Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-194
May 2012

TO: All Providers Participating in MassHealth

FROM: Julian J. Harris, M.D., Medicaid Director

RE: *All Provider Manuals* (Out-of-State Services)

MassHealth is amending the administrative and billing regulations to clarify when out-of-state services are covered, and to address changes in out-of-state acute hospital rates.

Out-of-State Acute Hospital Rates

Effective May 25, 2012, MassHealth is changing the way it pays for out-of-state acute inpatient and outpatient hospital services.

Acute Inpatient Hospital Rates

Effective for admissions on or after May 25, 2012, all out-of-state acute inpatient hospitals will be paid an out-of-state standard payment amount per discharge (SPAD) for each admission. A SPAD pays for the first 20 days of an admission, and should be billed on a single claim. The out-of-state SPAD rate is the median SPAD rate in effect for in-state hospitals on the date of admission, as calculated by EOHHS.

In addition, for members under age 21, each acute inpatient day following the first 20 days of admission will be paid an out-of-state outlier per diem rate. The out-of-state outlier rate is the median outlier per diem rate in effect for in-state hospitals on the date of service, as calculated by EOHHS. Outlier days must be billed on a separate claim from the SPAD claim.

Acute Outpatient Hospital Rates

Effective for services provided on or after May 25, 2012, out-of-state acute outpatient hospitals will be paid at the median payment amount per episode (PAPE) in effect for in-state acute hospitals on the date of service, as calculated by EOHHS, or in accordance with the applicable fee schedule established by the Division of Health Care Finance and Policy for services for which in-state acute hospitals are not paid the PAPE.

These rates will be updated each subsequent MassHealth Hospital Rate Year (HRY). The MassHealth HRY generally is in effect from October 1 through September 30 of a given year, and is published on the MassHealth Web site at www.mass.gov/masshealthpubs. Click on Special Notices for Hospitals.

These regulations are effective May 25, 2012.

MassHealth Web Site

This transmittal letter and attached pages are available on the MassHealth Web site at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages i, 1-15, 1-16, 2-21, and 2-22

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

All Provider Manuals

Page I — transmitted by Transmittal Letter ALL-185

Pages 1-15 and 1-16 — transmitted by Transmittal Letter ALL-178

Pages 2-21 and 2-22 — transmitted by Transmittal Letter ALL-177

1. Introduction

(C) Prior Authorization. Any covered services that require prior authorization in the MassHealth regulations (130 CMR 400.000 through 499.000) require prior authorization for the EAEDC Program.

450.107: Eligible Members and the MassHealth Card

(A) Eligibility Determination. MassHealth eligibility is determined in accordance with 130 CMR 501.000 et seq. Eligibility for the EAEDC Program is determined pursuant to 106 CMR 319.000 through 321.000, 701.000 through 701.600, 705.000 through 705.950, and 706.000 through 706.800.

(B) Eligibility Verification System. The MassHealth agency uses the Eligibility Verification System (EVS) for day-specific eligibility verification, and to communicate a member's MassHealth eligibility, coverage type, managed care status, restrictions, and other insurance information to health-care providers.

(C) MassHealth Card. The MassHealth agency issues a plastic identification card for most MassHealth members. The MassHealth card contains information necessary to access EVS. Members for whom the MassHealth agency pays health insurance premiums only may not have a MassHealth card.

(D) Temporary MassHealth Eligibility Card. When necessary, the MassHealth agency or the Department of Transitional Assistance issues a temporary MassHealth card to the cardholder for use until a plastic MassHealth card is issued. The temporary MassHealth card shows dates of eligibility, service restrictions, and other insurance information. If a discrepancy occurs between information given on a temporary MassHealth card and by EVS, the information on the temporary card prevails. To be paid for a covered service that was provided based on information given on a temporary card, a provider must produce a copy of the temporary card, and have otherwise met all other prerequisites for payment.

(E) Time-Limited Eligibility. The MassHealth agency may determine certain individuals to be eligible for MassHealth Standard or MassHealth Family Assistance coverage for a limited period of time if, on the basis of preliminary information, the individual appears to meet the applicable requirements. Coverage for members with time-limited eligibility begins 10 days before the date on which the MassHealth agency receives the Medical Benefit Request (MBR). The MassHealth agency may determine time-limited eligibility for

(1) MassHealth Standard or MassHealth Family Assistance for children under age 19; and

(2) MassHealth Family Assistance for persons who claim to have a positive human immunodeficiency virus (HIV) status.

450.108: Selective Contracting

(A) Use of Selective Contracts. The MassHealth agency may provide some services through selective contracts where such contracts are permitted by federal and state law.

(B) Termination of Provider Contracts. The MassHealth agency may terminate, in whole or in part, existing provider contracts where selective contracts are in effect. In the event of any such termination, the MassHealth agency notifies the affected providers in writing, at least 30 days prior to termination. Such termination does not affect payments to providers for services provided prior to the date of termination.

450.109: Out-of-State Services

(A) MassHealth covers services provided in another state to a MassHealth member, subject to all applicable limitations, including service coverage, prior authorization, and provider enrollment, only in the following circumstances:

(1) medical services are needed because of a medical emergency;

(2) medical services are needed and the member's health would be endangered if the member were required to travel to Massachusetts;

(3) it is the general practice for members in a particular locality to use medical resources in another state; or

(4) MassHealth determines on the basis of medical advice that the needed medical services, or necessary supplementary resources, are more readily available in the other state.

