions and the recent health reform efforts, MassHealth now covers more than 1 million low-income persons.

For this extension period, the Commonwealth's goals under the Demonstration continue to be:

- Achieving near-universal health care coverage for all citizens of the Commonwealth
- Continuing the redirection of spending from uncompensated care to insurance coverage
- Demonstrating successful cost-containment by reducing the rate of spending growth in the Medicaid budget for eligible populations
- Increasing access to and improving the quality of care for Demonstration enrollees

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and SCHIP Law, Regulation, and Policy.** All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents of which these terms and conditions are part, must apply to the Demonstration.

3. **Changes in Medicaid and SCHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy directive, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or SCHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

    a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change.

    b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments (SPAs) for changes to Demonstration populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or SCHIP State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan may be required except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements specified in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available

for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the Commonwealth consistent with the requirements of paragraph 15 to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group (EG)) the impact of the amendment;

   c) An up-to-date SCHIP allotment neutrality worksheet, if necessary;

   d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation including a conforming title XIX and/or title XXI State plan amendment, if necessary; and

   e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration**. States that intend to request Demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the Commonwealth must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

   The Commonwealth must also provide an interim evaluation report for the current extension period along with the extension request, as required by Section XII, paragraph 78.

9. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan, which shall cover a period of time not less than 6 months for non-emergent phase-outs, is subject to CMS approval. If the project is terminated or any

relevant waivers suspended by the State, FFP will be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out**. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration (or shorter emergency phase-out period), individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the State has materially failed to comply with the terms of the project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. **Finding of Non-Compliance.** The State does not relinquish its rights to administratively and/or judicially challenge CMS's finding that the State materially failed to comply.

13. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

14. **Adequacy of Infrastructure.** The Commonwealth will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) when any program changes to the Demonstration that require an amendment pursuant to paragraph 6, are proposed by the State.

16. **Quality Review of Eligibility**. The Commonwealth will continue to submit to the CMS Central and Regional Offices by December 31 of each year an alternate plan for Medicaid Eligibility Quality Control (MEQC) activities as permitted by Federal regulations and policy statement. Based on the approved MEQC activities, the Commonwealth will be assigned a payment error rate equal to the FFY 1996 state error rate for the duration of this 1115 demonstration project.

17. **FFP.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY AND ENROLLMENT

18. **Eligibility.** Individuals eligible under the Demonstration derive access to health care services via multiple pathways.

    The mandatory and optional Medicaid State plan populations described below derive their eligibility through the Medicaid State plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State plan, except as expressly waived and as described in these STCs. State plan eligibles are included in the Demonstration to generate savings to provide benefits to expansion populations. The Demonstration also enables the Commonwealth to mandate enrollment in managed care by waiving the freedom of choice requirement and to waive other specific Title XIX requirements.

    Groups which are made Demonstration-eligible by virtue of the expenditure authorities expressly granted in this Demonstration are subject to all applicable Medicaid laws or regulations in accordance with the Medicaid State Plan, except as specified as not applicable in the expenditure authorities for this Demonstration.

    The criteria for MassHealth eligibility are outlined in a table at the end of Section IV that shows each specific group of individuals; under what authority they are made eligible for the demonstration; the name of the eligibility and expenditure group under which expenditures are reported to CMS and the budget neutrality expenditure agreement is constructed; and the corresponding demonstration program under which benefits are provided. Attachment A provides a complete overview of MassHealth coverage for children, including the separate title XXI SCHIP program, which is incorporated by reference.

19. **Retroactive Eligibility.** Eligibility will be effective 10 calendar days prior to the Commonwealth's receipt of an application if certain conditions are met for the following demonstration programs: Standard, CommonHealth, Prenatal, Limited and direct coverage Family Assistance.

20. **Calculation of Financial Eligibility.** The financial eligibility for Demonstration programs are determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage type. The monthly income standards are determined according to annual Federal Poverty Level (FPL) standard published in the *Federal Register*.

21. **Presumptive Eligibility.** Presumptive eligibility is offered to certain children enrolled in MassHealth Standard and Family Assistance as well as pregnant women receiving services through the MassHealth Pre-Natal program.

    a) Presumptive eligibility begins 10 calendar days prior to the date the Medical Benefit Request (MBR) is received at the MassHealth Enrollment Center (MEC) or MassHealth

outreach site and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days after the begin date, the MBR will be deactivated and presumptive eligibility will end.

b) A child may receive presumptive eligibility only once in a 12-month period.

c) A presumptively-eligible child receiving services under the Family Assistance program is not assessed a monthly health insurance MassHealth premium

22. **Verification of HIV Disease.** For individuals who indicate on the MBR that they have HIV disease, a determination of eligibility will be made once family group income has been verified. Persons who have not submitted verification of HIV diagnosis within 60 days of the eligibility determination shall subsequently have their eligibility redetermined as if they did not have the HIV disease.

23. **Eligibility Exclusions.** Notwithstanding the eligibility criteria outlined in this section, the following individuals are excluded from this Demonstration. Payments or expenditures related to such individuals, however, may be included as allowable expenditures under the Safety Net Care Pool (SNCP) including the Designated State Health Programs (DSHP).

Individuals 65 years and older (unless a parent or caretaker relative of a child 18 years old or younger or an enrollee in the Medical Security Plan)
Individuals who are institutionalized
Participants in a Home and Community Based Waiver
Participants in Program of All-Inclusive Care of the Elderly (PACE)
Children eligible under TEFRA section 134 (Kaileigh Mulligan kids)
Children receiving title IV-E adoption assistance
Refugees (100 percent federally funded)

24. **Enrollment Caps.** The Commonwealth is authorized to impose enrollment caps on populations made eligible solely through the Demonstration. Setting and implementing specific caps are considered amendments to the Demonstration and must be made consistent with Section III, paragraph 7. Enrollment caps are not permitted for populations receiving hypothetical treatment under the budget neutrality agreement.

MassHealth Base Populations* (See para. 57. (d) for terminology.)					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
AFDC-Poverty Level infants	< Age 1: 0 through 185%	Title XIX	**Base Families**	Standard**	Up to 60 days presumptive eligibility for children with unverified income
Medicaid Expansion infants	< Age 1: 185.1 through 200%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**1902(r)(2) Children** **1902(r)(2) XXI RO**	Standard	Up to 60 days presumptive eligibility for children with unverified income
AFDC-Poverty Level Children and Independent Foster Care Adolescents	• Age 1 - 5: 0 through 133% • Age 6 - 17: 0 through 114% • Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets	Title XIX	**Base Families**	Standard	Up to 60 days presumptive eligibility for children with unverified income
AFDC-Poverty Level Children Medicaid Expansion Children I	• Age 6 - 17: 114.1% through 133% • Age 18: 0 through 133%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**Base Families** **Base Families XXI RO**	Standard	Up to 60 days presumptive eligibility for children with unverified income

MassHealth Base Populations (continued)*					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
Medicaid Expansion Children II	Ages 1 - 18: 133.1 through 150%	• Title XIX if insured at the time of application • Title XXI if uninsured at the time of application • Funded through title XIX if title XXI is exhausted	**1902(r)(2) Children** **1902(r)(2) XXI RO**	Standard	Up to 60 days presumptive eligibility for children with unverified income
Pregnant women	0 through 185%	Title XIX	**Base Families**	Standard	
Pregnant women ages 19 and older considered presumptively eligible	0 through 185%	Title XIX	**Base Families**	Pre-Natal	Presumptive eligibility for pregnant women with self-declared income
Parents and caretaker relatives ages 19 through 64 eligible under Section 1931 and Transitional Medical Assistance	0 through 133%	Title XIX	**Base Families**	Standard	
Disabled children under age 19	0 through 150%	Title XIX	**Base Disabled**	Standard	
Disabled adults ages 19 through 64	0 through 114%	Title XIX	**Base Disabled**	Standard	
Non-working disabled adults ages 19 through 64	Above 133%	Title XIX	**Base Disabled**	CommonHealth	Must spend-down to medically needy income standard to become eligible as medically needy
Pregnant women	185.1 through 200%	Title XIX	**1902(r)(2) Children**	Standard	
Pregnant women age 19 and older considered presumptively eligible	185.1 through 200%	Title XIX	**1902(r)(2) Children**	Pre-Natal	Presumptive eligibility for pregnant women with self-declared income

MassHealth Base Populations (continued)*					
Medicaid Mandatory and Optional State Plan Groups (Categorical Eligibility)	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
"Non-qualified Aliens," "Protected Aliens," or "Aliens with Special Status"	Otherwise eligible for Medicaid under the State Plan	Title XIX	**Base Families** **Base Disabled** **1902(r)(2) Children** **1902(r)(2) Disabled**	Limited	Member eligible for emergency services only under the State Plan and the Demonstration. Members who meet the definition and are determined to have a disability are included in the Base Disabled EG Members who are determined eligible via 1902(r)2 criteria are included in the 1902(r)(2) EG
Disabled adults ages 19 through 64	114.1 through 133%	Title XIX	**1902(r)(2) Disabled**	Standard	
Women eligible under the Breast and Cervical Cancer Treatment Program	0 through 250%	Title XIX	**BCCTP**	Standard	Women screened through the Centers for Disease Control and Prevention program

MassHealth Base Populations (continued)*					
Groups with a Categorical Link Made Eligible through the Demonstration ("Hypotheticals")	**Federal Poverty Level (FPL) and/or Other Qualifying Criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**MassHealth Demonstration Program**	**Comments**
Higher income children with disabilities	• < Age 1: 200.1 through 300% • Ages 1 - 18: 150.1 through 300%	• Title XIX if insured at the time of application or in crowd-out status*** • Title XXI via the separate XXI program (Funded through title XIX if title XXI is exhausted)	**CommonHealth** **CommonHealth XXI**	CommonHealth	The CommonHealth program existed prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the separate XXI State Plan and as authorized under this 1115 Demonstration. Certain children derive eligibility from both the authority granted under this demonstration and the separate XXI program.
Higher income children with disabilities ages 0 through 18	Above 300%	Title XIX	**CommonHealth**	CommonHealth	
Higher income adults with disabilities ages 19 through 64 working 40 hours a month or more	Above 133%	Title XIX	**CommonHealth**	CommonHealth ("working")	
19 and 20 year olds	0 through 300%	Title XIX	**CommCare-19-20** **Essential-19-20**	Commonwealth Care Essential	
Parents and caretaker relatives eligible per above, except for income	133.1 through 300%	Title XIX	**CommCareParents**	Commonwealth Care	

* Massachusetts includes in the MassHealth Demonstration almost all the mandatory and optional populations aged under 65 eligible under the State Plan. The Massachusetts State Plan outlines all covered populations not specifically indicated here.

** All Standard and CommonHealth members who have access to qualifying private insurance may receive premium assistance plus wrap-around benefits.

*** Crowd out status refers to children made ineligible for SCHIP due to the crowd out provisions contained within title XXI.

