

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 614.00: HEALTH SAFETY NET PAYMENTS AND FUNDING

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614.01: General Provisions

(1) Scope, Purpose, and Effective Date. 101 CMR 614.00 governs Health Safety Net payments and funding effective for dates of service beginning October 1, 2024, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers. The criteria for determining services for which acute hospitals and community health centers may be paid by the Health Safety Net are set forth in 101 CMR 613.00: *Health Safety Net Eligible Services*.

(2) Administrative Bulletins. The Health Safety Net office may issue administrative bulletins to clarify policies and understanding of substantive provisions of 101 CMR 614.00 and specify information and documentation necessary to implement 101 CMR 614.00.

614.02: Definitions

As used in 101 CMR 614.00, unless the context otherwise requires, terms have the following meanings.

340B Provider. An acute hospital or community health center eligible to purchase discounted drugs through a program established by § 340B of United States Public Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their Patients, and registered and listed as a 340B provider within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. Services of a 340B pharmacy may be provided at on-site or off-site locations.

Acute Hospital. A hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Administrative Day. A day of inpatient hospitalization on which a patient's care needs can be provided in a setting other than an inpatient acute hospital in accordance with the standards in 130 CMR 415.000: *Acute Inpatient Hospital Services* and on which the patient is clinically ready for discharge.

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Allowable Health Safety Net Payment. Total maximum, for all eligible services that would be payable if there were no shortfall.

Bad Debt. An account receivable based on services furnished to a patient that is

- (a) regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 101 CMR 613.06: *Allowable Bad Debt*;
- (b) charged as a credit loss;
- (c) not the obligation of a governmental unit or the federal government or any agency thereof; and
- (d) not a reimbursable health service.

Center for Health Information and Analysis (CHIA). The Center for Health Information and Analysis established under M.G.L. c. 12C.

Centers for Medicare & Medicaid Services (CMS). The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Charge. The uniform price for a specific service charged by a provider.

Community Health Center. A health center operating in conformance with the requirements of § 330 of the Public Health Service Act (42 U.S.C. § 254b), including all community health centers that file cost reports with CHIA. Such a health center must

- (a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
- (b) meet the qualifications for certification (or provisional certification) by the MassHealth agency and enter into a Provider agreement pursuant to 130 CMR 405.000: *Community Health Center Services*; and
- (c) operate in conformance with the requirements of 42 U.S.C. § 254b.

Disproportionate Share Hospital (DSH). An acute hospital with a minimum public payer mix of 63%.

Eligible Services. Services eligible for Health Safety Net payment pursuant to 101 CMR 613.03: *Eligible Services Requirements*, which include

- (a) reimbursable health services to low income patients;
- (b) medical hardship; and
- (c) bad debt.

Emergency Bad Debt. The amount of uncollectible debt for emergency services that meets the criteria set forth in 101 CMR 613.06: *Allowable Bad Debt*.

Emergency Services. Medically necessary services provided to an individual with an emergency medical condition as defined in 101 CMR 613.02: *Emergency Services* and eligible for payment pursuant to 101 CMR 613.03: *Eligible Services Requirements*.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

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Federal Poverty Level (FPL). Income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Financial Requirements. An acute hospital's requirement for revenue that includes, but is not limited to, reasonable operating, capital, and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

Fiscal Year (FY). The time period of 12 months beginning on October 1st of any calendar year and ending on September 30th of the following calendar year.

Governmental Unit. The Commonwealth, any department, agency, board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Patient Service Revenue. The total dollar amount of a hospital's charges for services rendered in a fiscal year.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of an acute hospital's or community health center's charge for services.

Health Connector. Commonwealth Health Insurance Connector Authority or Health Connector established pursuant to M.G.L. c. 176Q, § 2.

Health Insurance Plan. Medicare, MassHealth, the Premium Assistance Payment Program operated by the Health Connector, a qualified health plan, or an individual or group contract or other plan providing coverage of health care services issued by a health insurance company, as defined in M.G.L. c. 175, 176A, 176B, 176G, or 176I.

Health Safety Net. The payment program established and administered in accordance with M.G.L. c. 118E, §§ 8A, and 64 through 69 and regulations promulgated thereunder, and other applicable legislation.

Health Safety Net Office. The office within the Office of Medicaid established under M.G.L. c. 118E, § 65.

Health Safety Net Trust Fund. The fund established under M.G.L. c. 118E, § 66.

Health Services. Medically necessary inpatient and outpatient services as authorized under Title XIX of the Social Security Act. Health services do not include

- (a) nonmedical services, such as social, educational, and vocational services;
- (b) cosmetic surgery;
- (c) canceled or missed appointments;
- (d) telephone conversations and consultations;
- (e) court testimony;
- (f) research or the provision of experimental or unproven procedures; and

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(g) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives are payable.

