

Chapter 2

PAYMENT AND REIMBURSEMENT FOR HEALTH CARE SERVICES

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Scope Note

This chapter outlines the three sources for reimbursement for health care services: the United States government, the Commonwealth of Massachusetts, and private payors. Within the discussion of each source, the chapter covers reimbursement programs (e.g., Medicare Parts A, B, and C under the U.S. government section). The reader is informed as to how the financial implications of health care clients' business plans can be impacted by these programs, so that he or she will better be able to navigate basic contours of the most important reimbursement systems for his or her clients.

§ 2.1 INTRODUCTION

To be successful in business, one has to know how to follow the money. Yet in the health care “industry,” despite it accounting for \$2.47 trillion (or \$8,160 per person) in 2009, which is more than 17 percent of the gross domestic product (based on 2009 data from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary), very few of its participants understand how payment and reimbursement flow for the services rendered.

* Ethics commentary for an earlier version of this chapter was provided by James S. Bolan, Esq., of Brecher, Wyner, Simons, Fox & Bolan LLP in Newton.

Practice Note

For more statistical information, see the Centers for Medicare and Medicaid Web site at <http://www.cms.hhs.gov/MedicareProgramRates/Stats/Downloads/MedicareMedicaidSummaries2008.pdf>.

Perhaps this paradox arises because of the great complexity, bureaucracy, and diversity of payment systems. Alternatively, it may be because health care practitioners entered the field as healers and helpers first, and as businesspersons second. Regardless of the reasons, lawyers representing health care providers must have a solid working knowledge of the financial principles applicable to their clients, not only because lawyers should understand their clients' business, but because in the case of health care, the clients frequently do not.

Every enterprise must know the financial implications of its business plans. While there may be sound public interest or strategic motivations for implementing a business plan, to alter a course of conduct, or to decide to continue an old practice, without awareness of the reimbursement impact is reckless.

For example, if a community hospital determines that there is inadequate ambulance coverage in its primary service area, one solution to the shortage would be for the hospital to operate an ambulance service itself. But putting aside the community's need for the moment, the financial implications of the decision to offer the service are complex:

- Will the service produce revenue in excess of costs ("profit") or not?
- Will it generate increased revenue for the hospital in excess of any losses it might incur on its own?

If the service will lose money overall, then the decision to offer it would need to be made exclusively on the basis of the hospital's mission and not its margin.

Naturally, there are any number of legal issues that must be explored before deciding to offer ambulance services, including the following:

- Is a determination of need required?
- What type of ambulance service (i.e., advanced life support, chair car) should be offered?
- How should antikickback problems arising from a potential referral source (the hospital) operating the referral business (the ambulance company) be avoided?

- What financing vehicle should the hospital use to purchase the equipment and provide a working capital for the new service?

To perform the analysis, the management team first needs to be able to project the revenues for the services with a reasonable degree of confidence.

This simple hypothetical situation concerning whether or not a hospital should create a new ambulance service requires detailed knowledge of the payment for ambulance services made by the dominant payors in the market, including the following:

- Do most payors reimburse on a fee schedule?
- Are the fees adequate to cover the cost the hospital expects to incur in providing the service?
- Will the hospital's payors require some ambulance services to be bundled into hospital "prospective payments"?

The hospital needs to understand both the new risks it may be incurring and the compliance issues it may be creating. For example, if the hospital owns the ambulance, will that trigger greater obligations under the Emergency Medical Treatment and Active Labor Act (EMTALA) (the antidumping law)? Is there an "antikickback" problem created by having a separate health care supplier (the ambulance service) direct patients to the hospital? But assessing the adequacy of the reimbursement component in due diligence is necessary to learn whether starting an ambulance service makes *business sense* for the organization whose primary mission is to provide inpatient and outpatient acute care.

A second goal in this chapter (and related chapters in this manual) is to provide the reader with an understanding of health care providers increasing financial dependence on governmental payors as private insurance rates drop. According to U.S. Census Bureau figures released in a 2010 report, the number of uninsured reached 50.7 million. This marks an increase from the 2008 report, which showed that between 2006 and 2007 there were declines in both the total number of uninsured persons (47 million to 45.7 million) and the percent of the population without insurance (15.8 to 15.3 percent). These declines, however, followed several years of increases. For example, according to a September 2003 report, 15.2 percent of the population was uninsured for health care in 2002. U.S. Census Bureau, U.S. Dep't of Commerce, *Health Insurance Coverage in the United States: 2002* (Sept. 30, 2003), available at <http://www.census.gov/prod/2003pubs/p60-223.pdf>. This number increased by 2.4 million in 2002. The total number of uninsured Americans was 43.6 million in 2002. The number of uninsured will be closely watched in the near future, as national health care reform

anticipates reducing this number significantly. CMS estimates that close to 93 percent of the population will be insured by 2019.

Practice Note

For more statistical information, see “Income, Poverty, and Health Insurance Coverage in the United States: 2007,” found on the U.S. Census Bureau’s Web site at <http://www.census.gov/prod/2008pubs/p60-235.pdf>.

Similarly, according to a Massachusetts study reported in the *Boston Globe*, 6.7 percent of Massachusetts residents were uninsured in 2002, an increase from 5.9 percent in 2000. This increase was blamed on declining participation of employers in providing insurance coverage for their workers and an increase in the overall unemployment rate. However, since the implementation of the Massachusetts Health Reform Law (Chapter 58 of the Acts of 2006, properly titled, “An Act Providing Access to Affordable, Quality, Accountable Health Care”), the number of uninsured persons in the Commonwealth dropped dramatically. According to the U.S. Census bureau, by 2007 Massachusetts had the lowest percent of uninsured persons of any state in the country. While there are disputes as to the precise impact of the Health Reform Law on the level of uninsured persons in Massachusetts, there is no dispute that the numbers have dropped. The CDC released data in 2010 finding that only 3.7 percent of Massachusetts residents remain uninsured.

Practice Note

For more information, see August Census Report, p. 71, citing U.S. Census Bureau, Current Population Survey and 2006 to 2008 Annual Social and Economic Supplements.

Practice Note

For more information, see “Health Insurance Coverage in Massachusetts: Estimates from the 2008 Massachusetts Health Insurance Survey,” available at <http://www.mass.gov> (search “Health Insurance Coverage in Massachusetts”).

