Table of Contents

State/Territory Name: MA

State Plan Amendment (SPA) #: 23-0039

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

September 22, 2023

Mike Levine, Assistant Secretary
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

RE: **Massachusetts State Plan Amendment (SPA) Transmittal Number 23-0039**

Dear Assistant Secretary Levine:

We have reviewed the proposed State Plan Amendment (SPA) to Attachment 4.19-B of Massachusetts's state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on June 30th, 2023. This plan amendment updates the methods and standards used to determine rates of payment to community health centers.

Based upon the information provided by the State, we have approved the amendment with an effective date of April 1st, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Jerica Bennett at 1-410-786-1167 or jerica.bennett@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-0039

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
04/01/2023

5. FEDERAL STATUTE/REGULATION CITATION
42 USC 1396a(a)(13); 42 CFR Part 447; 42 CFR 440.10

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 0
b. FFY 24 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B pp. 2-2iv

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B pp. 2-2iii

9. SUBJECT OF AMENDMENT
An amendment regarding methods of payment for community health centers

10. GOVERNOR'S REVIEW *(Check One)*
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED: Not required under 42 CFR 430.12(b)(2)(i)

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Mike Levine

13. TITLE
Assistant Secretary for MassHealth

14. DATE SUBMITTED
06/30/23

15. RETURN TO
Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

FOR CMS USE ONLY

16. DATE RECEIVED
06/30/2023

17. DATE APPROVED
September 22, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
04/01/2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director, Division of Reimbursement Review

22. REMARKS

Instructions on Back

Methods and Standards for Establishing Payment Rates – Other Types of Care (cont.)

FQHCs/RHCs

☒ The payment methodology for FQHCs/RHCs will conform to section 702 of the BIPA 2000 legislation.

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements Prospective Payment System (PPS).

☒ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology. The payment amount determined under this methodology:

1. is agreed to by the state and the center or clinic; and
2. results in payment to the center or clinic of an amount that is at least equal to the PPS payment rate.

I. PPS Rate Methodology

A. Overview

The state has established individual PPS rates for each FQHC enrolled in the Massachusetts Medicaid program as a community health center. Each FQHC has an individual PPS rate for medical and behavioral health visits based on the FQHC's average total per-visit medical and behavioral health costs from calendar years (CYs) 1999 and 2000. Further, each FQHC that provides dental services also has an individual PPS rate for dental visits based on the FQHC's average total per-visit dental costs from CYs 1999 and 2000.

PPS rates, for medical and behavioral health visits and for dental visits, were adjusted for reasonableness by bounding 1999 and 2000 per-visit costs at the 50th and 75th percentiles of 1999 and 2000 costs reported by existing FQHCs enrolled in the Massachusetts Medicaid program as community health centers. FQHCs that did not provide cost data in 1999 and 2000 have PPS rates established using the mean PPS rate across all FQHCs. The medical and behavioral health PPS rates and dental PPS rates are inflated forward from CY 1999 and 2000 costs using the Medicare Economic Index (MEI) and are adjusted for changes in scope of services, as further described herein.

Newly created FQHCs, established on or after July 1, 2021, will receive an initial PPS rate equal to the mean medical and behavioral health PPS rate effective at the time of the FQHC's establishment and, as applicable, the mean dental PPS rate effective at the time of the FQHC's establishment. The initial PPS rates will be effective through the end of the FQHC's first full state fiscal year (SFY) of operation (July 1 through June 30 of each year). After the first full SFY in operation, the FQHC's individual PPS rates will be determined based on its reported costs from that first SFY, with per visit costs adjusted for reasonableness to equal not more than the highest PPS rates in effect as of the first day of the FQHC's second SFY in operation, and inflated forward by the MEI. A FQHC that is not newly established, but is newly providing dental services as of July 1, 2021, will be treated as a new FQHC for the purposes of establishing a dental PPS rate.

B. Managed Care Wrap Payments for FQHCs

In the event that payments to an FQHC, including managed care payments, are less than what the

FQHC would be paid under its individual PPS rate in the aggregate for its visits in each calendar quarter, the state will pay wrap payments up to the FQHC's individual PPS rate.

II. Alternative Payment Methodologies

The state pays FQHCs based on an alternative payment methodology (APM) that is agreed to by the FQHCs and is at least equal to their PPS rates. Specifically, the APM ensures that each FQHC is paid, in the aggregate as calculated on a quarterly basis, an amount at least equal to what the FQHC would have received through the FQHC's individual PPS rates for medical and behavioral health visits and for dental visits. The total APM is inclusive of claims-based APM payments and quarterly reconciliation payments, for medical and behavioral health visits and related services, and for dental visits.