MassHealth Expansion Populations (See para. 57. (d) for terminology.)					
Populations Made Eligible through the Demonstration	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
Children ages 1 through 18 (Non-disabled)	150.1 through 200%	• Title XIX if insured at the time of application • Title XXI via the separate XXI program if uninsured (Funded through title XIX if title XXI is exhausted)	**e-Family Assistance** **Fam Assist XXI** (if XXI is exhausted)	Family Assistance • Premium Assistance • Direct Coverage The premium assistance payments and FFP will be based on the children's eligibility. Parents are covered incidental to the child. No additional wrap is provided to ESI.	Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under this demonstration and the separate XXI program.
Adults under the age of 65 who are not otherwise eligible for medical assistance who work for a qualified small employer and purchase ESI	At or below 300%	Title XIX	**IRP**	Family Assistance/ Insurance Partnership	Enrollment in Family Assistance allows an individual to receive premium assistance through the Insurance Partnership. No additional wraparound is provided Individuals whose spouse or noncustodial children are receiving MassHealth must enroll in a health plan that provides coverage to the dependents
Aged 19 through 64 Long-term unemployed individuals or members of a couple and a client of DMH and/or receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC), not otherwise eligible for medical assistance	0 through 100%	Title XIX	**Basic**	Basic	Premium assistance is offered in lieu of direct coverage when there is other insurance. No additional wraparound is provided.
MassHealth Expansion Populations (continued)*					

Populations Made Eligible through the Demonstration	Federal Poverty Level (FPL) and other qualifying criteria	Funding Stream	Expenditure and Eligibility Group (EG) Reporting	Massachusetts Demonstration Program	Additional comments
Aged 19 through 64 Long-term unemployed individuals or members of a couple, and neither a client of DMH or receiving EAEDC, not otherwise eligible for medical assistance[1]	0 through100%	Title XIX	**Essential**	Essential	Premium assistance is offered in lieu of direct coverage when there is other insurance. No additional wraparound is provided.
Families receiving unemployment benefits, not otherwise eligible for medical assistance	At or below 400%	Title XIX	**MSP**	Medical Security Plan	
Individuals with HIV not otherwise eligible for medical assistance	0 through 200%	Title XIX	**e-HIV/FA**	Family Assistance	Premium assistance is offered in lieu of direct coverage when there is access to other insurance. Additional wraparound to private insurance is provided.

Individuals not otherwise eligible for MassHealth or programs outlined above					
Populations Made Eligible through the Demonstration (Additional populations)	**Federal Poverty Level (FPL) and other qualifying criteria**	**Funding Stream**	**Expenditure and Eligibility Group (EG) Reporting**	**Massachusetts Demonstration Program**	**Additional comments**
Individuals aged 19 and older not otherwise eligible for medical assistance, with no access to ESI, Medicare, or other subsidized health insurance programs, including the following groups:[2] • Low-income adults; • Pregnant women aged 19 and older; • Individuals living with HIV; and • Adults working for an employer with 50 or fewer employees who offers no insurance or who contributes < 33% (or < 20% for family coverage) towards insurance costs	• 0 through 300%; • 200.1 through 300%; • 200.1 through 300%; • At or below 300%	Title XIX	**SNCP-CommCare**	Commonwealth Care Program	

[1] Individuals in MassHealth Essential aged 19 and 20 are counted as a hypothetical base population.
[2] Parents and caretaker relatives in Commonwealth Care, and individuals aged 19 and 20 enrolled in Commonwealth Care are counted as hypothetical base populations.

V. DELIVERY SYSTEM

The MassHealth section 1115 Demonstration provides benefits through multiple delivery systems and programs. A fundamental philosophy of MassHealth is that the Commonwealth will enable beneficiaries to take advantage of available and qualified employer-sponsored insurance (ESI) when cost effective. These circumstances include the availability of ESI, the employer's contribution level meeting a State-specified minimum, and its cost-effectiveness. MassHealth pays for medical benefits directly (direct coverage) only when no other source of payment is available and cost-effective. Beneficiaries are required, as a condition of eligibility under most coverage types, to obtain or maintain private health insurance when MassHealth determines it is cost effective to do so, with the premium assistance necessary to make it affordable for the beneficiary. All Demonstration programs except MassHealth Prenatal and MassHealth Limited have a premium assistance component.

Under MassHealth premium assistance, the Commonwealth provides a contribution through reimbursement to the member or direct payment to the insurer, toward an employed individual's share of the premium for an ESI plan of which the individual is a beneficiary or covered dependent, and which meets a basic benefit level (BBL). The Commonwealth has identified the features of a qualified health insurance product, including covered benefits, deductibles and co-payments, which constitute the BBL. Each ESI plan is measured against the BBL, and a determination is then made regarding the cost-effectiveness of providing premium assistance rather than direct coverage. Premium assistance is the provided benefit under the Commonwealth Care for the purchase of a commercial health insurance product.

MassHealth benefits provided through direct coverage are delivered both on a fee for service (FFS) and capitated basis under the demonstration. Except as described below, MassHealth may require members eligible for direct coverage under Standard, Family Assistance, CommonHealth, Basic and Essential to enroll in managed care. Most members can elect to receive services either through the statewide Primary Care Clinician (PCC) Plan or from a MassHealth-contracted managed care organization (MCO). Currently, CommonHealth members may opt to enroll in managed care. Beginning July 1, 2009, managed care enrollment will be mandatory for CommonHealth members. In addition, children who are clients of the Departments of Children and Families or Youth Services who do not choose a managed care plan are required to enroll with the behavioral health contractor for behavioral health services and may choose to receive medical services on a fee for service basis. MassHealth may require such children to enroll in managed care for all services in the future.

25. **Managed Care Arrangements.** MassHealth may implement, maintain, modify (without amendment to the Demonstration), and claim FFP for all expenditures relating to any managed care arrangements authorized under Section 1932(a) of the Act or 42 CFR 438 et seq.

26. **(a) Primary Care Clinician (PCC) Plan.** The PCC Plan is a primary care case management program administered by MassHealth. In the PCC Plan, members enroll with a PCC who provides most primary and preventive care and who is responsible for providing

referrals for most specialty services. Members can access specialty services from any MassHealth provider, subject to PCC referral and other utilization management requirements. Members enrolled in the PCC Plan receive mental health and substance abuse services through a single Behavioral Health Program (BHP) contractor. The PCC Plan members are guaranteed unrestricted access to Family Planning services and are able to obtain these services from any participating provider without consulting their PCC or obtaining MassHealth's prior approval.

(b) Enhanced Primary Care Clinician Payments. In accordance with 432 CFR 438.6(c)(5)(iv) MassHealth may establish enhanced fee-for-service rate payments or capitated rate payments to Primary Care Clinicians for coordination of the care delivered to their enrolled PCC plan members. MassHealth may also establish pay-for-performance incentives using capitated or other payment arrangements for achieving certain quality of care benchmarks, for demonstrating certain levels of improvement for selected HEDIS or other quality indicators, and for implementing practice infrastructure designed to support the delivery of high-quality health care services to enrolled members.

27. **Managed Care Organizations (MCO).** MassHealth contracts with MCOs that provide comprehensive health coverage including behavioral health services to enrollees. MCO enrollees may receive family planning services from any 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 FFS basis and recoups the funds from the MCO. 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 area at any time for any reason.

28. **Exclusions from Managed Care Enrollment**. MassHealth may exclude the following individuals from enrollment in a MassHealth-contracted managed care plan.

    a) Individuals for whom MassHealth is a secondary payer (i.e., a member with other health insurance). For purposes of exclusion from managed care, "other health insurance" is defined as any medical coverage plan available to the member, including, but not limited to Medicare, CHAMPUS, or a private health plan. However, MassHealth may require children eligible for MassHealth Standard and CommonHealth, for whom MassHealth is a secondary payer, to enroll with the behavioral health contractor for behavioral health services;

    b) Individuals who are receiving MassHealth Standard, CommonHealth, or Family Assistance benefits during the presumptive eligibility period or the time-limited period while MassHealth investigates and verifies access to qualified and cost-effective private health insurance or the time-limited period while the member is enrolling in such insurance;

    c) Individuals receiving Prenatal and Limited coverage;

d) Individuals receiving Standard coverage who are receiving hospice care, or who are terminally ill as documented with a medical prognosis of a life expectancy of 6 months or less;

29. **Contracts.**

a) Managed Care Contracts**.** All contracts and modifications of existing contracts between the Commonwealth and MCOs must be prior approved by CMS. The Commonwealth will provide CMS with a minimum of 30 days to review and approve changes.

b) Public Contracts**.** Contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index), unless the contract is set at the same rate for both public and private providers.

c) Selective Contracting**.** Procurement and the subsequent final contracts developed to implement selective contracting by the Commonwealth with any provider group shall be subject to CMS approval prior to implementation, except for contracts authorized pursuant to 42 CFR 431.54(d).

VI. DEMONSTRATION PROGRAMS AND BENEFITS

Demonstration Programs. The Demonstration provides health care benefits to eligible individuals and families through the following specific programs. The Demonstration program for which an individual is eligible is based on the criteria outlined in section IV.

30. **MassHealth Standard.** Individuals enrolled in Standard receive State plan services. Individuals under age 21 will receive Early and Periodic Screening Diagnostic and Treatment (EPSDT) coverage.

    If available and cost effective, the Commonwealth will purchase cost-effective private health insurance on behalf of individuals eligible for Standard coverage. The individual will receive additional services to ensure that they are receiving no less then the benefits they would receive through direct coverage under the State Plan. Additional services are paid for on a FFS basis or in the managed care arrangements. These individuals are not required to contribute more towards the cost of their private health insurance than they would pay without access to private health insurance. Individuals who do not obtain or maintain available health insurance will be denied MassHealth benefits or lose MassHealth eligibility for all of those in the family group, except those who are under age 19 or pregnant.

31. **MassHealth Breast and Cervical Cancer Treatment Program (BCCTP**). The BCCTP is a health insurance program for women in need of treatment for breast or cervical cancer. This program offers MassHealth Standard benefits to certain women under 65 who do not otherwise qualify for MassHealth.

32. **MassHealth CommonHealth.** Individuals enrolled in CommonHealth receive the same benefits as those available under Standard; individuals under age 21 receive EPSDT services as well.

    If available and cost effective, the Commonwealth will purchase cost-effective private health insurance on behalf of individuals eligible for CommonHealth coverage. The individual will receive additional services to ensure that they are receiving no less then they would receive through direct coverage under the State Plan. Additional services are paid for on a FFS basis or in the managed care arrangements. These individuals are not required to contribute more towards the cost of their health insurance than they would pay without access to health insurance. Individuals who do not obtain or maintain available health insurance will be denied MassHealth benefits or lose MassHealth eligibility for all of those in the family group, except those who are under age 19 or pregnant.

33. **MassHealth Family Assistance.** Individuals enrolled in Family Assistance receive benefits similar to those provided under Standard. The Commonwealth may waive its requirement for children with access to ESI to enroll in ESI if the Commonwealth determines it is more cost effective to provide benefits under direct Family Assistance coverage than to provide premium assistance. There are two separate categories of eligibility under Family Assistance:

    a) **Family Assistance-HIV/AIDS.** Unlike other coverage types, persons with HIV who have access to ESI do not have to enroll in available ESI; however, if they choose to receive premium assistance, the Commonwealth will provide covered services that are not available from the ESI plan on a FFS basis.

    b) **Family Assistance-Children.** Children can be enrolled in Family Assistance if their family's gross income is between 150 percent and 200 percent of the FPL. Only premium assistance is provided if ESI is available to these children that is cost-effective, meets BBL and for which the employer contributes at least 50 percent of the premium cost. Parents of children eligible for Family Assistance may receive coverage themselves for ESI subsidized by Family Assistance if they work for a qualified employer. However, the premium assistance payment is based on the children's eligibility. Direct coverage is provided for children only during the presumptive eligibility period and the time span while the Commonwealth is investigating availability of and enrolling the child in ESI. Direct coverage Family Assistance under the separate title XXI program is provided through an MCO or the PCC plan for children without access to ESI.