Massachusetts’s experience is uncommon in the United States due to the Health Reform Law, and practitioners representing providers throughout New England or the country routinely confront very different market dynamics due to the differences in levels of uninsured persons. The gap in coverage for these 43.6 million Americans will be picked up by three sources:

- the patients, directly, through out-of-pocket payments;
- governmental payors; and

- free or uncompensated care from health care providers, which may in turn be reimbursed, at least in part, by state “uncompensated care” funds.

Health care providers, with the help of the counsel, must continually realign their businesses to these reimbursement dynamics.

This chapter is designed to provide an overview of the main federal and state health care reimbursement systems for use by lawyers new to the practice of health care law. The role of private payors and the various ways managed care has influenced the payment system will be addressed in a later chapter of this manual. Other chapters will provide more detailed discussions of reimbursement models applicable to various health care providers and the legal issues arising from them. This chapter is designed to present the payor and provider perspectives on payment and reimbursement. It is not intended to present a complete picture of reimbursement and coverage from a patient’s perspective.

§ 2.2 REIMBURSEMENT SYSTEMS OPERATED BY THE U.S. GOVERNMENT

The U.S. government funds and controls the operations of a number of health care payment systems. Some of these, such as the Medicare program, are exclusively federally funded. Others, most notably Medicaid and State Children’s Health Insurance Programs (SCHIP), are jointly funded by the federal government and the states. Private insurance systems are participants in both state and federal health plans as, for example, Medicare entities historically referred to as “fiscal intermediaries” and “carriers,” but now transitioning to Medicare Administrative Contractors (MACs).

As mentioned above, federal health care payments constitute a large and growing portion of the federal budget. Moreover, the department that oversees most of them, the U.S. Department of Health and Human Services (HHS) is among the largest departments in the government. It has a budget of more than \$834 billion and employs more than 65,000 people. It is also the largest grant-making organization in the United States. See the HHS Web site at <http://www.hhs.gov>. Health care lawyers need a working knowledge of the HHS and its programs. These programs include more than Medicare and Medicaid. The CMS has historically been the largest component of the HHS. Until the summer of 2000, the CMS was called the Health Care Financing Administration (HCFA). Other HHS agencies, some with well-known missions and others quite obscure, include the U.S. Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Public Health Service, the Centers for Disease

Control and Prevention (CDC), the Administration for Children and Families, the Indian Health Service, and some 300 other agencies, divisions, and programs.

§ 2.2.1 Medicare

(a) *Introduction to Medicare*

Congress founded the Medicare program, “Health Insurance for the Aged and Incapacitated Patient,” as Title XVIII of the Social Security Act in 1965, as part of President Johnson’s “Great Society.” As its name suggests, Medicare is a major payor of health care coverage for patients over the age of sixty-five, and this is the population that is customarily thought of when discussing whom Medicare covers. Medicare also provides coverage for patients who are under sixty-five but who have a qualifying disability and persons with end-stage renal disease (ESRD)—a disease of the kidneys usually requiring kidney dialysis. End-stage renal disease and hospice services have their own reimbursement schemes in light of the special needs of the beneficiaries, the chronic nature of ESRD patients, and the terminal illnesses that define hospice patients.

Medicare is divided into several parts: “Part A,” “Part B,” and “Part C,” (which is referred to as Medicare Advantage and was originally formed as Medicare+Choice (M+C)). CMS reported that in 2008, approximately 45 million people were enrolled in Parts A, B, or C, and over 9 million beneficiaries participated in a Medicare Advantage plan. (For more information, see p. 7 of the 2008 Summaries.)

In 2003, the Bush Administration and Congress negotiated the terms of a new Medicare benefit “Part D” provide coverage for outpatient, take-home prescription drugs. These drugs have been, historically, categorically excluded from coverage. As the costs of pharmaceuticals rose precipitously during the 1990s and many more drugs became available, the community demanded coverage for these expensive but necessary drugs. The administration would have preferred to offer prescription drugs only to beneficiaries enrolled in managed care organizations like M+C plans. However, Congress demanded that some level of drug coverage be offered to all beneficiaries even if they remain in traditional Medicare.

(b) *Medicare Part A: The Hospital Insurance Program*

Part A (also called Medicare “Hospital Insurance”) covers

- inpatient hospital care;

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- care in critical-access hospitals (CAHs)—specialized facilities in remote or rural areas offering forms of inpatient and outpatient services;
- care provided by skilled nursing facilities (SNFs);

(Text resumes on p. 2–7.)

- some care provided by home health agencies (HHAs); and
- hospice care.

These entities are called “providers,” as distinguished from Medicare “suppliers” like physicians, labs, ambulatory surgery centers, and other health care services under Part B. Each of these provider types receives payment on a different system, and each system has been subject to change throughout the history of the Medicare program. These systems are more fully described below. Medicare Part A is offered without additional premiums to persons who paid the so-called “Medicare tax” during their working years.

While all hospitals were historically reimbursed on the basis of their reasonable costs of providing necessary services to Medicare beneficiaries, nearly all acute and specialty services are now paid on a prospective payment basis. Some exceptions to prospective payment still exist, including cost-based reimbursement for “critical-access” hospitals and sole community provider hospitals.

The Part A program is administered for Medicare by private insurance companies that contract to serve as Medicare’s “fiscal intermediary.” They process cost reports, conduct audits, and generally are charged with the administration of the Medicare payment rules and regulations.

Cost Reimbursement Overview

Cost reimbursement was and is based upon a complex method of categorizing and organizing all of a provider’s cost and volume statistics for a cost reporting period (usually one year) and then allocating the costs to various cost centers. Those cost centers, which the Medicare program thinks are sufficiently related to “covered” patient care services, are “allowable” for purposes of Medicare cost reimbursement. The Medicare cost report then allocates a provider’s allowable costs to its various services (e.g., “inpatient” and “outpatient”) and apportions those costs to Medicare and other patients roughly based upon the fraction of patient care services represented by the Medicare patient population over the provider’s total patient population.

From Cost Report to Notice of Program Reimbursement

The cost reimbursement process begins with the completion of a Medicare cost report. For hospitals, the cost report is CMS-2552; for skilled nursing facilities, the form is CMS-2540; and for home health agencies, the form is CMS-1728. The provider’s reimbursement staff assembles the cost documentation from all departments of the facility and prepares the cost report.

