101 CMR 304.00: RATES FOR COMMUNITY HEALTH CENTERS

Section

304.01: General Provisions

(1) Scope, Purpose, and Effective Date. 101 CMR 304.00 governs the payment rates to be used by governmental units and purchasers under M.G.L. c. 152 (the Workers' Compensation Act) for community health center services. The rates contained in 101 CMR 304.00 are effective for dates of services on or after January 1, 2020.

(2) Coverage. The rates of payment under 101 CMR 304.00 constitute full compensation for community health center services provided to publicly aided individuals as well as full compensation for necessary administration, professional supervision, and supporting services associated with patient care. Any client resources or third-party payments received on behalf of a publicly aided individual will reduce, by that amount, the amount of the purchasing governmental unit's obligation for services rendered to the publicly aided individual.

(3) Disclaimer of Authorization of Services. 101 CMR 304.00 is not authorization for or approval of the services for which rates are determined. The purchasing governmental unit or purchaser under M.G.L. c. 152 is responsible for the definition, authorization, and approval of services.

(4) Coding Updates and Corrections. EOHHS may publish service code updates and corrections in the form of an administrative bulletin. Updates may reference coding systems including, but not limited to, the *American Medical Association's Current Procedural Terminology* (CPT). The publication of such updates and corrections will list

(a) codes for which only the code numbers change, with the corresponding cross references between existing and new codes;

(b) deleted codes for which there are no corresponding new codes; and

(c) codes for entirely new services that require pricing. EOHHS will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

(5) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify its policy on substantive provisions of 101 CMR 304.00 or to publish service code updates and corrections. In addition, EOHHS may issue administrative bulletins that specify the information and documentation necessary to implement 101 CMR 304.00.

304.02: Definitions

As used in 101 CMR 304.00, unless the context requires otherwise, terms have the meanings in 101 CMR 304.02.

340B Drug Pricing Program. A program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

Community Health Center (CHC). A facility licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51, that provides comprehensive ambulatory services and that is not financially or physically an integral part of a hospital.

304.02: continued

Cost Report. The document used to report cost and other financial and statistical data in a format requested by and approved by the Center for Health Information and Analysis or EOHHS.

Early and Periodic Screening, Diagnosis and Treatment Services. A program of health screening and other medical services for publicly aided individuals younger than 21 years old as required by federal law. Payment for such services is in accordance with 101 CMR 304.04.

Emergency Care. Medical care required immediately due to illness or injury with symptoms of sufficient severity that a prudent layperson would believe there is an immediate threat to life or high risk of permanent damage to the individual's health. Emergency conditions are those that require immediate medical treatment at the most accessible hospital equipped to provide emergency services. Emergency care does not include elective, primary, or urgent care.

Enhanced Global Delivery. The provision and supervision of case management, perinatal counseling (including, but not limited to, obstetrical-risk assessment and monitoring), in addition to pelvic or cesarean delivery, all routine prenatal visits, and one postpartum visit.

EOHHS. The Executive Office of Health and Human Services, established under M.G.L. c. 6A.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, division, or political subdivision of the Commonwealth.

Group Medical Visit. A session conducted by a physician other than a psychiatrist; a physician assistant; a nurse practitioner; or a registered nurse, to introduce appropriate health care topics that could include, but are not limited to, preventive medicine approaches to personal health and safety and to present self-help and personal management information concerning family medicine, adult medicine, sex education, and chronic illness.

Individual Medical Visit. A face-to-face meeting between a patient and a physician other than a psychiatrist; a physician assistant; a nurse practitioner; or a registered nurse within the community health center setting, for purposes of examination, diagnosis, or treatment.

Individual Mental Health Visit. A face-to-face meeting between a patient and either a psychiatrist or an advanced practice registered nurse (APRN) with a graduate degree and advanced training in psychiatric care (a psychiatric clinical nurse specialist or a psychiatric mental health nurse practitioner) within the community health center setting, for purposes of examination, diagnosis, or treatment.

Industrial Accident Patient. A person who receives medical services for which persons, corporations, or other entities are in whole or part liable under M.G.L. c. 152 (the Workers' Compensation Act).

MassHealth. The medical assistance and benefit programs administered by 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.

Nurse-midwife Medical Visit. A face-to-face meeting at a community health center between a patient and a nurse-midwife for prenatal and postpartum services. If a community health center chooses to be reimbursed by the enhanced global delivery rate set forth in 101 CMR 316.00: *Surgery and Anesthesia*, a nurse-midwife medical visit is not reimbursable.