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A. Medical and Behavioral Health APM

Effective January 1, 2022, the medical and behavioral health claims-based APM payments for medical and behavioral health visits subject to the medical and behavioral health PPS rate consist of the following rate payments:

- The individual medical visit rate is $216. Payment for obstetrical visits equals 100% of the individual medical visit rate. Payment for medical visits for EPSDT services equals 103% of the individual medical visit rate. Payment for group medical visits equals 20% of the individual medical visit rate. Payment for urgent care visits occurring before 7:00 A.M. or after 4:59 P.M, Monday through Friday, and urgent care visits occurring at any time on Saturday or Sunday, equals 124% of the individual medical visit rate. Payment for individual mental health visits, for both adults and children, equals 100% of the individual medical visit rate.
- The individual behavioral health visit rate is $140. Payment for group behavioral health visits equals 20% of the individual behavioral health visit rate.
- Behavioral health integration services (BHI) provided in connection with a medical or behavioral health visit are paid at a rate of $56.98.
- Collaborative care management services (CoCM) provided in connection with a medical or behavioral health visit are paid at a rate of $124.07.
- Medication treatment management services (MTM) and collaborative drug therapy management services (CDTM) provided in connection with a medical or behavioral health visit are paid at rates of $52, $34, and $24 for the initial 15 minutes with a new patient, the initial 15 minutes with an established patient, and subsequent 15 minute intervals with a new or established patient, respectively.

Each FQHC's total quarterly aggregate medical and behavioral health claims-based APM payments described above are then compared to what the FQHC would have been paid for total medical and behavioral health visits provided in the same calendar quarter under its medical and behavioral health PPS rate. If total aggregate quarterly claims-based APM payments, plus total aggregate quarterly managed care payments for medical and behavioral health visits, are less than what would have been paid through the medical and behavioral health PPS rate, the FQHC will receive a reconciliation payment equal to 100% of the difference for that calendar quarter, according to the methodology described in Section II.D.1, below. The quarterly reconciliation payment ensures that the total aggregate quarterly payments to FQHCs via the APM are at least equal to what each FQHC would be paid through their individual PPS rates for medical and

behavioral health visits in the calendar quarter. Payment to each FQHC resulting from the medical and behavioral health APM, inclusive of the claims-based APM payment and the quarterly reconciliation payment, is at least equal to the payment to the FQHC that would result from the medical and behavioral health PPS rate.

B. Dental APM

Effective January 1, 2022, the dental claims-based APM payments for dental visits subject to the dental PPS rate consist of the following rate payments:

- Payments for dental services in accordance with the dental rates approved in the State Plan at section j.1 of page 1c of Attachment 4.19-B, plus an FQHC dental enhancement fee rate add-on which, when added to the dental enhancement fee rate, totals $110 per individual dental visit.

Each FQHC's total quarterly aggregate dental claims-based APM payments described above are then compared to what the FQHC would have been paid for total dental visits provided in the same calendar quarter under its dental PPS rate. If total aggregate quarterly claims-based APM payments, plus total aggregate quarterly managed care payments for dental visits, are less than what would have been paid through the dental PPS rate, the FQHC will receive a reconciliation payment equal to 100% of the difference for that calendar quarter, according to the methodology described in Section II.D.2, below. The quarterly reconciliation payment ensures that the total aggregate quarterly payments to FQHCs via the APM are at least equal to what each FQHC would be paid through their individual PPS rates for dental visits in the calendar quarter. Payment to each FQHC resulting from the dental APM, inclusive of the claims-based APM payment and the quarterly reconciliation payment, is at least equal to the payment to the FQHC that would result from the dental PPS rate.

C. Managed Care

Managed care entities' actuarially sound capitation rates account for 1) accountable care sub-capitation payments, as applicable; and 2) all other managed care payments for valid claims, including out-of-network claims, submitted by FQHCs for a) medical and behavioral health visits, which are required to be paid at a rate not less than the medical and behavioral health claims-based APM payments, and b) dental visits, as applicable, which are required to be paid at a rate not less than the dental claims-based APM payments.