34. **MassHealth Insurance Partnership (IP).** The Commonwealth makes premium assistance payments available to certain members (including adults without children) with a gross family income at or below 300 percent of the FPL, who have access to qualifying ESI, and where a qualified small employer contributes at least 50 percent toward the premium.

    This design creates an overlap between the Insurance Partnership and premium assistance offered under the Standard, CommonHealth, and Family Assistance programs. The Insurance Partnership Program has two components: assisting employers with their health

insurance costs through an Insurance Partnership employer payment and assisting employees with payment of health insurance premiums through a premium assistance payment. The Insurance Partnership employee payment is based on amounts limited by State legislation to the value of the subsidies specified for the Commonwealth Care program.

Qualified employers will receive Insurance Partnership payments for each MassHealth member who receives premium assistance from MassHealth, no matter which MassHealth coverage type the member receives. All premium assistance payments made on behalf of MassHealth eligible members are eligible for FFP at the appropriate Federal matching rate as well as IP payments to employers offering "new" health insurance (insurance not offered prior to January 1, 1999).

35. **MassHealth Basic.** Individuals enrolled in Basic are receiving Emergency Aid to Elders, Disabled, and Children (EAEDC) or are Department of Mental Health (DMH) clients who are long-term or chronically unemployed. This Demonstration program provides either direct coverage through a managed care plan or premium assistance if qualified cost effective private insurance is available.

36. **MassHealth Essential**. Individuals enrolled in Essential are low-income, long-term unemployed individuals who are not eligible for Basic. This demonstration program provides either direct coverage through a managed care plan or premium assistance if qualified cost effective private insurance is available.

37. **MassHealth Limited.** Individuals are enrolled in Limited if they are Federally non-qualified non-citizens, whose immigration status makes them ineligible for other MassHealth programs. These individuals receive emergency medical services only.

38. **MassHealth Prenatal**. Pregnant women are enrolled in Prenatal if they have applied for Standard and are waiting for eligibility approval. These individuals receive short-term outpatient prenatal care (not including labor and delivery).

39. **Medical Security Plan (MSP).** Individuals are enrolled in MSP, a health plan provided by the Division of Unemployment Assistance (DUA), if they are receiving unemployment compensation benefits under the provisions of Chapter 151A of the Massachusetts General Laws. MSP provides health insurance to enrollees through premium assistance and direct coverage. Under premium assistance, partial premiums are paid for continuation of qualified ESI which began while the individual was still employed. Direct coverage is provided by DUA through the FFS system to an individual who does not have continued ESI available, or if the individual qualifies for a hardship waiver.

40. **Commonwealth Care (CommCare).** CommCare is a commercial insurance-based premium assistance program administered by the Commonwealth Health Insurance Connector Authority (Connector or Connector Authority), an independent State agency. Premium assistance is offered for the purchase of health benefits from an MCO either licensed under MGL c. 175 by the Massachusetts Division of Insurance or substantially compliant with licensure requirements, as determined by the Connector Authority.

41. **Benefits Offered under Certain Demonstration Programs.**

Table A. MassHealth Direct Coverage Benefits

Benefits	Standard	Common Health	Family Assistance	Basic	Essential
EPSDT	X	X			
Inpatient Acute Hospital	X	X	X	X	X
Adult Day Health	X	X			
Adult Foster Care	X	X			
Ambulance (emergency)	X	X	X	X	X
Audiologist Services	X	X	X	X	
Chiropractic Care	X	X	X	X	
Chronic Disease and Rehabilitation Hospital Inpatient	X	X	X		
Community Health Center	X	X	X	X	X
Day Habilitation	X	X			
Dental Services	X	X	X	X	X
Durable Medical Equipment and Supplies	X	X	X	X	X
Family Planning	X	X	X	X	X
Hearing Aids	X	X	X	X	
Home Health	X	X	X	X	
Hospice	X	X	X		
Laboratory/X-ray/ Imaging	X	X	X	X	X
Medically Necessary Non-emergency Transport	X	X			
Nurse Midwife Services	X	X	X	X	
Nurse Practitioner Services	X	X	X	X	X
Orthotic Services	X	X	X	X	
Outpatient Hospital	X	X	X	X	X
Outpatient Surgery	X	X	X	X	X

Oxygen and Respiratory Therapy Equipment	X	X	X	X	X

Benefits	Standard	Common Health	Family Assistance	Basic	Essential
Personal Care	X	X			
Pharmacy	X	X	X	X	X
Physician	X	X	X	X	X
Podiatry	X	X	X	X	X
Private Duty Nursing	X	X			
Prosthetics	X	X	X	X	X
Rehabilitation	X	X	X	X	X
Renal Dialysis Services	X	X	X	X	X
Skilled Nursing Facility	X	X			
Speech and Hearing Services	X	X	X	X	X
Targeted Case Management	X	X			
Therapy: Physical, Occupational, and Speech/ Language	X	X	X	X	X
Vision Care	X	X	X	X	Only exam and testing services provided by a physician or optometrist

Table B. Diversionary Behavioral Health Services Provided Through Managed Care Under the Demonstration

- Community Crisis Stabilization
- Family Stabilization Team Services
- Partial Hospitalization
- Acute Treatment Services for Substance Abuse
- Clinical Support Services for Substance Abuse
- Transitional Care Unit Services
- Enhanced Acute Treatment Services
- Outpatient Day Services
- Psychiatric Day Treatment
- Intensive Outpatient Program

- Structured Outpatient Addiction Program
- Enhanced Residential Care
- Program of Assertive Community Treatment
- Dialectical Behavioral Therapy
- Inpatient/Outpatient Bridge Visits
- Assessment for Safe and Appropriate Placement
- Comprehensive Child and Adolescent Assessment
- Emergency Services Program
- Community Based Acute Treatment for Children and Adolescents
- Intensive Community Based Acute Treatment for Children and Adolescents

VII. COST SHARING

42. **Overview.** Cost-sharing imposed upon individuals enrolled in the Demonstration varies across Demonstration programs and by FPL, except that no co-payments are charged for any benefits rendered to children under age 19 or pregnant women. Additionally, no premiums are charged to any individual enrolled in the Demonstration whose gross income is less than 150 percent FPL. Please see Attachment B for a full description of cost-sharing under the Demonstration. The Commonwealth has the authority to change cost-sharing for the Commonwealth Care program without amendment, updates to the cost-sharing will be provided upon request and in the annual reports.

VIII. THE SAFETY NET CARE POOL (SNCP)

43. **Description.** The Safety Net Care Pool (SNCP) was established effective July 1, 2005 for the purpose of reducing the rate of uninsurance in the Commonwealth while providing residual provider funding for uncompensated care, and care for Medicaid FFS, Medicaid managed care, Commonwealth Care and low-income uninsured individuals, as well as infrastructure expenditures and access to certain state health programs related to vulnerable individuals, including low-income populations as described in Attachment E.

44. **SNCP Effective Date.** Notwithstanding the effective date specified in STC paragraph 1 or in any other Demonstration documentation, all STCs, waivers and expenditure authorities relating to the SNCP are effective for dates of services beginning July 1, 2008 and ending June 30, 2011.

45. **Expenditures Authorized under the SNCP.** The Commonwealth is authorized to claim as allowable expenditures under the demonstration to the extent permitted under the SNCP limits under STC 46 the following categories of payments and expenditures. Federally-approved payments and expenditures within these categories are specified in Attachment E.

    a) Commonwealth Care. The Commonwealth may claim as allowable expenditures under the Demonstration to the extent permitted under the SNCP limits under STC 46 premium assistance under the Commonwealth Care health insurance program.

b) Designated State Health Programs (DSHP). The Commonwealth may claim as allowable expenditures under the Demonstration to the extent permitted under the SNCP limits under STC 46 DSHP, which are otherwise state-funded programs that provide health services.

c) Providers. As described in Attachment E, the Commonwealth may claim as an allowable expenditure under the Demonstration to the extent permitted under the SNCP limits under STC 46, payments to providers, including but not limited to, acute hospitals and health systems, non-acute hospitals, and other providers of medical services to support uncompensated care for Medicaid FFS, Medicaid managed care, Commonwealth Care, and low-income uninsured individuals. The Commonwealth may also claim as an allowable expenditure payments not otherwise eligible for FFP that are for otherwise covered services furnished to individuals who are inpatients in an Institution for Mental Disease (IMD).

d) Infrastructure and capacity-building. The Commonwealth may claim as allowable expenditures under the Demonstration to the extent permitted under the SNCP limits under STC 46 expenditures that support the improvement or continuation of health care services that benefit the uninsured, underinsured, and SNCP populations, such as capacity-building and infrastructure.

46. **Expenditure Limits under the SNCP.**

a) **Aggregate SNCP Cap.** For dates of service between July 1, 2008 and June 30, 2011 (SNCP extension period), the SNCP will be subject to a 3-year aggregate cap of $4.6 billion, as well as the overall budget neutrality limit established in Section XI. Because the aggregate SNCP cap is based in part on an amount equal to the Commonwealth's annual disproportionate share hospital (DSH) allotment, any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the Demonstration shall result in an equal change to the aggregate SNCP cap, and a corresponding change to the provider cap as described in subparagraph c. Such change shall be reflected in paragraphs 46 (a) and 46 (c), and shall not require a Demonstration amendment. The aggregate SNCP cap of $4.6 billion is based on an annual DSH allotment of $574,571,200, the Commonwealth's annual DSH allotment for FFY 2008.

b) **Infrastructure Cap.** The Commonwealth may expend an amount equal to no more than ten percent of the aggregate SNCP cap over the SNCP extension period for infrastructure and capacity building, as described in paragraph 45(d). No FFP will be available to reimburse the Commonwealth for infrastructure and capacity-building until the Commonwealth notifies CMS of the specific activities that will be undertaken to improve the delivery of health care to the uninsured, underinsured or SNCP populations. The Commonwealth must update Attachment E to reflect these activities; no Demonstration amendment is required. Progress reports on all such activities must be included in the quarterly and annual reports outlined in paragraphs 54 and 55, respectively.

c) **Provider Cap.** The Commonwealth may expend an amount for purposes specified in paragraph 45(c) equal to no more than the cumulative amount of the Commonwealth's annual DSH allotments for the SNCP extension period plus an additional $270,000,000 to allow for Transitional relief for private hospitals as approved in the September 30, 2010 amendment plus an additional $215,763,923 to allow for additional Public Service Hospital Safety Net Care payments approved in the September 30, 2010 amendment. Any change in the Commonwealth's Federal DSH allotment that would have applied for the SNCP extension period absent the Demonstration shall result in an equal change to the provider cap. Such change shall not require a Demonstration amendment. The provider cap is based on an annual DSH allotment of $574,571,200, the Commonwealth's annual DSH allotment for SFY 2008.

d) **DSHP Cap.** Expenditure authority for DSHP is limited to $385 million in SFY 2009, $288.8 million in SFY 2010 and $192.5 million in the SFY 2011. Total computable expenditures for DSHP shall be reduced by a fixed amount of 5.3 percent to determine allowable DSHP expenditures under the demonstration to account for the unknown immigration status of certain program recipients.

e) **Effect of Cost-Containment on Aggregate SNCP Cap.** If the Commonwealth generates additional savings above a pre-determined baseline level within the Demonstration, but outside of the SNCP, after implementing measurable cost-containment initiatives, the three-year aggregate SNCP cap may be increased by an equivalent amount. Any increase in the aggregate SNCP limit due to cost containment may only be expended towards Commonwealth Care.

f) **Budget Neutrality Reconciliation.** The Commonwealth is bound by the budget neutrality agreement described in section XI of this document. The Commonwealth agrees to reduce spending in the SNCP to comply with budget neutrality in the event that expenditures under the demonstration exceed the budget neutrality ceiling outlined in Section XI, paragraph 73. In that event, the Commonwealth must reduce expenditures for items 1 through 7 in chart A of attachment E before reducing expenditures to item 9, Commonwealth Care.

