

**Health Safety Net Trust Fund Payments:
Recommended Policies for Acute Hospitals and
Community Health Centers in Hospital Fiscal Year
2008**

*A Report by the Executive Office of Health and Human Services
Division of Health Care Finance and Policy*

Submitted in compliance with Chapter 58 of the Acts of 2006 § 124

May 1, 2007

I. Executive Summary

The Division of Health Care Finance and Policy ("the Division") has prepared this report pursuant to Section 124 of Chapter 58 of the Acts of 2006, which provides that:

(n)ot later than April 1, 2007, the division of health care finance and policy, in consultation with the secretary of health and human services, shall submit to the house and senate committees on ways and means a report on a new methodology for equitably allocating free care reimbursements from the Uncompensated Care Trust Fund to hospitals and community health centers beginning in hospital fiscal year 2008.

On March 29, 2007, the secretary of health and human services requested a thirty-day extension of the filing date to provide the Division additional time to complete its analyses.

Chapter 58 calls for the creation of the Health Safety Net Office ("HSNO") to administer the Health Safety Net Trust Fund ("HSNTF") successor to the Uncompensated Care Pool ("UCP"). For HSNTF fiscal year 2008, the office is required to develop regulations that specify the services that may be charged to the HSNTF, the eligibility criteria for individuals seeking health care services funded by the HSNTF and the payment methods to be used to reimburse acute hospitals and community health centers for services provided to eligible individuals. In the process of developing these regulations, the office intends to seek input from providers, health care consumers, health care payers, advocates and other interested parties through meetings and public consultative sessions prior to the release of proposed regulations. The anticipated timeframe for gathering input from interested parties is May and June in order to help formulate regulatory proposals for release in early July 2007.

This report summarizes the existing Uncompensated Care Pool ("UCP") payment structure and the changes mandated by Chapter 58, and makes recommendations for a revised payment model beginning October 1, 2007. Section II of the report is divided into three sections, with recommendations for Acute Hospitals, Community Health Centers ("CHCs"), and Outpatient Pharmacy Services, summarized below.

Although Chapter 58 requires that the HSNO implement a claims-based payment system based on Medicare principles effective October 1, 2007, the Division has determined that implementation of a full claims-based adjudication system for hospital services is not possible in the timeframe allotted without incurring exorbitant system costs. As explained in Section II, the Division recommends a phased-in approach that relies on Medicare payment principles and uses actual claims of service as the basis of payment. The Division's recommendation for hospitals is three-fold:

1. The Division will first establish more rigorous coding and edit requirements to its current UCP claims specification system. These requirements will be issued in the summer of 2007, and fully implemented

by January, 2008, following a transition period for hospitals to comply with the new requirements.

2. For the period from October 1, 2007 through March 31, 2008, the Division recommends using a modified “block-grant” payment system to facilitate continued cash-flow to hospitals. The payments, however, will be based on Medicare payment principles and adjusted for the shortfall allocation using the methods required under Chapter 58. Further, there will be a reconciliation to actual claims submitted later in the year.
3. For the period from April 1, 2008 through September 30, 2008, the Division recommends establishment of Medicare-based standardized discharge and per visit rates for each hospital. For services provided during this period, HSNO will pay hospitals based on actual claims of service. The claims will be subject to claims edits similar to those used by the Medicare program.

While the overall appropriation for the HSNTF will be a fixed amount, as it is now for the UCP, the payment rates required by Chapter 58 may significantly change the amount of payments to individual hospitals. The Division will closely analyze the effect of the conversion on hospitals and will consider mitigation strategies to ensure that payments to hospitals do not result in diminished access to necessary health services.

For community health centers, the Division recommends implementation of Chapter 58's requirement to use the Medicare Federally Qualified Health Center base rate for patient visits effective October 1, 2007. This rate would cover visits provided by physicians, nurse practitioners, physician assistants, clinical psychologists and clinical social workers and other licensed professionals. For services that are not covered in this global rate, the Division recommends exploring payment options including the use of existing MassHealth rates. The selected payment options would apply to dental, pharmacy, laboratory, radiology and other miscellaneous services.

