

Notice of Final Agency Action

SUBJECT: MassHealth: Payment for Acute Hospital Services effective October 1, 2011

AGENCY: Massachusetts Executive Office of Health and Human Services (EOHHS), Office of Medicaid

Introduction

The following describes and summarizes changes in MassHealth payment for services provided by in-state acute hospitals. A complete description of the rate year 2012 (RY2012) MassHealth acute hospital inpatient and outpatient payment methods and rates is available at www.mass.gov/masshealth, (click on the link to “MassHealth Regulations and Other Publications” and the link to “Special Notices for Hospitals”). For further information regarding RY2012 payment methods and rates, you may contact Kiki Feldmar at the Executive Office of Health and Human Services, Office of Acute and Ambulatory Care, 100 Hancock Street, 6th Floor, Quincy, MA, or by e-mail at kiki.feldmar@state.ma.us.

Change in Payment Method

1. Acute Hospital Inpatient Services

A. Summary of Rate Year 2012 Methodology for Calculating the Standard Payment Amount Per Discharge (SPAD) and other Inpatient Service Payments

For hospital rate year 2012, MassHealth will reimburse acute hospitals for Inpatient Admissions via a hospital-specific Standard Payment Amount per Discharge (SPAD). This fixed rate represents payment in full for all non-physician inpatient services for the first 20 days of an admission. Each hospital’s SPAD is derived from the statewide average hospital cost per admission in rate year 2005, standardized for casemix differences and area wage variation. An efficiency standard is determined by capping hospital costs, weighted by MassHealth discharges, at the 75% level of costs, except for Critical Access Hospitals for which 101% of Hospital costs will be included in the calculations. The statewide average is adjusted for inflation and outliers. Costs EOHHS determines are routine outpatient costs associated with admissions from the emergency department and routine and ancillary outpatient costs resulting from admissions from observation status are included in the calculation of the statewide average hospital cost per admission. For each hospital, this statewide average is then adjusted for each hospital’s wage area index and each hospital’s specific casemix index. The paid claims of each hospital for patients transferred to another acute hospital (the “transfer per diem”) are included in the calculation of each hospital-specific casemix index.

Several categories of costs are directly passed through into the hospital’s rate (that is, they are excluded from the statewide average and efficiency adjustments). Hospital-specific costs resulting from malpractice insurance and organ acquisition are treated as “pass-throughs.” Capital payments are paid on a per-discharge basis, and are efficiency-adjusted. Costs are based on each hospital’s FY05 Massachusetts Division of Health Care

Finance and Policy (DHCFP) 403 Cost Report, updated for the hospital's casemix index and inflation to the current year. The calculation of the pass-through payment amounts includes a determination of the MassHealth average length of stay (ALOS). The calculation of the capital payment amount includes a determination of the All-Payer Length of Stay. The ALOS is based on data obtained by the DHCFP and includes all MassHealth inpatient days, including outlier days.

For Hospitals with pediatric Specialty Units, payment for admissions to the pediatric Specialty Unit for which a SPAD is otherwise payable is made using a Pediatric SPAD. The Pediatric SPAD is calculated using the same methodology as the SPAD, except that the casemix index, discharges, and average length of stay are based on data from the pediatric Specialty unit.

Hospitals with greater than 63% of gross patient service revenue (GPSR) from governmental payers and free care, as determined by EOHHS, will receive a 5% add-on to their SPAD, and hospitals with higher than expected readmission rates will have their SPAD reduced by 2.20%.

EOHHS pays on a per diem basis under certain circumstances. Psychiatric services delivered in DMH-licensed psychiatric beds of acute hospitals are paid an all-inclusive statewide psychiatric per diem rate and acute hospitals are paid rehabilitation per diem for services delivered in Rehabilitation Units. Services delivered to individuals who transfer among hospitals or among certain settings within a hospital, as well as covered inpatient outlier days and administrative days, are paid per diem rates.

B. Summary of Changes

The payment method for acute inpatient hospital services includes the following changes from the RY2011 payment method:

1. It applies an operating inflation update of 1.665% for all acute hospitals and a capital inflation update of 1.50%.
2. It updates the inpatient outlier adjustment factor, which is used in the calculation of the statewide average payment amount per discharge, from 92.2% to 93.0%, based on recent data.
3. It updates the median nursing facility rate utilized in the calculation of the Administrative Day rate.
4. It changes certain adjustments to the SPAD as follows:
 - a. Eliminates the 8.977% adjustment to the SPAD for Pediatric Acute Care Hospitals in the Commonwealth.
 - b. Eliminates the 3.305% adjustment to the SPAD for Acute Care Hospitals that have a cumulative total of at least 125 licensed pediatric, pediatric ICU/CCU, and NICU beds and which accounted for at least 25% of the Hospital's total MassHealth RY09 matched HDD discharges.

- c. Eliminates the 4.41% adjustment to the SPAD for Public Service Hospitals which provide more than 10% of the statewide inpatient Medicaid days.
 - d. Changes the SPAD adjustment from a 10% to a 5% add-on for hospitals with greater than 63% of gross patient service revenue (GPSR) from governmental payers and free care, as determined by EOHHS.
 - e. It reduces the SPAD by 2.20% for hospitals with higher than expected readmission rates.
- 5. For Critical Access Hospitals it recognizes 101% of their operating costs in the calculation of their SPAD.
 - 6. It revised the payment reduction for cases where sterilization consent requirements are not met (applies to both inpatient and outpatient).

2. Outpatient Services

A. Summary of Rate Year 2012 Methodology for Calculating the Payment Amount Per Episode (PAPE) and Other Acute Outpatient Hospital Service Payments

The Payment Amount Per Episode (PAPE) methodology establishes a hospital-specific episodic rate for most MassHealth acute outpatient hospital services. The hospital-specific PAPE is based on an outpatient standard payment adjusted for hospital-specific casemix. Certain services, including laboratory services, are carved out of the PAPE calculation and payment. Laboratory and other carve-out services are paid for in accordance with the applicable fee schedules adopted by DHCFP.

Calculation of the outpatient statewide standard is based on MassHealth payments for outpatient services in the PAPE Base Year, as adjusted by (1) including outlier payments, (2) excluding payments for laboratory services, and (3) bundling only services received on the same day. The result of this calculation is adjusted for inflation to obtain the outpatient statewide standard for Hospital Rate Year 2012. The hospital-specific preliminary RY12 PAPE is determined by multiplying the outpatient statewide standard by each hospital's casemix index calculated by EOHHS. The hospital-specific RY12 PAPE is a blended rate that equally weights the hospital's RY11 PAPE and the preliminary RY12 PAPE determined as described above; provided, however, that no hospital's RY12 PAPE shall be less than 90% of the hospital's RY11 PAPE in effect on September 30, 2011.

B. Summary of Changes

The payment method for acute outpatient hospital services includes the following change from the Hospital Rate Year 2011 payment method:

- 1. It applies the operating inflation update of 1.665%.
- 2. For Critical Access Hospitals, it applies an additional 20% to the outpatient statewide standard.

3. In determining the hospital-specific outpatient casemix index, utilizes a 12-month average actual casemix, rather than trended casemix.
4. The RY12 PAPE is an equal blend of the Hospital's RY11 PAPE and the preliminary RY12 PAPE calculation; provided that, no Hospital's RY12 PAPE shall be less than 90% of its RY11 PAPE.

3. Supplemental Hospital Payments

In addition to the payments specified above, EOHHS makes supplemental payments to certain qualifying hospitals. Supplemental payments are made to hospitals that qualify as Public Service Hospitals, Essential MassHealth Hospitals, Acute Hospital with High Medicaid Discharges, and Freestanding Pediatric Specialty Hospitals, and are substantially similar to RY11 supplemental payment methods.

4. Pay for Performance

The Pay-for-Performance (P4P) program provides a method for quality scoring and converting quality scores to payments contingent upon hospital adherence to quality standards and achievement of performance thresholds and benchmarks in accordance with the provisions of G.L. c. 118E, sec. 13B. The maximum allocated amount for P4P for RY12 will be \$75M, which is planned to be paid in a subsequent rate year following finalization of RY12 P4P data. RY12 changes to the P4P program include:

1. Elimination of the Neonatal Intensive Care (NICU-1) measure.
2. It introduces an addition to the maternity measure set.
3. It initiates the reporting of a care coordination measure beginning January 1, 2012.
4. It changes the performance measurement for the clinical health disparities measure to a decile methodology.

Justification

The MassHealth hospital payment methods for Rate Year 2012 are substantially similar to those for 2011, except as specified above. All changes to hospital payment rates and methods are in accordance with state and federal law and are within the range of reasonable payment levels to acute hospitals.

Estimated Fiscal Effect

EOHHS estimates that the changes in inpatient and outpatient rates described herein, will increase the state's federal fiscal year 2012 fee-for-service expenditures for acute hospital services by approximately \$25.7M, which is the combination of a \$15.8M increase to inpatient payments, and a \$9.9M increase in outpatient payments.

Statutory Authority: M.G.L. c.118G; M.G.L. c.118E; St. 2011, c. 68; 42 USC 1396a; 42 USC 1396b; 42 USC 1315.

Related Regulations: 130 CMR 410, 415, 450; 42 CFR Part 447.

Section 2: Definitions

The following terms appearing capitalized throughout the RFA and its appendices shall be defined as follows, unless the context clearly indicates otherwise.

Administrative Day (AD) — a day of inpatient hospitalization on which a Member’s care needs can be provided in a setting other than an Acute Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416.

Ambulatory Patient Group (APG) — a group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation’s APG version 2.1 Grouper.

Ambulatory Patient Group Payment System (APG Payment System) — the payment system described in MassHealth’s Acute Hospital RFA and Contract effective February 1, 2002.

Behavioral Health (BH) Contractor — the entity with which EOHHS contracts to provide Behavioral Health Services to enrolled Members.

Behavioral Health Services — services provided to Members who are being treated for psychiatric disorders or substance-related disorders.

Casemix — the description and categorization of a hospital’s patient population according to criteria approved by EOHHS including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

Centers for Medicare & Medicaid Services (CMS) — the federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

Charge — the uniform price for each specific service within a Revenue Center of an Acute Hospital.

Clinical Laboratory Service — Microbiological, serological, chemical, hematological, biophysical, radio bioassay, cytological, immunohematological, immunological, pathological, or other examinations of materials derived from the human body, to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Coinsurance — a percentage of cost or a fee established by a Third-Party Insurance carrier for a specific service or item for which an individual is responsible when the service or supply is delivered. This cost or fee varies according to the individual’s insurance carrier.

Commonwealth Health Insurance Connector (Connector) — the authority established by G.L. chapter 176Q, section 2.

Commonwealth Care Health Insurance program (Commonwealth Care) — a program established by G.L. chapter 118H, section 2 and administered by the Connector, in consultation with the Office of Medicaid, which provides subsidies to assist eligible individuals in purchasing health insurance.

Community-Based Physician — any physician or physician group practice, excluding interns, residents, fellows, and house officers, who is not a Hospital-Based Physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths.

Contract (also **Hospital Contract** or **Agreement**) — the agreement executed between each selected Hospital and EOHHS, which is contained in **Appendix A** of the RFA, and incorporates all of the provisions of the RFA. Unless the context indicates that the term “RFA” refers exclusively to the procurement document as such, references to RFA shall constitute references to the Contract (or Agreement).

Contractor — each Hospital that is selected by EOHHS after submitting a satisfactory application in response to the RFA and that enters into a Contract with EOHHS to meet the purposes specified in the RFA.

Copayment — a predetermined fee that the Member is responsible for paying directly to the Provider for specific services.

Critical Access Hospital (CAH) – An acute hospital that is designated by CMS as a Critical Access Hospital.

Deductible — the amount an individual is required to pay in each calendar year, as specified in their insurance plan, before any payments are made by the insurer.

Department of Mental Health (DMH) — a department of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

Department of Public Health (DPH) — a department of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

Division of Health Care Finance and Policy (DHCFP) — a division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

DMH-Licensed Bed — a bed in a Hospital that is located in a unit licensed by the Department of Mental Health (DMH), pursuant to 104 CMR 27.00 et seq.

Emergency Aid to the Elderly, Disabled and Children — the program operated by the Department of Transitional Assistance, pursuant to M.G.L. c. 117A, that furnishes and pays for limited medical services to eligible persons.

Emergency Department (ED) — a Hospital’s Emergency Room or Level I Trauma Center which is located at the same site as the Hospital’s inpatient department.

Emergency Medical Condition — a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a Member or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services — covered Inpatient and Outpatient Services, including Behavioral Health Services, which are furnished to a Member by a Provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize a Member’s Emergency Medical Condition.

Episode — all Outpatient Services, except those described in **Section 4.C** and **Sections 5.C.3 through 5.C.8**, delivered to a MassHealth Member where the services were delivered on a single calendar day.

Episode Cost — a Hospital’s cost for delivering an Episode of care as determined by MassHealth and calculated as follows: Episode Cost is the product of the Hospital’s charges for those claim lines of an Episode that adjudicate to pay and the outpatient cost-to-charge ratio as calculated by DHCFP.

Excluded Units — Non-Acute Units as defined in this section; any unit which has a separate license from the Hospital; psychiatric and substance abuse units; and non-distinct observation units.

Executive Office of Health and Human Services (EOHHS) — the single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

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

Freestanding Pediatric Acute Hospital — an Acute Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Gross Patient Service Revenue — the total dollar amount of a Hospital’s charges for services rendered in a fiscal year.

Hospital (also **Acute Hospital**) — any Hospital licensed under M.G.L. c. 111, § 51 and which meets the eligibility criteria set forth in **Section 3** of the RFA.

Hospital-Based Physician — any physician or physician group practice (excluding interns, residents, fellows, and house officers) who contracts with a Hospital to provide Hospital Services to Members at a site for which the hospital is otherwise eligible for reimbursement under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.

Hospital Discharge Data (HDD) — Merged Casemix/Billing Tapes as accepted into DHCFP’s database as of May 2, 2011, for the period October 1, 2009 through September 30, 2010.

Hospital-Licensed Health Center (HLHC) — a Satellite Clinic that (1) meets MassHealth requirements for reimbursement as an HLHC as provided at 130 CMR 410.413; and (2) is approved by and enrolled with MassHealth’s Provider Enrollment Unit as an HLHC.