Primary or Elective Care. Medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes, but is not limited to, physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention, and referral when necessary. This care does not require the specialized resources of a hospital emergency department.

304.02: continued

Publicly Aided Individual. A person who receives health care and other services for which a governmental unit is in whole or in part liable under a statutory program of public assistance.

Purchaser under M.G.L. c. 152. An insurance company, self-insurer, or worker's compensation agent of a department of the Commonwealth, county, city, or district that purchases medical services subject to M.G.L. c. 152, § 1.

Supporting Services. Services including, but not limited to, health education, health outreach, medical social work services, nutrition services (other than the WIC program), and translation services.

Urgent Care. Services required promptly to prevent impairment of health due to symptoms that a prudent layperson would believe require medical attention, but are not life threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care does not include emergency care or primary or elective care.

304.03: General Rate Provisions and Maximum Allowable Fees

(1) Rate Determination. Rates of payment for authorized community health center services to which 101 CMR 304.00 applies are the lower of

(a) the community health center's usual charge to the general public (other than publicly aided individuals or industrial accident patients) for the same or similar services; or

(b) the schedule of allowable fees set forth in 101 CMR 304.04.

(2) Individual Consideration (I.C.). Non-listed procedures and services designated I.C. are individually considered items. The community health center's bill for such an item must be accompanied by a brief report of the procedure or service provided, including a pertinent history and diagnosis, a description of the service rendered, and the length of time spent with the patient. In making the determination of whether the service is appropriately classified as an individually considered item, the purchasing agency uses the following criteria:

(a) policies, procedures, and practices of other third-party purchasers of care, both governmental and private;

(b) the severity and complexity of the patient's disorder or disability;

(c) prevailing provider ethics and accepted practice; and

(d) time, degree of skill, and cost including equipment cost required to perform the procedure(s).

304.04: Rate Provisions

Code	Allowable Fee	Description
	(1) Fee Schedule.	
99050	$ 52.38	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (*e.g.*, holidays, Saturday or Sunday), in addition to basic service (Bill this code for urgent care provided Monday through Friday from 5:00 P.M. to 6:59 A.M., and Saturday from 7:00 A.M. to Monday 6:59 A.M.) (This code may be billed in addition to the individual medical visit.)
99381	$166.88	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than one year)
99382	$166.88	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; early childhood (age one through four years)

304.04: continued

Code	Allowable Fee	Description (continued)
	(1) Fee Schedule.	
99383	$166.88	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; late childhood (age five through 11 years)
99384	$166.88	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; adolescent (age 12 through 17 years)
99385	$166.88	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures; age 18 through 39 years
99391	$166.88	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than one year)
99392	$166.88	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age one through four years)
99393	$166.88	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age five through 11 years)
99394	$166.88	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	$166.88	Periodic comprehensive preventive medicine reevaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; age 18 through 39 years
G0469	$162.10	Federally qualified health center (FQHC) visit, mental health, new patient (individual mental health visit, new patient, adult)
G0469	$162.10	Federally qualified health center (FQHC) visit, mental health, new patient (individual mental health visit, new patient, child)
G0470	$162.10	Federally qualified health center (FQHC) visit, mental health, established patient (individual mental health visit, established patient, adult)

304.04: continued

Code	Allowable Fee Schedule	Description (continued)
G0470	$162.10	Federally qualified health center (FQHC) visit, mental health, established patient (individual mental health visit, established patient, child)
T1015	$162.10	Clinic visit/encounter, all-inclusive (individual medical visit excludes laboratory and radiology)
T1015-HQ	$ 31.79	Clinic visit/encounter, all-inclusive; group setting (group medical visit excludes laboratory and radiology)
T1015-TH	$158.92	Clinic visit/encounter, all-inclusive; obstetrical treatment/services, prenatal or postpartum (nurse-midwife medical visit excludes laboratory and radiology)

(2) Other Community Health Center Services. The rates of payment for other community health center services provided to publicly aided individuals and industrial accident patients are based on the applicable regulation and rates of payment for the specific care and services rendered as issued by EOHHS or the governmental unit or purchaser under M.G.L. c. 152 where the schedules of such governmental unit or purchaser under M.G.L. c. 152 have not been superseded by 101 CMR 304.00. Such care and services include, but are not limited to, those furnished by dentists, pharmacies, independent clinical laboratories, optometrists, opticians, podiatrists, psychologists, and other individual practitioners and noninstitutional providers.

(3) 340B Transition Supplemental Payments. Subject to federal approval, eligible community health centers will receive monthly supplemental payments in accordance with 101 CMR 304.04(3).

(a) Eligibility for the Supplemental Payments.