Hospital Cost Report. The Massachusetts Hospital Statement of Costs, Revenues, and Statistics reported to CHIA pursuant to 957 CMR 9.00: *Hospital Financial Data Reporting Requirements*.

Hospital Licensed Health Center. A satellite clinic, as defined in 101 CMR 613.02: Satellite Clinic, that

- (a) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center as provided at 130 CMR 410.413: *Medical Services Required on Site at a Hospital-licensed Health Center*; and
- (b) is approved by and enrolled with MassHealth's Provider Enrollment Unit as a hospital licensed health center.

Hospital Services. Services listed on an acute hospital's license by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; home health services; or separately licensed services, including residential treatment programs and ambulance services.

Individual Medical Visit. A face-to-face meeting at a community health center between a patient and a physician, physician assistant, nurse practitioner, nurse midwife, or registered nurse for medical examination, diagnosis, or treatment.

Low Income Patient. A patient who meets the criteria in 101 CMR 613.04(2): *Low Income Patient Determination*.

MassHealth. The medical assistance and benefit programs administered by the MassHealth agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Agency. The Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

MassHealth Drug List. The list of commonly prescribed drugs and therapeutic class tables published by EOHHS. The MassHealth Drug List specifies the drugs that are payable under MassHealth, and to the extent different, the Health Safety Net. The list also specifies which drugs require prior authorization.

Medical Hardship. Health Safety Net status available to Massachusetts residents as defined in 101 CMR 613.02: Resident and for which eligible services are eligible for payment pursuant to 101 CMR 613.03: *Eligible Services Requirements*.

Medically Necessary Service. A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate

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a disability, or result in illness or infirmity. Medically necessary services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

Medicare Advantage. A type of Medicare health plan established by Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Program (Medicare). The medical insurance program established by Title XVIII of the Social Security Act.

Office of Pharmacy Affairs (OPA). The Office of Pharmacy Affairs, and any successor agencies, is a division within the United States Department of Health and Human Services that monitors the registration of 340B pharmacies.

Patient. An individual who receives or has received medically necessary services at an acute hospital or community health center.

Pediatric Hospital. An acute hospital that limits services primarily to children and that qualifies as exempt from the Medicare Prospective Payment System (PPS).

Pharmacy Online Processing System (POPS). The MassHealth online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and patient eligibility verification.

Premium Assistance Payment Program Operated by the Health Connector. An insurance subsidy program that provides state subsidies for low-income individuals and families administered by the Health Connector.

Prospective Payment System (PPS) Rate. The Medicare Prospective Payment System rate for Community Health Centers set annually by CMS as described in 42 CFR 405.2467.

Provider. An acute hospital or community health center that provides eligible Services.

Public Payer Mix. The percentage of an acute hospital's gross patient service revenue attributable to Title XVII and Title XIX of the Social Security Act, the Health Safety Net or other government payers, as reported in the 2022 Hospital Cost Report published by CHIA; provided, however, that for each fiscal year beginning prior to October 1, 2025, Public Payer Mix is determined as of the source year for each such fiscal year and, only for such fiscal years, other government payers include the Premium Assistance Payment Program operated by the Health Connector.

Reimbursable Health Services. Eligible services provided by acute hospitals or community health centers to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or in part, and who meet the criteria for low income patient; provided that such services are not eligible for reimbursement by any other public or third party payer.

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Shortfall Amount. In a fiscal year, the positive difference between the sum of allowable Health Safety Net payments for all acute hospitals and the revenue available for distribution to acute hospitals.

Sole Community Hospital. Any acute hospital classified as a sole community hospital by the U.S. Centers for Medicare & Medicaid Services' Medicare regulations, or any acute hospital that demonstrates to the Health Safety Net Office's satisfaction that it is located more than 25 miles from other acute hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

Source Year. The fiscal year two years prior to the current fiscal year, from which data is collected to calculate current fiscal year payment rates, unless otherwise specified by the Health Safety Net Office through administrative bulletin.

Underinsured Patient. A patient whose health insurance plan or self-insurance plan does not pay, in whole or in part, for health services that are eligible for payment from the Health Safety Net Trust Fund, provided that the patient meets income eligibility standards set forth in 101 CMR 613.04: *Eligible Services to Low Income Patients*.

Uninsured Patient. A patient who is a resident of the Commonwealth, who is not covered by a health insurance plan or a self-insurance plan, and who is not eligible for a medical assistance program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program that requires such patient to make payment of deductibles or copayments, or fails to cover certain medical services or procedures is not uninsured.

Urgent Care Services. Medically necessary services provided in an acute hospital or community health center, as defined in 101 CMR 613.02: *Community Health Center*, and eligible for payment pursuant to 101 CMR 613.03: *Eligible Services Requirements*.