The Division's final recommendation concerns the payments for prescriptions provided by certain hospital outpatient and community health center pharmacies. While Chapter 58 requires the HSNO to use Medicare payment principles, this is not possible for pharmacy services given the design and operation of the Medicare Part D benefit. The Division therefore recommends the use of the Pharmacy On-line Payment System (POPS), currently used by the MassHealth program. The use of this system will substantially improve utilization controls and ensure an appropriate level of payment. Pharmacy claims will be priced through POPS and the data provided to the HSNO to make the appropriate monthly payment to the hospitals and CHCs.

Overall, the Division will continually monitor, evaluate, and modify these new payment methods as appropriate to ensure that hospitals and community health centers are paid fairly and timely for providing care to eligible patients. The Division recommends reporting to the Legislature on the effectiveness of the modified Medicare system after it has been in operation for a sufficient period of time to be evaluated.

II. Hospital Payments

Existing Payment Structure

The Uncompensated Care Pool pays for medically necessary services provided by acute care hospitals and community health centers (CHCs) to eligible low-income uninsured and underinsured individuals. In addition, the Pool pays hospitals for emergency services for uninsured individuals from whom the hospitals are unable to collect payment (these are known as emergency room bad debt charges or ERBD). The Pool is always the payer of last resort on any claim; when another public or private insurer is the primary payer, the Pool may be charged for the balance of charges for which the eligible individual is responsible. If an individual is uninsured, however, the Pool is the primary and only payer.

Prior to 2004, the Uncompensated Care Pool made payments to hospitals on a retrospective payment basis set forth in M.G.L. c. 118G, § 18. Payments during the hospital fiscal year were based on a rolling, twelve month average of submitted hospital charge data to which a hospital specific cost-to-charge ratio was then applied to determine actual hospital costs for UCP services. Payments were made based on this data and any shortfall between the total available funding and the provider demand was allocated based on a greater proportional need method which took into account the ratio of an individual hospital's patient care costs compared with state-wide patient care costs. Each fiscal year's actual UCP demand was compared with available funding and a retrospective final settlement would be made with all hospitals to reconcile monthly payments with final amounts.

Since FY 2004, the legislature has enacted language that calls for implementation of a prospective UCP payment system, which has become known as the "block grant system". This system relies upon prior period reported UCP charges (adjusted for inflation and identified changes between periods) to estimate the current pool year demand. Payments are then distributed based on available funding with 16 "safety net" hospitals receiving a payment "floor" of either 85% or 88% of their projected UCP demand. The safety net providers have been determined based upon their statewide percentage of "disproportionate share" payer mix¹ and then ranked by their ratio of total free care costs to all providers total free care costs. The largest two safety net providers, Boston Medical Center and Cambridge Health Alliance, have been paid 85% of projected free care costs; the other 14 safety net providers (which have varied each year) – have been paid 88% of projected free care costs. The remaining hospitals have been paid the remainder of the available funding based upon the ratio of each hospital's projected UCP demand to total remaining funding. Payments are disbursed in 12 equal payments over the course of the year. This system is entirely prospective in that there are no mechanisms to adjust payments to reflect actual UCP demand or a recalibration of the projected shortfall amounts. The recent trend of demand for services charged to the UCP has been

¹ MGL c. 118G defines disproportionate share payments to include Medicare, Medicaid, other government payments, and free care.

decreasing steadily from PFY 2005 levels, through 2006 and 2007 and has varied significantly among hospitals.

Chapter 58 Mandate

Section 30 of Chapter 58 of the Acts of 2006 replaces the Uncompensated Care Pool with the Health Safety Net Trust Fund, beginning on October 1, 2007. The Act established several requirements for acute hospital payments from the Fund, specifically,

- Payments must be based on Medicare payment principles, with adjustments to reflect differences in covered services and the populations served;
- Payments must be made based on actual claims of service that are screened for eligibility;
- Any shortfall, which occurs when payments from the Fund are projected to exceed the appropriation, must be allocated on a greater proportional need method.

