b. Physician Payment

Hospitals may not bill for hospital-based physicians or hospital-based entity services related to the provision of ancillary services.

6. Therapy Services

a. Payment for Therapy Services

The Division will reimburse acute outpatient hospitals for physical, occupational, or speech/language therapy services according both the Therapist Regulations in 130 CMR 432.000 and the hospital's cost-to-charge ratio or the hospital's usual and customary charges, whichever is lower.

The cost-to-charge ratio for all therapy costs was derived by taking total ancillary costs including capital from the FY93 RSC-403 (Schedule II, Line 78, Column 5) and dividing by the total ancillary revenues from the FY93 RSC-403 (Schedule II, Line 78, Column 8) to arrive at the hospital-specific aggregate ancillary cost-to-charge ratio.

b. Physician Payment

In addition to the therapy service payment, when a hospital-based physician or hospital-based entity provides physician services during therapy services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

7. <u>Recovery Room Services and Observation Services</u>

a. Fee Schedule

Hospitals will be reimbursed for recovery room and observation services as follows.

Each hospital's RY97 SPAD was multiplied by the number of its non-psychiatric Medicaid discharges for the period June 1, 1995 through May 31, 1996. This product was divided by the total number of non-psychiatric Medicaid discharges in the state for the same period. This average SPAD was then divided by the weighted average length of stay for all hospitals with the number of discharges for the period June 1, 1995 through May 31, 1996 used as each hospital's weight. The result was multiplied by 0.5079 to remove ancillaries, divided by 24 to get an hourly rate, and updated by an inflation factor of 2.14%.

The hourly rates were collapsed into three categories: 0 to 6 hours; 6 to 12 hours; and 12 to 24 hours. Each rate corresponds to the midpoint of the range; for example, the rate for 0 to 6 hours is 3 times the hourly rate.

If a hospital provides observation services for more than 24 consecutive hours, the hospital should treat the 25th hour as the beginning of a new time period.

b. Documentation

In order to qualify for reimbursement for recovery room services and observation services, the following information must be documented in the member's medical record:

i. the time the service begins and ends; and

ii. the reasons the service was necessary for that time period.

c. Physician Payment

In addition to the above observation fee, when a hospital-based physician or hospital-based entity provides physician services in connection with observation services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

Hospitals may not bill for hospital-based physician or hospital-based entity services related to the provision of recovery room services.

8. Significant Procedure APGs

The methodology for the reimbursement of Significant Procedure APGs is in effect for outpatient procedures.

a. Scope

As defined by the Division, Significant Procedure Groups consist of groups of most, but not all outpatient procedures, categorized based on CPT and HCPCS Level II, that are covered by the Division, as well as local procedure codes established by the Division. The codes that comprise each Significant Procedure Group are consistent with the latest available update of 3M Health Information Systems' Ambulatory Patient Groups, Version 2.0.

The Significant Procedures that will be subject to bundled, prospective reimbursement are those that fall within APGs 001-237, with some exceptions. These exceptions shall

be reimbursed as follows.

APG 057 Respiratory Therapy - see section IV.A.5;
APG 084 Cardiac Rehabilitation - see section IV.A.5;
APG 091 Chemotherapy by Extended Infusion) - see section IV.A.3 or 5, as applicable;
APG 092 Chemotherapy except by Extended Infusion - see section IV.A.3 or 5, as applicable;
APG 139 Hemodialysis - see section IV.A.13;
APG 140 Peritoneal Dialysis - see section IV.A.13;
APG 193 Electroconvulsive Therapy - see section IV.A.5