47. **Approval of Cost-Containment Initiatives described in paragraph 46(e)**

a) The Commonwealth must submit to CMS for approval the following information on each cost-containment initiative:

i. Identification of the cost-containment initiative;
ii. Complete description of the initiative;
iii. Detailed analysis of initiative;
iv. Baseline levels of each approved cost containment initiative; and
v. Cost calculation and projected net savings.

b) The Commonwealth must receive written approval from CMS before any cost-savings resulting from these initiatives are permitted to be applied to the aggregate SNCP cap; no Demonstration amendment is required. If such an increase is approved, the Commonwealth and CMS shall update section VIII and Attachment E as necessary to reflect the changes.

48. **Priority Expenditures under the SNCP.** The Commonwealth must support expenditures for premium assistance under Commonwealth Care as its first priority. Any increase in the aggregate SNCP limit due to cost containment pursuant to paragraphs 46 (e) and 47 may be allocated to support Commonwealth Care expenditures if projected Commonwealth Care expenditures exceed $2,333,477, 522 for dates of service between July 1, 2008, and June 30, 2011.

49. **SNCP Additional Reporting Requirements**. All SNCP expenditures must be reported as specified in section X, paragraph 57. In addition, the Commonwealth must submit updates to Attachment E as set forth below to CMS for approval.

a) The Commonwealth must submit to CMS for approval, updates to Charts A – C of Attachment E that reflect projected SNCP payments and expenditures for SFY 2009-2011, no later than 45 days after enactment of the state budget for each SFY. CMS shall approve the Commonwealth's projected SNCP payments and expenditures within 30 days of the Commonwealth's submission of the update, provided that all projections are within the applicable SNCP limits specified in paragraph 46.

The Commonwealth must submit to CMS for approval updates to Charts A – C of Attachment E that reflect actual payments and expenditures for each SFY, within 180 days after the close of the SFY. CMS shall approve the Commonwealth's actual SNCP expenditures within 45 days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable SNCP limits specified in paragraph 46.

The Commonwealth must submit to CMS for approval further updates to any or all of these charts as part of the quarterly operational report and at such other times as may be required to reflect projected or actual changes in SNCP payments and expenditures. CMS must approve the Commonwealth's updated charts within 45 days of the Commonwealth's submission of the update, provided that all SNCP payments and expenditures are within the applicable limits specified in paragraph 46.

No Demonstration amendment is required to update Charts A-C in Attachment E, with the exception of any new types of payments or expenditures in Charts A and B, or for any increase to Public Service Hospital Safety Net Care or Section 122 of Chapter 58 Safety Net Health System Payments.

As specified in Section IX, paragraph 54, on a quarterly basis, the Commonwealth must submit to CMS the following additional information regarding delivery system reform activities in Massachusetts. In particular, the Commonwealth must describe how SNCP

payments, in conjunction with other Medicaid payments under the State plan, were utilized by Cambridge Health Alliance and Boston Medical Center to fund system redesign. These reporting requirements shall not be construed to establish any requirement or limitation on Medicaid or SNCP payments or their uses:

i. Medical service cost and revenue;
ii. Overhead cost and revenue;
iii. Expenditures/investment associated with delivery reform (including capital, infrastructure, professional services, and system redesign investments)
iv. Purpose of expenditure (e.g., quality and oversight activities, systematic coordinated care activities associated with re-organization and ACO implementation, implementation of global payment reform, etc.)
v. Any measurable outcome associated with the expenditure;
vi. Detailed analysis of the measurable outcome associated with system changes and system investments (this should include any supporting financial information associated with the measurable outcome).

b) The Commonwealth must submit to CMS for approval a table of projected DSHP spending by approved program, no later than 45 days after enactment of the state budget for each SFY. CMS must approve the Commonwealth's projected DSHP expenditures within 15 days of the Commonwealth's submission of the update, provided that all DSHP projections are within the applicable SNCP limits specified in paragraph 46.

The Commonwealth must submit to CMS for approval an update to the table of projected DSHP spending that reflects actual DSHP expenditures for each SFY, within 180 days after the close of the SFY. CMS must approve the Commonwealth's actual DSHP expenditures within 45 days of the Commonwealth's submission of the update, provided that all DSHP expenditures are within applicable limits.

The Commonwealth may submit to CMS for approval further updates to the table of projected DSHP spending by approved program at such other times as may be required to reflect projected or actual changes in DSHP expenditures. CMS must approve the Commonwealth's updated charts within 45 days of the Commonwealth's submission of the update, provided that all DSHP expenditures are within applicable limits.

No Demonstration amendment is required to update the table of projected DSHP spending by approved program within the expenditure limits specified in 46(d). The Commonwealth is required to amend the Demonstration in order to add to the list of DSHP programs in Chart D of Attachment E.

IX. GENERAL REPORTING REQUIREMENTS

50. **General Financial Reporting Requirements.** The State must comply with all general financial requirements under Title XIX set forth in Section X.

51. **Compliance with Managed Care Reporting Requirements**. The State must comply with all managed care reporting regulations at 42 CFR 438 et. seq. except as expressly waived or identified as not applicable in the expenditure authorities incorporated into these STCs.

52. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in Section XI, including the submission of corrected budget neutrality data upon request.

53. **Quarterly Calls.** CMS shall schedule quarterly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

54. **Quarterly Operational Reports.** The Commonwealth must submit progress reports in the format specified in Attachment C no later than 60 days following the end of each quarter. The intent of these reports is to present the Commonwealth's analysis and the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

    a) Updated budget neutrality monitoring spreadsheets;

    b) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including approval and contracting with new plans; benefits, enrollment, grievances, quality of care, access, health plan financial performance that is relevant to the Demonstration, pertinent legislative activity, and other operational issues;

    c) Action plans for addressing any policy and administrative issues identified; and

    d) Evaluation activities and interim findings.

55. **Annual Report**. The Commonwealth must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 54. The Commonwealth must submit the draft annual report no later than October 1st of each year. Within 30 days of receipt of comments from CMS, a final annual report shall be submitted.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

56. **Quarterly Expenditure Reports.** The Commonwealth must provide quarterly expenditure reports using the form CMS-64 to report total expenditures under the Medicaid program, including through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the expenditures incurred as specified in Section XI.

57. **Reporting Expenditures Under the Demonstration.** In order to track expenditures under this demonstration, Massachusetts must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

    a) Cost settlements attributable to the Demonstration must be reported to CMS each quarter on a Form CMS-64.9P Waiver sheet as a line 10.b adjustment, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on Line 9 of the Form CMS-64 Summary Sheet or on Line 10.c of the Form CMS-64.9O as an overpayment, as outlined in Section 2500 of the State Medicaid Manual.

    b) Premiums and other applicable cost sharing contributions from enrollees that are collected by the Commonwealth under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, the total amounts that are attributable to the Demonstration must be separately reported on the CMS-64Narr by Demonstration year.

    c) Demonstration year reporting.
        i. Beginning July 1, 2005, all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, and separate schedules will be completed for demonstration years 6, 7, 8, and 9.
        ii. Beginning July 1, 2006, all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-7 will be reported as demonstration year 7, and separate schedules will be completed for demonstration years 8, 9, and 10.
        iii. Beginning July 1, 2007, all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, and separate schedules will be completed for demonstration years 9, 10, and 11.
        iv. Beginning July 1, 2008, all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for

demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-10 will be reported as demonstration year 10, and separate schedules will be completed for demonstration years 11 and 12. Demonstration year 12 includes dates of service from July 1, 2008, through June 30, 2009.

v. Beginning July 1, 2009, all expenditures and adjustments for demonstration years 1-5 will be reported as demonstration year 5, all expenditures and adjustments for demonstration years 6-8 will be reported as demonstration year 8, all expenditures and adjustments for demonstration years 9-11 will be reported as demonstration year 11, and separate schedules will be completed for demonstration years 12 and 13 and 14. All expenditures and adjustments for dates of service beginning July 1, 2008, will be reported on separate schedules corresponding with the appropriate demonstration year.

d) For each Demonstration year as described in paragraph 57 (c), 23 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver name noted below, to report expenditures for the following EGs and the Safety Net Care Pool. Expenditures should be allocated to these forms based on the guidance found below.

i.	**Base Families:**	Eligible non-disabled individuals enrolled in MassHealth Standard, as well as eligible non-disabled individuals enrolled in MassHealth Limited (emergency services only)
ii.	**Base Disabled:**	Eligible individuals with disabilities enrolled in Standard, as well as eligible disabled individuals enrolled in Limited (emergency services only)
iii.	**1902(r)(2) Children:**	Medicaid expansion children and pregnant women who are enrolled in MassHealth Standard, as well as eligible children and pregnant women enrolled in MassHealth Limited (emergency services only)
iv.	**1902(r)(2) Disabled:**	Eligible individuals with disabilities enrolled in Standard with income between 115 percent and 133 percent of the FPL, as well as eligible individuals with disabilities enrolled in MassHealth Limited (emergency services only)
v.	**BCCTP:**	Women eligible under the Breast and Cervical Cancer Treatment Program who are enrolled in Standard
vi.	**CommonHealth:**	Higher income individuals with disabilities enrolled in CommonHealth
vii.	**e-Family Assistance**	Eligible children receiving premium

		assistance through 200 percent of the FPL enrolled in Family Assistance
viii.	**CommCare-19-20**	19 and 20 year olds receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority
ix.	**Essential-19-20**	Eligible 19 and 20 year olds who are long-term unemployed and not receiving EAEDC or a client of DMH
x.	**CommCareParents**	Parents receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority
xi.	**Base Fam XXI RO**	Title XXI-eligible AFDC children enrolled in Standard after allotment is exhausted
xii.	**1902 (r)(2) XXI RO**	Title XXI-eligible Medicaid Expansion children enrolled in Standard after allotment is exhausted
xiii.	**CommonHealth XXI**	Title XXI-eligible higher income children with disabilities enrolled in title XIX CommonHealth after allotment is exhausted
xiv.	**Fam Assist XXI**	Title XXI-eligible children through 200 percent of the FPL eligible for Family Assistance under the demonstration after the allotment is exhausted
xv.	**e-HIV/FA**	Eligible individuals with HIV/AIDS through 200 percent of the FPL who are enrolled in Family Assistance
xvi.	**IRP:**	Subsidies or reimbursement for ESI made to eligible individuals and/or eligible employers, not including subsidies for individuals in other eligible groups
xvii.	**Basic:**	Eligible individuals who are long-term unemployed receiving EAEDC and/or a client of DMH
xviii.	**Essential:**	Eligible individuals who are long-term unemployed and not receiving EAEDC or a client of DMH
xix.	**MSP:**	Eligible individuals receiving unemployment benefits from the DUA
xx.	**SNCP-CommCare:**	Individuals receiving premium assistance for commercial health insurance products coordinated through the Commonwealth Health Insurance Connector Authority

xxi.	**SNCP-HSNTF:**	Expenditures authorized under the demonstration for the Health Safety Net Trust Fund (HSNTF)
xxii.	**SNCP-DSHP:**	Expenditures authorized under the demonstration for the Designated State Health Programs (DSHP)
xxiii.	**SNCP-OTHER:**	All other expenditures authorized under the SNCP