Overview of the Medicare Payment Systems for Acute Hospital Services

The Medicare program uses a complex, highly refined, prospective payment system to pay acute hospitals for services provided to Medicare patients. The Medicare program employs separate prospective payment systems for inpatient services and for outpatient services. Medicare introduced its Inpatient Prospective Payment System (IPPS) in 1983 and its conceptual equivalent, Outpatient Prospective Payment System (OPPS) in 2000. These systems are used to pay for the approximately 297,000 inpatient admissions and 3.8 million outpatient visits in Massachusetts hospitals each year for patients covered by Medicare. Medicare is by far the largest single payer of hospital services nationally and pays for approximately 37% of all acute care hospital inpatient services and 24% of all outpatient acute hospital services in Massachusetts².

Inpatient Services: A core feature of Medicare's inpatient payment system is its use of Diagnosis-related Groups (DRGs), a patient classification system designed to make payments to hospitals for individual patients based on the amount of resources that, on average, are required to treat the patient. Based on a patient's primary diagnosis, secondary diagnoses and any surgical and/or medical procedures performed, the DRG system assigns the patient into one of the more than 500 clinically-related DRGs. This system requires taking into account the thousands of diagnoses and procedure codes that exist when assigning a DRG to the patient.

Medicare payments to hospitals are based on the relative amount of resources that each DRG is expected to require through the "case weight" that is associated with the DRG. For example, for a DRG that has a case weight of 1.50, Medicare will pay the hospital one and one-half times the amount that it will pay for a DRG that has with a case weight with 1.00. Using such a system, Medicare's payments to individual hospitals takes into

² Medicare volume and revenue statistics derived from the DHCFP-403 FY2006 cost reports as-filed by hospitals.

account the expected resources needed to treat each individual hospital's mix of patients. Medicare payments to hospitals reflect the individual DRG assignment for each patient and result in a range of up to 538 different payment levels for inpatient services for each hospital. Medicare also provides "outlier payments" for cases that are extraordinarily expensive. In addition, the Medicare payment system modifies individual hospital payments to reflect other expenses that are unique to teaching hospitals or hospitals that serve a high volume of low-income patients.

On April 13, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the rates to be effective October 1, 2007. Under the proposed rule, CMS would implement a revised DRG system that better reflects differences in severity of illness within DRGs.

Outpatient Services:

Medicare pays for outpatient service using Ambulatory Payment Classification ("APC") groups. Similar to the inpatient DRGs, APCs are groupings of clinically and resource-related services that are classified based on a patient's diagnosis and on the procedures for the services the patient receives. Each APC is assigned a relative weight that reflects the differences in resources required to provide each grouping of services. As with IPPS, these relative weights are multiplied by a nationally standardized payment amount, or conversion factor, that adjusts for regional differences in wages. OPSS also has outlier payment mechanism for extraordinarily costly cases.

Although APCs are similar in concept to DRGs, there are several significant differences between the two systems. Most notably, APC payments do not capture all the services an outpatient receives because APCs do not include services that Medicare pays for on a fee schedule basis. Medicare has a number of fee schedules for ambulatory services, including the professional services of physicians and diagnostic clinical lab services. An APC, for example, would include the facility cost for an examining room or ambulatory surgical suite and any related supplies, but would not include the cost of the physician doing the examination or outpatient surgery, which are billed separately and paid according to the physician fee schedule. APCs, however, do include related tests or procedures that occur within a "window" of days before & after the outpatient encounter.

Implementation Options considered

Upon passage of Chapter 58, the Division conducted an assessment of the Commonwealth's ability to implement a Medicare claims-based payment system for the Fund. The Division identified several key issues to be addressed in order to implement the system:

- The most tangible metric of success of health care reform will be an increase in the number of Massachusetts residents covered by health insurance. This increase in the number of insured will directly translate into a decline in the use of the Health Safety Net Trust Fund. The Commonwealth must be sure to

balance the cost of implementing a new system against the anticipated decline in demand and use of the new system;

- Medicare requires specific coding rules and claims specifications for use with its groupers and payment systems. Hospitals have not historically coded UCP claims using these standards. Implementing these coding standards will require systems changes for the Commonwealth and for hospitals and will require time to implement these changes;
- Chapter 58 requires that any shortfall that exists between the rates and the available appropriation be allocated using a greater proportional need method, which accounts for differences among hospitals in hospital volume. This allocation will require complex modifications to the Medicare payment system.