b. APG Rate Development

The methodology for developing rates for Significant Procedure Groups is as follows. All paid Medicaid in-state acute outpatient hospital and Hospital-Licensed Health Center claims for State Fiscal Year 95 (July 1, 1994 to June 30, 1995) were bundled into Significant Procedure APGs. All other outpatient and E.D. services (e.g., Clinic and E.D. Visits, Lab, Radiology, Ancillaries, Observation and Recovery Room) that were provided one day before, the day of, and the day after a Significant Procedure (but not including physician services), were included in the bundle. The APG charge was then calculated based on the average charges for all surgical claims and other outpatient and E.D. services. A weight was assigned to each Significant Procedure Group based on the relative value of the charges among all instances of each Significant Procedure Group where only one non-consolidated (see Section IV.A.8.d) Significant Procedure occurred within the three day window (see Section IV.A.8.c). A conversion factor of $386.04, which was based on the average RY95 Medicaid payment per visit for all Significant Procedure Groups that will be subject to APG reimbursement, was calculated based on the following adjustments. The average RY95 Medicaid payment per visit was multiplied by an outlier adjustment factor of 95%, a coding refinement adjustment factor of 97%, and a 95% efficiency discount. The conversion factor was inflated by 3.16% and then 2.38% to reflect price changes from RY95 to RY97. The conversion factor was then inflated by the RY98 update factor of 2.14% to reflect price changes from RY97 to RY98.

The conversion factor was then multiplied by the relative weight of each significant procedure group to determine the RY99 reimbursement rate for each group.

c. Three Day Window

A three (3) day period of time is utilized to bundle all services around a procedure into a Significant Procedure Group. Outpatient and E.D. services (other than physician

services) provided by a hospital and its associated Hospital-Licensed Health Centers and its School-Based Health Centers the day before, the day of, and the day after a Significant Procedure are bundled into the APG. This period is referred to as the "three day window."

d. Multiple Procedures

Multiple Significant Procedures performed within the three day window will be reimbursed at 100% of the APG rate for the procedure in the highest rated Significant Procedure Group, and 50% of the APG rate for each additional Significant Procedure. Multiple procedures where a simple procedure typically accompanies the more complex procedure will be consolidated into one procedure according to the 3M APG consolidation list and will not receive separate reimbursement.

e. Outliers

In those cases where 45% of the hospital's total charges exceed the reimbursement rate for a bundled APG service by $1,872 or more because of the level of intensity and resources required for a particular member, the hospital may apply to have these services considered for outlier treatment and priced manually by the Division.

f. Physician Payment

In addition to the Significant Procedure Group payment, when a hospital-based physician provides services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

9. <u>The Norplant System</u>

a. Payment for Norplant Services

Hospitals will be reimbursed according to both the Physician Regulations in 130 CMR 433.000 and the fees established in the most recent promulgation of the DHCFP's Family Planning Regulations (114.3 CMR 12.00), when a hospital-based physician or a physician on behalf of a hospital-based entity inserts, removes, or removes and reinserts the Norplant System of Contraception. The hospital may only bill for the hospital-based physician payment as the fee (according to the DHCFP's Family Planning Regulations at 144.3 CMR 12.00) represents payment in full for all services associated with the Norplant System of Contraception.

b. Physician Payment

Hospitals will be reimbursed for hospital-based physicians or hospital-based entities as set forth in Section IV.A.1 above.

10. Off-Site Radiation and Oncology Treatment Centers

Hospitals that provide radiation and oncology treatment services thorough an Off-Site Radiation and Oncology Treatment Center it subcontracts with or owns will be reimbursed according to the lower of the Medicare fee schedule or the hospital's usual and customary charge. Only those services listed by the Division are reimbursable at the Off-Site Radiation and Oncology Treatment Center. These rates represent payment in full for services and the hospital is not entitled to any additional reimbursement (e.g., clinic visit payments, APGs, physician payments).

To be reimbursed for any services provided at an Off-Site Radiation and Oncology Treatment Center, the hospital must enroll that site with the Division as the appropriate provider type. If the site is not recognized by the Division as an Off-Site Radiation and Oncology Treatment Center provider type, no service provided to a member at that site is reimbursable.

11. Audiology Dispensing

a. Payment for Audiology Dispensing Services

Hospitals will be reimbursed for the dispensing of hearing aids only by a hospital-based audiologist according to the audiologist regulations at 130 CMR 426.00 et seq., and at the lower of the most current of the DHCFP fees as established in 114.3 CMR 23.00, or the hospital's usual and customary charge.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of audiology dispensing services.

