

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 304.00: RATES FOR COMMUNITY HEALTH CENTERS

Section

- 304.01: General Provisions
- 304.02: Definitions
- 304.03: General Rate Provisions and Maximum Allowable Fees
- 304.04: Rate Provisions
- 304.05: Adjustment to Ensure Title XIX Access or Quality
- 304.06: Program Innovation Provision
- 304.07: Modifiers for Provider Preventable Conditions That Are National Coverage Determinations
- 304.08: Reporting Requirements
- 304.09: Effect of Claims Submission for MassHealth Providers
- 304.10: Severability

304.01: General Provisions

- (1) Scope and Purpose. 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.
- (2) Applicable Dates of Service. Rates in 101 CMR 304.00 apply for dates of service provided on or after January 1, 2023, unless otherwise indicated.
- (3) 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.
- (4) 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.
- (5) 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)* and/or the *Healthcare Common Procedure Coding System (HCPCS)*. The publication of such updates and corrections will list:
  - (a) codes for which the code numbers change, with the corresponding cross references between new codes and the code being replaced. Rates for such new codes are set at the rate of the code that is being replaced;
  - (b) codes for which the code number remains the same, but the description has changed;
  - (c) deleted codes for which there are no corresponding new codes; and
  - (d) codes for entirely new services that require pricing. EOHHS will list these codes and apply individual consideration (I.C.) payment for these codes until appropriate rates can be developed.
- (6) 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.

304.02: continued

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 and, for the purposes of rates paid by MassHealth, meeting the definition and requirements established under 130 CMR 405.000: *Community Health Center Services*, that provides comprehensive ambulatory services and that is not financially or physically an integral part of a hospital.

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, Diagnostic and Treatment (EPSDT) 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 Behavioral Health Visit. A session conducted between two or more patients and an independently licensed mental or behavioral health clinician, a licensed mental or behavioral health clinician with supervision as required under such practitioners' licensure requirements, or an unlicensed clinician who completed a masters from an accredited educational institution and such degree allows eligibility for licensure as a behavioral health practitioner qualified to deliver outpatient behavioral health services, including clinical social work, mental health counseling, psychology, rehabilitative counseling or counseling education, and who is under appropriate supervision, and who must be actively moving toward licensure, within the community health center setting, conducted in-person or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS, for the purposes of examination, diagnosis or treatment for each patient in the session, and lasting a minimum of 30 minutes.

Group Medical Visit. A session conducted between two or more patients and a physician other than a psychiatrist; a physician assistant; a nurse practitioner; or a registered nurse, conducted in-person or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS, 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 Behavioral Health Visit. A meeting between a patient and an independently licensed mental or behavioral health clinician, a licensed mental or behavioral health clinician with supervision as required under such practitioners' licensure requirements, or an unlicensed clinician who completed a masters from an accredited educational institution and such degree allows eligibility for licensure as a behavioral health practitioner qualified to deliver outpatient behavioral health services, including clinical social work, mental health counseling, psychology, rehabilitative counseling or counseling education, and who is under appropriate supervision, and who must be actively moving toward licensure, within the community health center setting, conducted face-to-face or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS, for purposes of psychological assessment, diagnosis or treatment, and lasting a minimum of 16 minutes.

304.02: continued

Individual Dental Visit. A meeting between a patient and a clinician licensed to provide dental services payable under 101 CMR 314.00: *Dental Services* within the community health center setting, conducted face-to-face or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS, for purposes of providing such dental services and for which the CHC dental add-on, as described under 101 CMR 304.04(2)(b)1., is applied.

Individual Medical Visit. A 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, conducted face-to-face or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS, for purposes of examination, diagnosis, or treatment.

Individual Mental Health Visit. A 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, conducted face-to-face or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS, 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 meeting between a patient and a nurse-midwife for prenatal and postpartum services, conducted at a community health center or *via* a clinically appropriate telehealth modality in accordance with formal written guidance issued by MassHealth or EOHHS. If a community health center chooses to be reimbursed by the enhanced global delivery rate set forth in 101 CMR 316.00: *Rates for 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.