In completing its assessment, Division staff determined that the implementation and maintenance of a full Medicare claims-based system would require the services of a contractor with experience in Medicare claims adjudication. The Division hired a consultant with expertise in hospital claims processing to develop technical specifications for a Request for Responses (RFR) that sought the services of such a vendor. The Division anticipated that the vendor would receive claims from hospitals in Medicare formats, edit and price claims using Medicare specification requirements, provide customer service support to hospitals, and provide data to EOHHS. The RFR was released in December with responses due in January. Although five vendors had expressed interest during the request for information and question and answer stages, no vendor responded to the RFR. After closing the procurement, the Division solicited feedback from the vendors who had expressed interest in the solicitation. While each vendor gave some unique reasons for not responding, they all shared several key reasons for not responding:

- Each vendor noted that the timeframe allotted under Chapter 58 was insufficient. Vendors cited a requirement of between twelve to eighteen months after signing a contract as the minimum time necessary for the implementation of a claims adjudication system based on Medicare payment principles.
- Vendors expressed concerns regarding the unique financing structure of the UCP/HSN and the modifications to their existing systems that would be necessary to accommodate the HSN design.
- Vendors also cited the relatively low volume of free care claims (approximately 2.4 million in PFY 2006 including approximately 900,000 pharmacy claims) as investment prohibitive.
- Finally, the relative uncertainty of the future of the Health Safety Net given the impact of health care reform caused concern for the viability of the contract over its intended duration.

The Division also considered other strategies, including using the MassHealth claims processing system to adjudicate HSNO claims. Hospitals currently submit claims for inpatient and outpatient hospital services to the MassHealth program. By using the MassHealth system, EOHHS would be able to maintain more uniform standards for both HSNO and MassHealth claims, which would facilitate data analysis and policy coordination for the two programs. However, Chapter 58's requirement that the EOHHS use Medicare payment principles was an obstacle. MassHealth does not adjudicate or pay claims using the Medicare grouper, nor are the claims it receives coded to the level of specificity required for use with the Medicare groupers. The payment system used is a bundled system, which pays hospitals a single amount for inpatient services and a single amount for outpatient services. The MassHealth payment system relies on its own set of coding rules and claims specifications. Implementing changes to accommodate a Medicare payment system would require substantial modification, as well as financial and time investments. In addition, MassHealth is currently in the process of replacing its information systems infrastructure as it develops and implements a new MMIS system. While it may someday be possible to integrate the two payment systems, use of the MassHealth claims processing system is not a viable solution for FY 2008.

Another alternative considered was to modify the existing UCP claims system. Hospitals currently submit electronic claims for services charged to the UCP to the Division on a monthly basis. The advantage of modifying the existing system is continuity and stability for providers and the Commonwealth. While UCP claims are not coded with the required coding standards to be processed by the Medicare groupers, the Division could modify its claims submission requirements and systems as necessary.

Recommendation

After carefully considering the requirements of the legislation and the available implementation options, the Division's recommendation is to develop a modified Medicare payment system that will employ Medicare payment principles, grouping and editing software and to strike the appropriate balance between the Medicare systems complexity and its advantages.

In developing its recommended system, the Division convened a technical advisory committee comprised of representatives from the Massachusetts Hospital Association and its member hospitals. The Division has sought and received input from this group on a number of issues and anticipates continuing to work with this group through the implementation of the new payment system.