The cost report is then audited by the Medicare Part A fiscal intermediary. For smaller providers, these audits might be “desk audits,” in which the cost report is viewed by knowledgeable staff at the fiscal intermediary’s offices, and no on-site audit of the provider is made. For larger providers, the audit is usually done on-site. Small teams of auditors from the fiscal intermediary descend on the provider and check the underlying documentation of the provider to learn if the underlying documentation supports the costs claimed in the cost report.

The audit process results in a notice of program reimbursement (NPR) which states the fiscal intermediary’s findings and conclusions regarding the cost report. Most cost-reimbursed providers receive interim payments throughout the year, which are estimates of the amount the provider will be due after the actual costs of the year are reviewed. The NPR will show the intermediary’s conclusion about whether the provider is owed money from the Medicare program or has been overpaid. An overpayment results if the provider’s interim payments were higher than the amount the provider was due upon review of the cost report after audit.

If the fiscal intermediary believes the provider has made errors in claiming its costs, then the NPR will include an “audit adjustment report.” The audit adjustment report (AAR) shows the provider where in the cost report the fiscal intermediary believes that the costs claimed or the statistics used were not as required by Medicare regulations, the provider reimbursement manuals, or other program directives.

The AAR is normally preceded by a proposed audit adjustment report and the provider is normally entitled to an “exit conference” to discuss those adjustments with the intermediary, provide additional documentation, and resolve as many disputed items as possible. The AAR is required to give an exact citation to the regulation or manual provision that supports the fiscal intermediary’s objection to a particular cost or allocation. Sometimes the fiscal intermediary will cite a general reimbursement principle and not a specific provision that tells the provider what the real problem may be. In these cases, the provider will need to speak with the fiscal intermediary and review the intermediary’s work papers, which are documents the intermediary should share with the provider early during the review process. The exit conference is the last opportunity a provider has to resolve disputed items with its intermediary short of an appeal or a reopening of its cost report.

Reopening and Appeal of an NPR

There are two ways to have errors in an NPR and AAR corrected: reopening and appeal.

Reopening is a process by which the fiscal intermediary is asked to reopen a cost report to correct a material arrear. Reopening requests must be made within three years of the issuance of an NPR and are discretionary with the intermediary.

Reopening is no substitute for an appeal. Under Supreme Court precedent, including *Your Home Visiting Nurse Services, Inc. v. Shalala*, 525 U.S. 449 (1999), the provider has no viable redress if the provider is dissatisfied with the intermediary's response to the request for reopening. The provider cannot appeal an intermediary's refusal to reopen an NPR.

Thus, providers should appeal from an NPR if it is seriously dissatisfied with the NPR and has at least \$50,000 in Medicare payments at issue. Under current law and regulation 42 C.F.R. § 405.1841(b), the provider has only 180 days following the submission of the NPR to appeal to the Provider Reimbursement Review Board (PRRB). Although late-filed appeals may under unusual circumstances be permitted by the PRRB, those are extremely rare.

A PRRB appeal involves several steps that are traps for the unwary. Among other things, the provider must

- designate an official representative,
- file an appeal request meeting very specific requirements,
- exchange preliminary position papers with the fiscal intermediary,
- submit final position papers to the PRRB, and
- eventually, attend an in-person or on-the-record hearing before the PRRB in Baltimore.

In 2008, CMS issued a new Final Rule, and in 2009, CMS issued revisions to the PRRB new subregulatory instructions (Board Rules) that are intended to restrict providers' appeal rights by, among other things, limiting the addition of new issues to a cost report appeal after 240 days following the NPR. *See* 73 Fed. Reg. 30190 (May 23, 2008). It is not uncommon for an appeal to take ten years from the filing of the cost report with the intermediary to the resolution by the PRRB.

Once the PRRB rules on an appeal, the CMS administrator may review and modify, reverse, or affirm the PRRB's decision, either on request from the provider, the intermediary, or sua sponte. The administrator has sixty days from the receipt of the PRRB's decision to accept the case. However, the provider also has only sixty days from the date of the PRRB's decision to seek judicial review in district court of the PRRB's decision. Thus, a provider can lose its appeal

rights if the administrator declines to renew a PRRB decision adverse to the provider and the provider inadvertently allows the judicial review clock to run out.

Cost Reporting Guidance and Rules

Cost reporting rules are not detailed in the regulations; rather, they are based on lengthy manuals, not published under the procedures of the Administrative Procedures Act, and generally accepted accounting principles (GAAP), which controls in situations where the CMS has not specified a departure from GAAP in its regulations, manuals, or other instructions. *See Gurnsey v. Shalala*, 115 S. Ct. 1232 (1995). The specifics of cost-reporting are set out in a series of CMS manuals and are interpreted through PRRB, CMS administrator, and judicial decisions.

The primary cost reimbursement manual is the CMS's *Provider Reimbursement Manual*, CMS Pub. 15. Other relevant manuals include the *Medicare Intermediary Manual*, CMS Pub. 13, and the several provider-specific manuals, like the *Hospital Manual*, CMS Pub. 10, the *SNF Manual*, CMS Pub. 12, and the *HHA Manual*, CMS Pub. 11. The CMS has migrated away from these paper-based manuals to new online manuals organized thematically, rather than by provider-type. Practitioners should consult both for guidance.

Part A Prospective Payment Systems

The art of cost reimbursement is dying a slow death. As mentioned above, payments to most providers of services have now transitioned to "prospective payment" systems (PPSs). Prospective payment reimburses providers an estimated amount of money for each case (diagnosis), item, or procedure.

The first Part A PPS, for hospitals, "Hospital PPS," was created in 1983 under Pub. L. No. 98-21. *See* 42 C.F.R. § 413. The hospital outpatient department's reimbursement transformed from cost-based to prospective payment (OPPS) through Section 4523 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, and further modified by Sections 201 and 202 of the Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113. An inpatient PPS reimburses hospitals a fixed amount for each diagnosis-related group (DRG). Diagnostic codes are selected from a text called the "ICD-9-CM" (*International Classification of Diseases, Ninth Revision, Clinical Modification*, published by the U.S. Public Health Service and the CMS). Hospitals receive a fixed amount of money for each discharge in a particular DRG regardless of whether the case was simple or complex. For extremely expensive cases or patients with long-term stays, Medicare has a pressure release valve, known as outlier payments, designed to compensate facilities for unusually high cost patients.