12. Ambulance Services

a. Payment for Ambulance Services

Ambulance services shall be classified as either air or ground ambulance services. Ground ambulance services shall be reimbursed by the Division subject to all regulations pursuant to

130 CMR 407.000 et seq. Payment shall be the lower of the rates established by the DHCFP, under 114.3 CMR 27.00, et seq., or the hospital's usual and customary charge.

If the costs of ground ambulance services were included by the hospital in the FY90 cost base for FY90 outpatient department services, no additional reimbursement for ground ambulance service may be billed.

In order to receive reimbursement for air ambulance services, providers must have separate contracts with the Division for such services.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of ambulance services.

13. Dialysis Services

a. Payment for Dialysis Services

The Division will reimburse services for End-Stage Renal Disease (ESRD) provided by acute hospital outpatient departments at the lower of the established Medicare "composite rate" of payment as stated in regulation or the hospital's usual and customary charges. Medicaid will recognize all exceptions to the composite rate that are approved by the Health Care Finance Administration.

b. Physician Payment

In addition to the dialysis service payment, when a hospital-based physician or hospital-based entity provides physician services during dialysis, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

14. Psychiatric Day Treatment Program Services

a. Payment for Psychiatric Day Treatment Services

For services to members who are not enrolled in the MH/SAP, the Division will reimburse acute hospital outpatient department psychiatric day treatment programs which are enrolled with the Division as such according to the regulations as set forth in the Psychiatric Day Treatment Program regulations at 130 CMR 417.401 - 440, at the lower of rates promulgated by the DHCFP, as established in 114.3 CMR 7.03, or the hospital's usual and

customary charge.

Hospitals may not bill for psychiatric day treatment services in addition to outpatient clinic mental health services if both were delivered on the same day.

In order to qualify for reimbursement, Psychiatric Day Treatment Programs must be certified by the Division as described in 130 CMR 417.405 .

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of Psychiatric Day Treatment Program services.

15. Dental Services

a. Payment for Dental Services

All covered dental services will be reimbursed by the Division, subject to all regulations at 130 CMR 420.000 et seq., at the lower of the most current rates promulgated by the DHCFP, as established in 114.3 CMR 14.00 et seq., or the hospital's usual and customary charge, except when the conditions in 130 CMR 420.429(A) or (D) apply. When these conditions apply, the Division will reimburse the hospital according to Section IV.A.8.

b. Physician Payment

Hospitals may not bill for hospital-based physician or hospital-based entity physician services related to the provision of dental services, except when the conditions in 130 CMR 420.429(A) or (D) apply. Under those circumstances, in addition to the APG payment under Section 6.C.8, when a hospital-based physician or hospital-based entity provides physician services, the hospital may be reimbursed for such physician services in accordance with Section 6.C.1 above.

16. Adult Day Health Services

a. Payment for Adult Day Health Services
The Division will reimburse acute hospital outpatient departments as set forth in the Adult Day Health regulations at 130 CMR 404.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 10.00 et seq., or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Adult Day Health service payment, when a hospital-based physician or a hospital-based entity provides physician services during Adult Day Health Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

17. Early Intervention Services

a. Payment for Early Intervention Services

The Division will reimburse acute hospital outpatient departments as set forth in the Early Intervention Program regulations at 130 CMR 440.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 49.00 et seq., or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Early Intervention Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Early Intervention Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

18. Home Health

a. Payment for Home Health Services
The Division will reimburse acute hospital outpatient departments as set forth in the Home Health Agency regulations at 130 CMR 403.401-441, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 3.00 or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Home Health Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Home Health Services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1 above.

19. Adult Foster Care Services

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Non-Institutional Reimbursement

a. Payment for Adult Foster Care Services

The Division will reimburse acute hospital outpatient departments for Adult Foster Care services at the lower of the rates certified by the Office of Purchased Services in the Executive Office for Administration and Finance and as set forth in the **Adult Foster Care Guidelines**, or the hospital's usual and customary charge.

b. Physician Payment

In addition to the Adult Foster Care Service Payment, when a hospital-based physician or hospital-based entity provides physician services during Adult Foster Care Services, the hospital may be reimbursed for such physician services, in accordance with Section IV.A.1 above.

Adult Foster Care Guidelines and rates will be provided by the Division upon request.