614.03: Sources and Uses of Funds

- (1) Payments from the Health Safety Net Trust Fund through Fiscal Year 2024.
 - (a) Payment Adjustments. Acute hospital payments established under 101 CMR 614.06 may be adjusted to reflect additional funding made available during the fiscal year or to reflect the shortfall allocation in accordance with 101 CMR 614.03(1)(b). The Health Safety Net may reserve up to 10% of available funding to ensure that funding is available for the entire fiscal year.
 - (b) Shortfall Allocation. Through fiscal year 2024, the Health Safety Net office, using the best data available, estimates the projected total reimbursable health services provided by acute hospitals and community health centers; total medical hardship services; total bad debt for emergency and urgent care services; and total Health Safety Net administrative expenses. If the Health Safety Net office determines that, after adjusting for projected community health center payments and administrative expenses, Health Safety Net payments to acute hospitals will exceed available funding, the Health Safety Net office allocates the funding in a manner that

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reflects each acute hospital's proportional financial requirements for Health Safety Net payments through a graduated payment system. The Health Safety Net office allocates the shortfall to disproportionate share hospitals and other acute hospitals as follows.

1. Disproportionate Share Hospital. The Health Safety Net office determines disproportionate share hospital status using data reported on the hospital cost report for the source year.
 2. Allocation Method. The Health Safety Net office allocates the shortfall as follows.
 - a. Determine the ratio of each acute hospital's total patient care costs to the sum of all acute hospitals' total patient care costs.
 - b. Multiply this ratio by the total shortfall amount.
 - c. If calculated amount is greater than an acute hospital's allowable health safety net payments, then the shortfall allocation is limited to the acute hospital's allowable health safety net payments. If an acute hospital's allowable health safety net payment is \$0 or less, then the shortfall allocation is limited to \$0.
 - d. The Health Safety Net's gross liability to each acute hospital is limited by the acute hospital's allowable health safety net payments less the shortfall allocation calculated in 101 CMR 614.03(1)(b)2.a. through c.
 - e. Each disproportionate share hospital is paid the greater of
 - i. 85% of its allowable Health Safety Net payments; or
 - ii. the revised payment calculated according to the shortfall methodology in 101 CMR 614.03(1)(b)2.a. through e.
- (2) Payments from the Health Safety Net Trust Fund beginning Fiscal Year 2025.
- (a) Payment Adjustments. Acute hospital payments established under 101 CMR 614.06 may be adjusted to reflect additional funding made available during the fiscal year or to reflect the shortfall allocation in accordance with 101 CMR 614.03(2)(b). The Health Safety Net may reserve up to 10% of available funding to ensure that funding is available for the entire fiscal year.
 - (b) Shortfall Allocation. For fiscal years beginning on or after October 1, 2024, the Health Safety Net office, using the best data available, estimates the projected total reimbursable health services provided by acute hospitals and community health centers; total medical hardship services; total bad debt for emergency and urgent care services; and total Health Safety Net administrative expenses. If the Health Safety Net office determines that, after adjusting for projected community health center payments and administrative expenses, Health Safety Net payments to acute hospitals will exceed available funding, the Health Safety Net office allocates the funding in a manner that reflects each acute hospital's proportional financial requirements for Health Safety Net payments through a graduated payment system. The Health Safety Net office allocates the shortfall to disproportionate share hospitals and other acute hospitals as follows.
 1. Disproportionate Share Hospital. The Health Safety Net office determines disproportionate share hospital status using data reported on the hospital cost report for the source year.

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2. Allocation Method. The Health Safety Net office allocates the shortfall as follows.
- a. Determine the ratio of each acute hospital's total patient care costs to the sum of all acute hospitals' total patient care costs.
 - b. Multiply this ratio by the total shortfall amount.
 - c. If calculated amount is greater than an acute hospital's allowable Health Safety Net payments, then the shortfall allocation is limited to the acute hospital's allowable Health Safety Net payments. If an acute hospital's allowable Health Safety Net payment is \$0 or less, then the shortfall allocation is limited to \$0.
 - d. The Health Safety Net's gross liability to each acute hospital is limited by the acute hospital's allowable Health Safety Net payments less the shortfall allocation calculated in 101 CMR 614.03(2)(b)2.a. through c.
 - e. Subject to available funds, all disproportionate share hospitals are paid at an equal percentage of their total allowable Health Safety Net payments, up to an amount equal to 85% of such allowable Health Safety Net payments, after which each disproportionate share hospital is paid the greater of
 - i. 85% of its allowable Health Safety Net payments; or
 - ii. the revised payment calculated according to the shortfall methodology in 101 CMR 614.03(2)(b)2.a. through e.