The PPS concept was designed to align hospital's incentives with those of the payors by eliminating unnecessary tests and procedures. Hospitals that are able to contain their costs retain some of the savings. Inefficient hospitals, theoretically, must adjust their practices. Of course, these incentives might also tend to cause hospitals to release patients "sicker and quicker." In any event, the inpatient PPS system forever changed the lives of many health care workers: not the least of which is the "discharge planner."

In part because the PPS reined in Part A hospital cost increases, the Medicare program incorporated PPSs for other types of services. These changes were implemented under the Balanced Budget Act of 1997. As of 2004, hospitals have been joined in Medicare prospective payment systems for reimbursement by the skilled nursing facilities (SNF PPS), and home health agencies. Long-term care hospitals and units (LTCH PPS), *see* 69 Fed. Reg. 25673 (May 5, 2004), and rehabilitation hospitals and units (IRF PPS), *see* 68 Fed. Reg. 45673 (Aug. 1, 2003), moved to a PPS most recently. Hospices are paid by Medicare on a PPS-like system, as well, though it is more akin to capitation, discussed in a later chapter of this book. And the CMS is expected to prepare a PPS for psychiatric hospitals as directed by the Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Balanced Budget Refinement Act of 1999, Pub. L. No. 106-113.

The IPPS system was again refined in 2007 and 2008 with the implementation of severity-adjusted DRGs or "MS-DRGs." As the name suggests, these new codes are intended to increase a DRG based on the presence of complications or comorbidities present in the patient upon his or her admission to the hospital. Patients with these multiple conditions would be assigned to a higher MS-DRG and the hospital would receive greater reimbursement for treating these patients. Imbedded in this system is a methodology which attempts to include a quality-of-care component in the IPPS reimbursement system. Several provisions of the Deficit Reduction Act of 2005 (the DRA) required CMS to implement various systems of so-called "value-based purchasing," including a new policy of not paying the additional amounts associated with conditions that were not present on admission and were, presumably, acquired within the hospital or during the hospital stay. The payment reductions have only affected discharges occurring on or after October 1, 2008, and the list of conditions subject to this policy remains short. However, it is reasonable to assume that the list will grow and this new policy will become a significant compliance and reimbursement challenge for hospitals.

On May 4, 2010, CMS published new IPPS proposed rules for acute and long-term care hospitals. The rules include some temporary changes to payment provisions, as well as to permanent payment reductions. Hospitals should be aware of these new changes, as well as any changes under health care reform.

Remaining Utility of Cost Reporting

As most Part A services move to a PPS, cost reporting for Medicare still exists, but for only a few purposes.

First, there remain some cost reimbursed Part A services, and some cost-based providers—such as psychiatric hospitals and critical-access hospitals (CAHs). Cost reporting is still necessary to derive their payments.

Second, Medicare payments for graduate medical education are based on the costs of those programs both directly and indirectly. These payments are critical to teaching hospitals, and all derive from the cost report.

Third, payments for PPS “outliers,” particularly expensive cases, and payments to “disproportionate share hospitals” (hospitals treating an unusually high proportion of uninsured and underinsured persons), are based on the providers’ costs.

Finally, costs will continue to play a role in the CMS’s determination of future reimbursement rates. To the extent that the agency is required to base payments on cost, it will continue to need cost data.

(c) *Medicare Part B: The Medical Insurance Program*

If Medicare Part A covers most health care facility reimbursement, Medicare Part B covers most other types of health care service—most notably, physicians. As mentioned above, in Medicare nomenclature, Medicare Part A generally reimburses health care “providers,” and Medicare Part B covers the services of “suppliers.” Suppliers include

- physicians;
- physician assistants;
- nurse practitioners;
- ambulatory surgery centers (ASCs);
- labs;
- outpatient hospital care;
- physical and occupational therapists;
- independent diagnostic treatment facilities (IDTFs);

- clinical social workers;
- diagnostic x-rays;
- durable medical equipment, prosthetics, and orthotics (DME or DMEPOS);
- ambulances;
- some home health care; and
- some other medical services that Part A does not cover.

Part B also covers a great deal of facility services, such as outpatient hospital care, and laboratory and diagnostic testing (including mobile x-rays and services provided by independent diagnostic testing facilities (IDTFs)). Part B also covers some home health care services. Unlike Medicare Part A, Part B coverage is optional and requires the beneficiary to pay a small premium.

Medicare Part B is voluntary—eligible beneficiaries must enroll in the program, and pay an additional premium (\$96.40 per month in 2010 for most beneficiaries) with coinsurance and deductibles. Medicare supplemental insurance, private voluntary policies purchased by individuals, may cover the coinsurance and deductibles.

Reasonable Charge Gave Way to the Fee Schedule

Reasonable Charge

Medicare Part B has undergone similar changes, as did Part A over time. These changes were designed to control the costs to the program from perceived lack of incentives to limit services. Part B was established to provide coverage for physician services. Other types of suppliers were added to the Part B benefit over time. Physician reimbursement under the Part B program began with a system that paid doctors based on “reasonable charges,” defined as the lower of the actual billed charge, the customary charge, and the prevailing charge for a service. The program included a number of checks and controls on physician charges, but the basic system resulted in physician charge inflation in order to maximize reimbursement.

Resource-Based Relative Value Scale (RBVS)

Congress responded by mandating that the Medicare program establish a relative value scale for physician services to be used to determine fee schedule payments for physician services. A complex methodology known as the RBRVS was developed

for this purpose, and effective January 1, 1992, physician fee payments have been calculated using relative value units (RVUs) established under the RBRVS methodology. *See* SSA § 1848.

The RBRVS assigns national RVUs to each procedure based on the resources (costs and time) needed to perform each service or procedure. The RVU is composed of three components:

1. the “physician work component” (the time and intensity needed to perform the service or procedure);
2. the “practice expense” (the cost of overhead in the office or other setting where the procedure is performed); and
3. the “malpractice expense” (addressing the cost of insurance to the physician).

The national RVUs are adjusted by other factors, including a factor for geographic differences in practice cost (the geographic adjustment factor (GAF), which is the average of the individual geographic practice cost invoices (GPCI) for each of the three components of the RVU for each locality) and, finally, a conversion factor that translates the RVUs into fees Medicare will pay.

