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**State/Territory Name: Massachusetts**

**State Plan Amendment (SPA) #: 21-0022**

**This file contains the following documents in the order listed:**

- 1) Approval Letter
- 2) CMS-179
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



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July 19, 2022

MaryLou Sudders, Secretary  
The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Office of Medicaid  
One Ashburton Place, Room 1109  
Boston, MA 02108

Re: Massachusetts Disaster Relief SPA 21-0022

Dear Secretary Sudders:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 21-0022. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this

state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Massachusetts also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Massachusetts also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Massachusetts Medicaid SPA Transmittal Number 21-0022 is approved effective November 1, 2020. This SPA is in addition to those previously approved in Massachusetts and does not supersede anything approved in those SPAs.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Marie DiMartino at 617-565-9157 or by email at Marie.Dimartino@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Massachusetts and the health care community.

Sincerely,

Alissa M.  
Deboy -S

Digitally signed by Alissa  
M. Deboy -S  
Date: 2022.07.19  
08:27:46 -04'00'

Alissa Mooney DeBoy  
On Behalf of Anne Marie Costello, Deputy Director  
Center for Medicaid and CHIP Services

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <u>2 1 - 0 2 2</u>	2. STATE MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	

TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 11/01/2020
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5. TYPE OF PLAN MATERIAL (Check One)

NEW STATE PLAN       AMENDMENT TO BE CONSIDERED AS NEW PLAN       AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION Title 19 of the Social Security Act: Section 1135 of the Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY 21 \$ 61,940,000 b. FFY 22 \$ 22,400,000
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  Attachment 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)
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10. SUBJECT OF AMENDMENT

Rates for the vaccine and monoclonal antibody administration, vaccines administered by certain types of clinicians, and certain acute inpatient hospital and psychiatric inpatient hospital supplemental payments.

11. GOVERNOR'S REVIEW (Check One)

GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE 	16. RETURN TO  The Commonwealth of Massachusetts Executive Office of Health and Human Services Office of Medicaid One Ashburton Place, Room 1109 Boston, MA 02108
13. TYPED NAME Marylou Sudders	
14. TITLE Secretary	
15. DATE SUBMITTED 08/06/21	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED 8/6/21	18. DATE APPROVED 7/19/2022
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**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL 11/1/2020	20. SIGNATURE OF REGIONAL OFFICIAL Alissa M. DeBoy -S 
21. TYPED NAME Alissa Mooney DeBoy	22. TITLE On Behalf of Anne Marie Costello, Deputy Director Center for Medicaid and CHIP Services

23. REMARKS

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## Section 7 – General Provisions

### 7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

*Describe shorter period here.*

Except as provided in Section E, the policies and procedures described below shall be effective 11/1/2020 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

#### Request for Waivers under Section 1135

  X   The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a.   X   SPA submission requirements – the agency requests modification of the requirement to submit the SPA by December 31, 2020, to obtain a SPA effective date during the fourth calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b.   X   Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans),

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42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

- c.  Tribal consultation requirements– the agency requests modification of tribal consultation timelines specified in Massachusetts Medicaid state plan, as described below:

*Please describe the modifications to the timeline.*

The timeframe for tribal consultation in the State Plan is at least 30 days prior to SPA submission and an allowance of at least 14 days for feedback. We request to change the tribal consultation timeframe during the emergency period to conduct consultation the same date as submission of the SPA with an allowance of a week for feedback.

EOHHS consulted with the Massachusetts Indian Tribes by email on August 6, 2021 about the proposed state plan amendments included in this COVID-19 Disaster SPA Template. The Tribes were asked to respond with any advice or feedback regarding this state plan amendment by August 13, 2021.