(614.03(3) Reserved)

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(4) Final Reconciliation. The Health Safety Net office may implement a final reconciliation between the Health Safety Net and an acute hospital or a community health center for the fiscal year. The final reconciliation is calculated based on the Health Safety Net's payments to the acute hospital or community health center calculated pursuant to 101 CMR 614.06 and 101 CMR 614.07, and the payments made to the acute hospital or community health center during the fiscal year. The final reconciliation may occur when the Health Safety Net office determines that it has sufficiently completed relevant claims adjudication and audit activity, including for claims that were remediated by a payment or void during the fiscal year. For the purposes of the final reconciliation, the Health Safety Net office will not consider, for the purposes of payments, claims that exceed the billing deadlines or fail to meet other billing rules or grievance procedures established at 101 CMR 613.00: *Health Safety Net Eligible Services*. The final reconciliation will be completed not later than two fiscal years after the end of the fiscal year being reconciled. The Health Safety Net office will notify acute hospitals and community health centers upon completion of the final reconciliation for each fiscal year. A fiscal year will be closed and no further adjustments to payments in that fiscal year will occur after the final reconciliation.

(5) Post-reconciliation adjustments. The Health Safety Net office will recoup amounts identified as overpayments to acute hospitals or community health centers for any fiscal year in which the overpayments are identified, regardless of whether the final reconciliation described in 101 CMR 614.03(4) has been completed. In such instances, the Health Safety Net office will recoup through payments to the acute hospital or community health center otherwise owed for fiscal years that have not had final reconciliation until the full amount of overpayment has been recouped. The Health Safety Net office may also adjust for underpayments, as it determines necessary in its sole discretion. In such instances, the Health Safety Net office will make payments to providers who were underpaid, as determined by the Health Safety Net office, through fiscal years that have not had final reconciliation.

(101 CMR 614.04 and 614.05 Reserved)

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614.06: Payments to Acute Hospitals

(1) General Provisions.

(a) The Health Safety Net pays acute hospitals based on claims in accordance with the requirements of 101 CMR 613.00: *Health Safety Net Eligible Services*. The Health Safety Net office monitors the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the provider's service delivery patterns and/or billing activity, including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

(b) Payment Types.

1. The Health Safety Net office calculates Health Safety Net payments for each acute hospital service for which the Health Safety Net is the primary or secondary payer in accordance with 101 CMR 614.06(2) through (7).

2. The Health Safety Net office establishes payments for claims which the Health Safety Net is the secondary payer in accordance with 101 CMR 614.06(8).

3. The Health Safety Net office reduces payments by the amount of emergency bad debt recoveries and investment income on free care endowment funds. The Health Safety Net office determines the offset of free care endowment funds by allocating free care endowment income between Massachusetts residents and nonresidents using the best data available and offsetting the Massachusetts portion against Health Safety Net claims.

(c) Method of Payment. The Health Safety Net may make payments to acute hospitals for eligible services through a safety net care payment under the Massachusetts Section 1115 Demonstration Waiver, a MassHealth supplemental acute hospital rate payment, or a combination thereof. The Health Safety Net office may limit an acute hospital's payment for eligible services to comply with requirements under the Massachusetts Section 1115 Demonstration Waiver governing safety net care, including cost limits or any other federally required limit on payments under 42 U.S.C. § 1396a(a)(13) or 42 CFR 447.

(d) Provider Preventable Conditions. The Health Safety Net does not pay for services related to Provider Preventable Conditions defined in 42 CFR 447.26. The Health Safety Net office may issue administrative bulletins clarifying billing requirements and payment specifications for provider preventable conditions.

(e) Serious Reportable Events. The Health Safety Net does not pay for services related to serious reportable events as defined in 105 CMR 130.332(A): *Definitions Applicable to 105 CMR 130.332* based on standards by the National Quality Forum. The Health Safety Net office may issue administrative bulletins clarifying billing requirements and payment specifications for such services.

(2) Pricing for Inpatient Services. The Health Safety Net office prices acute hospital claims in accordance with the Medicare Inpatient Prospective Payment System (IPPS) for non-psychiatric claims and the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for psychiatric claims for the current fiscal year. Medicare pricing data is published in the *Federal Register* and pricing methodologies are described in 42 CFR 412. Claims from acute hospitals classified by Medicare as Critical Access Hospitals

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(CAHs), PPS-exempt hospitals, Medicare dependent rural hospitals, and sole community hospitals are priced in accordance with 101 CMR 614.06(2)(b).

(a) Inpatient Medical Pricing - Standard. The Health Safety Net office uses Medicare pricing data and the most current version of the Medicare severity diagnostic related group (MS-DRG) weights to calculate the inpatient medical pricing according to the IPPS for all acute hospitals, except as described under 101 CMR 614.06(2)(b). The Health Safety Net office may update pricing or weight values as needed to conform to changes implemented by the Medicare program during the fiscal year. The pricing calculation includes Medicare adjustments for items such as high-cost outliers, transfer cases, special pay post-acute DRGs, partially Medicare-eligible stays, and participation in the acute hospital inpatient quality reporting program.

(b) Inpatient Medical Pricing - Other Acute Hospitals.