Physicians and other suppliers who bill Medicare select the appropriate billing code based on the service performed or the supply used. These codes are called the health care common procedure coding system (HCPCS). The HCPCS closely mirrors the American Medical Association’s published “Current Procedural Terminology” (CPT) (now in its fourth edition). It is important to note that while HCPCS and CPT are very similar, Medicare regularly changes definitions and descriptions of how to code for services, leaving a practitioner who relies exclusively on the CPT to select codes for Medicare billing in the situation of miscoding.

The physician fee schedule is published annually in the Federal Register. (The physician fee schedule for calendar year 2011 was placed on display at the Federal Register on November 2, 2010). The proposed and final annual physician fee Schedule regulation is extremely important because not only does it show changes in reimbursement rates from prior years, it also includes many other important regulatory and reimbursement requirements for physicians and others who bill Medicare for physician services. The annual physician fee schedule regulation is carefully reviewed by health care lawyers promptly after publication.

(d) *Medicare Part C: Medicare+Advantage*

The Medicare Advantage program, or Part C, is the successor to M+C which was created under Section 4001 of the Balanced Budget Act of 1997. Medicare+

Choice supplements Parts A and B with a program administered by the CMS under which private insurance companies and other payors provide coverage to voluntarily enrolled Medicare beneficiaries. The program was established with the expectation of cost savings to the program. Under the law, the payment rates to the M+C plans are calculated on the basis of 95 percent of the amount the agency calculates it would have spent on the care of the patient had the patient remained in the traditional Medicare program (the adjusted average per capita cost (AAPCC)) with adjustments for geographic cost variations and the health and demographic status of the patients enrolled with the plan. These payment rates, called adjusted community rates (ACRs), are set for each contract year.

Under the implementing regulations, 42 C.F.R. § 422, the total amount paid to the M+C payor is calculated based on the health and demographic status of the patients enrolled with the plan, including various adjustments depending on the health status of the beneficiary, and whether or not the beneficiary is institutionalized (as in a nursing facility) or living at home. While 42 C.F.R. § 422 is the operating regulation for M+C, the program's main source of rules and interpretations reside in a set of operational policy letters (OPLs) found in a relatively understandable format on the CMS Web site. Payments on a county-by-county basis often differ significantly within a single state. The M+C program withered and was eventually reconstituted as Medicare Advantage through the December 8, 2003 Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA), Pub. L. No. 108-173, 117 Stat. 2066, Title II. Regulations implementing Medicare Advantage are at 42 C.F.R. § 422.1-422.2276. The legislative summary of the MMA provisions is found at <http://www.cms.hhs.gov/MMAUpdate/downloads/PL108-173summary.pdf>.

On the outside, Medicare Advantage plans look much like the old M+C plans and they have a similar regulatory structure. Contracting organizations must provide certain basic services, including all services that are covered by Part A and Part B of Medicare to which the beneficiary would be entitled where he or she not enrolled with the plan. 42 C.F.R. § 422.101(a). Medicare Advantage organizations may provide an array of additional benefits. These additional benefits may be paid for by the organization or the beneficiary or a combination of the two. Initially, M+C plans attempted to entice beneficiaries to join the plans with rich additional benefits at no cost. Medicare Advantage plans appear to have been more cautious.

Medicare Advantage plans have flexibility to make arrangements with providers, limit networks, and implement creative care management programs to limit cost and produce a profit under the payments they receive from Medicare. Providers (like hospitals, physicians, and nursing homes) must contract separately with each Medicare Advantage plan. Some health maintenance organizations (HMOs) that operate Medicare Advantage plans require (or strongly encourage) their

participating providers to also participate in the plans' Medicare Advantage programs, a practice that has not been tested in court.

Health care reform proposes to impact Medicare Advantage plans. Private insurer plans partaking in Medicare Advantage will potentially see a \$132 billion government payment reduction over a ten-year period.

(e) *Medicare Part D: The Medicare Prescription Drug Benefit*

It is no understatement that rising prescription drug costs are among the top two or three health care reimbursement challenges facing private and public payors. Advocacy groups have long chronicled the great need to provide expanded access to life-prolonging pharmaceuticals. Some private and even governmental payors have responded by seeking new sources of these products, such as from other countries like Canada. Such initiatives address pricing issues around the edges. But the fundamental question of who will pay for these drugs remains the key question for improved drug benefits.

Historically, self-administered drugs were among the benefits expressly excluded from Medicare Parts A and B, although M+C plans were able to provide some drug coverage. Following fierce debate and politicking, the MMA included a new Medicare prescription drug benefit (MPDB) for prescription drugs dispensed to outpatients (now known as "Part D"). The CMS issued its proposed rule to implement the MPDB on August 3, 2004. 69 Fed. Reg. 46631. In the several years since, access to prescription drug coverage under Medicare represents the single largest expansion of the Medicare benefit since the creation of Title XVIII.

Benefits under Part D began on January 1, 2006. Part D allows Medicare beneficiaries to enroll in a stand-alone prescription drug plan (PDP) or obtain prescription drug coverage from a Medicare Advantage prescription drug plan (MA-PDP). If neither of these options is available to a beneficiary, such beneficiary may enroll in a fall-back prescription drug plan. *See* 42 U.S.C. § 1860D-1(a).

For the prescription drug coverage, beneficiaries pay a small monthly premium and are also responsible for a deductible of the first \$250 spent on prescription drugs in each year. Medicare pays 75 percent of prescription drug costs between \$251 and \$2,250, up to \$3,600 in out-of-pocket costs. Medicare pays 95 percent of the costs after \$3,600. (The coverage gap in the middle is referred to as the "doughnut hole.") The deductible and premiums are eliminated for qualified low-income persons. *See* 42 U.S.C. § 1860D-2(b). If a drug is covered by Part A or Part B, no coverage for such drug is available under Part D.

The Future of the Prescription Drug Benefit

Even before the ink had dried on the MMA, opponents on both the left and the right sides of the aisle decried the new law as either too rich an expansion of the Medicare program or an inadequate benefit for the beneficiaries with an unprecedented windfall for the drug industry. In this summary, the author has attempted to avoid editorializing on the merits of the new drug benefit. It does appear certain that the drug benefit will remain in some form for as long as Medicare exists because it is nearly impossible to take back a benefit once it is given. However, it is reasonable to assume that some of the more controversial elements of the benefit (such as the prohibition on the CMS negotiating or setting prices or mandating formularies with the drug companies—billed as “noninterference” provisions) will be revisited as the financial impact of the law become better known.