The recommended system will be implemented in three phases:

1. Claims Specification Changes. In the summer of 2007, the Division will issue new claims specification requirements to incorporate the coding changes required by the Medicare program and to generally improve the quality of the claims data. This is a necessary step in order to ensure that the Medicare pricing software calculates appropriate rates for hospitals. The Division expects to modify its

systems begin collecting data from hospitals using the new specifications on or about July 1, 2007. During this phase-in period, hospitals will be able to submit claims using the current format or the Medicare format using the “837” record layout. The Division will provide hospitals with appropriate error reports in order to facilitate the transition to the Medicare coding requirements. As of January 1, 2008, all hospitals will be expected to fully comply with the new specifications. This will allow the use of the Medicare outpatient grouping system the Ambulatory Patient Classifications to be used to edit and evaluate outpatient services provided to Health Safety Net eligible patients.

2. Interim Payment System (October 1, 2007 – March 31, 2008). The Division intends to propose an interim “block payment” system for the above period in order to facilitate cash flow. Hospital claims for the UCP will continue to be submitted to DHCFP and will be used as the basis of the payment system. Pharmacy-only claims will be processed by the MassHealth vendor and priced according to MassHealth rules. Further explanation of the payment for pharmacy-only claims can be found in section IV. We anticipate that the interim block payment will be calculated as follows³:

- + *Inpatient medical/surgical per discharge rate * projected discharges*
- + *Inpatient psychiatric per day rate * projected psychiatric days*
- + *Outpatient per visit rate * projected outpatient visits*
- + *Outpatient pharmacy per claim * projected pharmacy claims*
- *Projected greater proportional need shortfall adjustment*

Under the interim payment system, hospitals will continue to receive monthly payments. In addition, the interim block payment will be subject to a retrospective reconciliation to account for actual inpatient, outpatient, and pharmacy volume, and the application of the greater proportional need shortfall calculation.

3. Standard payment system. Effective April 1, 2008, the HSNO will begin to pay hospitals on a standard payment system, similar in design to the payment model currently in use by the MassHealth program, but with payment rates that reflect Medicare pricing principles, grouping and claims editing systems. This system will make payments based on per discharge and per visit rates, described in greater detail in appendix A. However, payments will be made on the basis of actual claims submitted; as they are edited through the appropriate Medicare claims edit specifications in order to identify payable units of service: allowable inpatient discharges and allowable outpatient service days. Payments will continue to be made on a monthly payment cycle and will include the application of the greater proportional need shortfall distribution methodology.

The recommended system is a modified Medicare based payment system. As stated in the report, Medicare recognizes many different payment levels for inpatient and

³ More detail regarding the components of the rates can be found in Appendix A.

outpatient services provided to individual recipients. The recommended solution is a bundled payment system, using similar bundling methods currently used by the MassHealth program, the Division believes that its recommended system will meet the goals outlined for the Health Safety Net Office payments in Chapter 58. Specifically, the recommended solution will:

- Reflect Medicare payment principles and payment levels;
- Increase system integrity by implementing claims edits and verifying eligibility prior to payment;
- Maintain administrative simplicity by leveraging existing processes and information technology;
- Ensure sound value and minimal additional administrative investment for hospitals and the Commonwealth; and
- Ensure a smooth transition for hospitals.

After calculating the initial rates under the proposed model, the Division will carefully analyze the impact on individual hospitals. While the total spending for the HSNTF is established by appropriation, hospitals will receive different amounts depending on the rate methods outlined here. The Division will closely analyze the effect of the conversion on hospitals and will consider mitigation strategies to ensure that payments to hospitals do not result in diminished access to necessary health services.

The Health Safety Net Office will propose regulations that will specify the details of the payment system to be used for the HSN fiscal year 2008. We anticipate that these regulations will be proposed in early July with an anticipated effective date of October 1, 2007.

III. COMMUNITY HEALTH CENTERS

Chapter 58 also includes new requirements for payments from the Health Safety Net to Community Health Centers for care delivered to eligible individuals. In addition, there is no provision for maximum payments to CHCs nor for these entities to bear any burden of shortfall in funding that may occur in any fiscal year, which is distinct from the hospital providers. The Division has established a panel of CHC representatives to constitute a technical advisory committee (TAC) to advise, raise questions and provide feedback to staff regarding the HSNO CHC payment system. The Division intends to work closely with this group as it continues to examine CHC payment and systems issues in advance of developing a regulatory proposal that will define CHC payment rules for the HSN fiscal year beginning on October 1, 2007.