MassHealth payments to Primary Care Accountable Care Organizations (PCACOs) for the provision of accountable care sub-capitation payments, authorized under the Massachusetts Section 1115 Demonstration, account for such payments to PCACO participating FQHCs, which are priced based on the medical and behavioral health claims-based APM payment rates.

For the purposes of this state plan Attachment 4.19-B page 2i, accountable care sub-capitation payments are defined as prospective monthly payments, not including payments for clinical tier designation, by accountable care organizations to FQHCs for a defined set of primary care services (such services are paid at $0 upon claims submission to avoid duplicate payment).

D. Quarterly Reconciliation Payments for FQHCs

The state will determine the quarterly reconciliation payments to FQHCs according to the following methodologies:

1) For medical and behavioral health services:

a. If applicable, subtract total accountable care sub-capitation payments to the FQHC for the defined set of sub-capitation primary care services from what the FQHC would be paid under its individual PPS for those services;
b. Sum total claims-based APM payments for medical and behavioral health visits plus total managed care payments, other than accountable care sub-capitation payments, for medical and behavioral health visits, and subtract the total from what the FQHC would be paid under its individual PPS rate for those visits;
c. If Section II.B(1)a, above, is applicable for a particular FQHC, sum the amounts calculated in Section II.D(1)a and Section II.D(1)b, above, to determine the total medical and behavioral health quarterly reconciliation payment, provided that any negative amount calculated in Section II.D(1)a or Section II.D(1)b shall be determined to equal $0.
d. If Section II.D(1)a, above, is not applicable for a particular FQHC, the amount calculated in Section II.D(1)b, above, is the total medical and behavioral health quarterly reconciliation payment, provided that any negative amount calculated in Section II.D(1)b shall be determined to equal $0.

2) For dental services:
a. Sum total claims-based APM payments for dental visits plus total managed care payments, as applicable, for dental visits, and subtract the total from what the FQHC would be paid under its individual PPS rate for those visits;
b. The amount calculated in Section II.D(2)a, above, is the total dental quarterly reconciliation payment, provided that any negative amount calculated in Section II.D(2)a shall be determined to equal $0.

III. PPS Adjustments

A. MEI Adjustments

PPS rates, as described above, are inflated forward annually by the MEI, effective as of January 1 of each calendar year.

B. Changes in Scope of Services Adjustments

FQHCs that experience a change in their scope of services, including changes in intensity, type, duration, or amount of services or service delivery, that results in a material change in costs per visit may request adjustments to their PPS rates due to such changes in scope of services. A change in scope of services is material if the incremental change in cost per visit attributable to the change in scope of services amounts to at least a 3% change in cost per visit as compared to the FQHC's PPS rate as of the date of the request. Requests for scope of service changes may include cumulative changes that occurred over a period of up to eighteen months. Material changes in scope of services may result in PPS adjustments up to the higher of 10% above the requesting FQHC's PPS rate in effect as of the date of the request or the 75th percentile of costs reported through the most recent cost reports submitted after January 1, 2021, by all FQHCs as of the date of the request. Until such time as a new 75th percentile of costs can be determined based on cost reports submitted after January 1, 2021, the 75th percentile shall be adjusted annually by the MEI. PPS rates effective January 1, 2022 incorporate changes in scope of services that were implemented on or before December 31, 2020. PPS adjustments due to change in scope of services requests must be approved by EOHHS in order to take effect. Approved PPS adjustments due to a change in scope of services request will be effective as of the date on which the most recent change in scope of services included in the request was implemented.

IV. Time-Limited Supplemental Payments

Supplemental payments are made to FQHCs for which the calendar year 2016 gross margin earned on drugs purchased through the 340B Drug Pricing Program ("340B drugs") is greater than the projected annual impact of the increased per-visit class rate effective October 20, 2017. In total, supplemental payments to each eligible FQHC for the 12-month period beginning with October 2017 will equal the difference between the FQHC's 2016 gross margin earned on 340b drugs and the projected annual impact on the FQHC of the increased per-visit class rate effective October 20, 2017, less any gross margin earned on 340B drugs between October 1, 2017 and February 28, 2018. In total, supplemental payments to each eligible FQHC for the 27-month period beginning with October 2018, and the 12-month periods beginning with January 2021, January 2022, and January 2023 will equal, respectively, 100%, 75%, 50%, and 25% of the FQHC's supplemental payment amount for the 12-month period beginning with October 2017 prior to the reduction based on gross margin earned on 340B drugs between October 1, 2017 and February 28, 2018.