### Section A – Eligibility

1.  The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*Include name of the optional eligibility group and applicable income and resource standard.*

2.  The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a.  All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: \_\_\_\_\_

-or-

- b.  Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: \_\_\_\_\_



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3.    The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4.    The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5.    The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6.    The agency provides for an extension of the reasonable opportunity period for non- citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

**Section B – Enrollment**

1.    The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

*Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.*

2.    The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

*Please describe any limitations related to the populations included or the number of allowable PE periods.*



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3.  The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

*Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.*

4.  The agency adopts a total of \_\_\_\_\_ months (not to exceed 12 months) continuous eligibility for children under age enter age \_\_\_\_\_ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5.  The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every \_\_\_\_\_ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6.  The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a.  The agency uses a simplified paper application.
  - b.  The agency uses a simplified online application.
  - c.  The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

**Section C – Premiums and Cost Sharing**

1.  The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

*Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).*

2.  The agency suspends enrollment fees, premiums and similar charges for:
- a.  All beneficiaries

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b.    The following eligibility groups or categorical populations:

*Please list the applicable eligibility groups or populations.*

3.    The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

*Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.*

### Section D – Benefits

*Benefits:*

1.    The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2.   X   The agency makes the following adjustments to benefits currently covered in the state plan:

The agency will provide coverage for COVID-19 vaccination administrations by emergency medical technicians (EMTs), pharmacists, pharmacy interns, pharmacy technicians, dentists, public health dental hygienists, and dental hygienists under the Other Licensed Practitioner (OLP) benefit. The services of EMTs, pharmacists, pharmacy interns, pharmacy technicians, dentists, public health dental hygienists, and dental hygienists will be limited to the scope of practice authorized by state law and must be provided in accordance with applicable state licensure and other applicable federal and state requirements.

The agency will provide coverage for COVID-19 vaccination administration provided by mental health centers and substance use disorder treatment clinics under the clinic services benefit.

3.    The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

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4.  Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).
- a.  The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b.  Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

*Please describe.*

*Telehealth:*

5.  The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

*Please describe.*

*Drug Benefit:*

6.  The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

*Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.*

7.  Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8.  The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

*Please describe the manner in which professional dispensing fees are adjusted.*

9.  The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

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## Section E – Payments

*Optional benefits described in Section D:*

1. X Newly added benefits described in Section D are paid using the following methodology:

a. X Published fee schedules –

Effective date (enter date of change): 11/10/2020, except as otherwise noted (in each case, date of emergency use authorization (EUA) from the U.S Food and Drug Administration) (FDA)); updates made effective 03/19/2021 and 09/17/2021.

Location (list published location): <https://www.mass.gov/regulations/101-CMR-44600-covid-19-payment-rates-for-certain-community-health-care-providers>

b.   Other:

*Increases to state plan payment methodologies:*

1. The agency increases payment rates for the following services:

*Please list all that apply.*

1. Acute Inpatient and Outpatient Hospital Supplemental Payments
2. Psychiatric Inpatient Hospital Supplemental Payments

Effective dates for each of these payments are set forth hereinafter.

a.    Payment increases are targeted based on the following criteria:

*Please describe criteria.*

b. Payments are increased through:

i. X A supplemental payment or add-on within applicable upper payment limits:

*Please describe.*

1. Acute Inpatient and Outpatient Hospital Supplemental Payments

a. Acute Inpatient Hospital Expansion of Inpatient Behavioral Health Capacity Supplemental Payment

i. Definitions

1. For purposes of this Section E.2.b.i.1.a, the following terms shall have the following meanings:

- a. Baseline for the First Period – The number of DMH-Licensed Beds operated by the Hospital as of November 1, 2020, or, in the event that the Hospital acquired an inpatient facility after November 1, 2020, and prior to May 1, 2021, the number of DMH-Licensed Beds operated at such inpatient facility by the Hospital's predecessor as of November 1, 2020.
- b. Baseline for the Second Period – The Hospital's Baseline for the First Period plus the Hospital's Bed Increase for the First Period, or, in the event that the Hospital acquired an inpatient facility after April 30, 2021, the predecessor Hospital's Baseline for the First Period at such inpatient facility plus the predecessor Hospital's Bed Increase for the First Period at such inpatient facility.
- c. Bed Increase – The number of DMH-Licensed Beds above the Baseline for a Period that the Hospital commits to operationalize during that Period, including obtaining all necessary licensure and approval from DMH and DPH. In the event that the Hospital acquired an inpatient facility in the middle of a Period, its Bed Increase for that Period for such inpatient facility shall be the number of DMH-Licensed Beds above the Baseline for that Period that the Hospital commits to operationalize during that Period, including obtaining all necessary licensure and approval from DMH and DPH, inclusive of any DMH-Licensed Beds Operationalized at such inpatient