58. **Reporting Expenditures under the Demonstration for Groups that are Eligible First under the Separate Title XXI Program.** The Commonwealth is entitled to claim title XXI funds for expenditures for certain children that are also eligible under this title XIX Demonstration included within the Base Families EG, the 1902(r)(2) Children EG, the CommonHealth EG and the Family Assistance EG. These groups are included in the Commonwealth's title XXI State Plan and therefore can be funded through the separate title XXI program up to the amount of its title XXI allotment (including any reallocations or redistributions). Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or 64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual. If the XXI allotment has been exhausted, including any reallocations or redistributions, these children are then eligible under this title XIX Demonstration and the following reporting requirements for these EGs under the title XIX Demonstration apply:

Base Families XXI RO, 1902(r)(2) RO, CommonHealth XXI, and Fam Assist XXI:

a) **Exhaustion of Title XXI Funds.** If the Commonwealth has exhausted title XXI funds, expenditures for these optional targeted low-income children may be claimed as title XIX expenditures as approved in the Medicaid State plan. The Commonwealth shall report expenditures for these children as waiver expenditures on the Forms CMS 64.9 Waiver and/or CMS 64.9P Waiver in accordance with paragraph 57 (Reporting Expenditures Under the Demonstration).

b) **Exhaustion of Title XXI Funds Notification**. The Commonwealth must notify CMS in writing of any anticipated title XXI shortfall at least 120 days prior to an expected change in claiming of expenditures.

c) If the Commonwealth chooses to claim expenditures for **Base Families XXI RO, 1902(r)(2) RO, and CommonHealth XXI** groups under title XIX, the expenditures and caseload attributable to these EGs will:

   i. Count toward the budget neutrality expenditure limit calculated under section XI, paragraph 73 (Budget Neutrality Annual Expenditure Limit); and

ii. Be considered expenditures subject to the budget neutrality agreement as defined in paragraph 73, so that the Commonwealth is not at risk for caseload while claiming title XIX Federal matching funds when title XXI funds are exhausted.

d) If the Commonwealth chooses to claim expenditures for **Fam Assist XXI** under title XIX, the expenditures and caseload attributable to this EG will be considered expenditures subject to the budget neutrality agreement as defined in paragraph 73. The Commonwealth is at risk for both caseload and expenditures while claiming title XIX Federal matching funds for this population when title XXI funds are exhausted.

59. **Expenditures Subject to the Budget Neutrality Agreement.** For purposes of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in Section IV, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and /or 64.9P Waiver.

60. **Premium Collection Adjustment.** The Commonwealth must include Demonstration premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis on the CMS-64 Summary Sheet and on the budget neutrality monitoring workbook submitted on a quarterly basis.

61. **Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the Commonwealth must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

62. **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the Commonwealth made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made in accordance with 45 CFR 95.4 et seq. After the conclusion or termination of the Demonstration, the Commonwealth must continue to identify separately expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

63. **Reporting Member Months.** The following describes the reporting of member months for Demonstration populations:

a) For the purpose of calculating the budget neutrality agreement and for other purposes, the Commonwealth must provide to CMS, as part of the quarterly report required under paragraph 54, the actual number of eligible member months for the EGs i-x. defined in paragraph 57(d). The Commonwealth must submit a statement accompanying the quarterly report, which certifies the accuracy of this information.

To permit full recognition of "in-process" eligibility, reported counts of member months

may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

64. **Standard Medicaid Funding Process.** The standard process must be used during the Demonstration. Massachusetts must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality agreement and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the Commonwealth's estimate, as approved by CMS. Within 30 days after the end of each quarter, the Commonwealth must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the Commonwealth, and include the reconciling adjustment in the finalization of the grant award to the Commonwealth.

65. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole for the following, subject to the limits described in Section XI:

a) Administrative costs, including those associated with the administration of the Demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan; and

c) Net medical assistance expenditures and prior period adjustments made under section 1115 Demonstration authority with dates of service during the Demonstration extension period, including expenditures under the Safety Net Care Pool.

66. **Sources of Non-Federal Share.** The Commonwealth must certify that the matching non-Federal share of funds for the Demonstration is State/local monies. The Commonwealth further must certify that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the Commonwealth shall not be used as a source of non-Federal share for the Demonstration. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. All sources of the non-Federal share of funding are subject to CMS approval, which approval shall not be withheld for any source of funding that is in accordance with Federal law and regulations.

a) CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. Massachusetts agrees that all funding sources deemed unacceptable by CMS shall be addressed in accordance with Code of Federal Regulations, Title 42, Part 430 Subpart C.

b) Any amendments that impact the financial status of the program shall require Massachusetts to provide information to CMS regarding all sources of the non-Federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the Commonwealth as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the Commonwealth to return and/or redirect to the Commonwealth any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes, including health care provider-related taxes, fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

67. **State Certification of Funding Conditions.** The Commonwealth must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local monies have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the Commonwealth utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the Commonwealth would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the Commonwealth utilizes CPEs as the funding mechanism to claim Federal match for expenditures under the Demonstration, units of government must certify to the Commonwealth the amount of State or local monies used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the Commonwealth's claim for Federal match.

d) The Commonwealth may use intergovernmental transfers to the extent that such funds are derived from State or local monies and are transferred by units of government within the Commonwealth. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed

expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect to the Commonwealth any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

68. **Monitoring the Demonstration.** The Commonwealth will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

XI. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

69. **Budget Neutrality Effective Date.** Notwithstanding the effective date specified in STC paragraph 1 or in any other Demonstration documentation, all STCs, waivers, and expenditure authorities relating to budget neutrality shall be effective beginning July 1, 2008.

70. **Limit on Title XIX Funding**. Massachusetts will be subject to a limit on the amount of Federal title XIX funding that the Commonwealth may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit will consist of two parts, and is determined by using a per capita cost method combined with an aggregate amount based on the aggregate annual DSH allotment that would have applied to the Commonwealth absent the Demonstration (DSH allotment). Budget neutrality expenditure targets are calculated on an annual basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the Commonwealth using the procedures described in Section X, paragraph 57. The data supplied by the Commonwealth to CMS to calculate the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the Commonwealth's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

71. **Risk.** Massachusetts shall be at risk for the per capita cost for Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, Massachusetts will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Massachusetts at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

72. **Expenditures Excluded From Budget Neutrality Test.** Regular FMAP will continue for costs not subject to budget neutrality limit tests. Those exclusions include:

a) Expenditures made on behalf of enrollees aged 65 years and above and expenditures made on behalf of enrollees under age 65 who are institutionalized or enrolled in a home and community-based services waiver;

b) All long-term care expenditures, including nursing facility, personal care attendant, home health, private duty nursing, adult foster care, day habilitation, hospice, chronic disease and rehabilitation hospital inpatient and outpatient;

c) Expenditures for covered services currently provided to Medicaid recipients by other state agencies or cities and towns, whether or not these services are currently claimed for Federal reimbursement; and

d) Allowable administrative expenditures.

73. **Budget Neutrality Annual Expenditure Limit.** For each DY, two annual limits are calculated.

a) **Limit A.** For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the Commonwealth under section X, paragraph 63 for each EG, including the four hypothetical populations, times the appropriate estimated per member per month (PMPM) costs from the table in subparagraph (v) below;
ii. Starting in SFY 2006, actual expenditures for the CommonHealth EG will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline CommonHealth costs, or actual CommonHealth per member per most cost experience for SFYs 2009-2011;
iii. Starting in SFY 2009, actual expenditures for the CommCare-19-20, Essential-19-20 and CommCare Parents EGs will be included in the expenditure limit for the Commonwealth. The amount of actual expenditures to be included will be the lower of the trended baseline costs, or actual per member per most cost experience for these groups in SFYs 2009-2011;
iv. Historical PMPM costs used to calculate the budget neutrality expenditure limit in prior Demonstration periods are provided in Attachment D; and
v. The PMPMs for each EG used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Eligibility Group (EG)	Trend Rate	DY 12 PMPM	DY 13 PMPM	DY 14 PMPM
Mandatory and Optional State Plan Groups				
Base Families	6.95 percent	$466.84	$499.05	$533.73
Base Disabled	6.86 percent	$1011.95	$1081.37	$1155.55
BCCTP	6.86 percent	$3052.78	$3265.69	$3489.72
1902(r)2 Children	6.95 percent	$382.45	$407.87	$436.22
1902(r)2 Disabled	6.86 percent	$791.46	$846.68	$904.76
Hypothetical Populations*				
CommonHealth	6.86 percent	$466.52	$498.53	$532.73
CommCare-19 and 20 year olds	6.95 percent	$371.23	$397.03	$424.62
CommCare Parents	6.95 percent	$413.76	$442.52	$473.27
Essential-19 and 20 year olds	6.95 percent	$314.09	$335.92	$359.26

* "These PMPMs are the trended baseline costs used for purposes of calculating the impact of the hypothetical populations on the overall expenditure limit, according to the process listed in paragraph 73 (ii) and (iii)."

b) **Limit B.** The Commonwealth's annual DSH allotment.

c) The annual budget neutrality expenditure limit for the Demonstration as a whole is the sum of limit A and limit B. The overall budget neutrality expenditure limit for the Demonstration is the sum of the annual budget neutrality expenditure limits. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the Commonwealth may receive for expenditures on behalf of Demonstration populations as well as Demonstration services described in paragraph 41 during the Demonstration period.

d) Early Periodic Screening, Diagnosis, and Treatment (EPSDT) adjustment:

i. The Commonwealth must present to CMS for approval a draft evaluation plan outlining the methodology to track the following:

1. Baseline measurement of EPSDT service utilization prior to the EPSDT court-ordered remedial plan in Rosie D. v Romney (the Order) final judgment and final remedial plan established on July 16, 2007;

2. Increase, following entry of the Order, in utilization of :
a) EPSDT screenings;
b) standardized behavioral health assessments utilizing the Child and Adolescent Assessment Tool (CANS) (or other standardized assessment tool in accordance with the Order); and
c) State Plan services available prior to the entry of the Court Order.