Health care reform proposes to bolster Medicare Part D prescription drug benefits. As of 2010, individuals that fall into the “doughnut hole” will receive \$250, and thereafter the benefit will expand. By 2020, the benefit will cover 75 percent of drug costs that are currently considered in the doughnut hole.

(f) Medicare Secondary Payor

Medicare is secondary to all other health insurance a patient may be eligible under (third-party plans). If a third party makes a payment to or on behalf of a Medicare patient for a covered service that is less than Medicare would have made, then generally Medicare will pay the net remaining balance capped at the normal Medicare payment level. In such instances, Medicare is acting as a “secondary payor” (MSP).

The MSP program provides many employers an interaction with the HHS and the federal bureaucracy when their insurance programs cover beneficiaries who also have Medicare. For example, if Medicare pays for a service and the program later learns that the beneficiary has third-party coverage, Medicare is subrogated to any individual, provider, supplier physician, private insurer, state agency, or other entity entitled to payment. The MSP rules are found in SSA § 1862(b) and 42 C.F.R. § 411.

§ 2.2.2 Medicaid

Medicaid (Title XIX of the Social Security Act) is a joint Federal and state health care program. The Federal government pays approximately 50 percent of the costs of each state’s Medicaid plan. (The appropriateness of significant differences in the amount of federal financial participation among various states’

Medicaid programs is a regular issue for state legislatures and Medicaid regulators.) While states have considerable flexibility in operating the Medicaid programs (and, indeed, states are not even required to participate in Medicaid, though every one does), they must follow general requirements set by the federal government and obtain CMS approval of their state plans and any subsequent amendments to them.

Each state designates a Medicaid agency (in Massachusetts, the Office of Medicaid in the Executive Office of Health and Human Services) to administer its plan. The state plan is actually a number of documents, amendments, and attachments that together fully describe how the state delivers services to the Medicaid population, and any other populations the state has chosen to cover. The states must submit their “state plans” to the CMS for approval. Unless the CMS approves the plan, or any amendments to the plan, the federal government will not permit the state to change its program. States that change their programs without federal approval are subject, after a notice and hearing, to termination of federal Medicaid funds.

In addition, the Medicaid program includes an extensive waiver program to allow states to innovate in the delivery of service to their residents. Medicaid waivers allow the states to design novel health care programs (still jointly financed with state and federal money) that may depart from the ordinarily required strictures of the federal regulations. This is understandable as the needs of the communities differ greatly across the country. Moreover, Congress has long believed that the states are good places to experiment with new ways of covering the costs of health care. Permitting waivers has allowed states to test rationing care, offering preventative services, and other things that would be too costly or disruptive to offer through Medicare or some other national system until such care has been tested in the states almost like pilot projects. Massachusetts has operated its Medicare plan pursuant to a series of waivers since 1974, when it commenced a Medicaid prospective payment system for hospital services.

(a) *Mandatory Benefits*

All Medicaid state plans must cover a certain set of basic benefits (“mandatory” benefits). These benefits include the following:

- inpatient and outpatient hospital services (other than services in an “institution for mental diseases”);
- rural health clinic (RHC) services;
- federally qualified health center (FQHC) services;

- laboratory and x-ray services;
- nursing facility (NF) services;
- early and periodic screening, diagnosis, and treatment (EPSDT) for individuals who are eligible under the plan and are under age twenty-one;
- family planning services and supplies;
- physician services;
- certain home health benefits; and
- certain medical and surgical dental services.

(b) *Optional Benefits*

States may offer certain additional services, such as

- clinic services,
- nursing facility services for individuals under age twenty-one,
- intermediate care facility services for persons with mental retardation (ICF/MR),
- optometrist services,
- eyeglasses,
- prescription drugs,
- prosthetic devices,
- certain dental services,
- diagnostic services that do not fall within the mandatory category,
- rehabilitative services, and
- physical therapy services.

Note that some otherwise optional services become mandatory when provided as part of is the services customarily provided by a provider whose services are required to be covered by a Medicaid plan.

Health care reform legislates for the expansion of Medicaid to include 16 million additional people. The expansion reaches previously ineligible, childless adults. Beginning in 2013, Medicaid payment rates will also increase.

The Massachusetts Medicaid program (“MassHealth”) is described in § 2.3.1, below.

Ethics Commentary

Is there an ethical duty that a client/provider not seek to maximize reimbursement from government programs? Or, said another way, is it unethical to assist a client in arranging business affairs to maximize reimbursement?

There are certain assumptions underlying this question. First, because the question speaks about the client’s business affairs, there is an assumption that the client has sought legal advice from the attorney, and not business advice. In the latter event, attorney-client privilege does not apply and the conversations may not be confidential if the attorney is not acting as an attorney, but as a business advisor. In addition, the attorney’s malpractice insurance coverage may not apply if he or she is providing business advice and not legal advice. Second, an assumption underlying the question is that seeking to maximize reimbursement is an unlawful or illegal act. If it is illegal or unlawful, then see the ethics commentary at § 2.2.3(a), below.

Ethics Commentary

If a provider’s attorney knows that the provider will be breaking a rule of the governmental reimbursement program, what must the attorney do?

An assumption underlying this question is that breaking a rule constitutes fraudulent or criminal conduct. If so, see the previous ethics commentary at § 2.2.3(a), below. If breaking a rule is an act of lesser magnitude that might, at most, expose the client to civil liability and not licensure impairment, then zealous advocacy is appropriate.

§ 2.2.3 Other Federal Health Programs

This presentation has focused on the federal Medicare and Medicaid benefits, as they are the primary sources of reimbursement for private and voluntary health care providers in Massachusetts. It must be remembered, however, that the federal government supports several other significant health care programs including the Department of Veterans Affairs (VA) health system, Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), the Federal Employee Health Benefits Program (FEHB), and Black Lung and Railroad Retirement Benefits.