Existing Payment Structure

Unlike hospitals, the payment system for freestanding community health centers (CHC) is primarily a fee schedule paid on a fee-for-service basis for services provided to individuals who have been approved for UCP funded care. CHCs are currently paid a medical visit rate of \$105.56 per visit (95% of the Medicaid visit rate) when the care is provided by a physician, nurse practitioner or a physician's assistant. The Medicaid rate is based on reported CHC costs with adjustments for productivity, administrative cost limits and inflation. The UCP rate has most recently been set approximately \$3-5 lower than the Medicaid rate to encourage CHCs to be proactive in enrolling eligible patients in MassHealth. Visits with a clinical psychologist or a licensed clinical social worker are paid at 50% of the medical visit rate.

CHCs are allowed to bill 75% of the medical visit rate for dental services, and may include up to two procedures per visit at this reimbursement level. For visits in which more than two procedures are performed, CHCs may bill 75% of the medical visit rate and receive a flat add-on payment for each additional procedure.

CHCs with a pharmacy that operates under the provisions of the Federal 340B program may also bill the UCP for prescribed drugs on the MassHealth Drug List formulary that are provided to their eligible UCP patients. Payment is currently based on a formula designed to encourage provision of generic drugs (100% of the cost of generic or 90% of the cost of brand plus a dispensing fee of \$8.50 per prescription). CHCs may also charge a nominal patient co-payment to cover any reasonable un-reimbursed pharmacy costs. The Division is pursuing an option that will allow HSNO pharmacy claims to be processed through the MassHealth Pharmacy On-line Payment System (POPS). This possible change, discussed in greater detail in section IV, has received broad support from the current CHC pharmacies.

For ancillary services, such as lab services, radiology and miscellaneous ancillaries such as in-office surgeries and vaccinations, CHCs currently receive 25% of charges for each eligible service billed to the UCP for eligible individuals.

Chapter 58 Mandate and Medicare FQHC Rate

Section 30 of Chapter 58 of the Acts of 2006 requires that:

(f) for the purposes of paying community health centers for health services provided to uninsured individuals under this section, the office shall pay community health centers a base rate that shall be no less than the then-current Medicare Federally Qualified Health Center rate as required under 42 U.S.C. 13951 (a)(3), and the office shall add payments for additional services not included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent care, and emergency room diversion services.

In addition, Chapter 58 permits payments to CHCs for documented bad debt, an expense heretofore not considered payable to CHCs by the Uncompensated Care Pool. Development of the criteria and documents necessary to prove that reasonable collection efforts have failed will be developed in conjunction with policy development for allowable hospital bad debt.

The Medicare FQHC rate is currently \$115.33 for calendar year 2007, as compared to the current UCP rate of \$105.56. The FQHC rate will increase in January, 2008 by the Medicare Economic Index (MEI) – typically around 3%, which would approximate \$118.79.

The FQHC rate is an all-inclusive rate paid to CHCs to cover face-to-face visits with medical personnel. It includes some costs that the UCP currently pays for separately, such as surgeries, vaccines, and the professional component of x-rays and electrocardiograms under the 25% of charges method. Medicare pays 100% of the rate for physician, nurse practitioner, and physician's assistant services. For mental health services, Medicare pays 100% of the FQHC rate for diagnostic services by clinical psychologists, social workers and other licensed professionals, and 62.5% of the rate for therapeutic services by those same providers.

Recommendations

The Division recommends that the HSNO follow the Medicare service definition and bundled payment rules for services to be funded at the HSNO visit rate since that is to be set at the Medicare FQHC rate. The Division also recommends that the HSNO pay CHCs for mental health services at the same FQHC rates, and include the same range of eligible licensed professionals.

For dental services, which are not covered by Medicare, the Division is evaluating the feasibility of moving away from the current percentage of visit plus payment for additional procedure rate, and moving towards a fee-for-service system fully based on use of Current Dental Terminology coding. Use of these procedure codes is standard practice for MassHealth and other insurers. Options for coverage and payment levels are part of the analysis that the Division is currently conducting.