3. Cost and utilization of services contained in State Plan amendments

submitted by the Commonwealth in accordance with the Order and approved by CMS; and

4. Methodology for tracking and identifying new EPSDT services for purposes of budget monitoring.

ii. The draft evaluation plan with an appropriate methodology to track new EPSDT expenditures must be approved by CMS through the amendment process described in paragraph 7. Once an appropriate methodology to track new EPSDT expenditures is approved by CMS, these projected expenditures will be included in the expenditure limit for the Commonwealth, with an effective date beginning with the start of the new EPSDT expenditures, and reconciled to actual expenditure experience.

74. **Composite Federal Share Ratio.** The Federal share of the budget neutrality expenditure limit is calculated by multiplying the limit times the Composite Federal Share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the Commonwealth on actual demonstration expenditures during the approval period, as reported through MBES/CBES and summarized on Schedule C with consideration of additional allowable demonstration offsets such as, but not limited to premium collections and pharmacy rebates, by total computable Demonstration expenditures for the same period as reported on the same forms. FFP and expenditures for extended family planning program must be subtracted from numerator and denominator, respectively, prior to calculation of this ratio. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

75. **Enforcement of Budget Neutrality.** CMS shall enforce the budget neutrality agreement over the life of the Demonstration as adjusted July 1, 2008, rather than on an annual basis. However, if the Commonwealth exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the Commonwealth must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
Through DY 11	Cumulative budget neutrality limit plus:	0 percent
DY 12	Cumulative budget neutrality limit plus:	1 percent
DY 12 through DY 13	Cumulative budget neutrality limit plus:	0.5 percent
DY 12 through DY 14	Cumulative budget neutrality limit plus:	0 percent

In addition, the Commonwealth may be required to submit a corrective action plan if an analysis of the expenditure data in relationship to the budget neutrality expenditure cap indicates a possibility that the Demonstration will exceed the cap during this extension.

76. **Exceeding Budget Neutrality**. If the budget neutrality expenditure limit has been exceeded at the end of the Demonstration period, the excess Federal funds must be returned to CMS using the methodology outlined in paragraph 74, composite Federal share ratio. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

XII. EVALUATION OF THE DEMONSTRATION

77. **The Commonwealth Must Evaluate the Demonstration.** The Commonwealth must submit to CMS for approval a draft evaluation design no later than March 31, 2009.

    At a minimum, the draft design must include a discussion of the goals, objectives, and evaluation questions specific to the entire health care reform Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the Commonwealth. The draft design must identify whether the Commonwealth will conduct the evaluation, or select an outside contractor for the evaluation. Specific indicators to be addressed should include:

    - The number of uninsured in the Commonwealth;
    - The number of demonstration eligibles accessing ESI;
    - Growth in the Commonwealth Care Program;
    - Decrease in uncompensated care and supplemental payments to hospitals
    - The number of individuals accessing the Health Safety Net Trust Fund; and
    - Availability of access to primary care providers.

78. **Interim Evaluation Reports.** In the event the Commonwealth requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the Commonwealth must submit an interim evaluation report as part of its request for each subsequent renewal.

79. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft evaluation design within 60 days of receipt, and the Commonwealth shall submit a final design within 60 days after receipt of CMS comments. The Commonwealth must implement the evaluation design and submit its progress in each of the quarterly and annual progress reports. The Commonwealth must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The Commonwealth must submit the final evaluation report within 60 days after receipt of CMS comments.

80. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the Commonwealth must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the Demonstration.

XIII. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

Date - Specific	Deliverable	STC Reference
03/31/09	Draft Evaluation Design	Section XII, paragraph 77
07/01/10	Submit Demonstration Extension Application	Section III, paragraph 8
07/01/10	Submit Interim Evaluation Report	Section XII , paragraph 78

Annually	Deliverable	STC Reference
October 1st	Draft Annual Report	Section IX, paragraph 55
No later than 45 days after enactment of the state budget for each SFY	Updates to Charts A-C of Attachment E that reflect projected annual SNCP expenditures	Section VIII, paragraph 49
180 days after the close of the SFY	Updates to Charts A-C of Attachment E that reflect actual SNCP payments and expenditures	Section VIII, paragraph 49
No later than 45 days after enactment of the state budget for each SFY	Projected annual DSHP expenditures	Section VIII, paragraph 49
Quarterly	Quarterly Operational Reports	Section IX, paragraph 54
	Quarterly Expenditure Reports	Section X, paragraph 56
	Eligible Member Months	Section X, paragraph 63

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

	Federal Poverty Level (FPL) and/or Other qualifying Criteria	**Insurance Status upon application**	**Part of MassHealth Demonstration?**	**Funding Stream title XIX/XXI**	**Budget Neutrality Expenditure Eligibility Group (EG) Reporting**	**Demonstration Program**	**Comments**
Unborn Targeted Low Income Child	0 through 200%	Uninsured	No	Separate XXI		Healthy Start	
Newborn Children Under age 1	AFDC-Poverty Level Infants 0 through 185%	Any	Yes	XIX via Medicaid State Plan	**Base Families** *Without Waiver*	Standard	
	185.1 through 200%	Insured	Yes	XIX via Medicaid State Plan	**1902(r)(2) Children** *Without Waiver*	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI Medicaid Expansion (via Medicaid State Plan and XXI State Plan) Funded through title XIX if XXI is exhausted	**1902(r)(2) XXI RO** *Without Waiver* (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	
	200.1 through 300%	Insured or in crowd-out status*	No Federally Funded eligible program				
		Uninsured at the time of application	No	Separate XXI		Family Assistance	

This chart is provided for informational purposes only.
*Crowd out status refers to children made ineligible for SCHIP due to the crowd out provisions contained within title XXI.

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Newborn Children Under Age 1 and Disabled	200.1-300%	Insured or in crowd-out status*	Yes	XIX via demonstration authority only	**CommonHealth** *Hypothetical*	CommonHealth/ Premium Assistance with wraparound to direct coverage CommonHealth	
		Uninsured at the time of application	Yes (if XXI is exhausted)	Separate XXI Funded through XIX if XXI is exhausted via demonstration authority	**CommonHealth XXI** *Hypothetical* (member months and expenditures for these children are only reported if XXI funds are exhausted)	CommonHealth	The CommonHealth program was in extent prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the Separate XXI State Plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate XXI program but expenditures are claimed under Title XXI until the Title XXI allotment is exhausted.
	Above 300%	Any	Yes	XIX via demonstration authority only	**CommonHealth** *Hypothetical*	CommonHealth or CommonHealth Premium Assistance With wraparound to direct coverage CommonHealth	

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Ages 1 through 18 Non-disabled	AFDC-Poverty Level Children Age 1-5: 0 through 133% FPL Age 6 through 17: 0 through 114% Independent Foster Care Adolescents aged out of DCF until the age of 21 without regard to income or assets	Any	Yes	XIX	**Base Families** *Without waiver*	Standard	
	AFDC-Poverty Level Children Age 6 through 17: 114.1% through 133% Age 18: 0 through 133%	Insured	Yes	XIX	**Base Families** *Without waiver*	Standard	
		Uninsured	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	**Base Fam XXI** (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	
	Medicaid Expansion Children Ages 1 through 18: 133.1 through 150%	Insured	Yes	XIX	**1902(r)(2) Children** *Without waiver*	Standard	
		Uninsured at the time of application	Yes (if XXI is exhausted)	XXI XIX if XXI is exhausted	**1902(r)(2) Children RO** (member months and expenditures for these children are only reported if XXI funds are exhausted)	Standard	

	Federal Poverty	Insurance Status	Part of	Funding	Budget Neutrality	Demonstration	Comments

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

Population	Level (FPL) and/or Other qualifying Criteria	upon application	MassHealth Demonstration ?	Stream title XIX/XXI	Expenditure Eligibility Group (EG) Reporting	Program	
Children Ages 1 through 18 Non-disabled (cont'd)	All children Age 1 through 18: 150.1 through 200%	Insured	Yes	XIX via demonstration authority only	**E-Family Assistance**	Family Assistance Premium Assistance Direct Coverage	No additional wraparound is provided to ESI
		Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	**Fam Assist XXI RO** (member months and expenditures for these children are only reported if XXI funds are exhausted)	Family Assistance Premium Assistance Direct Coverage	No additional wrap is provided to ESI Children ages 1 through 18 from 150-200% FPL were made eligible under the authority provided by the 1115 demonstration prior to the establishment of the separate title XXI Children's Health Insurance Program and were not affected by the maintenance of effort date. With the establishment of the title XXI program, children who are uninsured at the time of application derive eligibility from both the authority granted under the 1115 demonstration and as authorized under the separate title XXI program, but expenditures are claimed under Title XXI until the Title XXI allotment is exhausted.
	200.1through 300%	Insured or in crowd-out status*	No Federally Funded eligible program				
		Uninsured at the time of application	No	Separate XXI			

ATTACHMENT A
OVERVIEW OF CHILDREN'S ELIGIBLITY IN MASSHEALTH

Population	Federal Poverty Level (FPL) and/or Other qualifying Criteria	Insurance Status upon application	Part of MassHealth Demonstration?	Funding Stream title XIX/XXI	Budget Neutrality Expenditure Eligibility Group (EG) Reporting	Demonstration Program	Comments
Children Aged 1 through 18 and Disabled	0 through 150%	Any	Yes	XIX via Medicaid State Plan	**Base Disabled** *Without Waiver*	Standard	
	150.1 through 300%	Insured or in crowd-out status*	Yes	XIX via Demonstration authority only	**CommonHealth** *Hypothetical*	CommonHealth/ Premium Assistance With wrap to direct coverage CommonHealth	
		Uninsured at the time of application	Yes	Separate XXI Funded through XIX if XXI is exhausted	**CommonHealth XXI** *Hypothetical* (member months and expenditures for these children are only reported if XXI funds are exhausted)	CommonHealth	The CommonHealth program was in extent prior to the separate XXI Children's Health Insurance Program and was not affected by the maintenance of effort date. The CommonHealth program is contained in the Separate XXI State Plan and as authorized under this demonstration. Certain children derive eligibility from both the authority granted under this demonstration and via the separate XXI program, but expenditures are claimed under Title XXI until the Title XXI allotment is exhausted.
	Above 300%	Any	Yes	XXI via Demonstration authority only	**CommonHealth** *Hypothetical*	CommonHealth/h Premium Assisi stance With wraparound to direct coverage CommonHealth	

ATTACHMENT B
COST SHARING

Cost-sharing imposed upon individuals enrolled in the Demonstration varies across coverage types and by FPL. However, in general, no co-payments are charged for any benefits rendered to children under age 19 or pregnant women. Additionally, no premiums are charged to any individual enrolled in the Demonstration whose gross income is less than 150 percent FPL. In the event a family group contains at least two members who are eligible for different coverage types and who would otherwise be assessed two different premiums, the family shall be assessed only the highest applicable premium.

