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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 14-029

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

April 25, 2016

Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Dear Secretary Sudders:

We are pleased to enclose a copy of approved Massachusetts State Plan Amendment (SPA) No. 14-029, which was submitted to my office on December 31, 2014. This SPA was submitted to revise your approved Title XIX State plan to describe the Rate Year 2015 payment methodology for chronic disease and rehabilitation hospital outpatient services. This SPA has been approved effective October 1, 2014.

Enclosed are copies of the following approved State plan pages.

- Attachment 4.19-B(2), pages 1-7.

If you have any questions regarding this matter you may contact Julie McCarthy at (617) 565-1244 or by e-mail at Julie.McCarthy@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Daniel Cohen, State Plan Coordinator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 014-029	2. STATE MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2014	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447.300, 447.302, and 447.321	a. FFY 2015 $439,000 b. FFY 2016 $439,000
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B (2) pp 1-7	Same

10. SUBJECT OF AMENDMENT:

Chronic Disease and Rehabilitation Outpatient Hospital Services.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO:
13. TYPED NAME: John W. Polanowicz	Michael P. Coleman State Plan Coordinator Office of Medicaid Executive Office of Health and Human Services One Ashburton Place, 11th Floor Boston, MA 02108
14. TITLE: Secretary	
15. DATE SUBMITTED: 12/30/14	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/31/2014	18. DATE APPROVED: 04/25/2016
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/2014	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS:

FORM CMS-179 (07-92)

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods used to Determine Rates of Payment for Chronic Disease and Rehabilitation Hospital Outpatient Services

OFFICIAL

Methods Used to Determine Rates of Payment for Chronic Disease and Rehabilitation Hospital Outpatient Services

I. Overview

The following sections describe the methods and standards utilized by the Commonwealth of Massachusetts, acting by and through its Executive Office of Health and Human Services (EOHHS) to establish rates of payment by contract for Outpatient Services rendered by Chronic Disease and Rehabilitation Hospitals to MassHealth Members.

II. Definitions

Charge -- The standard fee that a Hospital charges for a Hospital service rendered to a patient, regardless of payer source, and which is required be filed with the Division of Health Care Finance and Policy.

Chronic Disease and Rehabilitation Hospital (Hospital) – A non-acute hospital licensed by the Massachusetts Department of Public Health under M.G.L. c. 111, §51, with a majority of its beds providing chronic disease services and/or comprehensive rehabilitation services to patients with appropriate medical needs. This definition includes such a facility licensed with a pediatric specialty.

Division of Health Care Finance and Policy (DHCFP) -- An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services, established under M.G.L. c. 118G from 2003 until the passage of Chapter 224 of the Acts for 2012. EOHHS is DHCFP's successor agency for rate setting functions, and the Center for Health Information and Analysis is DHCFP's successor agency for certain other functions. All references to DHCFP or DHCFP regulations also refer to the applicable successor.

Hospital Outpatient Department -- A department or unit that operates under the Hospital's license and provides services to Members on an ambulatory basis provided that the hospital adheres to the applicable guidelines established in 42 CFR 413.65

MassHealth Program (MassHealth) -- The medical assistance benefit plans operated and administered by EOHHS pursuant to M.G.L. c. 118E, §1 *et seq.* and 42 U.S.C. §1396 *et seq.* (Medicaid).

Member -- A person determined by the MassHealth Program to be eligible for medical assistance benefits under M.G.L. c. 118E, §1 *et seq.*

Outpatient Cost to Charge Ratio -- A percentage applied to the Charges for Outpatient Services of a Hospital to calculate payment for Outpatient Services provided to Members under the MassHealth Program.

Outpatient Services – Rehabilitative and medical services provided to Members in a hospital Outpatient department. Such services include, but are not limited to, Radiology, Laboratory,

Diagnostic Testing, Therapy Services, (i.e., physical, speech, occupational and respiratory) and Day surgery services.

Usual and Customary Charges — Routine fees that Hospitals charge for outpatient services rendered to patients regardless of payer source.

III. Payment Methodology

A. Data Sources.

1. The base year for setting payment rates for Outpatient Services is the Hospital fiscal year (HFY) 2003, except that the base year for a Hospital with no fewer than 500 licensed beds as of June 30, 2007 is the HFY 2006. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2003 HCFP-403 cost report, except for a Hospital with no fewer than 500 licensed beds as of June 30, 2007, which uses the HFY 2006 HCFP-403. All references to specific schedules, columns and lines refer to the HCFP-403 report filed with and reviewed by the Division of Health Care Finance and Policy (DHCFP). Except where noted, all references are to the HFY 2003 version of the HCFP-403.