Inflation Factors for Capital Costs — the factors used by CMS to update capital payments made by Medicare. The Inflation Factors for Capital Costs between RY04 and RY12 are as follows:

- 0.7% reflects the price changes between RY04 and RY05
- 0.7% reflects the price changes between RY05 and RY06
- 0.8% reflects the price changes between RY06 and RY07
- 0.9% reflects the price changes between RY07 and RY08
- 0.7% reflects the price changes between RY08 and RY09
- 1.4% reflects the price changes between RY09 and RY10
- 1.5% reflects the price changes between RY10 and RY11
- 1.5% reflects the price changes between RY11 and RY12

Inflation Factors for Operating Costs — for price changes between RY04 and RY07, and between RY08 and RY12, a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes

between RY07 and RY08, the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY12 are as follows:

- 1.186% reflects price changes between RY04 and RY05
- 1.846% reflects price changes between RY05 and RY06
- 1.637% reflects price changes between RY06 and RY07
- 3.300% reflects price changes between RY07 and RY08
- 3.000% reflects price changes between RY08 and RY09 for the period October 1, 2008 through December 6, 2008
- 1.424% reflects price changes between RY08 and RY09 for the period December 7, 2008 through September 30, 2009
- 0.719% reflects the price changes between RY09 and RY10
- 1.820% reflects the price changes between RY10 and RY11
- 1.665% reflects the price changes between RY11 and RY12

Inpatient Admission — the admission of a Member to an Acute Hospital for the purpose of receiving Inpatient Services in that Hospital.

Inpatient Services — medical services, including behavioral health services, provided to a Member admitted to an Acute Hospital. Payment rules regarding Inpatient Services are found in 130 CMR Parts 415 and 450, the regulations referenced therein, Appendix F to the MassHealth Acute Inpatient Hospital Manual, MassHealth billing instructions, and the RFA.

Insurance Payment — a payment received from any entity or individual legally responsible for paying all or part of the medical claims of MassHealth Members. Sources of payments include, but are not limited to: commercial health insurers, Medicare, MCOs, personal injury insurers, automobile insurers, and Workers' Compensation.

Liability — the obligation of an individual to pay, pursuant to the individual's Third-Party Insurance, for the services or items delivered (i.e., Coinsurance, Copayment or Deductible).

Managed Care Organization (MCO) — any entity with which EOHHS contracts to provide Primary Care and certain other medical services, including behavioral health services, to Members on a capitated basis and which meets the definition of an MCO as set forth in 42 CFR Part 438.2. MCOs also contract with the Connector to provide services to Commonwealth Care enrollees.

MassHealth (also Medicaid) — the Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.

MassHealth Average Length of Stay (ALOS) — the sum of non-psychiatric inpatient days for MassHealth discharges from October 1, 2009, through September 30, 2010, reported by each Hospital to DHCFP, including Outlier Days, divided by the number of discharges using the casemix data accepted into DHCFP's database as of May 2, 2011.

Medicaid Management Information System (MMIS) — the state-operated system of automated and manual processes, certified by CMS, that meets the federal guidelines in Part 11 of the State Medicaid Manual, used to process Medicaid claims from providers of medical care and services furnished to Members, and to retrieve and produce service utilization and management information for program administration and audit purposes.

Member — a person determined by EOHHS to be eligible for medical assistance under the MassHealth program.

Non-Acute Unit — a chronic care, rehabilitation, or skilled nursing facility unit within a Hospital.

Observation Services — outpatient Hospital Services provided anywhere in an Acute Hospital to evaluate a Member’s condition and determine the need for admission to an Acute Hospital. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours. Payment rules regarding Observation Services are found in 130 CMR 410.414, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions, and the RFA.

Outlier Day — each day beyond 20 acute days, during a single admission, for which a Member remains hospitalized at acute status, other than in a DMH-Licensed Bed or an Excluded Unit.

Outpatient Department (also **Hospital Outpatient Department**) — a department or unit located at the same site as the Hospital’s inpatient facility, or at a School-Based Health Center that operates under the Hospital’s license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, Primary Care clinics, specialty clinics, and Emergency Departments.

Outpatient Services (also **Outpatient Hospital Services**) — medical services, including behavioral health services, provided to a Member on an outpatient basis, by or under the direction of a physician or dentist, in a Hospital Outpatient Department or Satellite Clinic for which a reimbursement method is specified in **Section 5.C**. Such services include, but are not limited to, Emergency Services, Primary Care services, Observation Services, ancillary services, and day surgery services. Payment rules regarding services provided to Members on an outpatient basis are found in 130 CMR Parts 410 and 450, Appendix F to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions, and the RFA.

PAPE Base Year — RY10, paid as of July 8, 2011.

PAPE Covered Services — MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, except those services described in **Section 4.C** and **Sections 5.C.3** through **5.C.8**.

Pass-Through Costs — organ acquisition and malpractice costs that are paid on a cost-reimbursement basis and are added to the Hospital-specific standard payment amount per discharge.

Patient — a person receiving health care services from a hospital.

Pay-for-Performance Program for Acute Hospitals (P4P) — MassHealth’s method for quality scoring and converting quality scores to rate payments contingent upon Hospital adherence to quality standards and achievement of performance thresholds and benchmarks in accordance with the provisions of G.L. c. 118E, sec. 13B.

Payment Amount Per Episode (PAPE) — a Hospital-specific payment for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode except those services described in **Section 4.C** and **Sections 5.C.3** through **5.C.8**.

Pediatric Specialty Unit — a designated pediatric unit, pediatric intensive care unit, or neonatal intensive care unit in an Acute Hospital other than a Freestanding Pediatric Acute Hospital, in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20, and which qualifies for a Pediatric Standard Payment Amount Per Discharge, as set forth in the qualifying Hospital’s **Appendix C**.

Pediatric Standard Payment Amount Per Discharge — a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of a Pediatric inpatient hospitalization in a Pediatric Specialty Unit, which is complete payment for an acute episode of illness, excluding the

additional payment of Outlier Days, Transfer Per Diems, Administrative Days and Physician Payments.

Primary Care — all health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, nurse practitioner, or nurse midwife to the extent the furnishing of those services is legally authorized in the Commonwealth.

Primary Care Clinician (PCC) — a physician, independent nurse practitioner, group practice organization, community health center, Hospital-Licensed Health Center or Acute Hospital Outpatient Department with an executed MassHealth PCC Plan Provider contract.

Primary Care Clinician Plan (PCC Plan) — a comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive Primary Care, behavioral health, and other medical services. See 130 CMR 450.118.

Provider — an individual or entity that has a written contract with EOHHS to provide medical goods or services to Members.

Psychiatric Per Diem — a statewide per diem payment for psychiatric services provided to members in DMH-Licensed beds who are not enrolled with the BH Contractor or MCO.

Psychiatric Per Diem Base Year — the base year for the psychiatric per diem is RY04, using RY04 DHCFF 403 Cost Reports as screened and updated as of as of March 10, 2006.

Public Service Hospital — any public Acute Hospital or any Acute Hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 which has a private sector payer mix that constitutes less than 35% of its Gross Patient Service Revenue (GPSR) and where uncompensated care constitutes more than 5% of its GPSR.

Quality and Performance Initiatives — data-driven systemic efforts, anchored on measurement-driven activities, including Pay-for-Performance (P4P) initiatives, to improve performance of health-delivery systems that result in positive outcomes and cost-effective care.

Rate Year (RY) — generally, the period beginning October 1 and ending the following September 30. RY12 will begin on October 1, 2011, and end on September 30, 2012.

Rehabilitation Services — services provided in an Acute Hospital that are medically necessary to be provided at a Hospital level of care, to a member with medical need for an intensive rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his/her ability to function with a reasonable expectation of significant improvement that will be of practical value to the Member measured against his/her condition at the start of the rehabilitation program.

Rehabilitation Unit — a distinct unit of rehabilitation beds in a Department of Public Health (DPH)-licensed Acute Hospital that provides comprehensive Rehabilitation Services to Members with appropriate medical needs.

Revenue Center — a functioning unit of a Hospital that provides distinctive services to a patient for a charge.

Satellite Clinic — a facility that operates under a Hospital's license, is subject to the fiscal, administrative, and clinical management of the Hospital, provides services to Members solely on an outpatient basis, is not located at the same site as the Hospital's inpatient facility, and demonstrates to EOHHS' satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

School-Based Health Center (SBHC) — a center located in a school setting which: (1) provides health services to MassHealth Members under the age of 21; (2) operates under a Hospital’s license; (3) is subject to the fiscal, administrative, and clinical management of a Hospital Outpatient Department or HLHC; and (4) provides services to Members solely on an outpatient basis.

SPAD Base Year — the hospital-specific base year for the Standard Payment Amount per Discharge is RY05 using the RY05 DHCFF 403 cost report as screened and updated as of June 2, 2008.

Standard Payment Amount Per Discharge (SPAD) — a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is the complete fee-for-service payment for an acute episode of illness, excluding the additional payment of Outlier Days, Transfer Per Diems, Administrative Days and Physician Payments.

Third-Party Insurance — any insurance, including Medicare, that is or may be liable to pay all or part of the Member’s medical claims. Third-Party Insurance includes a MassHealth Member’s own insurance.

Title XIX — Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or any successor statute enacted into federal law for the same purposes as Title XIX.

Total APG Payment — an adjusted calculation of total payment for PAPE Covered Services provided to MassHealth Members in the PAPE Base Year using MassHealth’s APG Payment System, calculating the Episode Cost using the RY10 outpatient cost-to-charge ratio.

Transfer Patient — any inpatient who meets any of the following criteria: (1) is transferred between Acute Hospitals; (2) is transferred between a DMH-Licensed Bed and a medical/surgical unit in an Acute Hospital; (3) is receiving treatment for a substance-related disorder or mental health-related services and whose enrollment status with the BH Contractor changes; (4) who becomes eligible for MassHealth after the date of admission and prior to the date of discharge; (5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge; (6) who transfers, after the date of admission, from the PCC Plan or non-managed care to an MCO, or from an MCO to the PCC Plan or non-managed care; or (7) has a primary diagnosis of a psychiatric disorder in a non-DMH-Licensed Bed.

Usual and Customary Charge — a routine fee that Hospitals charge for Acute Inpatient and Outpatient Services, regardless of payer source.

Section 3: Eligible Applicants

- A.** In-state Acute Hospitals are eligible to apply for a Contract pursuant to the RFA if they:
- 1.** Operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH);
 - 2.** Are Medicare-certified and participate in the Medicare program;
 - 3.** Have more than 50% of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by DPH; and
 - 4.** Currently utilize more than 50% of their beds exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by EOHHS.

In determining whether a Hospital satisfies the utilization requirement set forth in **Section 3.A.4**, EOHHS may evaluate, pursuant to an on-site audit or otherwise, a number of factors including, but not limited to, the average length of patient stay (see **Section 11.B.5**) at that Hospital.

- B.** The Hospital shall apply on behalf of all Inpatient Departments, Outpatient Departments, Emergency Departments and Satellite Clinics.
- C.** The Hospital is not permitted to apply on behalf of, or claim payment for services provided by, any other related clinics, Provider groups, or other entities, except as otherwise provided in **Sections 5.B.10** and **5.C**.

Section 4: Non-Covered Services, Program Initiatives and Ambulatory Services Not Covered by the RFA

A. Non-Covered Services

EOHHS will reimburse MassHealth-participating Hospitals at the rates established in the RFA and accompanying Contract for all covered Inpatient, Outpatient, and Emergency Services provided to MassHealth Members *except* for the following:

1. Behavioral Health Services for Members Enrolled with the BH Contractor

EOHHS' BH Contractor contracts with providers to form a network through which behavioral health services are delivered to MassHealth Members enrolled with the BH Contractor. Hospitals in the BH Contractor's network qualify for fee-for-service payments solely by the BH Contractor for services to Members enrolled with the BH Contractor, pursuant to contracts between the BH Contractor and each contracting Hospital.

Hospitals that are not in the BH Contractor's network (hereinafter "non-network Hospitals") do not qualify for MassHealth reimbursement for Members enrolled with the BH Contractor who receive non-Emergency or Post-Stabilization Behavioral Health Services, except in accordance with a service-specific agreement with the BH Contractor.

Non-network Hospitals that provide medically necessary behavioral health Emergency and Post-Stabilization Services to Members enrolled with the BH Contractor qualify for fee-for-service reimbursement solely by the BH Contractor. Such reimbursement is available only if the Hospital complies with the BH Contractor's billing requirements and any applicable service authorization requirements that are permissible under federal law at 42 USC 1396u-2(b)(2), 42 CFR 438.114, and 42 CFR 422.113(c). In accordance with the preceding federal law, and with 42 CFR 422.214(b), if a Member enrolled with the BH Contractor receives inpatient or outpatient behavioral health Emergency and Post-Stabilization Services and the BH Contractor offers to pay the non-network Hospital a rate equal to that Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education, the non-network Hospital must accept the BH Contractor's rate offer as payment in full for such behavioral health Emergency and Post-Stabilization Services. Nothing in this paragraph prohibits the BH Contractor from negotiating to pay any non-network Hospital at rates lower than the non-network Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for Behavioral Health Emergency and Post-Stabilization Services.

Hospitals are not entitled to any fee-for-service reimbursement from EOHHS, and may not claim such reimbursement for any services that are BH Contractor-covered services or are otherwise reimbursable by the BH Contractor. Any such fee-for-service payment by EOHHS shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

2. MCO Services

Hospitals that provide medically necessary MCO-covered services, including Emergency and Post-Stabilization Services, qualify for fee-for-service reimbursement solely by the MCO.

In accordance with 42 USC 1396u-2(b)(2), 42 CFR 438.114, 42 CFR 422.113(c), and 42 CFR 422.214(b), if an MCO offers to pay a non-network Hospital a rate equal to the Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the MCO's

MassHealth enrollees, that non-network Hospital must accept the MCO's rate offer as payment in full. This requirement does not prohibit an MCO from negotiating to pay any non-network Hospital at rates lower than the non-network Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for Emergency and Post-Stabilization Services.