(a) *Veterans Health Administration*

The VA health system operates a network of hospitals and other providers nationwide. Indeed, the VA system is the largest hospital system in the country, with more facilities than the largest private hospital companies. According to the U.S. Census Bureau, there are some 21 million to 22 million living veterans. Consequently, VA believes that about a quarter of the nation's population is potentially eligible for VA benefits and services as veterans, family members, or survivors of veterans. Veterans Affairs operates 163 hospitals, with at least one in each of the forty-eight contiguous states, Puerto Rico, and the District of Columbia. Veterans Affairs also operates more than 850 ambulatory care and community-based outpatient clinics, 137 nursing facilities, forty-three domiciliaries, and seventy-three comprehensive home-care programs. See the VA Web site at <http://www.va.gov>.

VA benefits are among the richest in the country, with beneficiaries paying little or nothing for a range of service, and far exceed those benefits offered by Medicare and Medicaid.

In Massachusetts, there are five VA hospitals (in Bedford, Brockton, Jamaica Plain, Leeds, and West Roxbury) and seventeen outpatient clinics.

Ethics Commentary

Is there an ethical requirement to inform "the government" if a client who is a provider has been overpaid by a government program?

There are several assumptions underlying this question, in addition to assuming that the provider has been overpaid; that he or she has no lawful entitlement to the funds; that he or she would be subject to a restitution or other civil action and, possibly, criminal action; and that there is no lawful basis to argue that the funds could be retained. The first assumption is that the attorney represents the provider, and the provider is a client in regard to the matter at hand. The second assumption is that there is no tribunal proceeding pending, thus rendering Mass. R. Prof. C. 3.3 inapplicable. In these circumstances, a number of the Massachusetts Rules of Professional Conduct apply.

Regarding the scope of the representation and obligations therein, see Rule 1.2(d) and (e), Rule 1.3 (diligence), Rule 1.4 (communication), Rule 2.1 (advisor), Rule 4.1(a) and (b) (truthfulness in statements to others), and Rule 1.6 (confidentiality of information).

If, under the facts assumed, the attorney seeks to counsel the client and the client fails to cooperate or determines to undertake steps that are inconsistent with the lawyer's obligations under the

rules, then withdrawal from representation may be required under Rule 1.16(b).

The question as to whether the attorney is permitted or obligated to disclose the existence of the unlawful act, notwithstanding the duty of confidentiality, even after withdrawal from representation, is one that is

- very fact-dependent;
- often extremely difficult to ascertain and determine; and
- angst-filled, at best.

In such an event, where the attorney has decided to terminate the attorney-client relationship, the attorney should seek counsel and advise the client to do so as well. The burden on the attorney is magnified by the tenets of Rule 8.4.

If the client is an entity, then see Rule 1.13.

§ 2.3 REIMBURSEMENT SYSTEMS OPERATED BY THE COMMONWEALTH OF MASSACHUSETTS

The Commonwealth of Massachusetts operates a number of health benefit programs, most notably the Massachusetts Medicaid program. In Massachusetts, Medicaid and the SCHIP are combined in the “MassHealth” program. The Commonwealth also operates a number of other programs and combinations of programs (like the Medicaid and SCHIP programs) that reimburse providers and beneficiaries for the costs of health care services. Finally, under the Health Reform Law, Massachusetts implemented a fundamental reorganization of its methods of covering low income and uninsured persons, through the creation of the Commonwealth Care Health Insurance (CCHIP) and Commonwealth Choice programs. Understanding this web of potential payors is often critical for lawyers representing patients, as well as provider and plan attorneys.

§ 2.3.1 Medicaid

The Medical Assistance or Medicaid program in Massachusetts is operated by MassHealth, under the Executive Office of Health and Human Services (EOHHS). Like Medicare, the Massachusetts Medicaid program had historically reimbursed many institutional providers based on their actual cost of delivering services. For most providers, Medicaid has migrated to straight fee schedule reimbursement, though for nursing facilities and hospitals, the earlier system has evolved into something of a hybrid of prospective payment and cost-based reimbursement.

(a) *Billing Requirements Versus Rate Setting*

Massachusetts Medicaid reimbursement *rules* are established in EOHHS regulations found at 130 C.M.R. §§ 400–499. Title 130 of the Code of Massachusetts Regulations lists the specific reimbursement and coverage rules for each provider type. The default billing rules are found at 130 C.M.R. § 450. Medicaid regulations in many ways shadow the Medicare requirements, sometimes by federal requirements seeking to standardize certain elements of the system (e.g., the Medicare conditions of participation define providers for Medicaid purposes), and other times because state regulators have seen Medicare as a useful default.

Medicaid *rates* are established through a rate setting process that historically operated in a fully separate agency, the Massachusetts Rate Setting Commission. Rate setting is a complex process of analyzing cost data from providers, policy-making that seeks to change behavior through channeling higher reimbursement to desired sources, and, finally, absorbing budget cuts that are often unprincipled in relation to the particular programs that are affected. It is also a highly politicized process.

Through series of reorganizations, the Massachusetts Rate Setting Commission and other related agencies, like the Massachusetts Department of Medical Security (DMS), merged and disappeared. Now, the rate setting process in Massachusetts is operated by the Massachusetts Division of Health Care Finance and Policy (DHCFP), at Two Boylston Street in Boston. The DHCFP’s regulations include the published rates for each provider type. The rate setting regulations and schedules are found at 114 C.M.R.

(b) *Services Covered*

As discussed above, the federal government requires states to cover certain mandatory services and gives states the option of covering other optional services. The Massachusetts state plan is rich and covers most of the optional services. **Exhibit 2A** contains a basic listing of the provider types and services covered by MassHealth, along with the regulation that specific the conditions of coverage and specific billing rules applicable to the provider or service.

§ 2.3.2 The Massachusetts Health Reform Programs

As noted earlier in this chapter, Chapter 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care, introduced fundamental changes to health care reimbursement in the Commonwealth. Chapter 58 became law on April 12, 2006, with the code mandate of expanding coverage,

and making it more affordable for all residents of the Commonwealth. Chapter 58 created the Commonwealth Health Insurance Connector Authority (the Connector) to operate the new programs. The Connector is an authority operated under the Department of Administration and Finance and is overseen by a separate, appointed board of directors of private and public persons—many representing specific interest groups and appointed by different branches of government. The Connector also “certifies” those plans that meet the standards of quality and affordability set by the Connector’s board.