1. Critical Access Hospitals and PPS-exempt Hospitals. The Health Safety Net office calculates a per discharge payment for discharges occurring at Medicare Critical Access Hospitals, PPS-exempt cancer and pediatric hospitals, and acute hospitals with fewer than 20 discharges in the source year as follows.

a. The Health Safety Net office determines the average charge per discharge using adjudicated and eligible Health Safety Net claims data from the source year that is available at the time of rate calculation.

b. The Health Safety Net office determines an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using data as reported on the hospital cost report for the source year.

c. The average cost per discharge is increased by a cost adjustment factor determined by the percent change from the IPPS index level for the source year and the IPPS index level forecast for the fiscal year, as calculated by the Health Safety Net office as of October 1st of the fiscal year, and an additional factor of 1%. The product of this calculation is the per discharge payment applicable to all discharges occurring during the current fiscal year, except that partially eligible stays are paid pursuant to 101 CMR 614.06(2)(b)3.

d. If the acute hospital has fewer than 20 discharges in the source year, the Health Safety Net office sets a payment on account factor for the acute hospital as described in 101 CMR 614.06(3)(b).

e. If a case qualifies as a transfer case under Medicare rules, the Health Safety Net office calculates a *per diem* rate, capped at the full discharge payment. The *per diem* rate is the hospital-specific payment calculated under 101 CMR 614.06(2)(b)1., divided by the acute hospital's average length of stay.

2. Sole Community Hospitals. The Health Safety Net office pays acute hospitals classified as sole community hospitals that do not otherwise qualify for payment according to 101 CMR 614.06(2)(b)1 as follows. The Health Safety Net office calculates a hospital-specific per discharge amount for such sole community hospitals, rather than the adjusted standardized amount. This amount is based on the hospital-specific rate provided by the Medicare fiscal intermediary, adjusted for inflation. The payments may include transfer, outlier, and special pay amounts, using the hospital-specific rate in these calculations, for qualifying cases.

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3. Medicare Dependent Rural Hospitals. The Health Safety Net office pays acute hospitals classified by Medicare as Medicare Dependent Rural Hospitals that do not otherwise qualify for payment according to 101 CMR 614.06(2)(b)1 as follows. The Health Safety Net office calculates a blended payment consisting of 75% of a hospital-specific payment and 25% of the Operating DRG Payment for such Medicare Dependent Rural Hospitals. The payments may include transfer, outlier, and special pay amounts, using the hospital-specific blended rate in these calculations, for qualifying cases.

(c) Inpatient Psychiatric Pricing.

1. Psychiatric Case. A case is classified as psychiatric if
 - a. the acute hospital has a Medicare psychiatric unit;
 - b. the primary diagnosis is related to a psychiatric disorder; and
 - c. the claim includes psychiatric accommodation charges.
2. Psychiatric Pricing. The Health Safety Net office uses Medicare pricing data to calculate a *per diem* price according to the IPF-PPS. The Health Safety Net office may update values as needed to conform to changes implemented by the Medicare program during the fiscal year. The pricing calculation includes Medicare adjustments such as a teaching hospital adjustment, electroconvulsive therapy (ECT) adjustment, high-cost outliers, adjustments for participation in the Inpatient Psychiatric Facilities Quality Reporting program, and any other adjustments in accordance with Medicare pricing provisions pursuant to 42 CFR 412.424, including adjustments for specific DRGs, the presence of comorbidities, patient age, and length of stay.

(d) Inpatient Rehabilitation Pricing.

1. Rehabilitation Case. A case is classified as rehabilitation if
 - a. the acute hospital has a Medicare rehabilitation unit; and
 - b. the claim includes rehabilitation accommodation charges.
2. Payment. Rehabilitation cases are paid on a *per diem* basis. The payment is determined using the acute hospital's most recently filed CMS-2552 Cost Report. The rate is the sum of total rehabilitation PPS payments and reimbursable bad debts, divided by total rehabilitation days, and multiplied by a cost adjustment factor, as calculated under 101 CMR 614.06(2)(b)1.c.

(e) Hospital-acquired Conditions.

1. All acute hospitals, including but not limited to PPS-exempt acute hospitals, are required to report the present on admission indicator for all diagnosis codes on inpatient claims.
2. The Health Safety Net office does not assign an inpatient case to a higher paying MS-DRG if a hospital-acquired condition that was not present on admission occurs during the stay. For hospital services paid pursuant to 101 CMR 614.06(2)(a) and (b), the DRG payment is reduced in accordance with Medicare principles.