1. Community health centers for which the calendar year 2016 gross margin earned on drugs purchased through the 340B Drug Pricing Program, as reported to the Center for Health Information and Analysis, is greater than the projected annual impact of the medical visit rate effective October 20, 2017, determined in accordance with 101 CMR 304.04(3)(c)3., will receive supplemental payments in accordance with 101 CMR 304.04(3).

2. Community health centers for which the calendar year 2016 gross margin earned on drugs purchased through the 340B Drug Pricing Program, as reported to the Center for Health Information and Analysis, is lower than or equal to the projected annual impact of the medical visit rate effective October 20, 2017, determined in accordance with 101 CMR 304.04(3)(c)3., will not receive supplemental payments in accordance with 101 CMR 304.04(3).

(b) Frequency and Duration of Supplemental Payments.

1. Supplemental payments will be made to eligible community health centers on a monthly basis.

2. Supplemental payments will be made for 75 months, beginning with October 2017.

(c) Calculation of Monthly Supplemental Payment Amounts for the First 12 Months of Payment. For each of the 12 months beginning with October 2017, a monthly supplemental payment will be made to eligible community health centers in an amount calculated in accordance with 101 CMR 304.04(3)(c). The amount of the monthly supplemental payment is calculated for each eligible community health center as follows:

1. Historical annual medical visit rate revenue is determined from claims data submitted by the community health center and MassHealth managed care organizations.

2. Projected annual medical visit rate revenue is calculated for the 12-month period beginning October 1, 2017, using the medical visit rate effective October 20, 2017, and medical visit claims and encounters, excluding behavioral health claims and encounters, including claims billed directly to the MassHealth Medicaid Management Information System (MMIS) by community health centers for state fiscal year 2015 and MassHealth managed care organization encounters for federal fiscal year 2016.

304.04: continued

3. Projected annual impact of the medical visit rate effective October 20, 2017, is determined by subtracting historical annual medical visit rate revenue determined in accordance with 101 CMR 304.04(3)(c)1. from projected annual medical visit rate revenue determined in accordance with 101 CMR 304.04(3)(c)2.

4. Projected annual impact of the medical visit rate effective October 20, 2017, determined in accordance with 101 CMR 304.04(3)(c)3. is subtracted from calendar year 2016 gross margin earned on drugs purchased through the 340B Drug Pricing Program, as reported to the Center for Health Information and Analysis.

5. The projected annual medical visit rate revenue determined in accordance with 101 CMR 304.04(3)(c)2. is multiplied by 0.75.

6. The lower of the amount calculated in accordance with 101 CMR 304.04(3)(c)4. and the amount calculated in accordance with 101 CMR 304.04(3)(c)5. is divided by 12 to determine the community health center's monthly supplemental payment amount for the 12 months beginning with October 2017.

(d) Calculation of Monthly Supplemental Payment Amounts for Subsequent Months. For the 63 months beginning with October 2018, monthly supplemental payments will be made to eligible community health centers in an amount calculated in accordance with 101 CMR 304.04(3)(d). Monthly supplemental payment amounts are calculated for each eligible community health center in accordance with the following.

1. The community health center's average monthly supplemental payment amount for the 27 months beginning with October 2018 is equivalent to the community health center's monthly supplemental payment amount for the 12 months beginning with October 2017 calculated in accordance with 101 CMR 304.04(3)(c)6.

2. The community health center's average monthly supplemental payment amount for the 12 months beginning with January 2021 is the product of the community health center's monthly supplemental payment amount for the 12 months beginning with October 2017 calculated in accordance with 101 CMR 304.04(3)(c)6. and 0.75.

3. The community health center's average monthly supplemental payment amount for the 12 months beginning with January 2022 is the product of the community health center's monthly supplemental payment amount for the 12 months beginning with October 2017 calculated in accordance with 101 CMR 304.04(3)(c)6. and 0.50.

4. The community health center's average monthly supplemental payment amount for the 12 months beginning with January 2023 is the product of the community health center's monthly supplemental payment amount for the 12 months beginning with October 2017 calculated in accordance with 101 CMR 304.04(3)(c)6. and 0.25.

(e) Impact on Allowable Fees in Subsequent Periods. Subject to promulgation of further rate setting regulations as may be necessary to implement this provision, for each of the four 12-month periods beginning in or around January 2021, January 2022, January 2023, and January 2024, the allowable fees described in 101 CMR 304.04(1) will be increased such that aggregate expenditures for such allowable fees in each period will increase over such expenditures from the previous 12-month period by 25% of the amount of aggregate expenditures for the 340B transition supplemental payments, as determined by EOHHS, in the 12-month period beginning October 2017 described in 101 CMR 304.04(3)(c), based on projected utilization, as determined by EOHHS.