One of the essential components of the program was the legal mandate that all residents purchase insurance if an “affordable” policy was available. While there are appeal procedures available for an individual to challenge the “affordability” of insurance to them, an unexcused failure to have coverage subjects the individual to a significant tax penalty of one-half of the premium of the lowest-cost Connector certified plan. The reason this provision was essential is because mandating coverage is intended to drive healthy, young, uninsured persons into the insurance risk pools, so their premium dollars could be included to cover the medical expenses of older or sicker beneficiaries. Simultaneously, Chapter 58 merged the small and nongroup insurance markets to bring the nongroup (individual) insured beneficiaries within the same rating systems as the small group (employer-sponsored) plans. Insured individuals are allowed to purchase these policies using pretax dollars, through IRS Section 125 Plans their employers are required to offer. The law and Connector regulations also provide a HIPAA-like health insurance portability right.

Chapter 58 required the Connector to create two separate insurance programs, the Commonwealth Care and Commonwealth Choice. Commonwealth Care (CCHIP) is a partly to fully subsidized health insurance program for beneficiaries with incomes up to 300 percent of the federal poverty level. Commonwealth Care includes a number of persons who would not have been eligible for Medicaid prior to Health Reform. The Commonwealth attempts to control enrollment to MassHealth and Commonwealth Care through a “universal gateway” computer system.

Commonwealth Choice commenced in July of 2007, and is a nonsubsidized insurance program intended for individuals with incomes too high for CCHIP, but who now have an obligation to purchase insurance. These persons can enroll in insurance through the Connector or by directly contacting one of the many plans offering Commonwealth Choice plans. Despite the fact that Commonwealth Choice was formed through Chapter 58 and the Connector, it really represents a category of private insurance, subject to the principles of managed care.

§ 2.4 PRIVATE PAYORS

This chapter has focused on the primary public payors of health care services, but one must remember that a substantial portion of the total health care services delivered in the United States are covered by private insurance. Although the term “private coverage” includes self-pay and health policies purchased by the individual (“nongroup” coverage), most private coverage is paid for by employers. These employer-sponsored health plans are often subject to the Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829, making them exempt from much state regulation.

A later chapter in this book will study the various models of private third-party payor coverage. It is worth noting that most private coverage mirrors the governmental payors in the methods of reimbursement to suppliers and providers. While there should be *more* opportunities for innovation with private coverage, the primary ways these plans pay for service are prospective payment and fee schedules. Later chapters will discuss capitation in greater detail, but, in essence, capitation pays a provider or group of providers a fixed amount per patient to deliver all services required by the patient during the contract period. Under Medicare, only the hospice benefit is truly capitated. Similarly to changes under Medicare, many plans and providers have drifted away from capitation arrangements, though some plans have capitation elements in their reimbursement schemes.

§ 2.5 CONCLUSION

One should note the following:

- Because health care reimbursement is so complex, the discussion in this short introductory chapter address only a few of the most basic concepts.
- The speed of change in payment and reimbursement systems requires careful practitioners to closely monitor changes. Reimbursement and payment knowledge has a very short shelf life.
- The governmental reimbursement systems are, though forty years old, still works in progress. One undeniable fact about the Medicare and Medicaid reimbursement systems is that there are thousands of moving parts, and they are connected. Tinkering with any component of either reimbursement scheme usually proves the law of unintended consequences.

Lawyers representing health care providers quickly learn how to navigate at least the basic contours of the most important reimbursement systems for their clients. This chapter is designed to provide an overview of some of the key laws and concepts. Later chapters of this book will drill down into reimbursement and payment issues in the context of overall regulation of hospitals, physicians, postacute and long-term care providers, physicians, and managed care organizations.

**EXHIBIT 2A—Provider Types and Services Covered
by MassHealth**

A

Abortion Clinics, 130 C.M.R. § 484

Acute Inpatient Hospitals, 130 C.M.R. § 415

Adult Day Health Services, 130 C.M.R. § 404

Audiologists, 130 C.M.R. § 426

C

Chiropractors, 30 C.M.R. § 441

Chronic Disease and Rehabilitation Inpatient Hospitals, 130 C.M.R. § 435

Community Health Centers, 130 C.M.R. § 405

D

Day Habilitation Programs, 130 C.M.R. § 419

Dental Services, 130 C.M.R. § 420

Durable Medical Equipment, 130 C.M.R. § 409

E

Early Intervention Programs, 130 C.M.R. § 440

F

Family Planning Agencies, 130 C.M.R. § 421

Freestanding Ambulatory Surgery Centers, 130 C.M.R. § 423

H

Hearing Aid Dispensers, 130 C.M.R. § 416

Home Health Agencies, 130 C.M.R. § 403

Hospices, 130 C.M.R. § 437

I

Independent Clinical Laboratories, 130 C.M.R. § 401

Independent Nurses, 130 C.M.R. § 414

M

Mental Health Centers, 130 C.M.R. § 429

N

Nursing Facilities, 130 C.M.R. § 456

O

Orthotics, 130 C.M.R. § 442

Outpatient Hospital Services, 130 C.M.R. § 410

Oxygen and Respiratory Therapy Equipment, 130 C.M.R. § 427

P

Personal Care, 130 C.M.R. § 422

Pharmacy, 130 C.M.R. § 406

Physicians, 130 C.M.R. § 433

Podiatrists, 130 C.M.R. § 424

PAYMENT & REIMBURSEMENT FOR HEALTH CARE SERVICES

Prosthetics, 130 C.M.R. § 428

Psychiatric Day Treatment Programs, 130 C.M.R. § 417

Psychiatric Hospital Outpatient Services, 130 C.M.R. § 434

Psychiatric Inpatient Hospitals, 130 C.M.R. § 425

Psychologists, 130 C.M.R. § 411

R

Rehabilitation Centers, 130 C.M.R. § 430

Renal Dialysis Clinics, 130 C.M.R. § 412

S

Speech and Hearing Centers, 130 C.M.R. § 413

Sterilization Clinics, 130 C.M.R. § 485

Substance Abuse Treatment, 130 C.M.R. § 418

T

Therapists, 130 C.M.R. § 432

Transportation, 130 C.M.R. § 407

V

Vision Care, 130 C.M.R. § 402

MASSACHUSETTS HEALTH AND HOSPITAL LAW MANUAL