Community Violence Prevention Task Force – Overview of MassHealth Requirements

Executive Office of Health and Human Services

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Creating a Medicaid Service

To create and claim federal dollars for a new Medicaid service, we must consider the following:

- Obtaining Federal authority
- Provider enrollment and billing
- Financing and Federal Financial Participation (FFP)

Obtaining legal authority to add a new Medicaid Service

- States can apply for State Plan Amendment (SPA) or 1115 Demonstration "Waiver" authority that allows the state to claim federal dollars for the approved service(s)

- State Plan Amendment (SPA)
  - Massachusetts submits SPAs to Centers for Medicare & Medicaid Services (CMS) on a quarterly basis
  - Upon receipt of approval from CMS, the state can start claiming federal dollars for service

- 1115 Demonstration "Waiver"
  - Massachusetts submits amendments to the Waiver on an ad-hoc basis
  - Allows for flexibility that is not available under SPA authority
  - Not a "routine" process, requires significant public and federal engagement and is typically a multi-year initiative

- State must:
  - Define eligible provider type(s) and allowable service(s);
  - Set payment rates;
  - Ensure services are available statewide and for all members for whom the service is medically necessary

Enrolling as a MassHealth Provider and Billing

- Meeting requirements for enrollment
  - Obtain a National Provider Identifier number (NPI)
  - Meet qualifications (experience, education, organizational structure, etc.)
  - Complete MassHealth and/or managed care provider application and related documentation as well as provider training (and revalidation every few years)

- Verifying MassHealth Eligibility for individuals receiving services
  - Ensure individuals receiving services are eligible for MassHealth on date services are provided either through MassHealth provider eligibility verification system (EVS) or through the member's managed care plan

- Submitting claims to MassHealth or a MassHealth-contracted managed care plan
  - Providers submit claims to MassHealth or managed care plan using covered codes for payment
  - Providers must be able to access MassHealth system directly or contract with billing entity to submit claims, resolve issues, and reconcile claims/payments

- Cooperating with oversight/audits
  - All enrolled providers are subject to oversight and audits from MassHealth
  - Can include reporting requirements, records review, on-site visits, etc.
  - Also subject to audit from other state and federal entities (Auditor, OIG, etc.)

Claiming Federal Financial Participation (FFP)

- To claim FFP from the federal government, the state must first expend state funding for allowable services in accordance with an approved SPA or Waiver.
- The MassHealth-enrolled provider (provider) must ensure that the individual receiving services is a MassHealth member and that the service is medically necessary.
- The provider must validate and document that the allowable service has been provided in order to bill for the service through the Medicaid Management Information System (MMIS) or the member's managed care plan.
- MassHealth or a MassHealth contracted managed care plan pays the provider a rate for services once all of the above criteria is documented and verified. MassHealth would then claim FFP from CMS.
- The provider must retain records for 7 years for audit or compliance issues.
- Certified Public Expenditures (CPEs) could also be used for Medicaid services delivered by state agencies, but the same criteria listed above would still need to be validated and documented.