101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 446.00: COVID-19 PAYMENT RATES FOR CERTAIN COMMUNITY HEALTH CARE PROVIDERS

Section

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446.01: General Provisions

(1) Scope and Purpose. 101 CMR 446.00 governs the rates of payment to certain community health care providers to be used by all governmental units for services provided to publicly aided individuals. The rates set forth in 101 CMR 446.03(1), (4), and (5) also apply to such services paid for by governmental units for individuals covered by M.G.L. c. 152 (the Workers' Compensation Act). These rates are for services related to the 2019 novel Coronavirus (COVID-19).

(2) Applicable Dates of Service. Rates contained in 101 CMR 446.00 apply for dates of service on or after November 10, 2020, except as otherwise noted.

(3) Disclaimer of Authorization of Services. 101 CMR 446.00 is not authorization for or approval of the services for which rates are determined pursuant to 101 CMR 446.00. Governmental units that purchase services are responsible for the definition, authorization, and approval of care and services provided to publicly aided individuals.

(4) Coverage. The rates of payment in 101 CMR 446.00 constitute payment in full for all services provided by an eligible provider, including administration and professional supervision services. The payment rates will apply to COVID-19 services provided by eligible providers to publicly aided individuals under the conditions described by the purchasing governmental unit.

(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 *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 existing and new codes and the codes 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 may list and price these codes according to the rate methodology used in setting rates when Medicare fees are available. When Medicare fees are not available, EOHHS may 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 and understanding of substantive provisions of 101 CMR 446.00, or to issue coding updates and corrections under 101 CMR 446.01(5).

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446.02: Definitions

As used in 101 CMR 446.00, terms have the meanings in 101 CMR 446.02, except as otherwise provided.

Clinical Care Team. The staff necessary to provide I&R Services to guests at an I&R site. The clinical care team may include physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses, certified nursing assistants, home health aides, masters of social work, licensed independent clinical social workers, and administrative support staff. EOHHS may approve other staff types to be part of the clinical care team, including staff with different clinical qualifications than those listed herein, as appropriate. The make-up of the clinical care team for each I&R community health center will be established in the special conditions amendment to each I&R community health center's provider contract.

COVID-19 Services. Services relating to the March 10, 2020, Declaration of State of Emergency within the Commonwealth due to the 2019 novel coronavirus (COVID-19), for which payment rates are set under 101 CMR 446.00.

Eligible Provider. A person, partnership, corporation, governmental unit, or other entity that provides authorized COVID-19 services and that also meets such conditions of participation as have been or may be adopted from time to time by a governmental unit purchasing COVID-19 services.

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

Governmental Unit. The Commonwealth of Massachusetts or any of its departments, agencies, boards, or commissions, or political subdivisions.

I&R Community Health Center. A community health center that has agreed to provide services at an I&R site through an executed special conditions amendment to its provider contract.

I&R Services. The services that the clinical care team at an I&R community health center must provide, as provided by the special conditions amendment to the provider contract.

I&R Site. A location, such as a hotel or motel, that separately contracts with EOHHS to provide safe, isolated lodging for individuals with a COVID-19 diagnosis.

Publicly Aided Individual. A person for whose medical and other services a governmental unit is in whole or in part liable under a statutory program.

446.03: General Rate Provisions and Payment

(1) Community Health Centers.
(a) General Rate Determination. Rates of payment for services for which 101 CMR 446.03(1) applies are the lowest of
1. the eligible provider's usual fee to patients other than publicly aided individuals;
2. the eligible provider's actual charge submitted; or
3. the schedule of allowable fees set forth in 101 CMR 446.03(1)(c), taking into account appropriate modifiers and any other applicable rate provisions in accordance with 101 CMR 446.03(1).

(b) Defined Terms. Terms used in 101 CMR 446.03(1) that have not been defined elsewhere in 101 CMR 446.00 have the meanings ascribed to those terms in 101 CMR 304.02: *Definitions*.

(c) Allowable Fee for I&R Services through Alternative Payment Methodology. Governmental units may pay I&R community health centers for I&R services they provide through a weekly, facility-specific, all-inclusive rate established through the alternative payment methodology described in 101 CMR 446.03(1)(c)1. through 3. This rate must be set forth and agreed to by each I&R community health center and the governmental unit through a contract or special conditions amendment to the provider contract, sufficient to cover the following allowable costs associated with the provision of I&R Services, as agreed to by the governmental unit and the I&R community health center.

