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

MassHealth
Transmittal Letter ALL-209
September 2014

TO: All Providers Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: All Provider Manual (Revised payment methodology for out-of-state acute hospitals)

This letter transmits amendments to the MassHealth administrative and billing regulations to address changes to out-of-state acute hospital payment methods and rates for inpatient services payable by the MassHealth agency. See 130 CMR 450.233(D). These changes are effective for admissions on or after October 1, 2014. The changes are being made to generally align with changes in the way in-state acute inpatient hospitals will be paid effective October 1, 2014.

The payment method for out-of-state acute hospital outpatient services is unchanged, except for making a minor clarification. The payment method to out-of-state acute hospitals that are not High MassHealth Volume Hospitals for inpatient or outpatient services that MassHealth determines are not available in-state, is also unchanged.

Out-of-state acute hospital rates will be updated each subsequent MassHealth hospital rate year (HRY). The MassHealth HRY is generally in effect from October 1 through September 30 of a given year, and updated rates will be published on the MassHealth website at www.mass.gov/eohhs/gov/laws-regs/masshealth/ (click on "Special Notices for Acute Hospitals").

MassHealth Website

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

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Services Center 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 Manual

Pages ii and 2-19 through 2-22

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(The pages listed here are no longer in effect.)

All Provider Manual

Page ii — transmitted by Transmittal Letter ALL-201

Pages 2-19 and 2-20 — transmitted by Transmittal Letter ALL-154

Pages 2-21 and 2-22 — transmitted by Transmittal Letter ALL-201

2. Administrative Regulations

450.200: Conflict Between Regulations and Contracts 2-1
450.201: Choice of Provider 2-1
450.202: Nondiscrimination 2-1
450.203: Payment in Full 2-2
450.204: Medical Necessity 2-2
450.205: Recordkeeping and Disclosure 2-3
450.206: Determination of Compliance with Medical Standards 2-5
450.207: Utilization Management Program for Acute Inpatient Hospitals....................... 2-5
450.208: Utilization Management: Admission Screening for Acute Inpatient Hospitals 2-6
450.209: Utilization Management: Prepayment Review for Acute Inpatient Hospitals 2-7
450.210: Pay for Performance Payments: MassHealth Agency Review.......................... 2-9
(130 CMR 450.211 Reserved)
450.212: Provider Eligibility: Eligibility Criteria 2-11
450.213: Provider Eligibility: Termination of Participation for Ineligibility 2-12
450.214: Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health and Human Services Order 2-12
450.215: Provider Eligibility: Notification of Potential Changes in Eligibility 2-12
450.216: Provider Eligibility: Limitations on Participation.. 2-13
450.217: Provider Eligibility: Ineligibility of Suspended Providers 2-13
(130 CMR 450.218 through 450.220 Reserved)
450.221: Provider Contract: Definitions 2-14
450.222: Provider Contract: Application for Contract.. 2-16
450.223: Provider Contract: Execution of Contract.. 2-16
450.224: Provider Contract: Exclusion and Ineligibility of Convicted Parties................ 2-18
(130 CMR 450.225 Reserved)
450.226: Provider Contract: Issuance of Provider Numbers 2-19
450.227: Provider Contract: Termination or Disapproval 2-19
(130 CMR 450.228 through 450.230 Reserved)
450.231: General Conditions of Payment 2-19
450.232: Rates of Payment to In-State Providers 2-20
450.233: Rates of Payment to Out-of-State Providers 2-20
(130 CMR 450.234 Reserved)
450.235: Overpayments 2-23
450.236: Overpayments: Calculation by Sampling 2-23
450.237: Overpayments: Determination 2-23
450.238: Sanctions: General 2-24
450.239: Sanctions: Calculation of Administrative Fine 2-25
450.240: Sanctions: Determination 2-25
450.241: Hearings: Claim for an Adjudicatory Hearing 2-26

450.226: Provider Contract: Issuance of Provider Numbers

(A) Upon execution of the provider contract, the Division will issue a provider number or numbers to be used to identify the provider that is the subject of the contract.

(B) For every case in which a provider is assigned two or more provider numbers, the provider must use each provider number only in conjunction with the facility or location to which the number is assigned. The Division, however, maintains its right to commence proceedings in accordance with the provisions of 130 CMR 450.234 through 450.248 against any or all of its provider numbers, regardless of the location or facility where the violation has been alleged to have occurred or the overpayment received.

450.227: Provider Contract: Termination or Disapproval

The Division may at its discretion disapprove a provider contract, and may terminate an existing contract, if the provider fails to disclose any information in accordance with the provisions of 130 CMR 450.222, 130 CMR 450.223, or 42 CFR 420.205.

(130 CMR 450.228 through 450.230 Reserved)

450.231: General Conditions of Payments

(A) Except to the extent otherwise permitted by state or federal regulations, no provider is entitled to any payment from MassHealth unless on the date of service the provider was a participating provider and the person receiving the services was a member.

(B) The "date of service" is the date on which a medical service is provided to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers to a member medical goods that had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date before the final delivery of the goods, the Division will pay the provider for the goods only under the following circumstances:

(1) the member must have been eligible for MassHealth on the date of the member's last visit with the provider before the provider orders or fabricates the goods;
(2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit;
(3) the provider has submitted documentation with the claim to the Division that verifies both the date of the member's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;
(4) the provider must not have accepted any payment from the member for the goods except copayments as provided in 130 CMR 450.130; and
(5) the provider must have attempted to deliver the goods to the member.