Hospitals are not entitled to any fee-for-service reimbursement from EOHHS, and may not claim such reimbursement for any services that are MCO-covered services or are otherwise reimbursable by the MCO. Any such fee-for-service payment by EOHHS shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

3. Commonwealth Care MCO Services

Hospitals that provide medically necessary MCO-covered services, including Emergency and Post-Stabilization Services, qualify for fee-for-service reimbursement solely by the MCO.

If an MCO under contract with the Connector offers to pay a non-network Hospital a rate equal to the Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the MCO's Commonwealth Care enrollees, that non-network Hospital is required to accept the MCO's rate offer as payment in full. This requirement does not prohibit an MCO from negotiating to pay any non-network Hospital at rates lower than the non-network Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for Emergency and Post-Stabilization Services.

Hospitals are not entitled to any reimbursement from EOHHS, and may not claim such reimbursement for any services provided to Commonwealth Care enrollees. Any payment by EOHHS for such services shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

4. Medical Security Plan Direct Coverage Health Plan Services

Hospitals that provide medically necessary Health Plan-covered services, including Emergency and Post-Stabilization Services, qualify for fee-for-service reimbursement solely by the Health Plan.

Effective January 1, 2012, if a Health Plan under contract with the Connector or the Department of Unemployment Assistance offers to pay a non-network Hospital a rate equal to the Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the Health Plan's Medical Security Plan Direct Coverage enrollees, that non-network Hospital is required to accept the Health Plan's rate offer as payment in full. This requirement does not prohibit a Health Plan from negotiating to pay any non-network Hospital at rates lower than the non-network Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for Emergency and Post-Stabilization Services.

Hospitals are not entitled to any reimbursement from EOHHS, and may not claim such reimbursement for any services provided to Medical Security Plan Direct Coverage enrollees. Any payment by EOHHS for such services shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

For purposes of this **Section 4.A.4**, the following terms have the following meanings:

Health Plan – any entity that enters into a contract with the Connector or the Department of Unemployment Assistance for the provision of health insurance plans or the arrangement of health care services under the MSP Direct Coverage Health Insurance Program, as defined in M.G.L. c. 151A and 430 CMR 7.07(1)(b).

Medical Security Plan Direct Coverage Enrollee – an individual, and any of the individual’s qualified dependents as defined in 430 CMR 7.00, determined by the Department of Unemployment Assistance to be eligible for participation in the MSP Direct Coverage Program, as defined in M.G.L. c. 151A and 430 CMR 7.07(1)(b), and enrolled by the Department of Unemployment Assistance or its designee in a health insurance plan offered by a Health Plan.

5. Air Ambulance Services

In order to receive reimbursement for air ambulance services, Hospitals must have a separate contract with EOHHS for such services.

6. Non-Acute Units and Other Separately Licensed Units in Acute Hospitals

Unless otherwise specified in the RFA, EOHHS shall not reimburse Acute Hospitals through the RFA and the accompanying contract for services provided to Members in Non-Acute Units, other than Rehabilitation Units, and any units which have a separate license, such as a skilled nursing unit, or any unit which is licensed to provide services other than Acute Hospital services as described in **Section 3.A.4**.

B. Program Initiatives

1. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives, other than those in the RFA, which provide, through contract or regulation, alternative reimbursement methodologies for Hospital services or certain Hospital services. In such cases, payment for such services is made pursuant to the contract or regulations governing the special program initiative, and not through the RFA and resulting Contract.

2. Demonstration Projects

It is an EOHHS priority to ensure that MassHealth Members receive quality medical care at sites of service that promote delivery of such medical care in a cost-effective and efficient manner. In furtherance of this objective, and subject to state and federal approval requirements, if any, EOHHS may, through separate contracts or through the RFA, institute demonstration projects with Hospitals to develop innovative approaches to delivery of services and payment for services. Such demonstration projects will be designed to focus on ensuring that Hospitals provide or facilitate the provision of quality services to MassHealth Members in a manner that is efficient and cost-effective and that may include alternative reimbursement methodologies for Hospital services or certain Hospital services.

3. MassHealth Drug List

To help ensure consistency in medication regimens and services, prescribers should conform to the MassHealth Drug List (see www.mass.gov/druglist) whenever medically appropriate for inpatients, outpatients, and upon discharge.

C. Ambulatory Services Not Covered by the RFA

The following services provided by Hospitals to MassHealth Members on an outpatient basis are not paid pursuant to the Acute Hospital RFA and Contract: ambulance services, psychiatric day treatment, early intervention, home health, adult day health and adult foster care. Hospitals must continue to conform to the separate provider participation and reimbursement requirements for those MassHealth programs.

Section 5: Reimbursement System

A. General Provisions

Acute Hospitals that participate in the MassHealth program under the terms of the Hospital Contract and its accompanying payment methodology shall accept payment at the rates established in the RFA as payment in full for services reimbursable by EOHHS that are rendered to MassHealth Members admitted as inpatients or treated as outpatients on or after October 1, 2011.

Non-acute units, other than Rehabilitation Units, and units within Hospitals that operate under separate licenses, such as skilled nursing units, will not be affected by this methodology.

Pursuant to M.G.L. c. 118E, §9 (as amended by c. 211 of the Acts of 2006), which describes pre-admission counseling for long-term care, Hospitals will undertake the following activities in connection with instructions that may be issued from time to time by EOHHS: (i) inform patients of the availability of EOHHS-approved counseling services; (ii) identify patients who might benefit from counseling; (iii) distribute informational materials to patients; and (iv) participate in training events organized by EOHHS.

B. Payment for Inpatient Services

1. Overview

Except as otherwise provided in **Sections 5.B.7 through 5.B.13**, fee-for-service payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be a Hospital-specific Standard Payment Amount per Discharge (SPAD) (see **Section 5.B.2**) which will consist of the sum of (1) a statewide average payment amount per discharge that is adjusted for wage area differences and the Hospital-specific MassHealth casemix; (2) a per-discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs; and (3) a per-discharge payment amount for the capital cost allowance, adjusted by a Hospital-specific casemix and by a capital inflation factor, as that sum may be adjusted pursuant to **Section 5.D.5**. Each of these elements is described in **Sections 5.B.2 through 5.B.4**.

For Hospitals with Pediatric Specialty Units, payment for admissions to the Pediatric Specialty Unit for which a SPAD is otherwise payable will be made using the Pediatric SPAD. The Pediatric SPAD is calculated using the same methodology as the SPAD, except that the casemix index, discharges, and average length of stay are based on data from the Pediatric Specialty Unit. In such cases, the Hospital's SPAD is calculated by excluding data from the Pediatric Specialty Unit for these components. Acute Hospitals with Pediatric Specialty Units will be identified in the qualifying Hospital's **Appendix C**.

For Critical Access Hospitals, payment for Inpatient Services is described in **Section 5.B.5**.

Payment for psychiatric services provided in DMH-Licensed Beds to MassHealth Members who are not served either through a contract between EOHHS and its BH Contractor or an MCO shall be made through an all-inclusive Psychiatric Per Diem (see **Section 5.B.7**).

Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD (see **Sections 5.B.7 and 5.B.8**).

Payment for physician services rendered by Hospital-Based Physicians will be made as described in **Section 5.B.10**.

2. Calculation of the Standard Payment Amount Per Discharge (SPAD)

In the development of each Hospital's standard payment amount per discharge (SPAD), EOHHS used the SPAD Base Year costs; and RY05 Merged Casemix/Billing Tapes as accepted by DHCFP as the primary sources of data to develop base operating costs per discharge.

The statewide average payment amount per discharge is based on the actual statewide costs of providing Inpatient Services in the SPAD Base Year cost report. The average payment amount per discharge in each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those costs and discharges from Excluded Units. Routine outpatient costs associated with admissions from the Emergency Department and routine and ancillary outpatient costs resulting from admissions from observation status were included. The cost centers which are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Malpractice costs, organ acquisition costs, capital costs, and direct medical education costs were excluded from the calculation of the statewide average payment amount per discharge.

The average payment amount per discharge for each Hospital was then adjusted by the Hospital's Massachusetts-specific wage area index and by the Hospital-specific RY05 all-payer Casemix Index that was determined by using RY05 discharges and using APR-DRG version 26 of the 3M grouper and Massachusetts weights. Massachusetts Hospitals' wages and hours were determined based on CMS's FY_2012_Proposed_Rule_Wage_Index_PUFs file, downloaded July 5, 2011 from the CMS web site at www.cms.hhs.gov.

Wage areas were assigned according to the same CMS file unless redesignated in a written decision from CMS to the Hospital provided to EOHHS by June 5, 2011. Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, Baystate Medical Center's wages and hours were included. This step results in the calculation of the standardized costs per discharge for each Hospital.

All Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of MassHealth discharges where MassHealth is the primary payer for the Hospitals was produced from the casemix data described below. The efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75% of the total number of statewide discharges in the HDD. The RY12 efficiency standard is \$8,910.68.

The statewide average payment amount per discharge was then determined by multiplying (a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by (b) the outlier adjustment factor of 93.0%; and by (c) the Inflation Factors for Operating Costs between RY05 and RY12. The resulting RY12 statewide average payment amount per discharge is \$8,108.80.

The statewide average payment amount per discharge was then multiplied by the Hospital's MassHealth Casemix Index adjusted for outlier acuity (using APR-DRG version 26 of the 3M Grouper and Massachusetts weights) and adjusted to the Hospital's Massachusetts-specific wage area index to derive the Hospital-specific standard payment amount per discharge (SPAD).

To develop the Hospital's RY12 Casemix Index, EOHHS used casemix HDD, which was then matched with the MassHealth SPAD, transfer, and outlier claims for MassHealth discharges where MassHealth is the primary payer during the same period to ensure that only MassHealth HDD-matched claims for discharges were included in the final Casemix Index calculations. The casemix data did not include discharges from Excluded Units. Calculations of the wage area indexes were derived from the CMS data file.

Costs for outpatient ancillary services for Members admitted from observation status are included in Hospital-specific SPADs.

An outlier adjustment is used for the payment of Outlier Days as described in **Section 5.B.9**.

When groupers are changed and modernized, it may be necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that EOHHS is following, and one that has been a feature of the Medicare Diagnosis-Related Group (DRG) program since its inception. EOHHS reserves the right to update to a new grouper.

3. Calculation of the Pass-Through Amounts per Discharge

The inpatient portion of malpractice insurance and organ acquisition costs was derived from each Hospital's RY10 DHCFP 403 cost report as screened and updated by DHCFP as of July 13, 2011. This portion of the Pass-Through amount per discharge is the sum of the Hospital's per-discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days for the SPAD Base Year and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

This portion of the RY12 Pass-Through amount per discharge is the product of the per diem costs of inpatient malpractice and organ acquisition costs and the Hospital-specific MassHealth Average Length of Stay, omitting such costs related to services in Excluded Units. The days used in the denominator are also net of days associated with such units.

4. Capital Payment Amount per Discharge

The capital payment per discharge is a standard, prospective payment. The capital payment is a casemix-adjusted capital cost limit, based on the SPAD Base Year costs updated by the Inflation Factors for Capital Costs between RY05 and RY12.

For each Hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, major moveable equipment, and long- and short-term interest. Total capital costs are allocated to Inpatient Services through the square-footage-based allocation formula of the DHCFP 403 cost report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. The capital cost per discharge was calculated by dividing total net inpatient capital costs by the Hospital's total SPAD Base Year days, net of Excluded Unit days, and then multiplying by the Hospital-specific all-payer Average Length of Stay.

The casemix-adjusted capital cost standard was determined by (a) dividing the cost per discharge by the All-Payer APR-DRG version 26 Casemix Index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of discharges. The casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75% of the total number of discharges.

Each Hospital's capital cost per discharge was then held to the lower of its capital cost per discharge or the casemix-adjusted efficiency standard, to arrive at a capped capital cost per discharge. Each Hospital's capped capital cost per discharge is then multiplied by the Hospital's number of MassHealth discharges. The product of the capped capital cost per discharge and the number of MassHealth discharges for each Hospital was then summed and divided by the total number of MassHealth discharges statewide, to arrive at a statewide weighted average capital cost per discharge.

The statewide weighted average capital cost per discharge was then updated by the Inflation Factors for Capital Costs for CMS-designated Rural and Urban Hospitals between RY05 and RY12. The statewide weighted average capital cost per discharge for RY12 is \$516.58.

The Hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the Hospital's RY12 Casemix Index as determined in **Section 5.B.2** above.

5. Critical Access Hospitals

The standard inpatient payment amount per discharge for a Critical Access Hospital shall be equal to the sum of 101% of the Hospital's RY05 cost per discharge, adjusted for casemix and inflation; and the Hospital-specific Pass-Through amount per discharge and the capital amount per discharge.

Derivation of per-discharge costs is described in **Section 5.B.2**.

Adjustments were made for casemix and inflation as described in **Section 5.B.2**.

Per diem payments will be calculated in accordance with **Sections 5.B.7** through **5.B.9**, **5.B.11** and **5.B.12**.

6. Maternity and Newborn Rates

Maternity cases in which delivery occurs will be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for *all* services (except physician services) provided in connection with such a maternity stay is included in the SPAD amount.