The Division is also assessing whether to increase the payment for prescribed drugs at centers with 340B pharmacies to the same level as MassHealth, i.e., 100% of drug cost plus a \$10 dispensing fee. The Division is also evaluating a standardized patient co-payment schedule similar to the method MassHealth currently employs. In addition, the Division describes in the next section of this report an option to change the method of managing and adjudicating pharmacy claims and gathering data on prescriptions from CHCs and hospitals.

For ancillary services, the Division is evaluating use of the MassHealth fee schedule for those ancillary services which are not included in the FQHC rate. Examples of these services would be for the technical component of x-rays, clinical laboratory tests, and screening mammography. Since MassHealth payment for most of these services is greater than the current UCP 25% of charges method, this should provide a financial benefit for the CHCs.

The Division intends to continue to seek and receive input from the CHC TAC on a number of issues related to the HSNO CHC payment system and anticipates continuing to work with this group through its implementation.

IV. PRESCRIBED DRUGS

Chapter 58 Mandate

Patients eligible for the Uncompensated Care Pool can receive prescribed drugs through certain hospital outpatient pharmacies and CHCs. As noted above, Chapter 58 requires that the HSNO use Medicare payment principles to pay hospitals and the Medicare FQHC base rate for CHCs. However, Medicare does not directly establish rates for prescribed drugs. Beneficiaries receive the drug benefit through separate Prescription Drug Plans or through Medicare Advantage Plans. The Division, therefore, recommends that HSNO use MassHealth payment principles for HSNO prescribed drug services.

Existing Payment Structure

Currently the UCP pays for prescribed drugs dispensed by hospital outpatient pharmacies the same way it pays for all other Pool services. That is, total charges for prescriptions provided are included in total charges for all other UCP services, reduced to an approximate cost level through the application of an overall cost to charge ratio, and becomes part of the allocation of available funding for allowable free care costs for all hospitals. Payments to CHCs for prescribed drugs, are based on a percent of drug cost plus a dispensing fee for each specific prescription.

Both of these payment methods lack essential pharmaceutical management systems used by virtually all other payers. In addition, with respect to CHCs, patient eligibility verification can only be conducted on a post-audit basis. Overall management of drug utilization has been very limited, and has lacked the program management advantages achieved by MassHealth and its Pharmacy On-line Payment System (POPS).

Consequently, the Division is pursuing the use of the MassHealth POP System to receive and adjudicate CHC 340B and hospital outpatient pharmacy (340B and non-340B) claims for HSNO members seen by clinicians employed by these eligible providers. We recommend transitioning to this system as soon as October 1, 2007 where feasible. This will have several advantages over the current system including:

1. Automatic member eligibility check coordinated with MassHealth
2. Authorization for pharmaceuticals that appear on the MassHealth Drug List
3. Edits for multiple prescriptions and early refills
4. Drug interaction edits
5. Real time feedback on fill authorization
6. HSNO will be able to receive usage reports from POPS to generate provider payment and review utilization patterns
7. Pharmacy providers will not longer need to track and retain separate records for reporting HSNO services to receive payment.

In addition, the Division is seeking to utilize the services of the University of Massachusetts Commonwealth Medicine's Drug Utilization Review team to authorize clinically necessary exceptions to coverage rules. Most of the CHC and hospital-based entities currently participate in

this system as MassHealth pharmacy providers and we anticipate the addition of the HSNO funded patient category to be a relatively straightforward programming process. Feedback from all current MassHealth providers has been positive and constructive. However, the few hospital outpatient pharmacies that do not currently participate in the MassHealth pharmaceutical program will incur additional software acquisition costs and administrative activities to use the new system. The Division will continue to make use of its CHC and hospital workgroups for facilitating this process as it is doing to successfully implement other features of the new payment systems.

APPENDIX A

Proposed HSNTF Rate Development.

In determining the acute hospital payment rates for the HSNTF interim block grant system and the standard payment system, the Division is considering the following methods. The Division is still continuing its analysis and, as required under Chapter 58, will consult with representatives of the Massachusetts Hospital Association prior to issuing formal regulations later this summer.