B. Emergency Department Services

NOTE: Rates for Emergency Department Services covered under a contract between the acute hospital and the MH/SAP Contractor that are provided to MassHealth members enrolled in the Division's MH/SAP shall be governed by terms agreed upon between the acute hospital and the MH/SAP Contractor as set forth in Section III.A.

Except for services reimbursable pursuant to Section III.B.3, reimbursement for all Emergency Room and Level I Trauma Center services provided the day before, the day of, or the day after a Significant Procedure (see Section II.A.8) shall be bundled into the reimbursement for a Significant Procedure APG.

Hospitals will be reimbursed only for those hospital services specified in Subchapter 6 of the Acute Outpatient Hospital Manual. Hospitals will be reimbursed only for physician services specified in Subchapter 6 of the Acute Outpatient Hospital Manual and only in accordance with Section IV.A.1 above.

1. Emergency Room Services and Level I Trauma Center Services

Rates by wage area were established using the same methodology as described for the clinic visit payment (see Section IV.A.2.a) except for the following:

a. For emergency services, the cost of Level I Trauma Centers were excluded from the calculation of the emergency room visit cost. Separate Level I Trauma Center rates were computed for hospitals with qualifying Level I Trauma Centers.

b. For Level I Trauma Center services in which the services of the Level I Trauma Center Team is <u>not</u> required, the costs of emergency services provided in the centers were separated from the costs of emergency services provided in other hospitals.

c. Hospitals will not be reimbursed the emergency room or Level I Trauma Center visit payment when an inpatient admission to the same hospital, on the same date of service, occurs following an emergency room or Level I Trauma Center service.

d. Hospitals will not be reimbursed at the emergency room or Level I Trauma Center visit rate for (i) primary care services provided to any recipient (ii) urgent care services provided to recipients enrolled in the PCCP, in an emergency room or Level I Trauma Center between 8:00 A.M. and 9:59 P.M. unless authorized by the recipient's PCC or unless the recipient's PCC is not available for authorization; and (iii) urgent care services provided in an E.D. to recipients not enrolled in the PCCP, when the hospital determines

that the recipient has the opportunity to receive urgent care elsewhere (e.g. the recipient's regular physician, an accessible community health center, or the hospital's outpatient clinic).

e All recipients seen in the E.D. must be screened in the E.D. in accordance with 42 U.S.C. 1396dd et seq. Reimbursement for a screening, will be according to the methodology in Section IV.B.3.

f. Physician Payment

In addition to the emergency room and Level I Trauma Center visit payment, when a hospital-based physician provides services during an emergency room or Level I Trauma Center service, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

2. Level I Trauma Center Team Services

Hospitals will be reimbursed for Level I Trauma Center Team services as described below for Level I Trauma Center visits in which the services of a Level I Trauma Team (as defined in Section II) are required.

a. Level I Trauma Team Visit Services Payment

Rates by wage areas were established using the same methodology as described for the clinic visit payment (as described in Section IV.A.2), except that the lower of cost or charge limitation was not imposed.

In order to receive the Level I Trauma Team services visit payment, the hospital must document in the recipient's medical record, the necessity for and the provision of Level I Trauma Team services for that visit.

Hospitals will not be reimbursed the Level I Trauma Team visit payment when an inpatient admission to the same hospital, on the same date of service, occurs following the Level I Trauma Team service.

b. Physician Payment

In addition to the per visit payment, when a hospital-based physician provides services during a Level I Trauma Team service, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

3. Emergency Department Screening Fee

The following Emergency Department Screening fee payments are excluded from the APG methodology. Hospitals will be separately reimbursed for emergency department screening as follows:

a. Conditions of Reimbursement

Hospitals will be reimbursed a separate screening fee only when a hospital-based physician or a physician providing services on behalf of a hospital-based entity provides screening services to MassHealth recipients in a hospital emergency department as follows:

i. the emergency department physician determines at any hour that a recipient requires elective or primary care;

ii the emergency department physician determines between the hours of 8:00 a.m. and 9:59 PM that a recipient enrolled in the Division's PCCP requires urgent care and the PCC declines to authorize emergency room services; or

iii the emergency room or Level I Trauma Center physician determines that a recipient not enrolled in the Division's PCCP requires urgent care, and the hospital determines that the recipient has the opportunity to receive this care elsewhere.