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

- (1) Prospective Payment System (PPS) Methodology.
  - (a) Medical and Behavioral Health PPS Rate for Existing Community Health Centers. Each community health center that is a federally qualified health center (FQHC), enrolled with MassHealth as a community health center as of June 30, 2021, has an individual medical and behavioral health PPS rate established using the community health center's average total per-visit medical and behavioral health costs from calendar years 1999 and 2000, adjusted by reasonableness and inflated forward by the Medicare Economic Index (MEI). 1999 and 2000 per visit costs were adjusted for reasonableness by bounding PPS rates at the 50<sup>th</sup> and 75<sup>th</sup> percentile of 1999 and 2000 costs reported by community health centers that existed at the time and continue to be enrolled with MassHealth as community health centers as of June 30, 2021. The PPS rates for community health centers that were not so enrolled or did not have cost data in 1999 and 2000 were set at the mean PPS rate across all community health centers adjusted for reasonableness and carried forward by the MEI. Community health centers that experienced a change in scope of service, including a change in intensity, type, duration, or amount of service or service delivery that results in a material change in costs per visit will receive an adjustment to their PPS; provided that expenses associated with changes in scope of service may include, but are not limited to, capital expenses.
  - (b) Dental PPS Rate for Existing Community Health Centers. Each community health center that is a FQHC, existing and providing dental services as of June 30, 2021, has an individual dental PPS rate calculated based on its 1999 and 2000 per visit dental costs, and adjusted for reasonableness, the MEI, and changes in scope, in the same manner as the adjustments to the medical and behavioral health PPS rate described in 101 CMR 304.04(1)(a).
  - (c) PPS Rates for New Community Health Centers or Community Health Centers Newly Providing Dental Services.
    1. An entity that becomes a community health center that is also a FQHC on or after July 1, 2021, will receive as its initial PPS rate the mean PPS rate of all Massachusetts community health centers that are FQHCs as of the date of the entity's enrollment as a MassHealth community health center. The initial PPS rate will be effective through the end of the first full state fiscal year of operation as a MassHealth community health center. The community health center must provide EOHHS all relevant and requested cost data from the first year of operation as a community health center. EOHHS will then review the cost data to determine the community health center's per visit costs, adjusting for reasonableness and bounding the per visit costs at not more than the highest PPS in effect for MassHealth community health centers as of the first day of the entity's second full state fiscal year of enrollment as a community health center. The medical and

304.04: continued

- behavioral health per visit costs, adjusted for reasonableness, will be the community health center's individualized medical and behavioral health PPS rate. The dental per visit costs, if applicable, adjusted for reasonableness, will be the community health center's individualized dental PPS rate. The individualized PPS rates will be effective for dates of service beginning on the first day of the second full state fiscal year of enrollment as a community health center, and will be adjusted thereafter in accordance with 101 CMR 304.04(1)(d).
2. A community health center that is newly providing dental services for the first time will be treated as a new community health center, in accordance with 101 CMR 304.04(1)(c)1., for the sole purpose of establishing a dental PPS rate.
- (d) PPS Adjustments. PPS rate adjustments occurring on or after January 1, 2022, include:
1. Annual MEI adjustments in effect for dates of services beginning January 1<sup>st</sup> of each year, as applied to the PPS rate in effect as of December 31<sup>st</sup> of the previous year.
  2. Changes in scope of service adjustments, as follows:
    - a. Community health centers that experienced a change in intensity, type, duration, or scope of service or service delivery that results in a material change in costs per visit may request adjustments to their PPS rates due to changes in scope of service, in a form and manner prescribed by EOHHS *via* administrative bulletin or other formal written issuance.
    - b. Change in scope of services may result in adjustments up to the higher of 10% above the requesting community health center's PPS rate in effect as of the date of the request or, if available, the 75<sup>th</sup> percentile of costs reported through the most recent cost reports submitted after January 1, 2021, by all community health centers as of the date of the request; provided that if no cost reports have been submitted since January 1, 2021, a maximum adjustment of up to 10% above the requesting community health center's PPS rate in effect as of the date of the request will apply.
    - c. Changes in scope of service may result in a PPS rate adjustment if the incremental change in cost per visit attributable to the changes in scope of service amounts to at least a 3% change in cost per visit as compared to the community health center's PPS rate as of the date of the request. Request for scope changes may include cumulative changes for up to 18 months.
    - d. PPS rates effective January 1, 2022, incorporate changes in scope that were implemented on or before December 31, 2020.
    - e. Change in scope adjustments to PPS rates must be approved by EOHHS in order to become effective and EOHHS may request additional information as necessary to evaluate the request. If approved, the PPS rate adjustment will be effective as of the date of the implementation of the most recent change in scope of service included in the request, which shall be no sooner than six months prior to the date of request.
- (e) PPS Rate Adjustment Notification. Individual community health center PPS rates will be updated, as adjusted in accordance with 101 CMR 304.04(1)(d), at least annually and notices will be provided to each individual community health center each time the community health center's PPS rate is adjusted.
- (f) Authority to Issue Additional Guidance. EOHHS may provide by administrative bulletin or other written issuance further detail on the PPS rate calculation methodology, appeals or dispute procedures, changes in scope of service eligible for PPS rate adjustments, or the process by which changes in scope of service are reviewed, considered, and determined.
- (2) Alternative Payment Methodology (APM). Through the APM, each community health center will be paid, in the aggregate as calculated on a quarterly basis, an amount at least equal to what the community health center would have received through the community health center's individual PPS rates for medical and behavioral health visits and for dental visits. The total APM is inclusive of the claims-based APM payments and the reconciliation wrap APM payments, as such payments are described in 101 CMR 304.04(2).

