956 CMR 2.00 **Medicaid Managed Care Organization ("MMCO") Participation in Commonwealth Care Health Insurance Program or CCHIP.**

Section 2.01 Authority

956 CMR 2.00 is promulgated in accordance with the authority granted to the Connector by M.G.L. c. 176Q.

Section 2.02 Purpose

The purpose of 956 CMR 2.00 and other regulations to be adopted by the Connector in the future is to implement the provisions of M.G.L. chs. 118H and 176Q and thereby facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups.

Section 2.03 Scope

956 CMR 2.00 contains the Connector's regulations of general applicability relative to MMCO participation in the Commonwealth Care Health Insurance Program under M.G.L. chs. 118H and 176Q. The Connector also promulgates other regulations, and publishes other documents affecting these programs, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins and other documents as necessary.

Section 2.04 Definitions

As used in 956 CMR 2.00, the following terms shall mean:

Board: the Board of the Commonwealth Health Insurance Connector, established by M.G.L. c. 176Q, §2.

Commonwealth Care Benefit: services that are covered by an MMCO which contracts with CCHIP.

Commonwealth Care Health Insurance Program or CCHIP: the program established under M.G.L. c. 118H.

Commonwealth Health Insurance Connector or Connector: the entity established pursuant to M.G.L. c. 176Q, § 2.

Co-payment: a fixed amount paid by an Enrollee for applicable services or for prescription medications at the time they are provided.

Coverage Date: the date medical coverage becomes effective.

Coverage Types: a scope of medical services, other benefits, or both that are available to Eligible Individuals who meet specific CCHIP eligibility criteria.

Criteria: the criteria for plans eligible for premium assistance under M.G.L. c. 176Q, § 3(a)(14), as set forth in this regulation 956 CMR 2.00.

Day: a calendar day unless a business day is specified.

Director: the Executive Director of the Connector.

Eligible Health Insurance Plans: A health insurance plan that meets the criteria, established by the Board, for receiving Premium Assistance Payments.

Eligible Individual: an uninsured individual who is a resident of the Commonwealth shall be eligible to participate in CCHIP in accordance with M.G.L. c. 118H if: (1) an individual's or family's household income does not exceed 300 per cent of the Federal Poverty Level; (2) the individual has been a resident of the Commonwealth for the previous six months; (3) the individual is not eligible for any MassHealth program, for Medicare, or for the State Children's Health Insurance Program established by M.G.L. c. 118, sec. 16C; (4) the individual's or family member's employer has not provided health insurance coverage in the last six months for which the individual is eligible and for which the employer covers at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan, unless waived by the Board pursuant to M.G.L. c. 118H, sec. 3(b); and (5) the individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan.

Eligibility Process: activities conducted by the Connector or its designee for the purposes of determining, redetermining, and maintaining the eligibility of Eligible Individuals for CCHIP participation.

Eligibility Process for MMCO: activities conducted by the Connector or its designee for the purposes of determining, redetermining and maintaining the eligibility of MMCOs for CCHIP participation.

Enrollee: an Eligible Individual enrolled by the Connector or its designee in a CCHIP MMCO, either by choice or assignment.

Enrollee Cost Sharing: personal spending by an Enrollee toward applicable Commonwealth Care Benefits, in addition to, but not including the Enrollee Premium Contribution.

Enrollee Premium Contribution: an Enrollee's periodic financial contribution for Commonwealth Care Benefits.

Federal Poverty Level or FPL: the income standard, by such name, issued annually in the *Federal Register*, as adjusted to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Health Maintenance Organization or HMO: an entity licensed by the Commissioner of the Massachusetts Division of Insurance to operate under M.G.L. c. 176G.

MassHealth: the medical assistance and benefit programs administered by the Executive Office of Health and Human Services ("EOHHS") pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Essential: a MassHealth program for the long-term unemployed and for disabled long-term unemployed aliens with special status who have income at or below 100 percent of the Federal Poverty Level and are not eligible for MassHealth Basic. See 130 CMR 505.007 and 130 CMR 450.105 (I).

Medicaid Managed Care Organization (MMCO): Subject to any limitations under Federal law and the requirements of Section 123 of Chapter 58 of the Acts of 2006, an entity with which the Executive Office of Health and Humans Services ("EOHHS") contracts as of July 1, 2006, and continues to contract to provide primary care and certain other medical services to members on a capitated basis to serve MassHealth enrollees, which is either a managed care organization as that term is defined under 42 CFR 438 where that entity entered into such contract pursuant to MassHealth's most recent MCO Request for Response or is a health plan referenced in Section 28 of Chapter 47 of the Acts of 1997.

Network: the collective group of service providers who have entered into provider contracts with an MMCO to provide health care services.

Premium: The sum of the Premium Assistance Payment and the Enrollee Premium Contribution.

Premium Assistance Payment: a periodic payment made to MMCOs by the Connector on behalf of Enrollees.

Primary Care Provider (PCP): the Enrollee's primary care practitioner or team selected by an Enrollee, or assigned to an Enrollee by the MMCO, to provide and coordinate the Enrollee's health needs and to initiate and monitor referrals for specialty services when required.

Provider: an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity that has a written agreement with the MMCO to provide health care services.

Quality Assurance: processes used by MMCOs to monitor and improve the quality of care provided to Enrollees.

Reimbursement: rates of payment paid by MMCOs to Providers for Commonwealth Care Benefits.

Resident: a person living in the Commonwealth, as defined by the office of Medicaid by regulation, including a qualified alien, as defined by section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, or a person who is not a citizen of the United States but who is otherwise permanently residing in the United States under color of law; provided, however, that the person has not moved into the Commonwealth for the sole purpose of securing health insurance under M.G.L. c. 118H; provided, further, that confinement of a person in a nursing home, hospital or other medical institution in the commonwealth shall not, in and of itself, suffice to qualify a person as a resident.