(B) MassHealth does not cover services provided outside the United States and its territories.

(130 CMR 450.110 and 450.111 Reserved)

450.112: Advance Directives

(A) Provider Participation. All hospitals, nursing facilities, MCOs, home health agencies, personal care agencies, hospices, and the MassHealth behavioral-health contractor must

(1) provide to all adults aged 18 or over, who are receiving medical care from the provider, the following written information concerning their rights, which information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change to

(a) make decisions concerning their medical care;

(b) accept or refuse medical or surgical treatment; and

(c) formulate advance directives (for example, living wills or durable powers of attorney for health care, or health-care proxy designations);

(2) provide written information to all adults about the provider's policies concerning implementation of these rights;

(3) document in the patient's medical record whether the patient has executed an advance directive;

(4) not condition the provision of care or otherwise discriminate against a patient based on whether that patient has executed an advance directive;

(5) ensure compliance with requirements of state law concerning advance directives; and

(6) educate staff and the community on advance directives.

(B) When Providers Must Give Written Information to Adults.

(1) A hospital must give written information at the time of the person's admission as an inpatient.

(2) A nursing facility must give information at the time of the person's admission as a resident.

(3) A provider of home health care or personal care services must give information to the person before services are provided.

(4) A hospice program must give information to the person before services are provided.

(5) An MCO must give information at the time the person enrolls or reenrolls with the MCO.

450.232: Rates of Payment to In-State Providers

Payment to all providers is made in accordance with the payment methodology applicable to the provider, subject to federal payment limitations. Without limiting the generality of the foregoing, payment to a Massachusetts in-state noninstitutional provider for any medical services payable under MassHealth is made in accordance with the applicable payment methodology established by DHCFP, or the MassHealth agency, subject to any applicable federal payment limit (see 42 CFR 447.304).

450.233: Rates of Payment to Out-of-State Providers

(A) Except as provided in 130 CMR 450.233(D), payment to an out-of-state institutional provider for any medical service payable under MassHealth is made by the MassHealth agency at the lesser of

(1) the rate of payment established for the medical service under the other state's Medicaid program;
(2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
(3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider, other than an acute hospital, must submit to the MassHealth agency a copy of the applicable rate schedule under its state's Medicaid program.

(C) Except as provided in 130 CMR 450.233(D), payment to an out-of-state noninstitutional provider for any medical service payable under MassHealth is made in accordance with the applicable fee schedule established by DHCFP or the MassHealth agency, subject to any applicable federal payment limit (see 42 CFR 447.304).

(D) Payment to an out-of-state acute hospital provider for any medical service payable under MassHealth is made as follows.

(1) Inpatient services are paid at the median payment amount per discharge in effect for in-state acute hospitals on the date of admission. In addition, for members under age 21, each acute inpatient day following the first 20 days of admission is paid at the median outlier per diem rate in effect for in-state hospitals on the date of service.
(2) Outpatient services are paid at the median payment amount per episode (PAPE) in effect for in-state acute hospitals on the date of service, or in accordance with the applicable fee schedule established by DHCFP for services for which in-state acute hospitals are not paid the PAPE.

(130 CMR 450.234 Reserved)

450.235: Overpayments

Overpayments include, but are not limited to, payments to a provider

(A) for services that were not actually provided or that were provided to a person who was not a member on the date of service;

(B) for services that were not payable under MassHealth on the date of service, including services that were payable only when provided by a different provider type and services that were not medically necessary (as defined in 130 CMR 450.204);

(C) in excess of the maximum amount properly payable for the service provided, to the extent of

such excess; for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;

(E) for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts;

(F) for services provided when, as of the date of service, the provider was not a participating provider, or was in any breach or default of the provider contract;

(G) for services billed that result in a duplicate payment; or

(H) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.

450.236: Overpayments: Calculation by Sampling

In any action or administrative proceeding to determine or recover overpayments, the MassHealth agency may ascertain the amount of overpayments by reviewing a representative sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. The MassHealth agency employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid and representative sample.

450.237: Overpayments: Determination

The existence and amount of overpayment may be determined in an action to recover the overpayment in any court having jurisdiction. The MassHealth agency may also determine the existence and amount of overpayments. The procedures described in 130 CMR 450.236 and 450.237 do not apply to overpayments resulting from rate adjustments, which are governed by methods described in 130 CMR 450.259.

(A) Overpayment Notice. When the MassHealth agency believes that an overpayment has been made, it notifies the provider in writing of the facts upon which the MassHealth agency bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), the MassHealth agency will so inform the provider. The MassHealth agency may notify the provider by letter, draft audit report, computer printout, or other format.

(B) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the overpayment notice. The reply must specifically identify and address all allegations in the overpayment notice with which the provider disagrees. With the reply, the provider may submit additional data and argument to support its claim for payment and must include any documentary evidence it wants the MassHealth agency to consider. Where the MassHealth agency states in the overpayment notice that the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), a provider may contest only the factual assertion that the federal or state agency made such a determination. The provider may not contest in any proceeding before or against the MassHealth agency the amount or basis for such determination.