(101 CMR 614.06(2)(f) Reserved)

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- (g) Administrative Days. The Health Safety Net pays administrative days at the *per diem* rate established by MassHealth pursuant to the Acute Hospital Request for Applications for the current fiscal year when the Health Safety Net is the primary payer.
- (h) Partially Eligible Days. The Health Safety Net pays only for the uninsured portion of an inpatient stay covered partially by Medicare, Medicaid, or any other payor.
- (3) Pricing for Outpatient Services. The Health Safety Net pays a per visit amount for each outpatient visit. An outpatient visit includes all outpatient services provided in a single day, excluding hospital-based physician services, dental services, pharmacy services, and vaccine administration services, as described in 101 CMR 614.06(4) through (7). The outpatient per visit amount is determined as follows.
- (a) For each acute hospital, the Health Safety Net office calculates an average outpatient charge per visit, using such adjudicated and eligible Health Safety Net claims data from the source year. Charges for outpatient visit claims that are \$20.00 or below, and charges for outpatient claims within 72 hours of an inpatient admission, or 24 hours of an inpatient admission in the case of a critical access hospital, are excluded.
- (b) The Health Safety Net office determines a hospital-specific Medicare payment on account factor (PAF), defined as the percent of Medicare outpatient charges that are paid on average. The PAF is calculated using the best available data and subject to review and adjustment by the Health Safety Net Office, including any necessary adjustment in payment for services rendered by hospital licensed health centers that are designated by the federal Health Resources and Services Administration as federally qualified health centers at parity with hospital outpatient services rendered at the acute hospital's main outpatient campus.
- (c) Except as described in 101 CMR 614.06(3)(d) through (f), the Health Safety Net Office determines an outpatient payment per visit by multiplying the average outpatient charge per visit by the PAF. This product is further adjusted by a cost adjustment factor as calculated in 101 CMR 614.06(2)(b)1.c.
- (d) For fiscal years beginning before October 1, 2025, only, disproportionate share hospitals and non-teaching acute hospitals receive a transitional add-on of 25% of the outpatient per visit payment rate.
- (e) The per visit payment for PPS-exempt cancer and pediatric hospitals and Medicare Critical Access Hospitals are determined using the ratio of costs to charges as reported on the hospital cost report for the source year and an additional factor of 1%, rather than the Medicare payment on account factor data.
- (f) Claims for outpatient visits that are less than or equal to \$20.00 are paid by multiplying the Medicare payment on account factor by the billed charges.
- (g) Claims for outpatient visits within 72 hours of an inpatient admission, or 24 hours of an inpatient admission in the case of a critical access hospital, are not payable.
- (4) Pricing for Physician Services. The Health Safety Net office prices hospital-based physician service claims based on the Medicare Physician Fee Schedule.

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- (5) Dental Services. The Health Safety Net Office prices claims for outpatient dental services provided at acute hospitals and hospital licensed health centers using the lesser of the allowable charges billed to the HSN, or the fees established in 101 CMR 314.00: *Dental Services*. No additional outpatient per visit payment is paid for dental services.
- (6) Acute Hospital Outpatient Pharmacies.
- (a) Prescribed Drugs. For acute hospitals with outpatient pharmacies, the Health Safety Net office prices prescribed drugs using rates set forth in 101 CMR 331.00: *Prescribed Drugs*, less any applicable cost sharing amount. The MassHealth Drug List specifies the drugs payable by the Health Safety Net. Claims are adjudicated by the MassHealth Pharmacy Online Payment System.
- (b) Part B Covered Services. Medical supplies normally covered by the Medicare Part B program that are dispensed by acute hospital outpatient pharmacies that are not Part B providers are priced at 20% of the rates set forth in 101 CMR 322.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment* and 101 CMR 331.00: *Prescribed Drugs*.
- (7) Vaccine Administration. The Health Safety Net office allows for separate payment for a vaccine administration and an individual medical visit only if the vaccine administration is not occurring on the same day as the office visit. A separate fee for the administration of vaccines is payable only when the sole purpose for a visit is vaccine administration. The fee is priced in accordance with the provisions of 101 CMR 317.00: *Rates for Medicine Services*.
- (8) Secondary Payer. The Health Safety Net pays inpatient and outpatient acute hospital claims and community health center claims for which it is not the primary payer as follows.
- (a) 95% Rule. If a claim billed to the Health Safety Net has a ratio of total billed net charges to total claim charges that is greater than 95%, the Health Safety Net pays the claim in accordance with the applicable primary payment rules.
- (b) Other Payor as Primary Payer. For any allowable claim for which Health Safety Net is not the primary payor, and for which 101 CMR 614.06(8)(a) does not apply, the Health Safety Net pays in accordance with 101 CMR 613.03(1).
- (c) Payment Not to Exceed Primary. Notwithstanding any other provision to the contrary, the Health Safety Net payment for a claim for which it is not the primary payer will not exceed the amount the Health Safety Net Office would have paid if it were the primary payer less the amounts other payers paid for the claim.
- (d) Administrative Bulletins. The Health Safety Net office may issue administrative bulletins to clarify billing policies and payment specifications for claims for which it is not the primary payor.
- (9) Bad Debt Pricing. Except as provided at 101 CMR 614.06(9)(a), the Health Safety Net office calculates emergency bad debt payments for inpatient, psychiatric, and outpatient emergency and urgent care services, using the methodology in 101 CMR 614.06(2) and (3), except that:
- (a) If an acute hospital has fewer than 20 emergency bad debt claims during the source year, the Health Safety Net office sets the emergency bad debt rate as the

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outpatient primary per visit rate established in 101 CMR 614.06(3), excluding the transitional add-on under 101 CMR 614.06(3)(d).