7. Payments for Psychiatric Services

Services provided to MassHealth Members in DMH-Licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive psychiatric per diem, as described below. This payment mechanism does not apply to cases in which psychiatric services are provided to Members enrolled with the BH Contractor or an MCO, except as set forth in **Sections 4.A.1** and **4.A.2**.

a. Statewide Standard Psychiatric Per Diem

The Statewide Standard Psychiatric Per Diem Rate is derived using the sum of the following: the Acute Hospital Psychiatric Standard for Overhead Costs, the Acute Hospital Psychiatric Standard for Direct Routine Costs, the Acute Hospital Psychiatric Standard for Direct Ancillary Costs, the Acute Hospital Psychiatric Standard for Capital Costs, plus the Adjustment to Base Year Costs.

b. Data Sources

The base year for inpatient costs is the hospital fiscal year (HFY) 2004. MassHealth utilizes the costs, statistics, and revenue reported in the HFY 2004 DHCFF-403 cost reports.

c. Determination of Base Year Operating Standards

- (1) The Standard for Inpatient Psychiatric Overhead Costs is the median of the Inpatient Psychiatric Overhead Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.
- (2) The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the Inpatient Psychiatric Direct Routine Costs Per Day (minus direct routine physician costs) for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.
- (3) The Standard for Inpatient Psychiatric Direct Ancillary Costs is the median of the Inpatient Psychiatric Direct Ancillary Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

d. Determination of Base Year Capital Standard

- (1) Each hospital's base year capital costs consist of the hospital's actual Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the hospital's capital expenses.
- (2) Each hospital's base year Psychiatric Capital Cost Per Day equals the base year psychiatric capital cost divided by the greater of: the actual base year psychiatric days or eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.
- (3) The Standard for Inpatient Psychiatric Capital Costs is the median of the Inpatient Psychiatric Capital Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

- e. Adjustment to Base Year Costs:** The Standards for Overhead Costs, Direct Routine Costs, and Direct Ancillary Costs are updated using a composite index, which is a blend of CMS' Hospital Prospective Market Basket and the Massachusetts Consumer Price Index. The CMS Capital Input Price Index adjusts the base year capital cost to determine the capital amount. The year-to-year update factors between the base year and RY07 were used in the rate calculation of the annual inflation rates for operating costs and capital costs.

The Inflation Factor for Operating Costs between RY08 and RY10 was applied to the rate calculated above to determine the RY12 Statewide Standard Psychiatric Per Diem rate.

Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD. See **Sections 5.B.8.b(4)**

and **5.B.8.b(5)** for payment rules involving transfers to and from DMH-Licensed Beds and BH managed care status.

8. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one Acute Hospital to another will be made on a transfer per diem basis, capped at the Hospital-specific SPAD for the Hospital that is transferring the patient.

In general, the Hospital that is receiving the patient will be paid on a per-discharge basis in accordance with the standard methodology specified in **Sections 5.B.2** through **5.B.4**, if the patient is actually discharged from that Hospital. This includes when a patient is transferred back and is subsequently discharged from the original Hospital. If the patient is transferred to another Hospital, then the transferring Hospital will be paid at the Hospital-specific transfer per diem rate, capped at the Hospital-specific SPAD, as adjusted in **Section 5.D.5**. Additionally, “back-transferring” Hospitals (Hospitals to which a patient is first admitted and then transferred back after having been transferred to another Acute Hospital) will be eligible for outlier payments as specified in **Section 5.B.9**.

The RY12 payment per day for Transfer Patients shall equal the statewide average payment amount per discharge adjusted by the hospital-specific casemix and wage index divided by the SPAD Base Year average all-payer length of stay of 4.59 days, to which is added the Hospital-specific capital and Pass-Through per diem payments which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay.

b. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be reimbursed on a transfer per diem basis capped at the Hospital-specific SPAD. This section outlines reimbursement under some specific transfer circumstances.

Hospitals receiving a transfer per diem may be eligible for outlier payments specified in **Section 5.B.9**, subject to all of the conditions set forth therein.

(1) Transfer to/from a Non-Acute, Skilled Nursing, or other Separately Licensed Unit within the Same Hospital

If a patient is transferred from an acute bed to a Non-Acute bed, except for a DMH-licensed bed or any separately licensed unit in the same Hospital, the transfer is considered a discharge. EOHHS will pay the Hospital-specific SPAD for the portion of the stay before the patient is discharged to any such unit.

(2) MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment in the PCC Plan, Fee-for-Service or MCO during a Hospital Stay; or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible, enrolls in or disenrolls from an MCO during the course of a Hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the transfer per diem rate, up to the Hospital-specific SPAD, or, if the patient is at the Administrative Day level of

of care, at the AD per diem rate, in accordance with **Section 5.B.11**. When a patient enrolls in or disenrolls from an MCO during the Hospital stay, the non-MCO days will be paid at the transfer per diem rate up to the SPAD.

(3) Admissions Following Outpatient Surgery or Procedure

If a patient who requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure, the Hospital shall be paid at the transfer per diem rate up to the Hospital-specific SPAD.

(4) Transfer between a DMH-Licensed Bed and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a DMH-Licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, BH network or non-network Hospital, or the type of service provided. See also **Section 5.B.8.b(5)**.

When a Member who is not enrolled with the BH Contractor transfers between a DMH-Licensed Bed and a non-DMH-Licensed Bed in the same Hospital during a single admission, EOHHS will pay the Hospital at the transfer per diem capped at the Hospital-specific SPAD for the non-DMH-Licensed Bed portion of the stay, and at the psychiatric per diem for the DMH-Licensed Bed portion of the stay. (See **Section 5.B.7**.)

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-Licensed Bed portion of the stay, and only if it is for medical (i.e., non-psychiatric/substance-related disorder) treatment. In that case, such payment will be at the transfer per diem rate capped at the Hospital-specific SPAD.

(5) Change of BH Managed Care Status during a Behavioral Health Hospitalization

(a) Payments to Hospitals without Network Provider Agreements with EOHHS' BH Contractor

When a Member is enrolled with the BH Contractor during an Emergency or Post-Stabilization behavioral health admission at a non-network Hospital, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor shall be paid by the BH Contractor provided that the Hospital complies with the BH Contractor's billing requirements and any applicable service authorization requirements that are permissible under federal law at 42 USC 1396u-2(b)(2), 42 CFR 438.114, and 42 CFR 422.113(c).

In accordance with the preceding federal law, and with 42 CFR 422.214(b), if the BH Contractor offers to pay the Hospital a rate equal to the applicable RFA rate less any amount for graduate medical education for Emergency and Post-Stabilization psychiatric or substance-related disorder services, the Hospital must accept the BH Contractor's rate offer as payment in full for all such Members.

This requirement does not prohibit the BH Contractor from negotiating to pay at a lower rate than the non-network Hospital's applicable RFA rate less any amount for graduate medical education for all such Emergency

and Post-Stabilization psychiatric or substance abuse-related disorder services provided at a non-network hospital.

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-Licensed Bed or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

(b) Payments to Hospitals that are in the BH Contractor's Provider Network

When a Member is enrolled with the BH Contractor during an emergency or non-emergency behavioral health Hospital admission, the portion of the Hospital stay during which the Member was enrolled with the BH Contractor shall be paid by the BH Contractor at the rates agreed upon by the Hospital and the BH Contractor provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures.

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the Psychiatric Per Diem rate for psychiatric services in a DMH-Licensed Bed; or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

9. Outlier Payments

A Hospital qualifies for an outlier per diem payment equal to 75% of the Hospital's transfer per diem in addition to the Hospital-specific standard payment amount per discharge or transfer per diem payment if *all* of the following conditions are met:

- a.** The Medicaid non-managed care length of stay for the hospitalization exceeds 20 cumulative *acute* days at that Hospital (not including days in a DMH-Licensed Bed or days paid by a third party);
- b.** The Hospital continues to fulfill its discharge planning duties as required in MassHealth regulations;
- c.** The patient continues to need acute level care and is therefore *not* on Administrative Day status on any day for which an outlier payment is claimed;
- d.** The patient is not a patient in a DMH-Licensed Bed on any day for which an outlier payment is claimed;
- e.** The patient is not a patient in an Excluded Unit within an Acute Hospital; and
- f.** The patient is under 21 years of age.

10. Physician Payment

For physician services provided by Hospital-Based Physicians to MassHealth patients, the Hospital will be reimbursed for the professional component of physician services in accordance with, and subject to, the Physician regulations at 130 CMR 433.000 et seq. Such

Such reimbursement shall be at the lower of (1) the fee established in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00, 17.00, 18.00 and 20.00 (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual charge submitted.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are not reimbursable separately. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the hospital.

Hospitals shall not be reimbursed for inpatient physician services provided by community-based physicians.

Physician fee schedules are available at the State House Bookstore and at <http://www.state.ma.us/DHCFP>.

11. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Care Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is \$198.53, which represents the median nursing facility rate that was effective September 1, 2011 for all nursing home rate categories, as determined by DHCFP.

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B-eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The AD rates for RY12 are \$253.72 for Medicaid/Medicare Part B-eligible patients and \$274.37 for Medicaid-only eligible patients.

MassHealth rules and regulations do not allow a patient to be admitted at an AD status, except in limited circumstances outlined in EOHHS regulations. In most cases, therefore, Administrative Days will follow an acute stay in the Hospital.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative MassHealth non-managed care acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status to determine the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative MassHealth non-managed care acute days), and then for Outlier Days, as described above.

12. Rehabilitation Unit Services in Acute Hospitals

A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided at an Acute Hospital.

The per diem rate for such Rehabilitation Services equals the median MassHealth RY12 Rehabilitation Hospital rate for Chronic Disease and Rehabilitation (CDR) Hospitals. Acute Hospital Administrative Day rates will be paid in accordance with **Section 5.B.11** for all days that a patient remains in the Rehabilitation Unit while not at Hospital level of care. Such units shall be subject to EOHHS' screening program for chronic and rehabilitation hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410 – 411.

13. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay.

The Infant Outlier Payment is calculated using the data and methodology as follows:

- (1) Data Source:** The prior year's claims data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.
- (2) Eligibility:** Eligibility for the adjustment is determined as follows:
 - (a) Exceptionally Long Lengths of Stay:** First, the statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.
 - (b) Exceptionally High Cost:** Exceptionally high cost is calculated for Hospitals providing services to infants less than one year of age as follows:
 1. The average cost per Medicaid inpatient discharge for each Hospital is calculated;
 2. The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated;
 3. The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two, and that amount is added to the Hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.
 - (c) Eligibility for an Infant Outlier Payment:** First, for each Hospital providing services to infants less than one year of age, the average Medicaid inpatient length of stay involving individuals less than one year of age is determined. If this Hospital-specific average Medicaid inpatient length of stay for infants less than one year of age equals or exceeds the threshold defined in **Section 5.B.13.a(2)(a)**, then the Hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants less than one year of age is calculated. If a Hospital has a Medicaid inpatient case with a cost that equals or exceeds the Hospital's own threshold defined in Section

5.B.13.a(2)(b) above, then the Hospital is eligible for an infant outlier payment.

- (d) Payment to Hospitals:** Annually, each Hospital that qualifies for an infant outlier adjustment receives an equal portion of \$50,000. For example, if two Hospitals qualify for an outlier adjustment, then each Hospital receives \$25,000.

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to children more than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay.

The Pediatric Outlier Payment is calculated using the data and methodology as follows:

- (1) Data Source:** The prior year's discharge data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.
- (2) Eligibility:** Eligibility for the adjustment is determined as follows:
 - (a) Exceptionally Long Lengths of Stay:** First, a statewide weighted average Medicaid inpatient length of stay is calculated. This is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. Second, the statewide weighted standard deviation for Medicaid inpatient length of stay is calculated. Third, the statewide weighted standard deviation for Medicaid inpatient length of stay is multiplied by two and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.
 - (b) Exceptionally High Cost:** Exceptionally high cost is calculated for Hospitals providing services to children greater than one year of age and less than six years of age as follows:
 1. The average cost per Medicaid inpatient discharge for each Hospital is calculated.
 2. The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated.
 3. The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two and added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.
 - (c) Eligibility for a Pediatric Outlier Payment:** For Acute Hospitals providing services to children greater than one year of age and less than six years of age, eligibility for a pediatric outlier payment is calculated as follows:
 1. The average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this Hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in **Section 5.B.13.b(2)(a)**, then the hospital is eligible for a Pediatric Outlier Payment.
 2. The cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this Hospital-specific Medicaid

Medicaid inpatient cost equals or exceeds the threshold defined in **Section 5.B.13.b(2)(b)**, then the Hospital is eligible for a Pediatric Outlier Payment.

3. Payment to Hospitals: Annually, each Acute Hospital qualifying for a pediatric outlier adjustment will receive \$1,000.

C. Outpatient Hospital Services

***Note:** Rates for all Outpatient Hospital Services (including Emergency Department services) that are covered under a contract between the Acute Hospital and EOHHS' BH Contractor and that are provided to MassHealth Members enrolled with EOHHS' BH Contractor, shall be governed by terms agreed upon between the Acute Hospital and the BH Contractor as set forth in **Section 4.A.1** of the RFA.*

A Hospital will be reimbursed in accordance with **Section 5.C** for Outpatient Services provided by Hospital Outpatient Departments and Satellite Clinics.

Except as otherwise provided for Outpatient Services specified in **Sections 5.C.3** through **5.C.8**, Hospitals will receive a Hospital-specific payment for each Episode, known as the Payment Amount Per Episode (PAPE).

Hospitals will not be reimbursed for Hospital services specified as non-payable in Subchapter 6 of the MassHealth Acute Outpatient Hospital Manual, unless such services are medically necessary services provided to a MassHealth Standard or CommonHealth Member under 21 years. Providers should refer to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) regulations at 130 CMR 450.140 et seq., regarding provision of EPSDT services to MassHealth Standard or CommonHealth Members under 21 years.

1. Payment Amount Per Episode (PAPE)

a. PAPE Rate Development

Each Hospital's RY12 PAPE is a blended rate that equally weights the Hospital's RY11 PAPE and the preliminary RY12 PAPE determined as calculated in this **Section 5.C.1.a**, provided, however, that no Hospital's RY12 PAPE shall be less than 90% of the Hospital's RY11 PAPE in effect on September 30, 2011.

The preliminary RY12 PAPE is the product of the Hospital-Specific Outpatient Casemix Index and the Outpatient Statewide Standard. These components are further described below.

- (1) **Hospital-Specific Outpatient Casemix Index:** The hospital-specific outpatient casemix index for the current Rate Year is an average of the monthly Average APG Weights per Episode between October 1, 2009 through September 30, 2010 for each hospital.

The monthly Average APG Weight per Episode for each month is the hospital's PAPE payments divided by the number of episodes then divided by the applicable conversion factor.

The applicable conversion factor is: October 1, 2009 through September 30, 2010 — \$132.40.

The sum of the monthly Average APG Weights Per Episode for October 1, 2009 through September 30, 2010 divided by 12 is the Hospital-Specific Outpatient Casemix Index for the current Rate Year.