Demonstration Program	Premiums	Co-payments
MassHealth Standard	$0	Prescription Drugs: Generic: Not to exceed $3 Brand: $3 Cap: $200 Per calendar year Non-psychiatric acute inpatient hospital stays : $3, Cap: $36 per calendar year for non-pharmacy services
MassHealth Breast and Cervical Cancer Treatment Program	$15-$72 depending on income	Standard co-payments apply
MassHealth CommonHealth	$15 and above depending on income and family group size	Standard co-payments apply
CommonHealth Children through 300% FPL Children with income above 300% FPL adhere to the regular CommonHealth schedule	$12-$84 depending on income and family group size	Standard co-payments apply
MassHealth Family Assistance: HIV/AIDS	$15-$35 depending on income	Standard co-payments apply
MassHealth Family Assistance: Premium Assistance	$12 per child, $36 max per family group	Member is responsible for all co-payments required under private insurance with a cost sharing limit of 5% of family income

Breast and Cervical Cancer Treatment Program Premium Schedule	
% of Federal Poverty Level (FPL)	**Premium Cost**
Above 133 to 160	$15
Above 160 to 170	$20
Above 170 to 180	$25
Above 180 to 190	$30
Above 190 to 200	$35
Above 200 to 210	$40
Above 210 to 220	$48
Above 220 to 230	$56
Above 230 to 240	$64
Above 240 to 250	$72

ATTACHMENT B
COST SHARING

CommonHealth Full Premium Schedule		
Base Premium	**Additional Premium Cost**	**Range of Premium Cost**
Above 100% to 150%	$15 per family group	$15
Above 150% FPL—start at $15	Add $5 for each additional 10% FPL until 200% FPL	$15 — $35
Above 200% FPL—start at $40	Add $8 for each additional 10% FPL until 400% FPL	$40 — $192
Above 400% FPL—start at $202	Add $10 for each additional 10% FPL until 600% FPL	$202 — $392
Above 600% FPL—start at $404	Add $12 for each additional 10% FPL until 800% FPL	$404 — $632
Above 800% FPL—start at $646	Add $14 for each additional 10% FPL until 1000%	$646 — $912
Above 1000% FPL—start at $928	Add $16 for each additional 10% FPL	$928 + greater

*A lower premium is required of CommonHealth members who have access to other health insurance per the schedule below.

CommonHealth Supplemental Premium schedule	
% of FPL	**Premium requirement**
Above 150% to 200%	60% of full premium per listed premium costs above
Above 200% to 400%	65% per above
Above 400% to 600%	70% per above
Above 600% to 800%	75% per above
Above 800% to 1000%	80% per above
Above 1000%	85% per above

Insurance Partnership: Employer Subsidy	**Tier of Coverage**	**Monthly Employer Subsidy**	
The insurance partnership also provides a monthly subsidy to qualified small employers	Individual Couple One adult, one child Family	$33.33 $66.66 $66.66 $86.33	
Insurance Partnership: Employee Contribution	**% of FPL**	**Premium Requirement for Individual**	**Premium Requirement for Couples**
Family Assistance via the Insurance Partnership The Insurance Partnership provides premium assistance (via the Family Assistance program) to certain employees who work for a small employer	Above 150% to 200% Above 200% to 250% Above 250% to 300%	$27.00 $53.00 $80.00	$54.00 $106.00 $160.00

ATTACHMENT C
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Under Section IX, paragraph 54, the Commonwealth is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration.

The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the Commonwealth. A complete quarterly progress report must include an updated budget neutrality monitoring workbook as well as updated Attachment E, Charts A-C.

NARRATIVE REPORT FORMAT:

Title Line One – MassHealth
Title Line Two – Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:
Example:
Demonstration Year: 12 (7/1/2008 – 6/30/2009)
Federal Fiscal Quarter: 1/2009 (10/08 – 12/08)

Introduction

Information describing the goal of the demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The Commonwealth should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the Commonwealth should indicate that by "0".

Note: Enrollment counts should be person counts, not member months.

Eligibility Group	Current Enrollees (to date)
Base Families	
Base Disabled	
1902(r)(2) Children	
1902(r)(2) Disabled	
BCCTP	
CommonHealth	
Essential 19-20	
CommCare 19-20	
CommCareParents	
e-Family Assistance	

e-HIV/FA	
IRP	
Basic	
Essential	
MSP	
SNCP-CommCare	
Base Fam XXI RO	
1902(r)(2) XXI RO	
CommonHealth XXI	
Fam Assist XXI	

Enrollment in Managed Care Organizations and Primary Care Clinician Plan

Comparative managed care enrollments for the previous quarter and reporting quarter are as follows:

Plan Type	June 30, 2008	September 30, 2008	Difference
MCO			
PCC			

Enrollment in Premium Assistance and Insurance Partnership Program

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Issues

Identify all significant program developments that have occurred in the current quarter, including but not limited to, approval and contracting with new plans, the operation of MassHealth and operation of the Commonwealth Health Insurance Connector Authority. Any changes to the benefits, cost-sharing or delivery system for demonstration populations receiving premium assistance to purchase health insurance via the Commonwealth Health Insurance Connector Authority must be reported here.

Policy Developments/Issues

Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the Commonwealth's actions to address these issues.

ATTACHMENT C
QUARTERLY OPERATIONAL REPORT CONTENT AND FORMAT

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Base Families				
Base Disabled				
1902(r)(2) Children				
1902(r)(2) Disabled				
BCCTP				
CommonHealth				
Essential 19-20				
CommCare 19-20				
CommCareParents				

B. For Informational Purposes Only

Expenditure and Eligibility Group (EG) Reporting	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
e-HIV/FA				
IRP				
Basic				
Essential				
MSP				
SNCP-CommCare				
Base Fam XXI RO				
1902(r)(2) RO				
CommonHealth XXI				
Fam Assist XXI				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences. Also discuss feedback received from other consumer groups.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in the current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT D
MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

The table below lists the calculated per-member per-month (PMPM) figures by eligibility group (EG) used to develop the Demonstration budget neutrality expenditure limits for the first eleven years of the MassHealth Demonstration. All Demonstration years are consistent with the Commonwealth's fiscal year (July 1 – June 30).

After DY 5, the following changes were made to the per member/per month limits:

1. MCB EG was subsumed into the Disabled EG;
2. A new EG, BCCTP, was added; and
3. the 1902(r)(2) EG was split between children and the disabled

DY	Time Period	Families		Disabled		MCB		1902(r)(2) Children		1902(r)(2) Disabled	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	Trend Rate	PMPM	Trend Rate	PMPM
1	SFY 1998	$199.06	7.71%	$491.04	5.83%	$438.39	5.83%	5.33%	$177.02	4.40%	$471.87
2	SFY 1999	$214.41	7.71%	$519.67	5.83%	$463.95	5.83%	5.35%	$186.49	4.80%	$497.12
3	SFY 2000	$230.94	7.71%	$549.97	5.83%	$491.00	5.83%	5.60%	$196.93	5.50%	$524.96
4	SFY 2001	$248.74	7.71%	$582.03	5.83%	$519.62	5.83%	5.70%	$208.16	5.30%	$554.88
5	SFY 2002	$267.92	7.71%	$615.96	5.83%	$549.91	5.83%	5.70%	$220.02	5.70%	$586.51

DY	Time Period	Families		Disabled		1902(r)(2) Children		1902(r)(2) Disabled		BCCTP	
		PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate	PMPM	Trend Rate
6	SFY 2003	$288.58	7.71%	$677.56	10.0%	$236.98	7.71%	$645.16	10.0%	$1891.62	10.0%
7	SFY 2004	$310.83	7.71%	$745.32	10.0%	$255.26	7.71%	$709.67	10.0%	$2080.78	10.0%
8	SFY 2005	$334.79	7.71%	$819.85	10.0%	$274.94	7.71%	$780.64	10.0%	$2288.86	10.0%
9	SFY 2006	$359.23	7.30%	$824.79	7.00%	$295.01	7.30%	$718.13	7.00%	$2449.08	7.00%
10	SFY 2007	$385.46	7.30%	$834.71	7.00%	$316.54	7.30%	$660.60	7.00%	$2620.52	7.00%
11	SFY	$413.60	7.30%	$901.39	7.00%	$339.65	7.30%	$724.31	7.00%	$2803.95	7.00%

ATTACHMENT D
MASSHEALTH HISTORICAL PER MEMBER/PER MONTH LIMITS

	2008										

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Safety Net Care Pool. The following charts reflect approved payments and expenditures for the Safety Net Care Pool (SNCP) for dates of service in SFY 2009-2011, consistent with and pursuant to section VIII, and subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII. This chart shall be updated pursuant to the process described in paragraph 49 (a).

Chart A: Approved SNCP expenditures for dates of service in SFY 2009-2011 (projected and rounded)

#	Type	Applicable caps	State law or regulation	Eligible providers	Total SNCP expenditure per SFY			3-year total	Applicable footnotes
					SFY 2009	SFY 2010	SFY 2011		
1	Public Service Hospital Safety Net Care Payment	Provider		Boston Medical Center Cambridge Health Alliance	$177.5M	$177.5M	$393.3M	$748.3M	(1)
2	Health Safety Net Trust Fund Safety Net Care Payment	Provider	114.6 CMR 13.00, 14.00	All acute hospitals	$150M	TBD	TBD	$398.2M	(2)
3	Section 122 of Chapter 58 Safety Net Health System Payments	Provider	S. 122 of C. 58 (2006)	Boston Medical Center Cambridge Health Alliance	$160M	$0M	$0M	$160M	(3)
4	Institutions for Mental Disease (IMD)	Provider	130 CMR 425.408, 114.3 CMR 46.04	Psychiatric inpatient hospitals Community-based detoxification centers	$14M	$14M	$14M	$42M	(4)
5	Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health	Provider		Shattuck Hospital Tewksbury Hospital Massachusetts Hospital School Western Massachusetts Hospital	$28M	$28M	$28M	$84M	(5)
6	State-Owned Non-Acute Hospitals Operated by the Department of Mental Health	Provider		Cape Cod and Islands Mental Health Center Corrigan Mental Health Center Lindemann Mental Health Center Quincy Mental Health Center SC Fuller Mental Health Center Taunton State Hospital Westborough State Hospital Worcester State Hospital	$102M	$102M	$102M	$306M	(5)
7	Transitional relief for private acute hospitals	Provider		BMC and other private acute hospitals			$270M	$270M	(7)
8	Designated State Health Programs	DSHP		n/a	$385M	$288.8M	$70M	$743.8M	
9	Commonwealth Care	n/a	C. 58 (2006)	n/a	$557.3M	$636.0M	$711.1M	$1,904.4M	(6)
	Total							$4,600.0M	

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

The following notes are incorporated by reference into chart A

(1) The provider-specific Public Service Hospital Safety Net Care payments approved by CMS are as follows:. For dates of service in SFY 2009, BMC, $52,000,000; CHA, $125,500,000. For dates of service in SFY 2010, BMC, $52,000,000; CHA, $125,500,000. For dates of service in SFY 2011, BMC, $52,000,000; CHA, $341,263,923. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment. The increases in 2011 are for payments to CHA based on the March 2010 amendment submission and are consistent with the state legislative authority as granted in Section 119 of Chapter 27 of the Massachusetts Acts of 2009 and Item 1599-1068 of Section 2 of chapter 131 of the Massachusetts Acts of 2010.

(2) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding.

(3) Any amount under item #3 in chart A for dates of service after June 30, 2009 shall require a Demonstration amendment. For SFY 2009, the payment amount for BMC is $106,666,667, and the payment amount for CHA is $53,333,333. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment.