facility by the predecessor Hospital during that Period prior to the acquisition.

- d. First Period – As determined by EOHHS, the period beginning November 1, 2020, and ending no later than June 14, 2021.
- e. Second Period – As determined by EOHHS, the period beginning on the day following the date that is the last day of the First Period, and ending December 31, 2021.
- f. Period – Either the First Period or the Second Period.
- g. Managed Care Entity (MCE) – An MCO or the BH Contractor.
- h. MassHealth Payer-Mix – As determined by EOHHS, the ratio of all dates of service on which a Member received inpatient BH services from the Hospital in a DMH-Licensed Bed to all dates of service on which the Hospital's patients received services in such beds, provided, further, that such dates of service include any dates of service on which a Member or patient was discharged to AD status from such DMH-Licensed Bed following such inpatient BH admission. For purposes of this definition, the numerator includes any date of service on which any of the following Members received services in such beds:

- i. Members receiving services on a fee-for-service basis;
- ii. Members enrolled with a Managed Care Entity;
- iii. Members with Third-Party Insurance.

- i. Operationalize – Hospital activities to make available licensed and staffed DMH-Licensed Beds for immediate occupancy, subject to the hospital's

standard operating procedures for referral and intake.

ii. Eligibility Criteria

A Hospital is eligible for an Expansion of Inpatient Behavioral Health Capacity Supplemental Payment if the Hospital:

1. Enters into a separate payment agreement with EOHHS relating to receipt of such payment;
2. Is privately-owned and operated;
3. Attests no later than June 1, 2021 to:

- a. The Hospital's Baseline for the First Period;
- b. The Hospital's Bed Increase during the First Period;
- c. The Hospital's Baseline for the Second Period; and
- d. The Hospital's Bed Increase during the Second Period.

4. Agrees:

- a. Not to delicense any of its DMH-Licensed Beds, whether currently licensed or otherwise, through the end of RY24, provided that a Hospital's transfer of some or all of its DMH-Licensed Beds to another hospital owned by or affiliated with the transferor Hospital, or owned by or affiliated with the same entity that owns the transferor Hospital, shall not be considered a delicensure of those beds, so long as such transfer does not result in a net decrease to the total number of DMH-Licensed beds operated by the transferor and transferee hospitals combined;
- b. That any supplemental payments made pursuant to this Section E.2.b.i.1.a are subject to recoupment, in whole or in



part, if the Hospital fails to license and operationalize its Bed Increases in a timely fashion, or otherwise fails to comply with any term, condition, or agreement described in this Section E.2.b.i.1 a;

- c. To maintain a MassHealth Payer-Mix of at least 20% in each of RY22, RY23, and RY24, provided that, for purposes of this Section E.2.b.i.1.a.ii.4.c, the Hospital's MassHealth Payer-Mix shall be calculated using only the Hospital's Bed Increases pursuant to this Section E.2.b.i.1 a;
- d. That if the Hospital is part of a system of Hospitals, that all DMH-licensed units within such system, and all psychiatric inpatient hospitals within such system, in the aggregate, will maintain a MassHealth Payer Mix in each of RY22, RY23, and RY24 that is no less than its MassHealth Payer Mix in FY19, as determined by EOHHS, provided that, for purposes of this Section E.2.b.i.1.a.ii.4.d, the system's MassHealth Payer-Mix shall be calculated using such system's current DMH-Licensed Beds, exclusive of any Bed Increases pursuant to this Section E.2.b.i.1.a; and
- e. To expend any supplemental payments pursuant to this Section E.2.b.i.1.a solely for the purpose of licensing and Operationalizing the Bed Increases described in this Section E.2.b.i.1.a.