1. The direct labor costs for the clinical care team, staffed appropriately to meet the clinical and administrative needs of the I&R site.
2. The costs to acquire and maintain sufficient amounts of medical supplies necessary to provide I&R services at the I&R site.
3. Appropriate set-up and other one-time costs associated with the provision of I&R services at the I&R site, which may include information technology equipment and services and office supplies.
4. For the costs described in 101 CMR 446.03(1)(c)1 through 3. to be considered allowable, the cost must, at a minimum, be reasonable, directly related to the provision of I&R services, and identified in the contract or special conditions amendment to the I&R community health center's provider contract.

(d) Billing and Disbursement of Payment. I&R community health centers must bill the governmental unit for the I&R services provided pursuant to 101 CMR 446.03(1) and a contract or special conditions amendment to the provider contract through weekly invoice. The government unit will pay the I&R community health center for such services weekly, upon receipt of such invoice, consistent with the terms of the contract or special conditions amendment to the provider contract.

(2) Medicine.

(a) General Rate Determination. Rates of payment for services for which 101 CMR 446.03(2) applies are the lowest of

1. the eligible provider's usual fee to patients other than publicly aided individuals;
2. the eligible provider's actual charge submitted; or
3. the schedule of allowable fees set forth in 101 CMR 446.03(2)(e), taking into account appropriate modifiers and any other applicable rate provisions in accordance with 101 CMR 446.03(2).

(b) Individual Consideration. Medical services services designated "I.C." are individually considered items. The governmental unit or purchaser analyzes the eligible provider's report of services rendered and charges submitted under the appropriate unlisted services or procedures category. The governmental unit or purchaser determines appropriate payment for procedures designated I.C. in accordance with the following standards and criteria:

1. the amount of time required to perform the service;
2. the degree of skill required to perform the service;
3. the severity or complexity of the patient's disease, disorder, or disability;
4. any applicable relative-value studies;
5. any complications or other circumstances that may be deemed relevant;
6. the policies, procedures, and practices of other third party insurers;

7. the payment rate for prescribed drugs as set forth in 101 CMR 331.00: *Prescribed Drugs*; and
8. a copy of the current invoice from the supplier.

(c) Defined Terms. Terms used in 101 CMR 446.03(2) that have not been defined elsewhere in this 101 CMR 446.00 have the meanings in 101 CMR 317.02: *General Definitions*.

(d) Codes and Modifiers.

1. Except as otherwise provided, the codes and modifiers for the services described in 101 CMR 446.03(2) are as defined in 101 CMR 317.04(3): *Modifiers* and 101 CMR 317.04(4): *Fee Schedule*.

2. "SL": State supplied vaccine or antibodies. This modifier is to be applied to codes to identify vaccine or antibodies provided at no cost, whether by the Massachusetts Department of Public Health or other federal or state agency. No payment shall be made for codes with this modifier.

(e) Allowable Fee for Remote Patient Monitoring (RPM) Bundled Services. The following code, modifier, and fee apply for the provision of RPM bundled services.

Code	Allowable Fee	Description of Code
99423 – U9	$870.72	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes. (Used for COVID-19 remote patient monitoring bundled services provided through any appropriate technology or modality, including up to 7 days of daily check-ins for evaluation and monitoring; multidisciplinary clinical team reviews of a member's status and needs; appropriate physician oversight; necessary care coordination; and provision of a thermometer and pulse oximeter for remote monitoring.)

(f) Allowable Fee for COVID-19 Vaccine and Vaccine Administration Applicable for Dates of Service on or after December 11, 2020. The following codes and fees apply for the listed COVID-19 vaccines and their administration.

Code	Allowable Fee	Description of Code
91300 SL	$0.00	Pfizer-Biontech COVID-19 Vaccine (SARSCOV2 VAC 30MCG/0.3ML IM)
0001A	$33.88	Pfizer-Biontech COVID-19 Vaccine Administration – First Dose (ADM SARSCOV2 30MCG/0.3ML 1st)
0002A	$56.78	Pfizer-Biontech COVID-19 Vaccine Administration – Second Dose (ADM SARSCOV2 30MCG/0.3ML 2ND)

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(g) Allowable Fee for COVID-19 Vaccine and Vaccine Administration Applicable for Dates of Service on or after December 18, 2020. The following codes and fees apply for the listed COVID-19 vaccines and their administration.

