

# **Table of Contents**

**State/Territory Name: Massachusetts**

**State Plan Amendment (SPA)#: 24-0010**

This file contains the following documents in the order listed:

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

**DEPARTMENT OF HEALTH & HUMAN SERVICES**  
Centers for Medicare & Medicaid Services  
601 E. 12th St., Room 355  
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

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May 31, 2024

Kathleen E. Walsh, 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 State Plan Amendment (SPA) 24-0010

Dear Secretary Walsh:

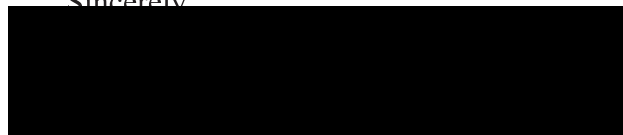
The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0010. This amendment proposes to update the methods and standards used by Massachusetts to pay Medicare crossover payments for ground ambulance services.

We conducted our review of your submittal according to statutory requirements in 1902(n)(1) of the Social Security Act. This letter informs you that Massachusetts Medicaid SPA TN MA-24-0010 was approved on May 31, 2024, with an effective date of January 1, 2024.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the Massachusetts State Plan.

If you have any questions, please contact Ambrosia Watts at (667) 414-0089 or via email at [Ambrosia.Watts1@cms.hhs.gov](mailto:Ambrosia.Watts1@cms.hhs.gov).

Sincerely,



Division of Program Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL  
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER <u>24-0010</u>	2. STATE <u>MA</u>
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3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR  
CENTERS FOR MEDICAID & CHIP SERVICES  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
1/1/24

5. FEDERAL STATUTE/REGULATION CITATION  
1902(n)(1) of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)  
a. FFY 24 \$ 5,805,000  
b. FFY 25 \$ 7,761,000

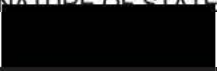
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT  
  
Supplement 1 to Attachment 4.19-B, pp.  
1-3

8. PAGENUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)  
  
Supplement 1 to Attachment 4.19-B pages 1-3

9. SUBJECT OF AMENDMENT  
  
An amendment to the payment methodologies for Medicare crossover rates for ground ambulance services.

10. GOVERNOR'S REVIEW (Check One)

<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT	<input checked="" type="checkbox"/> OTHER, AS SPECIFIED:
<input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED	Not required under 42 CFR 430.12(b)(2)(i)
<input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL	

11. SIGNATURE OF STATE AGENCY OFFICIAL  


12. TYPED NAME  
Mike Levine

13. TITLE  
Assistant Secretary for MassHealth


14. DATE SUBMITTED  
03/29/2024

15. RETURN TO  
  
The Commonwealth of Massachusetts  
Executive Office of Health and Human Services  
Office of Medicaid  
One Ashburton Place, 3rd Floor  
Boston, MA 02108

**FOR CMS USE ONLY**

16. DATE RECEIVED 03/29/2024	17. DATE APPROVED 05/31/2024
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**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL 01/01/2024	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL James G. Scott	21. TITLE OF APPROVING OFFICIAL Director Division of Program Operations

22. REMARKS

State Plan under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters “SP.”

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item \_\_\_\_ of this attachment (see 3. Below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters “MR.”
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item 1 of this attachment, for those groups and payments listed below and designated with the letters “NR.”
4. Any exception to the general methods used for a particular group or payment are specified on Page 3 in item 1 of this attachment (see 3. Above).

State Plan under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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QMBs:	Part A <u>SP</u> Deductibles	<u>SP</u>	Coinsurance
	Part B <u>SP</u> Deductibles	<u>SP</u>	Coinsurance
Other Medicaid Recipients	Part A <u>SP</u> Deductibles	<u>SP</u>	Coinsurance
	Part B <u>SP</u> Deductibles	<u>SP</u>	Coinsurance
Dual Eligible (QMB Plus)	Part A <u>SP</u> Deductibles	<u>SP</u>	Coinsurance
	Part B <u>SP</u> Deductibles	<u>SP</u>	Coinsurance

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SP – State Plan – Medicaid  
MR – Medicare rates

State Plan under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance  
Special Rates (NR)

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Item 1. For ground ambulance services, the State Medicaid Agency pays the full deductible and coinsurance for Medicare Part B services, so that providers of ground ambulance services receive the full Medicare Rate.