iii. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make one or more prospective supplemental payments to each Hospital that qualifies for this payment pursuant to Section E.2.b.i.1.a.ii, in accordance with the methodology that follows. EOHHS will pay each qualifying Hospital the sum of: (\$150,000 x Bed

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Increases during the First Period) +  
(\$120,000 x Bed Increases during the Second  
Period).

(Effective November 1, 2020 through the last day of the Presidential and Secretarial  
emergency declarations related to the COVID-19 outbreak (or any renewals  
thereof))

b. Supplemental Payment for Acute Inpatient Hospitals  
Accepting COVID-Positive MassHealth Members Needing  
Inpatient BH Services

i. Eligibility Criteria

1. A Hospital is eligible for a Supplemental  
Payment for Hospitals Accepting COVID-  
Positive MassHealth Members Needing  
Inpatient BH Services if the Hospital:

- a. Demonstrates that each of its units with  
one or more DMH-licensed beds  
(Applicable Units) has been designated  
as either a Tier 1 or a Tier 2 facility by  
DMH, in accordance with DMH Bulletin  
#20-05R;
- b. Agrees to:

- i. Comply with all applicable  
DMH requirements, including  
any conditions of designation  
as either a Tier 1 or Tier 2  
facility; and
- ii. Provide periodic reports in a  
form and on a cadence to be  
prescribed by EOHHS.

c. Admits at least one Member after  
October 31, 2020, and prior to July 15,  
2021 who satisfies each of the following  
criteria:

- i. The Hospital admits the  
Member into a DMH-Licensed  
Bed for the primary purpose  
of rendering inpatient BH  
services;

- ii. The Member is confirmed to have been positive for SARS-CoV-2 at the time of admission to the DMH-Licensed Bed based on a SARS-CoV-2 Molecular Diagnostic test or an FDA-approved rapid antigen test administered before admission or within 96 hours after admission; and
- iii. The Member is not suspected to have become COVID-positive from exposure occurring within the admitting hospital or from interactions with any member of the hospital's staff or other currently COVID-positive patients at the hospital.

2. A hospital designated Tier 1 by DMH must also demonstrate that:

- a. It satisfies each of the eligibility criteria set forth above, except for Section E.2.b.i.1.b.i.1.c.ii; and
- b. for each Member described in Section E.2.b.i.1.b.i.1.c:

- i. the Member's test results were negative or pending upon admission;
- ii. the Member's test results later come back as positive or the Member is given another SARS-CoV-2 Molecular Diagnostic test or an FDA-approved rapid antigen test within 96 hours of admission which comes back as positive; and
- iii. the hospital was unable to transfer the Member to a hospital designated by DMH as Tier 2.

c. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments within RY21 to each Hospital satisfying the eligibility criteria set forth in Section E.2.b.i.1.b.i. Each eligible Hospital's payment shall be \$941 for each date of service between November 1, 2020, and July 15, 2021, on which the Hospital rendered:

- Services reimbursed through the Psychiatric Per Diem rate to a Member described in Section E.2.b.i.1.b.i.1.c, in the case of a Tier 2 Hospital, or Sections E.2.b.i.1.b.i.1.c.i, E.2.b.i.1.b.i.1.c.iii, and E.2.b.i.1.b.i.2, in the case of a Tier 1 Hospital, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation; or
- Services reimbursed through Administrative Day Per Diem rate to a Member described in Section E.2.b.i.1.b.i.1.c, in the case of a Tier 2 Hospital, or Sections E.2.b.i.1.b.i.1.c.i, E.2.b.i.1.b.i.1.c.iii, and E.2.b.i.1.b.i.2, in the case of a Tier 1 Hospital, who was discharged to Administrative Day status from a DMH-Licensed Bed following an inpatient BH admission, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation, inclusive of the Member's preceding inpatient BH stay.