Code	Allowable Fee	Description of Code
91301 SL	$0.00	Moderna COVID-19 Vaccine (SARSCOV2 VAC 100MCG/0.5ML IM)
0011A	$33.88	Moderna COVID-19 Vaccine Administration – First Dose (ADM SARSCOV2 100MCG/0.5ML1ST)
0012A	$56.78	Moderna COVID-19 Vaccine Administration – Second Dose (ADM SARSCOV2 100MCG/0.5ML2ND)

(h) Allowable Fee for COVID-19 Treatment Applicable for Dates of Service on or after November 10, 2020. The following codes and fees apply for the listed COVID-19 treatment services.

Code	Allowable Fee	Description of Code
Q0239 SL	$0.00	Injection, bamlanivimab, 700 mg
M0239	$309.60	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring

(i) Allowable Fee for COVID-19 Treatment Applicable for Dates of Service on or after November 21, 2020. The following codes and fees apply for the listed COVID-19 treatment services.

Code	Allowable Fee	Description of Code
Q0243 SL	$0.00	Injection, casirivimab and imdevimab, 2400 mg
M0243	$309.60	Intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring

(3) Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment, and Supplies.

(a) General Rate Determination. Rates of payment for services for which 101 CMR 446.03(3) applies are the lowest of

1. the eligible provider's usual fee to patients other than publicly aided individuals;
2. the eligible provider's actual charge submitted; or
3. the schedule of allowable fees set forth in 101 CMR 446.03(3)(d) and (e), taking into account appropriate modifiers and any other applicable rate provisions in accordance with 101 CMR 446.03(3).

(b) Defined Terms. Terms in 101 CMR 446.03(3) have the meaning defined in 101 CMR 322.02: *General Definitions*.

(c) Codes and Modifiers. Except as otherwise provided, the codes and modifiers for the DME services described in 101 CMR 446.03(3) are as defined in 101 CMR 322.03(13): *Modifiers* and 101 CMR 322.06: *Allowable Fees and Rate Schedule*.

(d) Allowable Fee for Distribution of Personal Protective Equipment (PPE).
1. Authorization for the provision of, and billing and payment for, distribution of PPE to certain MassHealth members is governed by an executed special conditions amendment to a MassHealth DME provider's provider contract.
2. The fee and modifier in 101 CMR 446.03(3)(d)2. apply for distribution of PPE.

Code	Allowable Fee	Description of Code
E1399 U9	$40.00	Durable medical equipment, miscellaneous. (Used for PPE distribution services, specifically the packaging, preparing, and delivering or shipping of a 2-week supply PPE kit to an authorized individual during the COVID-19 public health emergency)

(e) Allowable Fee for Non-sterile Gloves. The following fee in 101 CMR 446.03(3)(e) is in effect for non-sterile gloves.

Code	Allowable Fee	Description of Code
A4927	$11.00	Gloves, non-sterile, per 100

(f) Reporting Requirements. Reporting requirements for 101 CMR 446.03(3) are those in 101 CMR 322.04: *Reporting Requirements*.

(4) Ambulance and Wheelchair Van Services.
(a) General Rate Determination. Rates of payment for services for which 101 CMR 446.03(4) applies are the lowest of
1. the eligible provider's usual fee to patients other than publicly aided individuals;
2. the eligible provider's actual charge submitted; or
3. the schedule of allowable fees set forth in 101 CMR 446.03(4)(c), taking into account appropriate modifiers and any other applicable rate provisions in accordance with 101 CMR 446.03(4).
(b) Defined Terms. Terms used in 101 CMR 446.03(4) that have not been defined elsewhere in this 101 CMR 446.00 have the meanings ascribed to those terms in 101 CMR 327.02: *General Definitions*.
(c) Allowable Fees for Ambulance and Wheelchair Van Services. The following code and allowable fee applies, notwithstanding the definition of "trip" in 101 CMR 327.02: *General Definitions.*

Code	Allowable Fee	Description of Code
A0998	$157.88	Ambulance response and treatment, no transport (Used for medically necessary visits to patients to obtain and transport specimens for COVID-19 diagnostic testing)
A0120	$100.00	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems. (Each way. Used only for non-emergency wheelchair van transport for a person under investigation or known to have COVID-19.)

(d) Billing Certification. Each eligible provider who submits an invoice to a governmental unit for authorized ambulance services must certify to the accuracy of the level of services provided, as listed on its invoice.

(e) Reporting Requirements. Reporting requirements under 101 CMR 446.03(4) are those in 101 CMR 327.05: *Reporting Requirements*.

(5) Prescribed Drugs.

