4. Program Regulations:

130 CMR 457.000: *Freestanding Birth Center Services*

457.401: Introduction

130 CMR 457.000 establishes the requirements for the provision and payment of freestanding birth center (FBC) services under MassHealth. All freestanding birth centers participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 457.000 and 130 CMR 450.000: *Administrative and Billing Regulations*. FBCs must render services in accordance with all applicable statutes and regulations, including DPH regulations at 105 CMR 142.000: *Operation and Maintenance of Birth Centers*, and all applicable regulations cited therein.

457.402: Definitions

The following terms used in 130 CMR 457.000 have the meanings given in 130 CMR 457.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 457.000 is not determined by these definitions, but by application of 130 CMR 457.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

Freestanding Birth Center (FBC). A health facility not operated under a hospital license that is licensed by the Department of Public Health (DPH) as a birth center, pursuant to 105 CMR 142.000: *Operation and Maintenance of Birth Centers*. A freestanding birth center does not include individual or group-practice offices.

Low-risk Pregnancy. A normal, uncomplicated prenatal course as determined by documentation of adequate prenatal care and the anticipation of a normal, uncomplicated labor and birth, as defined by reasonable and generally accepted criteria adopted by professional groups for maternal, fetal, and neonatal health care.

457.403: Eligible Members

(A)(1) MassHealth Members. The MassHealth agency pays for freestanding birth center services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states, for each coverage type, which services are covered and which members are eligible to receive those services.

(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage types, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

457.404: Provider Eligibility

The MassHealth agency pays only freestanding birth centers who are participating in MassHealth on the date of service. Freestanding birth centers must meet the following eligibility requirements.

(A) In-state Providers. To be eligible for participation as a MassHealth FBC provider, the applicant must meet the MassHealth and DPH requirements specified as follows:

(1) for each service location, complete and submit the application for enrollment to MassHealth on the form provided for this purpose by MassHealth;
(2) be located and legally doing business in the Commonwealth of Massachusetts;
(3) operate under an FBC clinic license issued by DPH, in accordance with 105 CMR 142.000: *Operation and Maintenance of Birth Centers*;
(4) be accredited by the Commission for the Accreditation of Birth Centers (CABC);
(5) have a written agreement with a nearby hospital providing obstetrical and newborn services for the transfer of their patients for emergency treatment beyond that provided by the FBC; and
(6) employ a director who is responsible to the governing body for the operation and maintenance of the center. The director must be a certified nurse-midwife, or an obstetrician or family practitioner with obstetrical privileges in a nearby hospital licensed in Massachusetts or operated by the Commonwealth.

(B) Out-of-state Providers. To participate in MassHealth, an out-of-state FBC must meet the requirements specified as follows:
(1) obtain a MassHealth provider number from the MassHealth agency;
(2) participate in its own state's Medicaid program;
(3) operate as a provider of freestanding birth center services as authorized by the governing or licensing agency in its state;
(4) be accredited by the Commission for the Accreditation of Birth Centers (CABC); and
(5) employ a director who is responsible to the governing body for the operation and maintenance of the center. The director must be a certified nurse-midwife, or an obstetrician or family practitioner with obstetrical privileges in a nearby hospital licensed in its state.

457.405: Maximum Allowable Fees

The Executive Office of Health and Human Services (EOHHS) determines the payment rate for freestanding birth center services in accordance with 101 CMR 355.00: *Rates for Freestanding Birth Center Services*. Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 457.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

457.406: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary freestanding birth center services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 457.000, and with prior authorization.

457.407: Covered Services

The MassHealth agency pays for medically necessary FBC services, including the following:

(A) prenatal visits;

(B) ultrasound;

(C) low-risk labor and delivery;

(D) postpartum visit(s);

(E) newborn care services; and

(F) labor care prior to hospital transfer.

457.408: Noncovered Services

The MassHealth agency does not pay FBCs for the following services:

(A) surgical procedures such as forceps delivery, tubal ligation, abortion, or cesarean section;

(B) services that are not provided by a licensed provider within the scope of their practice and authorized under state law or regulation;

(C) home births; or

(D) general or regional anesthesia.

457.409: Service Limitations

Surgical procedures must be limited to those normally provided during an uncomplicated birth, including episiotomy and repair. Local anesthesia may be administered when performed within the scope of practice of the health care provider. Members who are participating in the Primary Care Clinician (PCC) plan do not require a referral for FBC services.

457.410: Recordkeeping Requirements

FBCs are governed by recordkeeping provisions at MassHealth regulations 130 CMR 457.410 and 130 CMR 450.000: *Administrative and Billing Regulations*, and DPH regulations at 105 CMR 140.000: *Licensure of Clinics*.

(A) Payment for any service listed in 130 CMR 457.000 is conditioned upon its full and complete documentation in the member's medical record. An FBC must maintain a record of all medical services provided to a member for at least six years following the date of service. Payment for maintaining the member's medical record is included in the fee for the FBC service. Each medical record must contain sufficient information to document fully the nature, extent, quality, and necessity of the care furnished to the member for each date of service claimed for payment. If the documentation is not sufficient to justify the service for which payment is claimed by the FBC, the MassHealth agency will not pay for the service or, if payment has been made, may consider such payment to be an overpayment subject to recovery in accordance with 130 CMR 450.000.

(B) The medical record for each member must contain, at a minimum, the following information:
(1) member's name, date of birth, home address and telephone number, and spouse or other person to contact in an emergency;
(2) date of each member visit with FBC staff;
(3) obstetrical and medical history;
(4) diagnostic observations, evaluations, and therapeutic plans;
(5) orders for any medication, test, or treatment;
(6) records of any administration of medications, treatment, or therapy;
(7) laboratory, radiology, and other diagnostic reports;
(8) progress notes;
(9) reports of any consultations, special examinations, or procedures;
(10) referrals;
(11) discharge summary where appropriate; and
(12) in addition to items 1 through 11 above, in regard to each newborn, the medical record must include the following:
(a) the condition of the infant at birth to include Apgar Score (or its equivalent) at one minute and five minutes, time of sustained respiration, details of physical abnormalities, and pathological states;
(b) date and hour of birth, birth weight, and period of gestation;
(c) number of cord vessels and any abnormalities of the placenta;
(d) verification of eye prophylaxis;
(e) metabolic screening;
(f) treatments, medications, and special procedures; and
(g) condition at discharge or transfer.

REGULATORY AUTHORITY

130 CMR 457.000: M.G.L. c 118E, §§ 7 and 12.