(Effective November 1, 2020 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

c. Supplemental Payments for Acute Inpatient and Outpatient Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020

#### **i. Eligibility Criteria**

In order to qualify for a Supplemental Payment for Acute Inpatient and Outpatient Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020, a Hospital must satisfy each of the following criteria:

1. the Hospital has a statewide relative price less than 0.90, as calculated by the Center for Health Information and Analysis (CHIA) according to data from the most recent available year;
2. the Hospital has a public payer mix equal to or greater than 60 percent, as calculated by CHIA according to data from the most recent available year; and

3. the Hospital is not owned, financially consolidated or corporately affiliated with a provider organization, as defined by G.L. c. 6D, § 1:
  - a. that owns or controls 2 or more acute care hospitals licensed under section 51 of chapter 111; and
  - b. for which the total net assets of all affiliated acute care hospitals within the provider organization is greater than \$600,000,000, as calculated CHIA according to data from the most recent available year.

For purposes of this **Section E.2.b.i.1.c.i**, a Hospital's mere clinical affiliation with a provider organization, absent ownership, financial consolidation, or corporate affiliation, shall not disqualify an eligible Hospital from payments authorized under this section.

In addition, to qualify for a Supplemental Payment for Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020, a Hospital meeting the eligibility criteria set forth above must enter into a separate payment agreement with EOHHS relating to payment under this provision.

#### **ii. Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make monthly payments within RY21, beginning in January 2021, to each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.1.c.i**. Pursuant to section 63 of chapter 260 of the Acts of 2020, EOHHS shall calculate each such qualifying Hospital's monthly payment by:

- First, determining each such Hospital's average monthly Medicaid payments for inpatient and outpatient acute hospital services for the preceding year or the most recent year for which data is available (Average Monthly Medicaid Payment). This figure shall be as determined by EOHHS.
- Second, calculating each such Hospital's supplemental monthly payment by multiplying such Hospital's Average Monthly Medicaid Payment by 5 percent (Supplemental Monthly Payment).

In accordance with section 63 of the chapter 260 of the Acts of 2020, in the event that the sum of all Supplemental Monthly Payments to all qualifying Hospitals in either FY21 or FY22 exceeds \$35 million, each qualifying Hospital's Supplemental Monthly Payment shall be reduced on a pro rata basis.

(Effective January 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

2. Psychiatric Inpatient Hospital Supplemental Payments

a. Expansion of Inpatient Behavioral Health Capacity Supplemental Payment

i. Definitions

1. For purposes of this Section E.2.b.i.2.a, the following terms shall have the following meanings:

- a. Baseline for the First Period – The number of DMH-Licensed Beds operated by the Hospital as of November 1, 2020, or, in the event that the Hospital acquired an Inpatient Site after November 1, 2020, and prior to May 1, 2021, the number of DMH-Licensed Beds operated by the Hospital's predecessor at such Inpatient Site as of November 1, 2020.
- b. Baseline for the Second Period – The Hospital's Baseline for the First Period plus the Hospital's Bed Increase for the First Period, or, in the event that the Hospital acquired an Inpatient Site after April 30, 2021, the predecessor Hospital's Baseline for the First Period at such Inpatient Site plus the predecessor Hospital's Bed Increase for the First Period at such Inpatient Site.
- c. Bed Increase – The number of DMH-Licensed Beds above the Baseline for a Period that the Hospital commits to

operationalize during that Period, including obtaining all necessary licensure and approval from DMH and DPH. In the event that the Hospital acquired an Inpatient Site in the middle of a Period, its Bed Increase for that Period for such Inpatient Site shall be the number of DMH-Licensed Beds above the Baseline for that Period that the Hospital commits to operationalize during that Period for such inpatient facility, including obtaining all necessary licensure and approval from DMH and DPH, inclusive of any DMH-Licensed Beds operationalized at such Inpatient Site by the predecessor Hospital during that Period prior to the acquisition.