- (2) **Outpatient Statewide Standard** — the PAPE Base Year Outpatient Statewide Standard is adjusted so that the total payment for PAPE Covered Services provided in the PAPE Base Year equals the Total APG Payment in the PAPE Base Year. The result of this calculation is a PAPE Base Year Outpatient Statewide Standard of \$129.13.

The PAPE Base Year Outpatient Statewide Standard is then adjusted to account for volume and casemix changes between the PAPE Base Year and the current Rate Year. This adjusted amount is then multiplied by the Inflation Factors for Operating Costs between RY11 and RY12. The resulting RY12 Outpatient Statewide Standard is \$168.40.

For Critical Access Hospitals, the Outpatient Statewide Standard is 120% of the Outpatient Statewide Standard noted above. The resulting RY12 Outpatient Statewide Standard for Critical Access Hospitals is \$202.08.

b. Payment System

MassHealth processes and pays clean outpatient claims in accordance with 130 CMR 450 et seq.

2. Emergency Department Services

a. Required Screening

All Members presenting in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24 must be screened and stabilized in accordance with applicable requirements at 42 U.S.C. 1395dd et seq., M.G.L. c. 118E, section 17A, and all applicable regulations.

b. Payment for Emergency Services

Hospitals will be reimbursed for Emergency Services provided in the Emergency Department in the same manner as other Outpatient Services.

3. Outpatient Hospital Services Payment Limitations and PCC Plan Notification Requirements

a. Payment Limitations on Outpatient Hospital Services Preceding an Admission

Hospitals will not be separately reimbursed for Outpatient Hospital Services when an Inpatient Admission to the same Hospital, on the same date of service, occurs following the provision of Outpatient Hospital Services. See **Section 5.B.8.b(3)**.

b. Payment Limitations on Outpatient Hospital Services to Inpatients

Hospitals will not be reimbursed for Outpatient Services provided to any Member who is concurrently an inpatient of any Hospital. The Hospital is responsible for payment to any other Provider of services delivered to a Member while an inpatient of that Hospital.

c. Notification Requirements

For all PCC Plan Members, Hospitals must notify the Member's PCC within 48 hours after providing Emergency Department services. The Hospital must also notify the

Member's PCC within 48 hours of the Member's discharge from an Inpatient Admission. Said notice in both cases shall be the Hospital discharge instructions that are provided to the patient, which includes the Member's diagnosis, treatment, and discharge instructions.

4. Physician Payments

- a.** A Hospital may only receive reimbursement for physician services provided by Hospital-Based Physicians to MassHealth Members. The Hospital must claim payment for the professional component of physician services in accordance with, and subject to: (1) the Physician regulations at 130 CMR 433.000 et seq.; (2) the Acute Outpatient Hospital regulations at 130 CMR 410.000 et seq.; and (3) other rules regarding physician payment as set forth in the RFA.
- b.** Such reimbursement shall be the lower of (1) the fee established in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00, 17.00, 18.00 and 20.00 (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge for physician fees; or (3) the Hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than Hospital-Based Physicians as defined in **Section 2**.
- c.** Hospitals will be reimbursed for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.
- d.** Physician Services provided by residents and interns are not separately reimbursable.
- e.** Hospitals will not be reimbursed for physician services if those services are (1) provided by a Community-Based Physician; or (2) as further described in **Section 5.C**.
- f.** In order to qualify for reimbursement for physician services provided during the provision of Observation Services, the reasons for the Observation Services, the start and stop time of the Observation Services, and the name of the physician ordering the Observation Services, must be documented in the Member's medical record.

Physician fee schedules are available at the State House Bookstore and at <http://www.state.ma.us/DHCFP>.

5. Laboratory Services

a. Payment for Laboratory Services

Hospitals will be reimbursed for laboratory services according to the Outpatient Hospital regulations at 130 CMR 410.455 through 410.459, subject to all restrictions and limitations described in regulations at 130 CMR 401.000.

The maximum allowable payment for a laboratory service shall be at the lowest of the following:

- (1)** The amount listed in the most current applicable DHCFP Clinical Laboratory Services fee schedule at 114.3 CMR 20.00 and the Surgery & Anesthesia fee

schedule at 114.3 CMR 16.00 (available at the State House Bookstore and at <http://www.state.ma.us/DHCFP>);

- (2) The Hospital's Usual and Customary Charge; or
- (3) The amount that would be recognized under 42 U.S.C. §13951(h) for tests performed for a person with Medicare Part B benefits.

b. Physician Services

No additional payment shall be made for any physician service provided in connection with a laboratory service, except for Surgical Pathology Services. The maximum allowable payment is payment in full for the laboratory service.

6. 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 according to the DHCFP fees as established in 114.3 CMR 23.00.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of audiology dispensing services.

7. Vision Care Dispensing

a. Payment for Vision Care Services

Hospitals will be reimbursed for the dispensing of ophthalmic materials only by a Hospital-Based optometrist, ophthalmologist or other practitioner licensed and authorized to write prescriptions for ophthalmic materials and services according to the Vision Care regulations at 130 CMR 402.000 et seq., and according to the DHCFP fees as established in 114.3 CMR 15.00.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of vision care services.

8. Dental Services

a. Payment for Dental Services

Hospitals will be reimbursed for covered dental services according to the Dental regulations at 130 CMR 420.000 et seq. according to the DHCFP fees as established in 114.3 CMR 14.00 et seq., except when the conditions in 130 CMR 420.430(A)(2) or (D) apply. When these conditions apply, EOHHS will reimburse the Hospital according to **Section 5.C.1**. The Hospital-based Dentist may not bill for any professional component of the service that is billed by the hospital.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician (which, as defined in **Section 2**, includes dentists) services related to the provision of dental services, except when the conditions in 130 CMR 420.430(A)(2) or (D) apply. Under those circumstances, in addition to the PAPE payment under **Section 5.C.1**, when a Hospital-Based Physician provides physician services, the Hospital may be reimbursed for such physician services in accordance with **Section 5.C.4**. The Hospital-Physician may not bill for any professional component of the service that is billed by the hospital.

D. Reimbursement for Unique Circumstances

1. Public Service Hospital Providers

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Public Service Hospitals. The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to Public Service Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Public Service Hospitals shall be determined by EOHHS.

2. Essential MassHealth Hospitals

a. Qualification

In order to qualify for payment as an Essential MassHealth Hospital, a Hospital must itself meet, or be within a system of hospitals, any one of which meets at least four of the following criteria, as determined by EOHHS, provided that all hospitals within such system are owned or controlled, directly or indirectly, by a single entity that (i) was created by state legislation prior to 1999; and (ii) is mandated to pursue or further a public mission:

- (1) The Hospital is a non-state-owned public Acute Hospital.
- (2) The Hospital meets the current MassHealth definition of a non-profit teaching hospital affiliated with a Commonwealth-owned medical school.
- (3) The Hospital has at least 7% of its total patient days as Medicaid days.
- (4) The Hospital is an acute-care general Hospital located in Massachusetts that provides medical, surgical, Emergency and obstetrical services.
- (5) The Hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

b. Reimbursement Methodology

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Essential

Essential MassHealth Hospitals. The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to Essential MassHealth Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Essential MassHealth Hospitals shall be determined by EOHHS.

3. Acute Hospitals with High Medicaid Discharges

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Acute Hospitals with High Medicaid Discharges when compared with other participating MassHealth Hospitals. To be eligible for a payment pursuant to this section, a Hospital must have more than 2.7% of the statewide share of Medicaid discharges, as determined by dividing each Hospital's total Medicaid discharges as reported on the Hospital's HCF-403 cost report by the total statewide Medicaid discharges for all Hospitals.

The payment amount for inpatient services is the lower of (1) the variance between the Hospital's inpatient Medicaid payments and charges, or (2) the Hospital's Health Safety Net Trust Fund-funded payment amount.

The payment amount for outpatient services is the lower of (1) the variance between the Hospital's outpatient Medicaid payments and costs, or (2) the Hospital's Health Safety Net Trust Fund-funded payment amount.

EOHHS reserves the right to make payments to Acute Hospitals with High Medicaid Discharges in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Acute Hospitals with High Medicaid Discharges shall be determined by EOHHS.

4. Supplemental Payment for Freestanding Pediatric Acute Hospitals

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, waiver provisions, and payment limits, and full federal financial participation, EOHHS will make a supplemental payment equal to \$3.85 million to Freestanding Pediatric Acute Hospitals, to account for high Medicaid volume. Such payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the Hospital Rate Year.

EOHHS reserves the right to make payments to Freestanding Pediatric Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Freestanding Pediatric Acute Hospitals shall be determined by EOHHS.

5. SPAD Adjustments

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make an adjustment to the SPAD for certain Hospitals as described below.

- a. Any Hospital that has greater than 63% of its gross patient service revenue (GPSR) from governmental payers and free care, as determined by EOHHS, will be eligible for an additional 5% of its SPAD (including Pediatric SPAD), as calculated in **Sections 5.B.2 through 5.B.5**.
- b. Any Hospital with a rate of potentially preventable readmissions (PPR) exceeding the statewide average PPR rate (based on FY 2009 data), as adjusted to reflect hospital-specific casemix and severity of illness during the initial admission as calculated in accordance with **Section 8.1**, will receive a 2.20% reduction to their SPAD (including Pediatric SPAD), as calculated in **Sections 5.B.2 through 5.B.5**.
- c. Any Hospital eligible for both SPAD Adjustments specified in **Sections 5.D.5.a and 5.D.5.b** will receive a single combined adjustment to its SPAD equal to 2.8%.
- d. The adjustments specified in **Sections 5.D.5.a and 5.D.5.b** shall not apply when calculating per diem rates; provided, however that the adjustments do apply when capping the transfer per diem rate at the Hospital-specific SPAD.

E. Safety Net Care Acute Hospital Payments

In accordance with the terms and conditions of the Commonwealth's 1115 waiver governing the Safety Net Care Pool (SNCP), and subject to compliance with all applicable federal requirements, the Commonwealth will make an additional payment above the amounts specified in **Sections 5.B, 5.C, and 5.D** to Hospitals which qualify for such payment under any one or more of the payment classifications listed below for the period of RY12 ending June 30, 2012. SNCP payments are authorized by the Centers for Medicare and Medicaid Services (CMS) on a state fiscal year basis for each applicable waiver year.

Only Hospitals that have an executed Contract with EOHHS, pursuant to the RFA, are eligible for SNCP payments.

All SNCP payments are subject to federal approval and the availability of federal financial participation.

1. Public Service Hospital Safety Net Care Payment

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, waiver provisions, payment limits, and full federal financial participation, EOHHS will make a Public Service Hospital Safety Net Care payment to qualifying Hospitals.

In order to qualify for a Public Service Hospital Safety Net Care Payment, a hospital must:

- a. be a public or public-service hospital as defined in **Section 2**;
- b. have a volume of Medicaid and free care charges in Fiscal Year 1993, or for any new hospital, in the base year as determined by DHCFP, that is at least 15% of its total charges; and

- c. be an essential safety-net provider in its service area, as demonstrated by delivery of services to populations with special needs including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers.

The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make SNCP payments to Public Service Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive SNCP as Public Service Hospitals shall be determined by EOHHS.

2. Health Safety Net Trust Fund Safety Net Care Payment

The eligibility criteria and payment method for this payment classification are specified in DHCFP regulations at 114.6 CMR 14.00 and the Special Terms and Conditions of the Commonwealth's 1115 waiver governing Safety Net Care. Eligible Hospitals will receive these payments on a periodic basis during the term of their RY11 Hospital Contract.

F. Federal Financial Participation (FFP)

1. FFP Denials

If any portion of the reimbursement pursuant to the RFA is not approved or is the basis of a disallowance by CMS, EOHHS may recoup, or offset against future payments, any payment made to a Hospital in excess of the approved reimbursement.

2. Exceeding Limits

a. Hospital-Specific Limits

If any payments made pursuant to the RFA exceed any applicable federal Hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and limits based on federally approved payment methods, EOHHS may recoup, or offset against future payments, any payment made to a Hospital in excess of the applicable limit.

b. Aggregate Limits

If any payments made pursuant to the RFA exceed applicable federal aggregate payment limits, including, but not limited to, upper payment limits provided for in federal law, regulations, and the Commonwealth's 1115 waiver, EOHHS may exercise its discretion to apportion the disallowance among the affected Hospitals and to recoup from, or offset against future payments to such Hospitals, or to otherwise restructure payments in accordance with approved payment methods.

G. Billing

The Contractor shall bill for all non-professional services through an 837I or on the UB04 form and all professional component services for Hospital-Based Physician (Inpatient and Outpatient) Services through an 837P or on the CMS 1500 form, except where otherwise indicated by MassHealth regulations, billing instructions, Provider bulletins, or other written statements of

policy, and in compliance with all applicable regulations, billing instructions, Provider bulletins, and other written statements of policy, as they may be amended from time to time.

H. Treatment of Reimbursement for Members in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, EOHHS shall reimburse participating Hospitals for services provided to MassHealth Members who are at acute inpatient status prior to October 1, 2011, and who remain at acute inpatient status on or after October 1, 2011, at the Hospital's rates established prior to this RY12 RFA. Reimbursement to participating Hospitals for services provided to MassHealth Members who are admitted on or after October 1, 2011, shall be reimbursed at the RY12 Hospital rates.

I. 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.

J. Compliance with Legal Requirements

The parties agree to comply with, and are subject to, all state and federal statutes, rules, and regulations governing the MassHealth Program, and reimbursement and delivery of Acute Hospital services, including but not limited to Acute Inpatient Hospital regulations at 130 CMR 415.00 et seq., Outpatient Hospital regulations at 130 CMR 410.000 et seq., and Administrative and Billing regulations at 130 CMR 450.00 et seq.; provided, however, that in the event of any conflict between the documents that are part of the Hospital's Contract with EOHHS and any MassHealth regulation now existing or hereinafter adopted, the terms of the Contract shall prevail. All references to statutes and regulations refer to such statutes and regulations as they may be amended from time to time. In addition, the parties must comply with all applicable billing instructions and Provider bulletins, and other written statements of policy issued by EOHHS and its divisions, as they may be amended from time to time.

