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State/Territory Name: Massachusetts

State Plan Amendment (SPA)#: 24-0042

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

March 25, 2025

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) 24-0042

Dear Ms. Walsh:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) MA-24-0042. This amendment proposes to update the payment methodologies for Medicare crossover payments for certain Durable Medical Equipment services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulation 42USC 1396a(n). This letter informs you that Massachusetts' Medicaid SPA TN 24-0042 was approved on March 21, 2025, effective October 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.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 24-0042

2. STATE: MA

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
10/01/2024

5. FEDERAL STATUTE/REGULATION CITATION
42USC 1396a(n)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 25 $ 139,000
b. FFY 26 $ 139,000

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

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement 1 to Attachment 4.19-B pp. 1-3

9. SUBJECT OF AMENDMENT

An amendment to update the payment methodologies for Medicare crossover payments for certain DME services

10. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED: Not required under 42 CFR 430.12(b)(2)(i)

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Mike Levine

13. TITLE
Assistant Secretary for MassHealth

14. DATE SUBMITTED
12/31/2024

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

FOR CMS USE ONLY

16. DATE RECEIVED
12/31/2024

17. DATE APPROVED
03/21/2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10/01/2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
James G. Scott

21. TITLE OF APPROVING OFFICIAL
Director
Division of Program Operations

22. REMARKS

Instructions on Back

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

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

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 items 1 and 2 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 items 1 and 2 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

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

Payment of Medicare Part A and Part B Deductible/Coinsurance

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

SP – State Plan – Medicaid
MR – Medicare rates

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

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

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

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.

Item 2. The State Medicaid Agency pays a supplemental payments in a total aggregate amount of $260,000 to providers that meet the requirements of Attachment 4.19-B page 1p2 and Supplement 1 of Attachment 4.19-B pages 1-3 for ceiling lift services provided to dual eligible members, so that providers receive total payments equal to the full Medicaid rate for ceiling lift services provided to non-dual eligible members.