- d. First Period – As determined by EOHHS, the period beginning November 1, 2020, and ending no later than June 14, 2021.
- e. Second Period As determined by EOHHS, the period beginning on the date following the date that is the last day of the First Period, and ending December 31, 2021.
- f. Period – Either the First Period or the Second Period.
- g. Managed Care Entity (MCE) – An MCO or the BH Contractor.
- h. MassHealth Payer-Mix – As determined by EOHHS, the ratio of all dates of service on which a Member received Inpatient Services from the Hospital in a DMH Licensed Bed, and all dates of a Member’s inpatient hospitalization defined as Administratively Necessary Days (AND), to all dates of service on which the Hospital's patients received such services in such beds. For purposes of this definition, the numerator includes any date of service on which any of the following Members received services:

- i. Members receiving services on a fee-for-service basis;
- ii. Members enrolled with a Managed Care Entity;



iii. Members with Third-Party Insurance.

i. Operationalize – Hospital activities to make available licensed and staffed DMH-Licensed Beds for immediate occupancy, subject to the hospital’s standard operating procedures for referral and intake.

ii. Eligibility Criteria

A Hospital is eligible for an Expansion of Inpatient Behavioral Health Capacity Prospective Supplemental Payment if the Hospital:

1. Enters into a separate payment agreement with EOHHS relating to receipt of such payment;
2. Attests no later than June 1, 2021, to:

- a. The Hospital’s Baseline for the First Period;
- b. The Hospital’s Bed Increase during the First Period;
- c. The Hospital’s Baseline for the Second Period; and
- d. The Hospital’s Bed Increase during the Second Period.

3. Agrees:

a. Not to delicense any of its DMH-Licensed Beds, whether currently licensed or otherwise, through the end of RY24, provided that a Hospital's transfer of some or all of its DMH-Licensed Beds to another hospital owned by or affiliated with the transferor Hospital, or owned by or affiliated with the same entity that owns the transferor Hospital, shall not be considered a delicensure of those beds, so long as such transfer does not result in a net decrease to the total number of DMH-Licensed beds operated by the transferor and

transferee hospitals combined;

- b. That any supplemental payments made pursuant to this Section E.2.b.i.2.a are subject to recoupment, in whole or in part, if the Hospital fails to license and operationalize its Bed Increases in a timely fashion, or otherwise fails to comply with any term, condition, or agreement described in this Section E.2.b.i.2.a;
- c. To maintain a MassHealth Payer-Mix of at least 20% in each of RY22, RY23, and RY24, provided that, for purposes of this Section E.2.b.i.2.a.ii.5.c, the Hospital's MassHealth Payer-Mix shall be calculated using only the Hospital's Bed Increases pursuant to this Section E.2.b.i.2.a;
- d. That if the Hospital is part of a system of Hospitals, that all DMH-licensed units within such system, and all psychiatric inpatient hospitals within such system, in the aggregate, will maintain a MassHealth Payer Mix in each of RY22, RY23, and RY24 that is no less than its MassHealth Payer Mix in FY19, as determined by EOHHS, provided that, for purposes of this Section E.2.b.i.2.a.ii.5.d, the system's MassHealth Payer-Mix shall be calculated using such system's current DMH-Licensed Beds, exclusive of any Bed Increases pursuant to this Section E.2.b.i.2.a;
- e. To expend any supplemental payments pursuant to this Section E.2.b.i.2.a solely for the purpose of licensing and Operationalizing the Bed Increases described in this Section E.2.b.i.2.a; and

iii. Methodology

- 1. Subject to compliance with all applicable federal rules and payment limits, EOHHS will make one or more prospective supplemental payments to each Hospital that qualifies for this payment pursuant to Section E.2.b.i.2.a.ii, in accordance with the methodology that follows. EOHHS will pay each qualifying Hospital the sum of: (\$100,000 x Bed

Increases during the First Period) + (\$80,000 x Bed Increases during the Second Period).