K. Eligibility Verification

EOHHS will pay the Hospital only for a covered service delivered to a Member who, on the date of service, is (1) eligible under MassHealth to receive that service, and (2) not enrolled with a MassHealth managed care provider (including EOHHS' Behavioral Health contractor) that covers the service. Each day of an inpatient Hospital stay constitutes a discrete "date of service." A Member who meets the foregoing conditions on a given date of service may not meet such conditions on all dates of service comprising a Hospital stay. The Hospital is responsible for determining, through the MassHealth Recipient Eligibility Verification System (REVS), that the Member meets the conditions stated herein on each discrete date of service.

L. Errors in Calculation of Pass-Through Amounts, Capital Costs, or Casemix

As set forth below, EOHHS will make corrections to the final Hospital-specific rate retroactive to the effective date of the Contract resulting from the RFA. Such corrections will not affect computation of any statewide average or statewide standard amounts or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

1. Errors in Calculation of Pass-Through or Capital Costs

- a. If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY12 Pass-Through Costs or capital costs, resulting in an amount not consistent with the methodology, a Hospital may request a correction, which shall be at the sole discretion of EOHHS.
- b. To qualify for a correction, Hospitals must submit, no later than January 31, 2012, copies of the relevant report(s), as referenced in **Sections 5.B.3** and **5.B.4**, highlighting items found to be in error, to Kiki Feldmar at the following address:

Kiki Feldmar
Executive Office of Health and Human Services
Office of Acute and Ambulatory Care
100 Hancock Street, 6th Floor
Quincy, MA 02171
kiki.feldmar@state.ma.us

2. Incorrect Determination of Casemix

- a. Casemix shall be calculated on claims for inpatient discharges as described in **Section 5.B** and for outpatient Episodes as described in **Section 5.C**. In the event of an error in the calculations of casemix made by EOHHS or DHCFP for Inpatient or Outpatient Services, resulting in an amount not consistent with the methodology, a Hospital may request a correction to its RY12 casemix, which shall be at the sole discretion of EOHHS.
- b. In the event of a Hospital reporting error where the effect of the error is a decrease in the Hospital's SPAD of 30% or more, EOHHS may, in its sole discretion, consider revised data submitted to DHCFP or EOHHS by the Hospital.
- c. To qualify for a correction, Hospitals must contact EOHHS in writing, no later than March 31, 2012, and must include with their request for a correction all of the necessary documentation for each and every contested claim that is part of the requested correction to demonstrate that an error has occurred. Requests for corrections that do not include all necessary documentation will not be considered.

Please contact Kiki Feldmar at the following address:

Kiki Feldmar
Executive Office of Health and Human Services
Office of Acute and Ambulatory Care
100 Hancock Street, 6th Floor
Quincy, MA 02171
kiki.feldmar@state.ma.us

3. Change in Services Affecting Casemix

In the event that a Hospital opens or closes, during the Contract year, an Inpatient Service that the Hospital believes will have a significant effect on casemix, the Hospital must provide EOHHS with a data analysis of the casemix effect for the current Rate Year and the subsequent Rate Year if it requests a casemix adjustment. EOHHS may, in its sole discretion, consider revised data submitted by the Hospital.

M. Data Sources

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, EOHHS shall select such substitute data sources or other methodology(ies) that EOHHS deems appropriate in determining Hospitals' rates.

N. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or 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, EOHHS, in its sole discretion, shall determine on a case-by-case basis: (1) whether the Hospital qualifies for reimbursement under the RFA; and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of the RFA to the extent that EOHHS deems possible. EOHHS' determination shall be based on the totality of the circumstances. In cases where any such rate may, in EOHHS' sole discretion, affect computation of any statewide average or statewide standard payment amount and/or any cost standard, MassHealth provider numbers are not assignable to new entities.

See **Sections II.5.a and II.5.d of Appendix A** in the RFA, and **Appendix B, item 11** in the RFA, for requirements in the event of Hospital change of ownership.

Section 6: Payment and Reporting Provisions

All payments under the RFA are subject to the following provisions, as well as all other rules and regulations governing service limitations, claims payment, billing and claims processing procedures, utilization control requirements and all other MassHealth conditions of payment.

A. Services Requiring Practitioner Prior Approval

EOHHS will not reimburse a Hospital for services provided when the practitioner is required to, but fails to obtain prior authorization, referrals or other approval for the service. It is the Hospital's responsibility to ensure that a practitioner providing services in the Hospital has obtained the necessary approvals.

B. Hospital Payments in the Event of Third-Party Coverage

1. Except to the extent prohibited by 42 U.S.C. § 1396a(a)(25)(E) or (F), the Hospital must make diligent efforts, as defined under 130 CMR 450.316(A), to identify and obtain Insurance Payments before billing MassHealth.
2. For Inpatient Admissions, Outpatient Services, and Emergency Department Services where the Member has Third-Party Insurance coverage, EOHHS will pay the Hospital according to Third-Party Liability provisions at 130 CMR 450.316-321.

C. Notification of Hospital Election to Offer Reduced Medicare Coinsurance Amounts

Acute Hospitals have an option to elect to reduce a Medicare beneficiary's Coinsurance amount under the Medicare outpatient prospective payment system. Such election must be made in writing to the Hospital's fiscal intermediary (FI), specifying the services to which it applies. The first such election must have been made by June 1, 2000, and for future years by December 1 of the year preceding the calendar year for which the election is being made. See 42 CFR 419.42.

Hospitals electing to take such an option must forward a copy of their notification to the FI to:

Executive Office of Health and Human Services
Office of Medicaid
Attn.: Claims Coordination Unit
UMass-CHCF
The Schrafft Center
529 Main Street, 3rd Floor
Charlestown, MA 02129

D. Sterilization

EOHHS will pay for an inpatient stay for a sterilization or for outpatient sterilization services only when the Hospital meets all requirements regarding Member consent and service delivery as set forth in MassHealth regulations. For any sterilization for which the Hospital does not demonstrate compliance with Member consent requirements, including submission of all required documentation according to all applicable regulations, MassHealth will deduct an amount equal to the Hospital's PAPE from the applicable Hospital payment amount. Furthermore, the performance of a sterilization without meeting all such requirements may result in sanctions against the Hospital in accordance with 130 CMR 450.238 et seq. as well as the applicable provisions of the RFA.

E. Cost Reporting Requirements

All Acute Hospitals are required to submit documents needed for the calculation of MassHealth payment rates to DHCFP and EOHHS in accordance with all applicable instructions and requirements. These documents include, but are not limited to, DHCFP 403 cost reports, DHCFP merged billing and discharge filings, and CMS Medicare 2552 cost reports. If a Hospital does not submit the information specified above in a timely fashion as specified in 114.1 CMR 42.03(2), such a Hospital may have a 5% reduction applied to its SPAD payment rate beginning 45 days after the required submission date. This reduction shall accrue in a cumulative manner of 5% for each month of non-compliance.

For example, the downward adjustment to the Hospital's SPAD for the first month would equal 5%; if the requested documentation is not received for another month, the downward adjustment to the Hospital's SPAD for the second month shall equal 10%. The adjustment shall not, in any case, exceed 50% of the SPAD. If a Hospital is not in full compliance with the submission of the aforementioned information at such time as the Hospital's rate is subject to change (i.e., at the start of a new Rate Year, or upon commencement of an amendment that affects the SPAD rate), at no time can the new rate exceed the adjusted current rate. If, however, the new SPAD rate is less than the rate currently in effect, then the new rate will become effective and potentially subject to further adjustment.

Hospitals must separately identify in the DHCFP 403 cost report any costs associated with Rehabilitation Units, in accordance with the instructions of DHCFP.

F. Accident Reporting

Hospitals shall use reasonable efforts to determine whether a Member's injury is due to an accident or trauma (e.g., automobile accident, accident at work). In the event that a MassHealth Member is treated at a Hospital for injuries resulting from an accident or trauma, the Hospital shall notify EOHHS in writing of the following information, at the address below:

1. Patient's name, MassHealth number (SSN or RID), address, and date of birth;
2. Date(s) of service (*from-to*);
3. Date of injury;
4. Type of accident (e.g., auto accident, accident at work, slip and fall);
5. Insured's name and address;
6. Insurance company's name;
7. Insured's attorney's name, address and telephone number.

Such written notification shall be sent to the following address:

Office of Medicaid
Accident Trauma Recovery Unit
P.O. Box 15205
Worcester, MA 01615-0203
Phone: (800) 754-1864

G. MassHealth Co-payments

For any Hospital service for which a Member co-payment is applied pursuant to 130 CMR 450.130, EOHHS shall deduct the co-payment amount from the applicable Hospital payment amount specified in the RFA. Hospitals may not refuse services to any Member who is unable to

pay the co-payment at the time the service is provided, and must otherwise comply with all applicable state and federal requirements regarding co-payments.

Section 7. Pay-for-Performance Quality Reporting Requirements and Payment Methods

This section sets forth the MassHealth Pay-for-Performance (P4P) Program quality reporting requirements and payment methods. For RFA12, P4P payments described in **Section 7.5** are contingent upon the Hospital's performance of all applicable requirements specified in **Section 7**.

7.1 Pay-for-Performance

The MassHealth P4P program shall operate under the following principles:

- A. Reward hospitals for excelling in and improving quality of care delivered to MassHealth members, including the reduction of racial and ethnic health disparities.
- B. Evaluate Hospital performance using quality measures for maternity, pediatric asthma, pneumonia, surgical care infection, and health disparities as set forth in **Section 7.3**.
- C. Assess hospital performance annually, in accordance with methods set forth in **Section 7.4**, to calculate performance scores that will be converted to P4P payments.
- D. Make payments to Hospitals in accordance with the methods for calculating payments set forth in **Section 7.5** of the RFA.
- E. To be eligible to receive P4P payments, Hospitals must adhere to the following quality reporting standards:
 - 1. Submit complete data, as described in **Section 7.3**, for each required measure listed in **Table 7-1**, and meet data submission deadlines set forth in **Section 7.6.A**;
 - 2. Comply with all data collection and submission guidelines published in the applicable EOHHS Technical Specifications Manual version listed in **Section 7.6.A** to ensure completeness and accuracy of data submitted;
 - 3. Identify and authorize individuals to conduct electronic data transactions, via the EOHHS designated secure portal, on the Hospital's behalf;
 - 4. Meet the minimum reliability standards for data elements and pass data validation as defined in **Section 7.4.B**; and
 - 5. Achieve quality standards and performance benchmarks on reported measures data.
- F. Failure to timely submit all data and reporting in the form and formats required by EOHHS may render the Hospital ineligible for some or all payments under **Section 7** of the RFA. All Hospitals contracting with EOHHS are required to participate in P4P quality reporting for all applicable measures. A Hospital's performance with respect to the requirements in **Section 7** may affect its present and future participation in the MassHealth program and/or its rate of reimbursement.

7.2 Hospital Key Quality Representative Requirements

Each Hospital must identify and designate two key quality representatives, with the appropriate expertise to coordinate and communicate with EOHHS on all aspects of **Section 7** requirements during the Contract period.

The two key quality representatives shall act in accordance with, but not be limited to, the following responsibilities:

- A. Serve as the primary contact for all correspondence pertinent to the Hospital’s quality performance reports, including responding to all inquiries and requests made by EOHHS, in accordance with the timeframes and format specified by EOHHS.
- B. Notify EOHHS of any changes in the key quality representatives that occur during the contract period as soon as the information becomes available, using the *Hospital Quality Contacts Form*;
- C. Use the mailbox address: Masshealthhospitalquality@state.ma.us to expedite communication between EOHHS and the Hospital on **Section 7** requirements and comply with the following conditions that apply to use of this e-mail address:
 - 1. Only the two key quality representatives are automatically entered into the e-mail distribution list of the EOHHS mailbox system. Requests to add other staff not listed on the Hospital Quality Contact Form to this mailbox must be requested in writing.
 - 2. Key quality representatives will receive ongoing updates from the EOHHS mailbox system on quality reporting requirements and other quality-related initiatives during the Contract period.
 - 3. Key quality representatives are responsible for disseminating updates sent from the EOHHS private mailbox system and communicating to all staff and/or third-party vendors involved in quality performance reporting.
- D. **Reporting Requirement.** Each Hospital must complete and submit information on all staff involved in quality reporting using the *Hospital Quality Contacts Form* by the date set forth in **Section 7.6.A**.

7.3 Performance Measures

P4P quality reporting applies to hospital services for MassHealth members which includes individuals under 65 years of age who are enrolled in the Primary Care Clinician (PCC) Plan and with fee-for-service coverage where Medicaid is the primary payer.

- A. **Performance Measures Data.** In RY12, the quality performance measures set includes continuation of data collected in the previous rate year (Q1-2011: January 1, 2011 - March 31, 2011 discharge data) and introduces new measures reporting effective with the Q1-2012 submission cycle. **Table 7-1** identifies the specific quality measures by measure ID and name.