2. The calculations use each Hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by DHCFP.

3. If the specified data source is unavailable or inadequate, The MassHealth program will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data. If required information is not furnished by a Hospital within the applicable time period, it may not receive any increase to its rate.

B. Rates for Outpatient Services.

1. A Chronic Disease and Rehabilitation Hospital will be paid for Outpatient Services using a Hospital-specific Outpatient Cost-to-Charge Ratio. The Outpatient Cost-to-Charge Ratio is a fixed percentage that is applied to a Hospital's Usual and Customary Charges for Outpatient Services, based on Charges filed with the Division of Health Care Finance and Policy. Payment for a particular Outpatient Service shall be equal to the product of the Cost-to-Charge Ratio times the Hospital's Usual and Customary Charge for the Outpatient Service, on file as of the previous July 1.. Any such payment shall not exceed the Hospital's Usual and Customary Charge.

2. The Cost-to-Charge Ratio for an individual Hospital is calculated by dividing its outpatient costs (Schedule XVIII) by its outpatient service revenue (schedule XI), as derived from the DHCFP-403 cost report.

3. MassHealth payment for a new Outpatient Service is based upon the Charge that is filed with the DHCFPand is equal to the product of the Cost-to Charge Ratio times such Charge. A new Outpatient Service is a service that is instituted after July 1 of each year. A Hospital must provide written notification to the DHCFP at least thirty (30) days in advance of implementation of any Charge for a new Outpatient Service.

4. For laboratory services in a Hospital Outpatient Department, the maximum allowable payment shall be at the lowest of the following:

    a. Rates under the agency's fee schedules for applicable Clinical Laboratory Services, which were set as of August 1, 2014, are effective for services provided on or after 10/1/2014 and are published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-320.pdf; or rates under the agency's fee schedule for applicable Surgery & Anesthesia Services, which were set as of August 31, 2012, are effective for services provided on or after 10/1/2014 and are published at http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/114-3-16.pdf. These fee schedules apply only to private providers; or
    b. The Hospital's Usual and Customary Charge; or
    c. The amount that would be recognized under 42 U.S.C. §1395l(h) for tests performed for a person with Medicare Part B benefits.

5. All claims for Outpatient Services are required to itemize services. MassHealth Transmittal Letter OPD-52, dated January 2004, requires hospitals to use HCPCS codes when submitting claims. Claims for any outpatient service without a HCPCS/CPT code will be denied.

6. In accordance with the General Appropriation Act for fiscal year 2006, any hospital whose outpatient rate of payment, under the payment methodology for hospital fiscal year 2006, would be less than the rate in effect during hospital fiscal year 2005, the MassHealth program will continue to pay at the applicable outpatient rate of payment in effect during hospital fiscal year 2005.

C. **Provider Preventable Conditions**

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B(2) (Chronic Disease and Rehabilitation Hospital Outpatient Services) of this State plan where applicable.

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒ Additional Other Provider-Preventable Conditions identified below:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

    1. Foreign object retained after surgery.
    2. Air Embolism
    3. Blood incompatibility
    4. Stage III and IV Pressure Ulcers
    5. Falls and Trauma, related to:
        - fractures
        - dislocations
        - intracranial injuries
        - crushing injuries
        - burns
        - other injuries

- In addition, the following:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Other Provider-Preventable Conditions ("OPPCs") above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above

When a hospital reports a PCC, MassHealth will reduce payments to the Hospital as follows:

1. Payments for Outpatient Services: MassHealth will not pay for services which the hospital indicates are PPC-related and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Follow-Up Care in Same Hospital: If a hospital reports that it provided follow-up outpatient services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license. MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided during the follow-up visit, payment will be made, but MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth

Charges for services, including co-payments or deductions, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursements according to the methodology above.

D. Serious Reportable Events

The non-payment provisions set forth in this Section III.D. apply to the following serious reportable events (SREs), where applicable:

1. Discharge or release of a patient / resident of any age, who is unable to make decisions, to other than an authorized person.
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances.

3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient / resident of any age.
5. Sexual abuse / assault on a patient or staff member within or on the grounds of the healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital services include:

1. All services provided during the outpatient visit during which a preventable SRE occurred; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

   a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

   b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

Non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital services provided to the patient following a preventable SRE.