1. *Inpatient Medical Surgical Rates.* The Division will calculate a hospital specific per discharge inpatient rate from the Medicare published federal per discharge rate, adjusted for wage area and other hospital-specific adjustments. Because the inpatient UCP claims are coded in a manner that will allow the use of the Medicare inpatient grouper, the Division will use claims from a prior period to determine the appropriate casemix adjustment to be applied to each hospital's rate.
2. *Inpatient Psychiatric Per Diem Rates.* Many acute hospitals in the Commonwealth have psychiatric units that provide inpatient services to the uninsured population. For these services, the Division will calculate per day rates using the Medicare inpatient psychiatric per diem rates, including any hospital-specific adjustments.
3. *Outpatient Rates.* Because UCP outpatient claims are not coded in a manner that allows the use of the Medicare outpatient grouper, outpatient rates will be developed from a Payment on Account Factor (PAF) derived from data reported to hospitals by Medicare and reviewed and verified by Division staff. The PAF will represent the ratio of Medicare payments to Medicare charges. This PAF will be multiplied against UCP base period allowable outpatient charges to yield allowable HSNO outpatient payments, and then divided by allowable outpatient visits to determine an outpatient payment per visit.
4. *Outpatient Pharmacy Claims.* A small number of hospitals maintain outpatient pharmacies that dispense prescriptions to uninsured patients. As described in section IV, the Division recommends that the HSNO adjudicate these claims using the Pharmacy On-Line Payment System ("POPS") currently used by MassHealth.
5. *ER Bad Debt:* Most acute hospitals provide emergency care to individuals who are uninsured and from whom the hospital has pursued reasonable collection activity for these services. Chapter 58 continues to provide for payments from the Health Safety Net Office for emergency services in these circumstances. The Division is currently evaluating alternative payment methods to meet this requirement. The Division anticipates that it will develop a methodology for these payments to include in the proposed regulation for HSNO payments.

APPENDIX B

Chapter 58 of the Acts of 2006, Section 30:

Section 59.

... (4) The office shall reimburse acute hospitals for health services provided to individuals based on the payment systems in effect for acute hospitals used by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services to administer the Medicare Program under Title XVIII of the Social Security Act, including all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of the annual increase in the Medicare hospital market basket index. The Division shall, in consultation with the Division of health care finance and policy and the Massachusetts Hospital Association, promulgate regulations necessary to modify these payment systems to account for:—

- (i) the differences between the program administered by the office and the Title XVIII Medicare program, including the services and benefits covered;
- (ii) grouper and DRG relative weights for purposes of calculating the payment rates to reimburse acute hospitals at rates no less than the rates they are reimbursed by Medicare;
- (iii) the extent and duration of covered services;
- (iv) the populations served;
- (v) and any other adjustments to the payment methodology under this section as deemed necessary by the office, based upon circumstances of individual hospitals.

Following implementation of this section, the office shall ensure that the allowable reimbursement rates under this section for health services provided to uninsured individuals shall not thereafter be less than rates of payment for comparable services under the Medicare program, taking into account the adjustments required by this section.

(5) For the purposes of paying community health centers for health services provided to uninsured individuals under this section, the office shall pay community health centers a base rate that shall be no less than the then-current Medicare Federally Qualified Health Center rate as required under 42 U.S.C. 13951 (a)(3), and the office shall add payments for additional services not included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent care, and emergency room diversion service.

(6) Reimbursements to acute hospitals and community health centers for bad debt shall be made upon submission of evidence, in a form to be determined by the office, that reasonable efforts to collect the debt have been made.

(b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after consultation with the Division of health care finance and policy, and using the best data available, provide an estimate of the projected total reimbursable health services provided by acute hospitals and community health centers and emergency bad debt costs, the total funding available, and any projected shortfall after adjusting for reimbursement payments to community health centers. In the event that a shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health services, the office shall allocate that shortfall in a manner that reflects each hospital's proportional financial requirement for reimbursements from the fund, including, but not limited to, the establishment of a graduated reimbursement system and under any additional regulations promulgated by the office.