(4) IMD claiming is based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding. Three payment types make up the IMD category listed in item #4 in chart A; inpatient services at psychiatric inpatient hospitals, administrative days, and inpatient services at community-based detoxification centers.

(5) Expenditures for items #5-6 in chart A are based on unreimbursed Medicaid and uninsured costs, and are approved by CMS on an aggregate basis. Consequently, the total and provider-specific amounts expended may vary depending on volume, service mix, and cost growth.

(6) Expenditures for Commonwealth Care Premium Assistance are based on actual enrollment, capitation rates, and expected enrollee contributions, and are approved by CMS on an aggregate basis. Consequently, the amount for each year may vary.

(7) Transitional Relief for Private Hospitals is distributed based on a formula that utilizes information from the Division of Health Care Finance and Policy (DHCFP) 403 cost report, and is approved by CMS on an aggregate basis. Consequently, actual provider-specific payment amounts may vary based on volume, service mix, cost growth, and payer mix. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment.

Chart B: SNCP payments to BMC/BPHC/CPHC for dates of service in SFY 2009-2011 (projected and rounded)

Chart A #	Payment type	BMC/BPHC			CPHC			Applicable footnotes
		SFY 2009	SFY 2010	SFY 2011	SFY 2009	SFY 2010	SFY 2011	
1	Public Service Hospital Safety Net Care Payment	$52M	$52M	$52M	$125.5M	$125.5M	$341.3M	(1)
2	Health Safety Net Trust Fund Safety Net Care Payment	$32.8M	$12.6M	$12.6M	$0M	$0M	$0M	(2)
3	Section 122 of Chapter 58 Safety Net Health System Payments	$106.7M	$0M	$0M	$53.3M	$0M	$0M	(3)
4	Transitional Relief for Private Hospitals			$180.4				
	Total	$191.5M	$64.6M	$245.0	$178.8M	$125.5M	$341.3	

The following notes are incorporated by reference into chart B

(1) The provider-specific Public Service Hospital Safety Net Care payments approved by CMS are as follows:. For dates of service in SFY 2009, BMC, $52,000,000; CHA, $125,500,000. For dates of service in SFY 2010, BMC, $52,000,000; CHA, $125,500,000. For dates of service in SFY 2011, BMC, $52,000,000; CHA, $341,263,923. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment. The increases in 2011 are for payments to CHA based on the March 2010 amendment submission and are consistent with the state legislative authority as granted in Section 119 of Chapter 27 of the Massachusetts Acts of 2009 and Item 1599-1068 of Section 2 of chapter 131 of the Massachusetts Acts of 2010.

(2) Health Safety Net Trust Fund (HSNTF) Safety Net Care Payments are made based on adjudicated claims, and approved by CMS on an aggregate basis. Consequently, actual total and provider-specific payment amounts may vary depending on volume, service mix, rates, and available funding.

(3) Any amount under item #3 in chart A for dates of service after June 30, 2009 shall require a Demonstration amendment. For SFY 2009, the payment amount for BMC is $106,666,667, and the payment amount for CHA is $53,333,333. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment.

(4) Transitional Relief for Private Hospitals is distributed based on a formula that utilizes information from the Division of Health Care Finance and Policy (DHCFP) 403 cost report, and is approved by CMS on an aggregate basis. Consequently, actual provider-specific payment amounts may vary based on volume, service mix, cost growth, and payer mix. The Commonwealth may decrease these payment amounts based on available funding without a Demonstration amendment; any increase will require a Demonstration amendment.

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Chart C: All Demonstration and State Plan costs/payments (millions) for BMC/CPHC for dates of service in SFY 2009-2011 (projected and rounded)

Cambridge Health Alliance	SFY 2009	SFY 2010	SFY 2011
Base payments/costs			
Base CHA costs	$ 237.5	$ 225.2	$233.4
Base CHA payments			
Medicaid FFS inpatient/outpatient	$ 37.1	$ 38.0	$ 39.4
Medicaid FFS physician	$ 8.6	$ 7.2	$ 9.5
MMCO/Commonwealth Care inpatient/outpatient	$ 61.7	$ 54.7	$ 60.3
MMCO/Commonwealth Care physician	$ 8.5	$ 8.2	$ 14.3
Uninsured self-pay	$ 0.7	$ 0.7	$ 1.0
Total base CHA payments	$ 116.6	$ 108.8	$ 124.6
(Over)/under costs	$ 120.8	$ 116.4	$ 108.8
Unreimbursed health system costs[3]			
Medicaid/low-income uninsured			
Capital	$ 7.1	$ 3.1	$ 7.6
Unreimbursed Medicaid outpatient costs for dual eligibles	$ 6.4	$ 6.4	$ 6.4
Social, financial, interpreter and other services	$ 11.3	$ 10.5	$ 10.5
CMS - 2552 Line 99.01	$ 0.8	$ 0.8	$ 0.8
Total unreimbursed health system costs for Medicaid/low-income uninsured	$ 25.6	$ 20.8	$ 25.3
(Over)/under costs	$ 146.4	$ 137.3	$ 134.1
Supplemental payments			
Health Safety Net SNC payment	$ -	$ -	$ -
Essential MassHealth Hospital rate payment	$ -	$ -	$ -
Section 122 supplemental payment	$ 53.3	$ -	$ -
Medical Assistance Trust Fund supplemental payment (IGT)	$ 145.0	$148.0	$ 360.8
High Public Payer supplemental payment		$ -	$ -
Total supplemental payments	$ 198.3	$148.0	$ 360.8
(Over)/under costs	$ (51.9)	$(10.7)	$(226.7)
Intergovernmental transfer	$59.2	$56.8	$138.6
(Over)/under costs, Cambridge Health Alliance	$5.5	$48	$(88.1)

[3] Payments made based on unreimbursed health system costs are not infrastructure expenditures subject to the limit described in paragraph 45 (b).

ATTACHMENT E
SAFETY NET CARE POOL PAYMENTS

Boston Medical Center	SFY 2009	SFY 2010	SFY 2011
Base payments/costs			
Base BMC costs	$510.1	$513.5	$516.7
Base BMC payments			
Medicaid FFS inpatient/outpatient	$ 136.6	$142.4	$142.4
Medicaid FFS physician	$ 12.2	$12.5	$12.5
MMCO/Commonwealth Care inpatient/outpatient	$ 121.2	$121.0	$121.0
MMCO/Commonwealth Care physician	$ 30.0	$30.6	$30.6
Uninsured self-pay	$ 10.7	$11.2	$11.2
Total base BMC payments	$ 310.7	$317.9	$317.9
(Over)/under costs	$ 199.4	$195.6	$198.9
Unreimbursed health system costs[4]			
Medicaid/low-income uninsured			
Capital	$ 56.1	$ 75.3	$ 75.3
Interpreter services	$ 3.5	$ 3.8	$ 3.8
Ambulance services for low-income uninsured	$ 6.4	$ 7.3	$ 7.3
Integrated delivery system for low-income/uninsured at hospital/CHCs	$ 5.1	$ 17.1	$ 5.1
Low-income outreach counselors	$ 1.4	$ 1.3	$ 1.3
Community education	$ 0.9	$ 0.9	$ 0.9
Prenatal, labor, and postnatal support for at-risk pregnant women	$ 1.2	$ 1.2	$ 1.2
Medical, educational, nutritional, and mental health support for young people with HIV/AIDS	$ 1.1	$ 0.4	$ 0.4
Social, legal, and medical consultations for BMC clinicians who suspect pediatric abuse	$ 0.3	$ 0.3	$ 0.3
Boston Center for Refugee Health & Human Rights - health care for refugees and survivors of torture and related trauma	$ 0.4	$ 0.4	$ 0.4
Total unreimbursed health system costs for Medicaid/low-income uninsured	$ 76.3	$ 108.1	$ 96.0
(Over)/under costs	$ 275.8	$ 303.7	$ 294.9
Supplemental payments			
Health Safety Net SNC payment	$ 32.8	$ 12.6	$ 12.6
Public Service Hospital rate payment	$ 37.7	$ 50.0	$ 50.0
Section 122 supplemental payment	$ 106.7	$ -	$ -
Medical Assistance Trust Fund supplemental payment	$ 52.0	$ 52.0	$ 52.0
High Public Payer supplemental payment	$ -	$ -	$ -

[4]Payments made based on unreimbursed health system costs are not infrastructure expenditures subject to the limit described in paragraph 45 (b).

Transitional Relief for Private Hospitals			$ 180.3
Total supplemental payments	$ 229.2	$ 114.6	$ 114.6
(Over)/under costs	$ 46.6	$ 189.1	$ -
Total (over)/under costs, Boston Medical Center	$ 46.6	$189.1	$ -

Data sources for Chart C

CHA
All CHA SFY 2009-2011 data is as of 8/26/2010 (UCCR and MassHealth).

BMC
All BMC SFY 2009-2011 data is as of 8/31/2010 (UCCR, BMC data, and MassHealth). BMC reports low-income uninsured costs net of any self-payments.

ATTACHMENT E

Designated State Health Programs (DSHP). The following programs are authorized for claiming as DSHP, subject to the overall budget neutrality limit and the Safety Net Care Pool (SNCP) limits described in section VIII. Any changes to the list of programs will require an amendment pursuant to the process outlined in paragraph 7. This chart shall be updated pursuant to the process described in paragraph 49 (b).

Chart D: Approved Designated State Health Programs (DSHP)

Agency	Program name
DMH	Recreational therapy services
DMH	Occupational therapy services
DMH	Individual support
DMH	Community Mental Health Center (CMHC) continuing care (non-inpatient)
DMH	Homeless support services
DMH	Individual and family flexible support
DMH	Comprehensive psychiatric services
DMH	Day services
DMH	Child/adolescent respite care services
DMH	Day Rehabilitation
DMH	Community rehabilitative support
DMH	Adult respite care services
DOC	Department of Corrections - DPH/Shattuck Hospital Services
DPH	Community Health Centers
DPH	CenterCare
DPH	Renal Disease
DPH	SANE program
DPH	Growth and nutrition programs
DPH	Prostate Cancer Prevention - Screening component
DPH	Hepatitis C
DPH	Multiple Sclerosis
DPH	Stroke Education and Public Awareness
DPH	Ovarian Cancer Screening, Education, and Prevention
DPH	Diabetes Screening and Outreach
DPH	Breast Cancer Prevention
DPH	Universal Immunization Program
DPH	Pediatric Palliative Care
EHS	Children's Medical Security Plan
ELD	Prescription Advantage
ELD	Enhanced Community Options (ECOP)
ELD	Home Care Services
ELD	Home Care Case Mgmt and Admin
ELD	Grants to Councils on Aging
HCF	Fisherman's Partnership
HCF	Community Health Center Uncompensated Care Payments
MCB	Turning 22 Program - personal vocational adjustment
MCB	Turning 22 Program - respite
MCB	Turning 22 Program - training
MCB	Turning 22 Program - co-op funding
MCB	Turning 22 Program - mobility

MCB	Turning 22 Program - homemaker
MCB	Turning 22 Program - client supplies
MCB	Turning 22 Program - vision aids
MCB	Turning 22 Program - medical evaluations
MRC	Turning 22 Services
MRC	Head Injured Programs
VET	Veterans' Benefits