b. Rate Methodology

The emergency department screening fee is based on the average cost per screening visit and the rate for a comprehensive physician's office visit. The bundled rate includes components for professional services, ancillary services required to determine the acuity of the patient's condition, educational instruction on the use of the Division's PCC/managed care system for members enrolled in the PCCP, educational instruction on accessing primary care/urgent services in community health centers, hospital outpatient clinics, and physicians for members not enrolled in the PCCP, related educational materials and administrative duties. The Emergency Department screening fee is the exclusive reimbursement for services provided under the circumstances set forth in section IV.B.1.c.

No additional reimbursement, including but not limited to, ancillary services, professional services, and Emergency Department visit payments applies.

C. Reimbursement for Unique Circumstances

1. Pediatric Specialty Clinics

Payment for services provided in pediatric specialty (non-primary care) outpatient clinics at pediatric specialty hospitals and at hospitals with pediatric specialty (inpatient) units, per Section II, shall equal the weighted average FY90 Medicaid costs per visit for such clinics, multiplied by an inflation factor of 3.35% to reflect inflation between RY92 and RY93; by an inflation factor of 3.01% to reflect inflation between RY93 and RY94; by an inflation factor of 2.80% to reflect inflation between RY94 and RY95; by an inflation factor of 3.16% to reflect inflation between RY95 and RY96; by an inflation factor of 2.38% to reflect inflation between RY96 and RY97; by an inflation factor of 2.14% to reflect inflation between RY97 and RY98; and by an inflation factor of 1.9% to reflect inflation between RY98 and RY99. Based on total FY90 charges, total FY90 costs, total FY90 Medicaid charges, and total FY90 Medicaid visits totaled across all Division-approved pediatric specialty clinics in each qualifying hospital, the Division shall then calculate a cost-to-charge ratio and the Medicaid weighted average charge per visit, and multiply the latter by the former to calculate the weighted average FY90 pediatric specialty clinic cost per visit.

Qualifying hospitals shall have reported FY90 total Medicaid charges and total Medicaid visits individually for each pediatric specialty clinic approved as such by the Division. (FY91 quarterly data may be substituted if the clinic was not open for a full year in FY90.) Henceforth, hospitals will report corresponding charge and visit data on a quarterly basis.

2. Non-Profit Acute Teaching Hospitals Affiliated with a State-Owned University Medical School

a. Subject to section IV.C.2.b, the payment amount for outpatient, emergency department, and hospital-licensed health center services at non-profit acute care teaching hospitals affiliated with a state-owned university medical school shall be as follows. The data used for this payment will be from the most recent submission of the hospitals' or predecessor hospitals' DHCFP-403 report(s).

The hospital's total outpatient charges are multiplied by the hospital's overall outpatient cost to charge ratio (the hospital's outpatient cost to charge ratio is calculated using the DHCFP-403 total outpatient costs located on schedule II, column 10, line 114 as the numerator and total outpatient charges located on schedule II, column 11, line 114 as the denominator) in order to compute the total outpatient costs. The total outpatient costs are then multiplied by the Medicaid outpatient utilization factor (this factor is calculated by dividing the total Medicaid

outpatient charges by the total hospital outpatient charges) in order to calculate Medicaid outpatient costs. Medicaid outpatient costs are then multiplied by the inflation rates for those years between the year of the cost report and the current rate year.

b. Any payment amount in excess of amounts which would otherwise be due any non-profit teaching hospital affiliated with a state-owned university medical school pursuant to sections IV.A and IV.B is subject to specific legislative appropriation and intergovernmental funds transfer.

D. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA). If any portion of the reimbursement methodology is not approved by HCFA, the Division may recover any payment made to a hospital in excess of the approved methodology.

E. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

F. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining hospitals' rates. Such rates may, in the Division's sole discretion, affect computation of any of the efficiency standards applied to outpatient costs.

G. Hospital Change of Ownership

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the hospital during the effective period of the RFA, the Division, in its sole discretion, shall determine, on a case by case basis (1) whether the