(b) The Health Safety Net office pays hospital licensed health centers 75% of the PPS Rate as published by Medicare for Bad Debt claims for urgent care services.

(c) The emergency bad debt outpatient rate does not include the 25% add-on cited in 101 CMR 614.06(3)(d).

(d) The Health Safety Net only pays acute hospitals for bad debt claims that are emergency bad debt or bad debt claims for urgent care services.

(10) Medical Hardship. The Health Safety Net pays for claims for patients deemed eligible for medical hardship pursuant to 101 CMR 613.00: *Health Safety Net Eligible Services*. The Health Safety Net office reduces the amount of the billed charges by any applicable third-party payments, third-party contractual discounts, patient payments, and the amount of the medical hardship contribution. If any such adjustments are applicable, the claim is paid as a secondary claim in accordance with the provisions of 101 CMR 614.06(8). If there are no applicable adjustments and the billed charges are not reduced, the Health Safety Net pays the claim as if it were a primary Health Safety Net claim.

(11) Other. The Health Safety Net makes an additional payment of \$3.85 million to freestanding pediatric hospitals with more than 1,000 Medicaid discharges during the source year for which a standard payment amount per discharge was paid by MassHealth pursuant to the acute hospital request for applications, as determined by paid claims in the Medicaid Management Information System as of June 15, 2016, and for which MassHealth was the primary payer.

614.07: Payments to Community Health Centers

(1) General Provisions.

(a) The Health Safety Net pays community health centers based on claims submitted to the Health Safety Net office, less applicable cost sharing amount, in accordance with the requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* and claims specifications determined by the Health Safety Net office. The Health Safety Net office monitors the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the provider's service delivery patterns, including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

(b) The Health Safety Net will pay a community health center for prescribed drugs only if the community health center is providing prescribed drugs in accordance with 101 CMR 613.03(2): *Reimbursable Health Services*.

(2) Payments for Services.

(a) The Health Safety Net will pay community health centers a Medicare-based rate per patient per day for reimbursable health services unless otherwise specified by the table below. Payment will be either the PPS Rate, or the total charges applicable under the PPS rate for services furnished, whichever is less. The PPS rate will be adjusted for geographic differences in the cost of services based on the Medicare FQHC PPS Geographic Adjustment Factors. In addition, the PPS rate will be increased according to

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42 CFR 405.2467 when a community health center furnishes care to a patient that is new to the community health center or to a patient receiving a comprehensive initial visit or an annual wellness visit.

(b) The PPS Rate applies to individual medical visits, surgical procedures, behavioral health visits including individual diagnostic or treatment services, diagnostic vision care, medical nutrition therapy, diabetes self-management treatment, and tobacco cessation services. Only one visit per patient per day can be billed with the following exceptions:

1. when a behavioral health visit occurs on the same day as a medical visit; or
2. when an illness or injury necessitating a visit occurs on the same day as another visit.

(c) For Reimbursable Health Services not included in the PPS Rate, the Health Safety Net pays community health centers according to the following table, except for claims for bad debt for urgent care services. Payments for such services are based on the corresponding regulations named in the table. Some reimbursable health services listed in the table may be payable as individual consideration in the regulations named. For individual consideration codes billable to the Health Safety Net, the payment rate is calculated as (total payments made to community health centers by MassHealth for the code) / (total number of claims paid to community health centers by MassHealth for the code) during the source year. If MassHealth payment and claims information for a code is not available for source year, the rate for the code will be based on Medicare fee schedules or other relevant sources. The Health Safety Net pays only for services listed in the HSN CHC Billable Procedure Codes list, in accordance with 101 CMR 613.03: *Eligible Services Requirements*.