2. The amount of each such qualifying Hospital's prospective supplemental payment pursuant to this Section E.2.b.i.2.a will be specified in the payment agreement between EOHHS and that Hospital.

(Effective November 1, 2020 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

b. Supplemental Payment for Hospitals Accepting COVID-Positive Patients

i. Eligibility Criteria

1. A Hospital is eligible for a Supplemental Payment for Hospitals Accepting COVID-Positive MassHealth Members Needing Inpatient BH Services if the Hospital:

- a. Demonstrates that each of its units with one or more DMH-licensed beds (Applicable Units) has been designated as either a Tier 1 or a Tier 2 facility by DMH, in accordance with DMH Bulletin #20-05R;

- b. Agrees to:

- i. Comply with all applicable DMH requirements, including any conditions of designation as either a Tier 1 or Tier 2 facility; and
- ii. Provide periodic reports in a form and on a cadence to be prescribed by EOHHS.

- c. Admits at least one Member after October 31, 2020, and prior to July 15, 2021 who satisfies each of the following criteria:

- i. The Hospital admits the Member into a DMH-Licensed Bed for the primary purpose of rendering Inpatient services;

- ii. The Member is confirmed to have been positive for SARS-CoV-2 at the time of admission to the DMH-Licensed Bed based on a SARS-CoV-2 Molecular Diagnostic test or an FDA-approved rapid antigen test administered before admission or within 96 hours after admission; and
- iii. The Member is not suspected to have become COVID-positive from exposure occurring within the admitting hospital or from interactions with any member of the hospital's staff or other currently COVID-positive patients at the hospital.

2. A hospital designated Tier 1 by DMH must also demonstrate that:

- a. It satisfies each of the eligibility criteria set forth above, except for Section E.2.b.i.2.b.i.1.c.ii; and
- b. for each Member described in Section E.2.b.i.2.b.i.1.b:

- i. the Member's test results were negative or pending upon admission;
- ii. the Member's test results later come back as positive or the Member is given another SARS-CoV-2 Molecular Diagnostic test or an FDA-approved rapid antigen test within 96 hours of admission which comes back as positive; and
- iii. the hospital was unable to transfer the Member to a hospital designated by DMH as Tier 2.

ii. Methodology

- Subject to legislative appropriation or authorization, compliance

with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment or payments within RY21 to each Hospital satisfying the eligibility criteria set forth in Section E.2.b.i.2.b.i.; Each eligible Hospital's payment shall be \$941 for each date of service between November 1, 2020, and July 15, 2021, on which the Hospital rendered:

- Services reimbursed as described in Section E.2.b.i.2.b.i.2.c, in the case of a Tier 2 Hospital, or Sections E.2.b.i.2.b.i.1.c.i, E.2.b.i.2.b.i.1.c.iii, and E.2.b.i.2.b.i.2, in the case of a Tier 1 Hospital, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation; or
- Services reimbursed through Administrative Day Per Diem rate to a Member described in Section E.2.b.i.2.b.i.1.c, in the case of a Tier 2 Hospital, or Sections E.2.b.i.2.b.i.1.c.i, E.2.b.i.2.b.i.1.c.iii, and E.2.b.i.2.b.i.2, in the case of a Tier 1 Hospital, who was discharged to AND status following an inpatient admission, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation, inclusive of the Member's preceding Inpatient Stay.

(Effective November 1, 2020 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

c. Supplemental Payments for Hospitals with Temporary Dedicated COVID Units Admitting COVID-Positive MassHealth Members

**i. Definitions**

1. Dedicated COVID Unit – A DMH-approved psychiatric unit within a Hospital into which the Hospital will admit only COVID-Positive Patients in need of Inpatient Services. Units will only meet this definition during the period specifically approved by DMH.
2. COVID-Positive Patient – A patient who is confirmed to be infected with SARS-CoV-2 upon admission to a Hospital through a Molecular Diagnostic test or an FDA-approved rapid antigen test.
3. COVID-Positive MassHealth Member – A COVID-Positive Patient who is a Member.