Table 7-1. Quality Performance Measures Data Set

Measure ID #	Measurement Category and Name	Measure Reporting Status
MAT-1 MAT-2a MAT-2b	Maternity Intrapartum Antibiotic Prophylaxis for Group B Streptococcus Perioperative Antibiotics for Cesarean Section –Antibiotic Timing Perioperative Antibiotics for Cesarean Section – Antibiotic Selection	
MAT-3	Elective Delivery Prior to 39 Completed Weeks Gestation	Add Reporting as of Q3-2011 discharges
CAC-1a CAC-2a CAC-3	Pediatric Asthma Children's Asthma Care - Inpatient Use of Relievers Children's Asthma Care - Inpatient Use of Corticosteroids Children's Asthma Care – Home management plan of care	No change
PN-3b	Community Acquired Pneumonia Blood culture performed in ED prior to first antibiotic received in hospital	

PN-4 PN-5c PN-6	Adult smoking cessation advice/counseling Initial antibiotic received within 6 hrs of hospital arrival Appropriate antibiotic selection for CAP in immuno-competent patients	No change
SCIP-1a SCIP-2a SCIP-3a	Surgical Care Infection Prevention Prophylactic antibiotic received within 1 hour prior to surgical incision Appropriate antibiotic selection for surgical prophylaxis Prophylactic antibiotic discontinued w/in 24 hrs after surgery end time	No change
HD-2	Health Disparities Clinical Health Disparities Measure	No change
CCM-2 CCM-3	Care Coordination Care Coordination - Transition record with data received by patient Care Coordination - Timely Transmission of transition record	Phase-In Reporting as of Q1-2012 discharges

1. *Clinical Measures.* Hospitals are required to collect and submit data on all clinical measures they are eligible to report on based on population mix for treatment of conditions and type of service provided. Hospitals are required to collect and report all quality measures data, using the updated measure specifications in **Table 7-4**, below. As noted in **Table 7-1**, measure reporting requirements for RY12 have been modified as follows:
 - a. *Maternity Measures:* The maternity measures category has expanded to include collection and reporting of the maternity (MAT-3) measure. Hospitals are required to collect and report the MAT-3 clinical measures data, beginning with the Quarter 3-2011 discharge period submission cycle. Hospitals must also collect and report on revised MAT-1 and MAT-2a measures data, beginning with the Quarter 3-2011 discharge period, using the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**.
 - b. *Neonate Measure:* The NICU-1 measure has been discontinued from quality reporting requirements as of the Q2-2011 discharge period. Hospitals should not report NICU-1 measures data for any quarter discharge periods in RY12.
 - c. *Care Coordination Measures:* Reporting of new measures begins with the Q1-2012 submission cycle. Hospitals are required to collect and report on the care coordination measures, listed in **Table 7-1**, as of Q1-2012 (January 1, 2012 - March 31, 2012) discharge data. Details on reporting requirements are provided in the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**.
 - d. *All Medicaid Payer Data Collection.* Reporting will expand to include all Medicaid payer data for the clinical measures listed in **Table 7-1**. Reporting begins with the Q1-2012 (January 1, 2012 - March 31, 2012) discharge data submission cycle. Details on Medicaid payer reporting requirements are provided in the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**.
 - e. *Clinical Health Disparities Measure:* This measure will be comprised of aggregate data from all clinical measures, listed in **Table 7-1**, on which the hospital is eligible to report. Hospitals must ensure that all clinical measures data collected includes Race, Hispanic Indicator, and Ethnicity codes and allowable values as required by DHCFP regulations. In addition, Hospitals must ensure that the sampling of cases requested for chart validation purposes includes proper documentation to verify the Race, Hispanic Indicator, and Ethnicity codes against the clinical measures data files being submitted as required in the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**.
2. *EOHHS Measures Specifications.* All Hospitals must adhere to the data collection and submission guidelines, published in the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**, for the reporting of all clinical measures listed in **Table 7-1**. The manual contains technical details on data element definitions, clinical algorithms for inclusion and exclusions that apply to numerators/denominators,

sampling guidelines, data abstraction tools, XML schema, data dictionaries, portal system specification requirements, Medicaid payer, race/ethnicity codes, and more. Refer to **Section 7.6.A** of the RFA for the appropriate updated versions of the *EOHHS Technical Specifications Manual* that apply to clinical measures data reporting.

3. *Clinical Data File Completeness Requirements.* Hospitals are required to submit complete data on all clinical measures in the form of electronic data files, aggregate ICD patient population data, and proper documentation for chart validation purposes for each quarterly discharge period being reported. The electronic data files must conform to the XML file layout format with all required MassHealth patient identifier data. Each Hospital must also enter the ICD patient population data that supplements the upload of electronic data files, for each reporting quarter, via the secure portal, in accordance with instructions set forth in the applicable *EOHHS Technical Specifications Manual*, by submission deadlines listed in **Table 7-5**.

7.4 Performance Assessment Methods

Hospital performance will be determined by computing a performance score for each measure the Hospital reports on. The performance assessment methods are described below.

A. Measure Rates. Each measure will be calculated using the following methods:

1. *Individual Clinical Measure Rate:* the measure rate is calculated by dividing the numerator by the denominator for each measure to obtain a percentage for the measures listed in **Table 7-1** (except for HD-2).
2. *Clinical Health Disparities Composite Measure:* this measure is calculated by dividing the composite numerator rate by the composite denominator rate stratified by race/ethnicity reference and comparison groups which is converted to a disparity index value. The composite numerator rate is created by summing the numerators of all clinical measures and the composite denominator rate is created by summing the denominators of all individual clinical measures the hospital is eligible to report on. The composite measure and disparity index value are calculated only for Hospitals that report on more than one racial group in their electronic data files. The numerators and denominators for this measure are defined in the applicable *EOHHS Technical Specifications Manual* listed in **Section 7.6.A**.

B. Data Validation Requirements. All reported measures are subject to data validation that requires meeting the minimum reliability standard of 80 percent for data elements. Hospitals are considered to have “passed” validation if the overall agreement score of 80 percent has been met. Passing data validation is required prior to computing a Hospital’s performance scores on each measure category pursuant to **Section 7.5**. The applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A** provides detailed information on data validation methods that apply to all quality measures.

C. Individual Clinical Measures Performance Assessment. Each measure’s performance will be assessed on levels for attainment, improvement and benchmark defined as follows:

1. Setting Performance Thresholds

- a. *Attainment Threshold:* represents the minimum level of performance that must be achieved to earn attainment points on each measure. The attainment threshold is defined as the median performance of all hospitals (50th percentile) in the previous reporting year.
- b. *Improvement Range:* represents the level of improvement above the attainment threshold, but below the benchmark, that must be achieved on each measure to earn improvement points; and

- c. *Benchmark*: represents the highest level (exemplary) performance achieved to earn the maximum amount of quality points on each measure. The benchmark performance level is set at the top decile (90th percentile) of all hospitals in the previous reporting year.

Performance thresholds are derived from hospital-reported data to calculate minimum attainment thresholds, improvement range and benchmarks on each measure.

Performance benchmarks for the MassHealth specific measures (maternity and pediatric asthma) are calculated based on the previous year's reported data. Performance benchmarks for the national hospital quality measures (pneumonia, surgical infection prevention) are calculated based on state-level data reported to the CMS Hospital Compare website in the previous year.

2. Assessing Performance

A Hospital's performance score on each clinical measure reported will be calculated using the methods described below.

- a. *Quality Point System*. Hospitals can earn a range of quality points (from 0-10 points) based on where its performance score for the clinical measure rate falls relative to the attainment, improvement and the benchmark as follows:
 - 1) *Attainment Threshold Points*. A Hospital can earn points for attainment based on relative placement between the attainment and benchmark. If a Hospital's rate for the measure is:
 - i. *Less than* the attainment threshold, it will receive zero (0) points for attainment.
 - ii. *Within the attainment range (greater than or equal to the attainment but below the benchmark)*, it will receive anywhere from 1-10 points for attainment.
 - iii. *Equal to or greater than* the benchmark, it receives 10 points for attainment.
 - 2) *Improvement Range Points*. A Hospital can earn points for improvement (if its rate is above the attainment threshold but below the benchmark) based on how much the measure rate has improved from the previous reporting year period. If a Hospital's score for the measure is:
 - i. *Equal to or less than* previous year, it will receive zero (0) points for improvement.
 - ii. *Within the improvement range*, it will receive anywhere from 0-10 points for improvement.
 - iii. *Equal to or greater than* the benchmark, it receives 10 points for improvement.

If the Hospital has failed validation, per **Section 7.4.B**, in the previous reporting year, data from that period is considered invalid for use in calculating baseline performance. Therefore, the Hospital would not be eligible for improvement points. However it may be eligible for RY12 attainment points based on calculation of RY12 data for the measure if it passed validation in RY12.

- b. *Total Performance Score*. The total performance score reflects a percentage of quality points earned out of the total possible points for each measure category pursuant to **Section 7.5**.

D. Clinical Health Disparities Performance Assessment. Effective RY12, health disparities measure performance will be assessed on a target attainment level using the following methods:

1. Setting Performance Thresholds

- a. *Decile Thresholds.* Performance will be assessed using a method that determines the hospital’s rank, relative to other hospitals, based on the decile threshold system. Hospitals that meet the measure calculation criteria, per **Section 7.4.A.2**, are divided into ten groups or deciles based on their disparity index value, so that approximately the same number of hospitals falls in each decile group.
 - b. *Target Attainment Threshold.* The target attainment threshold represents the minimum level of performance that must be achieved to earn incentive payments. The target attainment is defined as the boundary for a disparity index value that falls above the 2nd decile group, as shown in **Table 7-2** below.
- 2. Assessing Performance.** The Hospital’s clinical health disparity performance score will be calculated using the following methods:
- a. *Disparity Index Value Ranking.* All Hospital disparity index values, computed per **Section 7.4.A.2**, are rounded to six decimal places. All index values are then divided into ten equal groups and ranked from highest to lowest so approximately the same number of hospitals falls in each decile group.
 - b. *Conversion Factor.* Each decile group is assigned a weighted conversion factor associated with the decile threshold, as shown in **Table 7-2** below:

Table 7-2. Decile Performance Thresholds

Performance Threshold	Decile Group	Conversion Factor
Top Decile	10 th decile	1.0
	9 th decile	.90
	8 th decile	.80
	7 th decile	.70
	6 th decile	.60
	5 th decile	.50
	4 th decile	.40
	3 rd decile	.30
Lower Deciles	2 nd decile	0
	1 st decile	(zero)

To meet the target attainment threshold the Hospital’s disparity index value must exceed the value above the 2nd decile cut-off point to fall in the next decile. Index values that fall into the 1st and 2nd decile group are assigned a conversion factor of zero. A disparity index value that falls within the same given decile group are assigned the same conversion factor.

- 3. Composite Performance Score.** The health disparities composite performance score is the assigned conversion factor as shown in **Table 7-2**. Performance scores are calculated only for Hospitals that meet the measure calculation criteria, per **Section 7.4.A.2**, and validation requirements per **Section 7.4.B**, using only the Hospital’s current year reported data, per **Section 7.4.E.2** below.

E. Performance Evaluation Periods. In RY12, each Hospital’s performance scores will be evaluated as follows:

- 1. **Individual Clinical Measures:** In RY12, each Hospital’s clinical performance scores will be evaluated as follows:
 - a. Comparative performance will be evaluated using calendar year measures data reported in the comparison year (January 1, 2011 to December 31, 2011 discharge

period) and previous year’s reported data (January 1, 2010 to December 31, 2010 discharge period).

- b. For detailed information about comparative performance periods that apply to each quality measure category refer to the *RY12 EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**.
2. **Clinical Health Disparities Measure:** Effective RY12, each Hospital’s performance scores will be evaluated as follows:
- a. The Hospital’s performance score will be evaluated using measures data reported on the current calendar year between January 1, 2011 to December 31, 2011 discharge periods *only*. The decile ranking method evaluates performance on a year-by-year basis and does not use comparison year data.
 - b. Each year the Hospital’s performance rank will be determined using the decile threshold method described in **Section 7.4.D.2**.

7.5 Pay-for-Performance (P4P) Payment Methods

As set forth in **Section 7.4** of the RFA, a Hospital may qualify to earn P4P payments if they meet data validation requirements and achieve performance thresholds for measures listed in **Section 7.3** of the RFA. Each measure is calculated using the methods outlined in **Section 7.4** to produce performance scores that are converted into P4P payments. This section describes the methods used to convert individual and composite measure performance scores into hospital P4P payments.

A. Performance Score Calculations. A Hospital’s performance score, for each individual clinical measure it is eligible to report on, is calculated based on the quality point system methods outlined in **Section 7.4** of the RFA. The following methods apply to computing the points earned:

1. *Attainment Points.* The number of “attainment points” a Hospital receives is determined by the ratio of the difference between the Hospital’s measure rate and the attainment threshold divided by the difference between the *benchmark* and the *attainment threshold*. This ratio is multiplied by 9 and increased by 1. The Hospital’s “attainment points” will be calculated based on the following formula:

$$\frac{\text{Hospital's Measure Rate} - \text{Attainment}}{\text{Benchmark} - \text{Attainment}} \times 9 + 1 = \text{Hospital's Attainment Points Earned}$$

2. *Improvement Points.* The number of ‘improvement points’ a Hospital receives is determined by the ratio of the difference between the Hospital’s Current Measure Rate and the Previous Year’s Measure Rate divided by the difference between the benchmark and the Previous Year’s Measure Rate. This ratio is multiplied by 10. The Hospital’s “improvement points” will be calculated based on the following formula:

$$\frac{\text{Current Measure Rate} - \text{Previous Year's Measure Rate}}{\text{Benchmark} - \text{Previous Year's Measure Rate}} \times 10 = \text{Hospital's Improvement Points Earned}$$

All attainment and improvement points earned will be rounded up to the nearest integer.

3. *Total Performance Score.* The total performance score, for the individual clinical measures, reflects a percentage of quality points earned out of the total possible points for each measure category, pursuant to **Section 7.5**. For each quality measure category, the quality points awarded are the higher of the attainment or the improvements points earned.

earned. The total awarded quality points for each measure category is divided by the total possible points to obtain the total performance score based on the following formula:

$$\frac{\text{Total Awarded Points}}{\text{Total Possible Points}} \times 100\% = \text{Total Performance Score}$$

4. *Composite Performance Score.* The performance score for the clinical health disparities measure reflects the equivalent of the assigned conversion factor, per **Section 7.4.D**, multiplied by 100% as follows:

$$(\text{Conversion Factor}) \times 100\% = \text{Composite Performance Score}$$

B. Hospital P4P Payment Calculations

1. *Maximum Allocated Amount.* Incentive payments under the RFA may cumulatively total no more than the maximum amount allotted for each quality measure category in **Table 7-3** below.

Table 7-3. Maximum Allocated Amounts

Quality Measure Category	Maximum Allocated Amount
Maternity	\$33,000,000
Pediatric Asthma	\$ 3,000,000
Community Acquired Pneumonia	\$ 11,000,000
Surgical Care Infection Prevention	\$ 11,000,000
Health Disparities –Clinical	\$ 17,000,000

2. *Estimated Quality Measure Category per Discharge Amount.* **Table 7-4** below estimates the per-discharge amount based on FY10 MassHealth hospital discharge data (HDD) for each measure category. Note that this is estimated data only; the final quality measure category per-discharge amount will be determined based on FY11 HDD when available.