Type of Service	Payment Rules	Payment Source
Medical Visit – Urgent Care (code 99051)	Payable separately from an individual medical visit.	Rate for 99050 in 101 CMR 304.00: <i>Rates for Community Health Centers</i>
Pulmonary diagnostic (technical component only)	Payable separately only if not occurring on the same day as an individual medical visit.	101 CMR 317.00: <i>Rates for Medicine Services</i>
Cardiology diagnostic (technical component only)	Payable separately from an individual medical visit.	101 CMR 317.00: <i>Rates for Medicine Services</i>
Obstetrical labor and delivery services	Payable separately from an individual medical visit	101 CMR 316.00: <i>Rates for Surgery and Anesthesia Services</i>
Behavioral health (group treatment, medication management, psychological testing, and methadone services)	Payable separately from an individual medical visit.	For group treatment and medication visits, rates in 101 CMR 306.00: <i>Rates of Payment for Mental Health Services Provided in Community Health Centers and Mental Health Centers</i> ;

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Type of Service	Payment Rules	Payment Source
		for psychological testing, rates in 101 CMR 329.00: <i>Psychological Testing, Treatment, and Related Services</i> ; for methadone services, rates in 101 CMR 346.00: <i>Rates for Certain Substance-related and Addictive-Disorders Programs</i>
Radiology	Payable separately from an individual medical visit.	101 CMR 318.00: <i>Rates for Radiology Services</i>
Clinical Laboratory	Payable separately from an individual medical visit.	101 CMR 320.00: <i>Rates for Clinical Laboratory Services</i>
Dental	Payable separately from an individual medical visit.	Lesser of allowable charges billed to the HSN, or fees established in 101 CMR 314.00: <i>Rates for Dental Services</i>
340B Pharmacy Services	Payment will be reduced by the amount of patient cost-sharing, as applicable under 101 CMR 613.00: <i>Health Safety Net Eligible Services</i> .	101 CMR 331.00: <i>Prescribed Drugs</i>
Vision Care (dispensing and repair)	Payable separately from an individual medical visit.	101 CMR 315.00: <i>Vision Care Services and Ophthalmic Materials</i>
Family Planning Services	Family planning counseling, prescribed drugs, family planning supplies, and related laboratory tests are payable in addition to an individual medical visit. An individual medical visit is not payable for the sole purpose of replenishing a patient's supply of contraceptives.	101 CMR 312.00: <i>Rates for Family Planning Services</i>
Preventive Services/Risk Factor Reduction (code 99402)	Payable separately from an individual medical visit.	101 CMR 312.00: <i>Rates for Family Planning Services</i>

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Type of Service	Payment Rules	Payment Source
Immunization Visits	Payable separately only if not occurring on the same day as an individual medical visit.	101 CMR 317.00: <i>Rates for Medicine Services</i>
Vaccines Not Included in the Individual Medical Visit or Supplied by the Department of Public Health	Payable separately from an individual medical visit.	101 CMR 317.00: <i>Rates for Medicine Services</i>

(3) Bad Debt Payments for Urgent Care Services. The Health Safety Net pays community health centers at 75% of the payment rates in 101 CMR 614.07(2) for bad debt claims for urgent care services that meet the requirements in 101 CMR 613.00: *Health Safety Net Eligible Services*. The Health Safety Net only pays community health centers for bad debt claims that are emergency bad debt or bad debt claims for urgent care services.

614.08: Reporting Requirements

(1) General. Each provider must file with or make available to the Health Safety Net office or to an entity designated by the Health Safety Net office to collect data, as applicable, information that is required or that the Health Safety Net office deems reasonably necessary for implementation of 101 CMR 614.00.

(a) The Health Safety Net office may revise the data specifications, the data collection scheduled, or other administrative requirements by administrative bulletin.

(b) The Health Safety Net office or its designee may audit data submitted under 101 CMR 614.00 to ensure accuracy. The Health Safety Net office may adjust payments to reflect audit findings. Providers must maintain records sufficient to document compliance with all documentation requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* and 101 CMR 614.08.

(2) Acute Hospitals.

(a) The Health Safety Net office may require acute hospitals to submit interim data on revenues and costs to the Health Safety Net or to an entity designated by the Health Safety Net office to collect data to monitor compliance with federal upper limit, cost limit, and disproportionate share payment limits. Such data may include, but not be limited to, gross and net patient service revenue for Medicaid non-managed care, Medicaid managed care, the Premium Assistance Payment Program operated by the Health Connector, and all payers combined; and total patient service expenses for all payers combined.

(101 CMR 614.08(2)(b) Reserved)

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(c) Penalties. The Health Safety Net office may deny payment for eligible services to any acute hospital that fails to comply with the reporting requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* or 101 CMR 614.08 until such acute hospital complies with the requirements. The Health Safety Net office will notify such acute hospital in advance of its intention to withhold payment.

(3) Community Health Centers. The Health Safety Net office may deny payment for eligible services to any community health center that fails to comply with the reporting requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* or 101 CMR 614.08 until such community health center complies with the requirements. The Health Safety Net office will notify such community health center in advance of its intention to withhold payment.

(101 CMR 614.08(4) and (5) Reserved)

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614.09: Severability

The provisions of 101 CMR 614.00 are severable. If any provision or the application of any provision to any acute hospital, community health center, or circumstance is held to be invalid or unconstitutional, such invalidity will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 614.00 or the application of such provisions to acute hospitals, community health centers, or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 614.00: M.G.L. c. 118E.