(C) For the purposes of 130 CMR 450.231, a provider who directly services the member and who also produces the goods for delivery to the member has "fabricated" an item if the provider has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary member visits.

(D) A provider is responsible for verifying a member’s eligibility status on a daily basis, including but not limited to members who are hospitalized or institutionalized. In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider’s failure to verify a member’s MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member’s MassHealth eligibility determination, see 130 CMR 450.311. For payment to out-of-state providers providing services on an emergency basis, see 130 CMR 450.312.

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) for covered services described in 130 CMR 450.105(D) for MassHealth Senior Buy-in members and 130 CMR 450.105(A) for MassHealth Standard members may be made upon the Division's receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act. QMB-only providers are not required to be registered as such with the Division as of the date the medical services were delivered, but are required to sign a QMB-only provider contract with the Division or become a participating provider in MassHealth before receiving payment for such claim.

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 by the MassHealth agency is made in accordance with the applicable payment methodology established by EOHHS, 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 by the MassHealth agency is the lowest 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 current 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 by the MassHealth agency is made in accordance with the applicable fee schedule established by EOHHS, 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 by the MassHealth agency is made as follows.

(1) Inpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for inpatient services as specified in 130 CMR 450.233(D)(1)(a) through (c). For purposes of 130 CMR 450.233(D), a "High MassHealth Volume Hospital" means any out-of-state acute hospital provider that had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available as determined by the MassHealth agency at least 90 days prior to the start of each federal fiscal year.

(a) Payment Amount Per Discharge.

(i) Out-of-State APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge ("Out-of-State APAD") for inpatient services. The Out-of-State APAD is calculated using the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals on the date of admission, which is then multiplied by the MassHealth DRG Weight assigned to the discharge based on the information contained in a properly submitted inpatient acute hospital claim.

a. "MassHealth DRG Weight" for purposes of 130 CMR 450.233(D) is the MassHealth relative weight determined by the MassHealth agency for each unique combination of APR-DRG and Severity of Illness (SOI).

b. "APR-DRG" or "DRG" for purposes of 130 CMR 450.233(D) refers to the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned to a claim by the 3M APR-DRG Grouper.

(ii) Out-of-State Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, then the out-of-state acute hospital is also paid an outlier payment for that discharge ("Out-of-State Outlier Payment"). The Out-of-State Outlier Payment is equal to the marginal cost factor in effect for in-state acute hospitals on the date of admission multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The "calculated cost of the discharge" for purposes of 130 CMR 450.233(D) shall be determined by the MassHealth agency by multiplying the out-of-state acute hospital's allowed charges for the discharge by the following cost-to-charge ratio:

1. For a High MassHealth Volume Hospital, the hospital's inpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.

2. For all other out-of-state acute hospitals, the median in-state acute inpatient hospital cost-to-charge ratio in effect on the date of admission based on MassHealth discharge volume, as determined by the MassHealth agency.

b. The "discharge-specific outlier threshold" for purposes of 130 CMR 450.233(D) is equal to the sum of the Out-of-State APAD corresponding to the discharge, and the fixed outlier threshold in effect for in-state acute hospitals on the date of admission.

(b) Out-of-State Transfer Per Diem. If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid for inpatient services provided to that member at a transfer per diem rate ("Out-of-State Transfer Per Diem"), capped at the sum of the transferring hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by the MassHealth agency. No other payments specified in 130 CMR 450.233(D)(1) apply.

(i) The Out-of-State Transfer Per Diem is equal to the sum of the transferring hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by the MassHealth agency, divided by the mean in-state acute hospital all-payer length of stay for the particular DRG assigned, as determined by the MassHealth agency.

(c) Out-of-State Psychiatric Per Diem. If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, including psychiatric and substance abuse services, the out-of-state acute hospital shall be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem in effect for in-state acute hospitals on the date of service ("Out-of-State Psychiatric Per Diem"). No other payments specified in 130 CMR 450.233(D)(1) apply.

(2) Outpatient Services. Except as provided in 130 CMR 450.233(D)(3), all out-of-state acute hospital providers are paid for outpatient services at the median payment amount per episode (PAPE) in effect for in-state acute hospitals on the date of service based on episode volume, as determined by the MassHealth agency, or in accordance with the applicable fee schedule established by EOHHS for services for which in-state acute hospitals are not paid the PAPE.

(3) Services Not Available In-State.

(a) For medical services payable by the MassHealth agency that are not available in-state as determined by the MassHealth agency, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid the rate of payment established for the medical service under the other state's Medicaid program (or equivalent) as determined by the MassHealth agency, or such other rate as the MassHealth agency determines necessary to ensure member access to services.

(b) For an inpatient service that is not available in-state, as determined by the MassHealth agency, payment to the out-of-state acute hospital under 130 CMR 450.233(D)(3)(a) will also include acute hospital outpatient services that the MassHealth agency determines are directly related to the service that is not available in-state.

(c) In order to receive payment under 130 CMR 450.233(D)(3), an out-of-state acute hospital provider must

(i) submit to the MassHealth agency a complete list of services that are to be performed, along with their corresponding charges; and

(ii) coordinate the case with clinical staff designated by the MassHealth agency.

(130 CMR 450.234 Reserved)