(a) Defined Terms. Terms used in 101 CMR 446.03(5) that have not been defined elsewhere in 101 CMR 446.00 have the meanings ascribed to those terms in 101 CMR 331.02: *General Definitions*.

(b) Delivery Fee. Eligible providers will receive a payment adjustment to the professional dispensing fee when medications are delivered to a personal residence (including homeless shelters). The payment adjustment will be the lower of the provider's usual and customary charge for prescription delivery or $8.00, and will be made only when the MassHealth agency is the primary payer. The fee is payable only for deliveries to members living in personal residences and is not payable for claims for members living in any type of institution or residential facility (except for homeless shelters).

(c) Reporting Requirements. Reporting requirements for 101 CMR 446.03(5) are those in 101 CMR 331.03: *Reporting Requirements*.

(6) Testing Services.

(a) General Rate Determination. Rates of payment for services under 101 CMR 446.03(6) applies are the lowest of

1. the eligible provider's usual and customary charge to patients other than publicly aided individuals;
2. the eligible provider's actual charge submitted; or
3. the schedule of allowable fees set forth in 101 CMR 446.03(6)(c) and (d), taking into account appropriate modifiers and any other applicable rate provisions in accordance with 101 CMR 446.03(6).

(b) Defined Terms. Terms used in 101 CMR 446.03(6) that have not been defined elsewhere in 101 CMR 446.00 have the meanings ascribed to those terms in 101 CMR 320.02: *Definitions.*

(c) Individual Consideration (I.C.). Unlisted procedures and laboratory tests designated I.C. are individually considered items. The eligible provider's bill for such a test must be accompanied by a brief report of the procedure or test performed and the eligible provider's usual and customary charge for that procedure or test. Determination of appropriate payments for procedures and tests designated I.C. are in accordance with the following standards and criteria:

1. time required to perform the procedure;
2. degree of skill required in the procedure performed;
3. severity or complexity of the patient's disease, disorder, or disability;
4. policies, procedures, and practices of other third-party purchasers of care;
5. prevailing medical-laboratory ethics and accepted custom of the medical-laboratory community; and
6. such other standards and criteria as may be adopted by EOHHS. In no event may an eligible provider bill or be paid in excess of the usual and customary charge for the service.

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(d) Allowable Fees for Certain COVID-19 Testing Services – Not Including Laboratory Analysis. The allowable fees in 101 CMR 446.03(6)(d) apply for the listed COVID-19 testing services performed by an eligible provider at a mobile testing site where the eligible provider is not required to perform, pay for, or contract for the laboratory analysis.

Allowable Fee	Description of Service
$20.81	Ordering, resulting, and follow-up counseling services, per COVID-19 test completed by an eligible mobile testing vendor where the provider is not required to perform, pay for, or contract for the laboratory analysis
$60.00	COVID-19 specimen collection completed by an mobile testing vendor, including test administration or observation, and specimen transport services, per hour, per staff member

(e) Allowable Fees for Certain COVID-19 Testing Services – Including Laboratory Analysis. The allowable fees in 101 CMR 446.03(6)(e) apply for the listed COVID-19 testing services where the eligible provider is required to perform, pay for, or contract for the laboratory analysis:

Allowable Fee	Description of Service
$144.27	Site-based or mobile COVID-19 testing service administered or observed by an eligible provider, including specimen collection, laboratory processing, ordering, resulting, and follow-up counseling services, per test
Individual Consideration	Self-administered COVID-19 testing service completed by an eligible provider, including transport of testing materials, laboratory processing, ordering, resulting, and follow-up counseling services, per test

(f) Billing Certification. Each eligible provider who submits an invoice to a governmental unit for authorized services under 101 CMR 446.03(6) must certify to the accuracy of the level of services provided, as listed on its invoice.

446.04: Special Contracts

Notwithstanding 101 CMR 446.03, a governmental unit may enter into a special contract with an eligible provider under which the governmental unit will pay for services authorized but not listed herein, or authorized services performed in exceptional circumstances.

446.05: Reporting Requirements

(1) Required Reports. Except as otherwise provided, reporting requirements are governed by 957 CMR 6.00: *Cost Reporting Requirements*.

(2) Penalty for Noncompliance. Except as otherwise provided, the purchasing governmental unit may impose a penalty in the amount of 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 446.05(2).

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446.06: Severability

The provisions of 101 CMR 446.00 are severable and if any provisions of 101 CMR 446.00 or the application of such provisions to any person or 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 446.00 or application of such provisions to eligible providers or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 446.00: M.G.L. c.118E.