**ii. Eligibility Criteria.**

A Hospital is eligible to receive a Supplemental Payment for Hospitals with Temporary Dedicated COVID Units Admitting COVID-Positive MassHealth Members if the Hospital:

1. Demonstrates that DMH has approved the creation of a Dedicated COVID Unit within the Hospital;
2. Agrees:

- a. to comply with all applicable DMH requirements, such as any conditions of approval for the Dedicated COVID Unit; and
- b. not to admit or transfer-in non-COVID-Positive Patients to the Dedicated COVID Unit while the unit remains a Dedicated COVID Unit, unless the non-COVID-Positive Patient had previously tested positive for Sars-CoV-2 within 60 days prior to admission; and

2. admits at least one COVID-Positive MassHealth Member to the Dedicated COVID Unit during the period in which DMH has approved the unit as a Dedicated COVID Unit, but no later than February 28, 2021.

**iii. Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make one or more supplemental payment or payments within RY21 to each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.2.c.ii** for each period beginning on or after January 1, 2021 in which the Hospital operated a Dedicated COVID Unit in accordance with the methodology that follows.

1. Each eligible Hospital shall receive a payment or payments equal to the amount calculated by multiplying \$300 by the number of days that the Hospital operated the DMH-approved Dedicated COVID Unit

State/Territory: Massachusetts

by the number of beds in that DMH-approved Dedicated COVID Unit, for all dates of service the hospital operates the DMH-approved dedicated COVID-Unit prior to June 1, 2021

2. In addition to any payment pursuant to Section **E.2.b.i.2.c.iii.**, each eligible Hospital operating a DMH-approved Dedicated COVID Unit during the entirety of the period between January 1, 2021 and March 31, 2021, shall receive a lump sum payment of \$120,000

(Effective January 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

- ii.  An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: \_\_\_\_\_

Through a modification to published fee schedules –

Effective date (enter date of change):

Location (list published location):

Up to the Medicare payments for equivalent services.

By the following factors:

*Please describe.*

*Payment for services delivered via telehealth:*

3.  For the duration of the emergency, the state authorizes payments for telehealth services that:



State/Territory: Massachusetts

- a.  Are not otherwise paid under the Medicaid state plan;
- b.  Differ from payments for the same services when provided face to face;
- c.  Differ from current state plan provisions governing reimbursement for telehealth;

*Describe telehealth payment variation.*

- d.  Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
  - i.  Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
  - ii.  Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

*Other:*

4.  Other payment changes:

For physicians, other licensed practitioners, mental health centers, substance use disorder treatment clinics, and AOHs, COVID-19 vaccine administrations will be paid for at the rates set in the fee schedule published here: <https://www.mass.gov/regulations/101-CMR-44600-covid-19-payment-rates-for-certain-community-health-care-providers>, beginning for dates of service on or after December 11, 2020, except as otherwise noted (in each case, date of EUA from the FDA).

For physicians, other licensed practitioners, and AOHs, monoclonal antibody infusion services will be paid at the rates set in the fee schedule published here: <https://www.mass.gov/regulations/101-CMR-44600-covid-19-payment-rates-for-certain-community-health-care-providers>, beginning for dates of service on or after November 10, 2020, except as otherwise noted (in each case, date of EUA from the FDA).

#### **Section F – Post-Eligibility Treatment of Income**

- 1.  The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
  - a.  The individual's total income
  - b.  300 percent of the SSI federal benefit rate
  - c.  Other reasonable amount: \_\_\_\_\_
- 2.  The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1.

State/Territory: Massachusetts

above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

*Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.*

**Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information**

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. \*\*\*CMS Disclosure\*\*\* Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.