304.04: continued

(a) 1. Medical and Behavioral Health Services Fee Schedule.

<u>Code</u>	<u>Allowable Fee</u>	<u>Description</u>
99050	\$52.38	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed ( <i>e.g.</i> , 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	\$222.00	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	\$222.00	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)
99383	\$222.00	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	\$222.00	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	\$222.00	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	\$222.00	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	\$222.00	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	\$222.00	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)

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

304.04: continued

<u>Code</u>	<u>Allowable Fee</u>	<u>Description</u>
99394	\$222.00	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	\$222.00	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
99605	\$52.00	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, new patient (CDTM or MTM services, limit of two units per calendar year, telehealth permitted as appropriate)
99606	\$34.00	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; initial 15 minutes, established patient (CDTM or MTM services, limit of one unit per visit and six units per calendar year, telehealth permitted as appropriate)
99607	\$24.00	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided; each additional 15 minutes (List separately in addition to code for primary service) (CDTM or MTM services, limit of three units per visit and 12 units per calendar year, telehealth permitted as appropriate)
G0469	\$216.00	Federally qualified health center (FQHC) visit, mental health, new patient (individual mental health visit, new patient)
G0470	\$216.00	Federally qualified health center (FQHC) visit, mental health, established patient (individual mental health visit, established patient)
T1015	\$216.00	Clinic visit/encounter, all-inclusive (individual medical visit excludes laboratory and radiology)
T1015-HQ	\$43.20	Clinic visit/encounter, all-inclusive; group setting (group medical visit excludes laboratory and radiology)
T1015-TH	\$216.00	Clinic visit/encounter, all-inclusive; obstetrical treatment/services, prenatal or postpartum (nurse-midwife medical visit excludes laboratory and radiology)
T1040	\$140.00	Medicaid certified community behavioral health clinic services, per diem (Clinic visit/behavioral health encounter, all-inclusive individual behavioral health visit)
T1040-HQ	\$28.00	Medicaid certified community behavioral health clinic services, per diem (Clinic visit/behavioral health encounter, all-inclusive behavioral health visit; group setting)
G0511	\$56.98	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month (Behavioral health integration; applies to all MassHealth community health centers)
G0512	\$124.07	Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month (applies to all MassHealth community health centers)