(f) Authority to Issue Additional Guidance. EOHHS reserves the right to issue an administrative bulletin on these supplemental payment provisions including, but not limited to, an administrative bulletin to implement changes in the payment amounts and dates to account for any period during which 101 CMR 304.00 is in effect and MassHealth Managed Care Organizations (MCOs) continue to cover 340B drugs for MassHealth members.

304.05: Adjustment to Ensure Title XIX Access or Quality

A community health center may request an adjustment of rates if it can demonstrate that access to service delivery is threatened. In order to qualify, the community health center must obtain certification from EOHHS that, without an increase in rates, access to services to MassHealth members will be jeopardized or that the quality of service will fall below levels acceptable to EOHHS and required by Title XIX. If EOHHS makes such a certification, the community health center may submit an application for a rate adjustment. The community health center's application must include a copy of EOHHS certification, the number of clients in need of the particular service, the number of visits required, evidence of the direct relationship between services and the cost of providing care and the minimal additional costs to adequately provide the services. EOHHS will review and act on a request for a change in rates within 60 days of the receipt of a completed application.

304.06: Program Innovation Provision

(1) Review of Program Innovation Applications. A community health center may apply for a prospective adjustment of its payment rates under 101 CMR 304.00 or establishment of a rate separate from its payment rates under 101 CMR 304.00 in order to implement a program innovation that advances a high priority policy initiative of the Commonwealth. EOHHS will review and act on such a request within 60 days after receipt of a program innovation application consisting of, but not limited to, a description of the purpose and scope of the program innovation, including number of personnel involved and proposed implementation process and timeline, and a detailed budget of expected additional costs and project volume associated with the program innovation.

(2) Criteria. An application pursuant to 101 CMR 304.06(1) may be submitted on the basis of implementing a program innovation that advances a current high priority policy initiative of a state agency.

(3) Implementation Schedule. EOHHS will not approve an application submitted pursuant to 101 CMR 304.06(1), unless the community health center demonstrates that it will implement the program innovation within three months of the effective date of the adjustment of its payment rates or the effective date of the separate rate. EOHHS reserves the right to lower the rate retroactive to the date on which the program innovation became effective if the program innovation is not implemented or if actual costs are lower than projected.

(4) Authority to Issue Additional Guidance. EOHHS reserves the right to issue an administrative bulletin on this program innovation provision including, but not limited to, an administrative bulletin to specify requirements related to applications, evaluation, use of funds, recordkeeping, and reporting.

304.07: Modifiers for Provider Preventable Conditions That Are National Coverage Determinations

The following are modifiers for use in reporting provider preventable conditions that are National Coverage Determinations. For more information on the use of these modifiers, *see* Appendix V of the MassHealth Community Health Center Manual.

Modifier	Description
PA	Surgical or other invasive procedure on wrong body part
PB	Surgical or other invasive procedure on wrong patient
PC	Wrong surgery or other invasive procedure on patient

304.08: Reporting Requirements

(1) Required Reports. Reporting requirements are governed by 957 CMR 6.00: *Cost Reporting Requirements*.

304.08: continued

(2) Penalty for Noncompliance. A purchasing governmental unit may reduce the payment rates of any community health center that fails to timely file required information with the Center for Health Information and Analysis or EOHHS, as applicable, by 5% during the first month of noncompliance, and by an additional 5% during each month of noncompliance thereafter (*i.e.*, 5% reduction during the first month of noncompliance, 10% reduction during the second month of noncompliance, and so on). The purchasing governmental unit will notify the community health center prior to imposing a penalty for noncompliance.

304.09: Effect of Claims Submission for MassHealth Providers

(1) Payment by MassHealth for community health center services pursuant to 101 CMR 304.00 constitutes an alternative payment methodology for federally qualified health center services as described by 42 U.S.C. § 1396a(bb)(6).

(2) Submission of claims for payment from MassHealth pursuant to 101 CMR 304.00 by community health centers enrolled in MassHealth constitutes agreement to be paid pursuant to the alternative payment methodology as required by 42 U.S.C. § 1396a(bb)(6)(A).

304.10: Severability

The provisions of 101 CMR 304.00 are severable, and if any provision of 101 CMR 304.00 or application of such provision to any community health center or any circumstances is held to be invalid or unconstitutional, such invalidity will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 304.00 or applications of such provisions to community health centers or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 304.00: M.G.L. c. 118E.