Risk Selection: the occurrence when a disproportionate share of high or low users of healthcare services enrolls in a health plan.

State Children's Health Insurance Program (SCHIP): A program established under Title XXI of the Social Security Act.

Uncompensated Care Pool: The fund established pursuant to M.G.L. c. 118G, § 18.

Section 2.05 Administration of the Connector

The Connector formulates requirements, procures contracts, develops Criteria and determines eligibility for MMCOs and for Eligible Individuals.

Section 2.06 General Provisions

(1) **Submission of Proposed Plan by MMCO**: Subject to the provisions of Section 123 of Chapter 58 of the Acts of 2006 concerning satisfaction of enrollment targets, only an MMCO may file a proposed plan with the Connector in order to participate in the CCHIP. Each MMCO wishing to participate in the CCHIP program must file a proposed plan with the Connector which addresses, but is not limited to, the following criteria:

(a) ***Benefits and Coverage***

1. Benefits: Benefits offered by the MMCO shall provide as comprehensive coverage as feasible, encourage access to preventive services and discourage inappropriate utilization.
2. Cost Sharing: The MMCO shall offer Enrollees choices that fit their circumstances, assure appropriate utilization, and balance Enrollee Premium Contributions against point-of-service costs; provided that no Eligible Health Insurance Plan may require an annual deductible.
3. Enrollment: The MMCO's enrollment process shall facilitate movement from reliance on the Uncompensated Care Pool to reliance in CCHIP, provide broad choice of plan designs to Enrollees, and discourage any intentional or unintentional Risk Selection.

(b) ***Provider Network, Contracting and Utilization Management***

1. Network Design: The MMCO Network design shall encourage a choice of provider Networks, promote cost-effective delivery of health care, and assure geographic access.
2. Reimbursement: MMCO Reimbursement shall promote Providers' efficiency and quality of care.
3. Utilization Management: MMCO utilization management shall, at a minimum, meet current MassHealth standards, and continuously improve upon these standards over time.

(c) ***Marketing and Premium***

1. Marketing and Outreach: The MMCO's marketing and outreach programs shall inform and educate the citizens of the Commonwealth about Commonwealth Care, educate Enrollees about managed care, promote transition from receiving care financed by the Uncompensated Care Pool to participating in CCHIP, and be inclusive and non-discriminatory.
2. Premium Structure: The total Premium structure shall be as affordable as feasible, discourage any intentional or unintentional Risk Selection

and discriminatory marketing, and encourage transition from receiving care financed by the Uncompensated Care Pool to participating in CCHIP.

(d) ***Finance and Operations***

1. Operations and Governance: The MMCO's operations and governance shall meet or demonstrate progress toward meeting standards that apply to HMOs.
2. Solvency: The MMCO shall meet or demonstrate progress toward meeting standards of solvency to protect Enrollees from the interruption of coverage and Providers from the loss of earned payments. See M.G.L. c. 176G; 211 CMR 43.
3. Customer Service: The MMCO's customer service shall provide Enrollees with easy access to plan information, and personal assistance to facilitate timely access to care and appropriate use of the MMCO's Commonwealth Care Benefits.

(e) ***Quality Assurance***

1. Quality Assurance: The MMCO shall have systems in place to monitor and seek to improve the quality of care provided to Enrollees, and shall continuously improve on methods to measure, monitor and disclose said quality.
2. Patient Protection: The MMCO shall adopt and implement policies which shall facilitate each Enrollee's ability to receive timely and appropriate health care by qualified Providers, while protecting their personal health information in accordance with applicable state and federal law.
3. Non-Discrimination: The MMCO and its Providers will not use any policy or practice that has the effect of excluding an Eligible Individual from coverage or discriminating against an Eligible Individual or Enrollee because of race, color, religion, national origin, sex, sexual orientation, marital status, health status, personal appearance, political affiliation, source of income, or age.

(2) Required reports for MMCOs: each eligible MMCO must file with the Connector the following information as requested by the Connector in writing:

(a) Financial reporting: The MMCO shall provide the Connector with timely and accurate financial reports and data to monitor appropriateness of program expenses and financial status of the MMCO.
(b) Clinical reporting: The MMCO shall provide the Connector with timely and accurate clinical reports and data to measure actual performance against reasonable access and quality of care standards.

(c) Administrative reports: The MMCO shall provide the Connector with timely and accurate administrative reports and data to assure that health plans are maintaining adequate service levels for members and providers.

Section 2.07 Administrative Information Bulletins

(1) The Connector may, from time to time, issue administrative information bulletins to clarify upon its policy and understanding of substantive provisions of 956 CMR 2.00. In addition, the Connector may issue administrative information bulletins which specify the information and documentation necessary to implement 956 CMR 2.00. The Connector may also issue administrative bulletins containing interpretations of 956 CMR 2.00 and other information to assist persons subject to this regulation meet their obligations under 956 CMR 2.00.

(2) MMCOs, providers, and Eligible Individuals should refer to the Connector's regulations, and other documents published affecting these plans and programs for more detailed information and guidance, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins, carrier bulletins, MMCO bulletins and other documents as necessary.

Section 2.08 Severability of Provisions

The provisions of 956 CMR 2.00 are hereby declared to be severable. If any such provisions or the application of such provisions or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 2.00 or the applications of such provisions or circumstances other than those held invalid.

REGULATORY AUTHORITY

956 CMR 2.00: M.G.L. chs. 118H and 176Q.