304.04: continued

2. EOHHS will calculate each community health center's total medical and behavioral health claims-based APM amounts paid in each quarter by summing the community health center's total amounts received for the services described in 101 CMR 304.04(2)(a)1., including claims paid through MassHealth fee-for-service and claims paid through MassHealth managed care, as those terms are defined in 130 CMR 501.001: *Definition of Terms*. This total quarterly medical and behavioral health claims-based APM amount is the amount used to determine the medical and behavioral health reconciliation wrap payment, calculated each quarter under 101 CMR 304.04(2)(c).
- (b) Dental Services Claims-based APM Payments.
1. Community health centers may bill 101 CMR 314.00 for dental services rendered in accordance with that regulation. In addition, community health centers may bill the dental enhancement fee established under 101 CMR 314.00 for each separate individual dental visit provided by the community health center; provided that the dental enhancement fee established under 101 CMR 314.00 will be increased by an amount that, when added to such dental enhancement fee, totals \$110 when billed to MassHealth by community health centers for MassHealth members (the "CHC dental add-on"); and provided further that the dental enhancement fee and the CHC dental add-on may be billed not more than once per member per day. Hospital-licensed health centers are not eligible for the CHC dental add-on.
  2. EOHHS will calculate each community health center's total MassHealth dental claims-based APM amounts paid in each quarter by summing the community health center's quarterly MassHealth dental claims paid under 101 CMR 314.00, including dental MassHealth fee-for-service paid claims, claims paid through MassHealth managed care, as defined in 130 CMR 501.001, paid dental enhancement fees, and the quarterly CHC dental add-on paid claims. This total quarterly dental claims-based APM amount is the amount used to determine the dental reconciliation wrap payment, calculated each quarter under 101 CMR 304.04(2)(c).
- (c) Reconciliation Wrap APM Payments. For each calendar quarter, MassHealth will provide required reconciliation wrap APM payments to community health centers that are Federally Qualified Health Center for the purposes of 42 U.S.C. § 1396a(bb) and that are not hospital licensed health centers.
1. A reconciliation wrap APM payment is required up to the medical and behavioral health PPS, if a community health center's total quarterly MassHealth medical and behavioral health claims-based APM payments described under 101 CMR 304.04(2)(a)2. are less than what the community health center would have received if it had been paid for such services on a per visit basis through its individual medical and behavioral health PPS rate. Such reconciliation wrap APM payment will equal the difference between the total MassHealth quarterly medical and behavioral health claims-based APM payments and what would have been paid for MassHealth medical and behavioral health visits through the medical and behavioral health PPS rate, in the aggregate, in the calendar quarter. For the purposes of calculating the medical and behavioral health reconciliation wrap APM payment, "visit" will include all individual medical visits, individual mental health visits, individual behavioral health visits, nurse-midwife medical visits, group medical visits, and group behavioral health visits; provided however, that group medical visits and group behavioral health visits will amount to 20% of a visit.
  2. A reconciliation wrap APM payment is required for the dental PPS if a community health center's total MassHealth quarterly dental claims-based APM payments described under 101 CMR 304.04(2)(b)2., are less than what the community health center would have received if it had been paid for such services on a per visit basis through its individual dental PPS rate. Such reconciliation wrap APM payment will equal the difference between the total MassHealth quarterly dental claims-based APM payments and what would have been paid for MassHealth dental visits through the dental PPS rate, in the aggregate, in the calendar quarter. For the purposes of calculating the dental reconciliation wrap APM payment, "visit" will include all individual dental visits.
  3. EOHHS will issue an administrative bulletin or other written issuance to clarify or provide further detail on this reconciliation wrap payment process including, but not limited to, clarifying the codes corresponding to counting the relevant medical and behavioral health visits and individual dental visits.



304.04: continued

(3) 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 pharmacies, independent clinical laboratories, optometrists, opticians, podiatrists, and other individual practitioners and noninstitutional providers.

(4) 340B Transition Supplemental Payments. Subject to federal approval, eligible community health centers will receive monthly supplemental payments in accordance with 101 CMR 304.04(4).

(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(4)(c)3., will receive supplemental payments in accordance with 101 CMR 304.04(4).

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(4)(c)3., will not receive supplemental payments in accordance with 101 CMR 304.04(4).

(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(4)(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.

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(4)(c)1. from projected annual medical visit rate revenue determined in accordance with 101 CMR 304.04(4)(c)2.

4. Projected annual impact of the medical visit rate effective October 20, 2017, determined in accordance with 101 CMR 304.04(4)(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(4)(c)2. is multiplied by 0.75.

6. The lower of the amount calculated in accordance with 101 CMR 304.04(4)(c)4. and the amount calculated in accordance with 101 CMR 304.04(4)(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.

304.04: continued

(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(4)(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(4)(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(4)(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(4)(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(4)(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(2)(a) 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(4)(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.

304.06: continued

(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.

<u>Modifier</u>	<u>Description</u>
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*; provided, however, that the frequency of any required cost reports and the penalties, which will be no more severe than the penalties permitted under 101 CMR 304.08(2), will be determined and announced *via* administrative bulletin or other written issuance published by EOHHS.

(2) Penalty for Noncompliance. The purchasing governmental unit may impose a penalty in the amount up to 15% of its payments to any provider that fails to submit required information. The purchasing governmental unit will notify the provider in advance of its intention to impose a penalty under 101 CMR 304.08(2).

304.09: Effect of Claims Submission for MassHealth Providers

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).

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.