Table 7-4. Estimate of Quality Measure Category Per-Discharge Amounts

Quality Measure Category	Maximum Allocated Amount	Estimated Eligible Medicaid Discharges	Estimated Per Discharge Amount
Maternity	\$33,000,000	11,178	\$2,952.23
Pediatric Asthma	\$ 3,000,000	462	\$6,493.51
Community Acquired Pneumonia	\$ 11,000,000	1,420	\$7,746.48
Surgical Care Infection Prevention	\$ 11,000,000	1,321	\$8,327.02
Health Disparities – Clinical	\$ 17,000,000	14,381	\$1,182.12
TOTAL	\$75,000,000		

C. P4P Payment Calculation

Incentive payment calculations of each quality measure category will be based on the following methods:

1. *Eligible Medicaid Discharges.* The eligible Medicaid discharges for each measure category listed in **Table 7-4** will be based on the following:
- a. **Individual Clinical Measures.** For the clinical measures, the eligible Medicaid discharges are based on the FY11 MassHealth hospital discharge data (HDD) and ICD requirements for each measure category, pursuant to **Section 7.3**.
 - b. **Clinical Health Disparities Measure.** For the health disparities composite measure,

measure, the estimated eligible Medicaid discharges are based on the sum of all discharges from the FY11 HDD only for the clinical measures (maternity, pediatric asthma, pneumonia, surgical infection prevention), that the hospital was eligible to report on and meets criteria for composite measure calculation per **Section 7.4.A.2**.

2. *Quality Measure Category per Discharge Amount.* The final per-discharge amounts will be determined based upon FY11 HDD for each measure category. To determine these amounts, EOHHS will use the following formula:
 - a. For each quality measure category, EOHHS has established a maximum allocated amount, noted in **Table 7-4** above.
 - b. The allocated amount will be divided by the statewide estimated eligible Medicaid discharges to determine the per-discharge amount for each measure category using the following formula:

$\frac{\text{Maximum Allocated Amount}}{\text{Statewide Estimated Eligible Medicaid Discharges}}$	= Quality Measure Category per-Discharge Amount
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3. *Total Performance Score.* Performance scoring for each quality measure is calculated pursuant to **Section 7.5** of the RFA.
4. *P4P Payment Formula.* P4P payment calculations for each quality measure category will be calculated based on the following formulas:
 - a. **Individual Clinical Measure Categories:** Incentive payments will be calculated by multiplying the eligible Medicaid discharges by quality measure category per-discharge amount by the total performance score, per **Section 7.5.A.3**, using the following formula:

$\begin{aligned} &(\text{Eligible Medicaid discharges}) \times \\ &(\text{Quality Measure Category per-Discharge Amount}) \times \\ &(\text{Total Performance Score}) \end{aligned}$	= Hospital P4P Payment Clinical Measure Category
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- b. **Clinical Health Disparities Measure:** Incentive payments will be calculated by multiplying the eligible Medicaid discharges by quality measure category per-discharge amount by the composite performance score per **Section 7.5.A.4**, using the following formula:

$\begin{aligned} &(\text{Eligible Medicaid discharges}) \times \\ &(\text{Quality Measure Category per-Discharge Amount}) \times \\ &(\text{Composite Performance Score}) \end{aligned}$	= Hospital P4P Payment Health Disparity Measure Category
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A Hospital’s total RY12 P4P payment will be the sum of the P4P payments for each quality measure category for which the hospital qualifies for payment.

7.6 Pay-for-Performance Quality Reporting Instructions

Each Hospital must submit all information required for each measure listed in **Section 7.3** and comply in accordance with reporting requirements set forth below.

A. Measure Reporting Requirements and Timelines

Measure Reporting Requirements and Timelines are listed in **Table 7-5**, below.

Table 7-5. Measure Reporting Requirements and Timelines

Submission Due Date	Data Reporting Requirement	Detailed Reporting Instructions	Reporting Format
October 3, 2011	Hospital Quality Contacts Form	Acute Hospital RFA Section 7.2	HospContact_2012 Form
November 18, 2011	Qtr 2: Data (Apr -June 2011) Qtr 2: ICD Population Data	RY2011 Technical Specs Manual (Version 4.1)	Electronic Data Files; and ICD On-line data entry form via MassQEX Portal
February 10, 2012	Qtr 3: Data (July – Sept 2011) Qtr 3: ICD Population Data	RY2012 Technical Specs Manual (Version 5.0)	Electronic Data Files; and ICD On-line data entry form via MassQEX Portal
May 11, 2012	Qtr 4: Data (Oct – Dec 2011) Qtr 4: ICD Population Data	RY2012 Technical Specs Manual (Version 5.0)	Electronic Data Files; and ICD On-line data entry form via MassQEX Portal
August 10, 2012	Qtr 1: Data (Jan – Mar. 2012) Qtr 1: ICD Population Data	RY2012 Technical Specs Manual (Version TBD)	Electronic Data Files; and ICD On-line data entry form via MassQEX Portal

B. Technical Specifications Manual. EOHHS publishes a comprehensive manual as a supplement to the RFA, which contains technical information to assist hospitals in data collection and reporting of measures required in **Section 7.3**. The contents of this manual may be updated during the contract Rate Year to clarify measurement and reporting instructions as needed. Hospitals are responsible for downloading and using the appropriate versions of the applicable *EOHHS Technical Specifications Manual* instructions that apply to each quarterly discharge data period being collected and submitted, as noted in **Section 7.6.A**. *Failure to adhere to appropriate versions of the manual will result in the portal rejecting clinical data files.* Versions of the manuals are available on the MassQEX website at <http://massqex.ehs.state.ma.us/index/specs>; click the “Specifications Manual” tab (if necessary) and the “Special Notices to Hospitals” link.

C. MassHealth Quality Exchange (MassQEX) Portal. EOHHS has designated the MassQEX website as the secure portal for the submission of all electronic data required in **Section 7.3** that meets HIPAA requirements to ensure data confidentiality is protected. All Hospitals must identify and authorize staff that will conduct data transactions on their behalf, plus meet portal system requirements. All users of the MassQEX portal system are required to complete the on-line registration form via the website, which requires authorization from the Hospital’s Chief Executive Officer and the EOHHS vendor to establish user accounts for uploading data, per instructions set forth in the *EOHHS Technical Specifications Manual*. The MassQEX web portal can only be accessed by registered users through the following URL: <http://www.mass.gov/masshealth/massqex>.

D. ICD On-line Data Entry Form. All aggregate ICD patient population data must be reported via the secure web portal using the on-line data entry form. This form is only visible to registered users after they have logged into the MassQEX system. Hospitals must comply with ICD data entry for each quarterly submission cycle even when the hospital has zero cases to report during a given quarter. Only Hospitals, and not third-party data vendors, are authorized to enter ICD data. Instructions on how to access and enter the ICD data are contained in the appropriate *EOHHS Technical Specifications Manual*.

E. Third-Party Data Vendors. Hospitals can identify third-party vendors to conduct clinical data file transactions on their behalf via the MassQEX secure portal. Third-party data vendors must follow the registration process and establish user accounts, if previously authorized by the Hospital. Hospitals are responsible for communicating directly with their data vendors on all aspects of data reporting requirements set forth in **Section 7** of the RFA, including adherence to the appropriate versions of the *EOHHS Technical Specifications Manual* to ensure completeness and accuracy of data files submitted on the Hospital’s behalf.

- F. Hospital Quality Contact Form.** Each Hospital must complete and submit information on all staff involved in quality reporting using the HospContact 2012.pdf fillable form. Forms are due at the beginning of the rate year and must be resubmitted when any change in key quality representatives occurs.

An electronic version of this form is posted on the MassQEX website. Click the “Specifications Manual” tab (if necessary) and the “Special Notices to Hospitals” link. Forms can also be obtained by sending a request to the EOHHS mailbox at Masshealthhospitalquality@state.ma.us.

- G. Mailing Hard Copy Submissions.** By the date specified above, Hospitals must mail one hard copy of the *Hospital Quality Contacts Form*, with a typed cover letter using Hospital stationary, that identifies content enclosed to Kiki Feldmar at the following address:

Ms. Kiki Feldmar
Executive Office of Health and Human Services
MassHealth Office of Acute and Ambulatory Care
100 Hancock Street, 6th Floor
Quincy, MA 02171

Hard-copy submissions must be postmarked by close of business on the due dates listed in **Section 7.6.A** of the RFA.

Section 8: Other Quality- and Performance-Based Payments

The following provisions regarding potentially preventable readmissions (PPRs), provider preventable conditions (PPCs), and Serious Reportable Events (SREs), reflect and further EOHHS' commitment to value-based purchasing and to help ensure safer and cost-effective care delivery to MassHealth members by encouraging Hospitals to establish measures and actions to actively improve performance in patient care safety, reduce readmissions, and avoid preventable errors.

8.1 Potentially Preventable Readmissions (PPRs)

In general, hospitals with a rate of PPRs exceeding the statewide average PPR rate (based on FY 2009 data), as adjusted to reflect hospital-specific casemix and severity of illness during the initial admission, will receive a reduction to their Standard Payment Amount per Discharge (SPAD). This reduction will be applied to hospitals identified using the methodology described below.

A. Determination of Readmission Rates

PPRs are identified in 2009 HDD for MassHealth Primary Care Clinician and Fee-for-Service non-psychiatric discharges (payer types 103 and 104 as reported by the hospital) by using the 3M PPR software version 28.0.

1. Hospital-specific Actual PPR Rate

A hospital's PPR rate is calculated as:

$$\frac{\text{\# of initial admissions with one or more qualifying readmissions}}{\text{\# of initial admissions at risk for a PPR.}}$$

The numerator is the number of initial admissions with one or more qualifying clinically related readmissions within a 30-day period. The denominator is the number of initial admissions at risk for a potentially preventable readmission, excluding deaths and admissions that meet the criteria for one or more global exclusions occurring in the index hospitalization, for the related population for the same time period.

2. Statewide Average PPR Rates

In order to determine the statewide average PPR rates, the average actual PPR rate in each All-Patient Refined Diagnosis Related Group (APR-DRG) and severity of illness is calculated to establish a PPR norm for each APR-DRG.

3. Hospital-specific Expected PPR Rate (based on the Statewide Average PPR Rates)

To account for a hospital's mix of patient types and patient severity of illness during the initial admission, hospital-specific expected PPR rates are adjusted for casemix and severity of illness (SOI). The expected number of PPRs for each APR-DRG and SOI in a hospital is calculated by multiplying the statewide average PPR rate for the APR-DRG and SOI by the number of initial admissions at risk for a PPR in the Hospital for that APR-DRG and SOI.

$$\begin{aligned} &\text{Expected \# of PPRs (by APR-DRG and SOI) =} \\ &\quad \text{Statewide average rate (by APR-DRG and SOI)} \\ &\quad \times \text{hospital-specific \# of initial admissions at risk for a PPR (by APR-DRG and SOI)} \end{aligned}$$

The hospital-specific expected PPR rate is determined by dividing the total expected number of PPRs across all APR-DRGs for that hospital by the total number of initial admissions at risk for a PPR.

$$\text{Hospital-specific Expected PPR Rate} = \frac{\text{Sum of expected \# of PPRs (by APR-DRG)}}{\text{Hospital-specific \# of initial admissions at risk for a PPR}}$$

B. Calculation of payment reduction

Hospitals with a Hospital-specific actual PPR rate exceeding the hospital-specific expected PPR rate (based on the statewide average PPR rates) receive a 2.20% reduction to their Standard Payment Amount per Discharge (SPAD) (including Pediatric SPAD). Only hospitals with more than 40 initial admissions at risk for a PPR are subject to this reduction.

8.2 Provider Preventable Conditions

The Hospital agrees to take such action as is necessary in order for EOHHS to comply with all federal and state laws, regulations, and policy guidance relating to the reporting and non-payment of provider preventable conditions, including Section 2702 of the Patient Protection and Affordable Care Act and regulations promulgated hereunder. EOHHS shall amend the RFA and Contract as EOHHS, in its sole discretion, deems necessary to implement any such laws. The Hospital agrees that, notwithstanding any other provision in the RFA and Contract, EOHHS may terminate the hospital's Contract immediately upon written notice, in the event the hospital fails to agree to any such amendment.

8.3 Serious Reportable Events

A. Definitions

1. For purposes of this section, a Serious Reportable Event (SRE) shall mean any incident identified as such by the Massachusetts Department of Public Health (DPH) in its regulations at 105 CMR 130.332.
2. For purposes of this section, "preventable" is defined as DPH has defined the term in its regulations at 105 CMR 130.332 and means events that could have been avoided by proper adherence to applicable patient safety guidelines, best practices, and hospital policies and procedures.

B. Scope of Non-Reimbursable Services

1. MassHealth's SRE policy applies to both Hospitals and Hospital-Based Physicians.
2. Hospitals are prohibited from charging or seeking reimbursement from MassHealth or the member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, an SRE occurring on premises covered by the hospital's license that was preventable, within the hospital's control, and unambiguously the result of a system failure, as described in DPH regulations ("preventable SRE"). Non-reimbursable Hospital and Hospital-based physician services include:
 - a. All services provided during the inpatient admission or outpatient visit during which a preventable SRE occurred; and
 - b. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:
 - (1) At a facility under the same license as the hospital at which a non-billable SRE occurred; or

- (2) On the premises of a separately licensed hospital or ambulatory surgery center with common ownership or a common corporate parent of the hospital at which a non-billable SRE occurred.
- c. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.
- d. The non-payment provision of the RFA also applies to third-party liability and/or crossover payments by MassHealth.
- e. A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in **Section 8.3.B.2.b**, and that provides inpatient or outpatient services to a patient who previously incurred an SRE, may bill MassHealth for all medically necessary Hospital and Hospital-Based Physician services provided to the patient following a preventable SRE.

C. Required Reporting

1. Preventability determination (“updated SRE report”)

In accordance with DPH regulations at 105 CMR 100.332(C), as may be amended, Hospitals must make a preventability determination following the occurrence of an SRE. Consistent with DPH regulations and the intent of the *HealthyMass* Serious Reportable Events Task Force Policy Guidelines issued June 16, 2009, MassHealth requires that:

- a. A hospital shall establish policies and procedures for a documented review process to determine whether an SRE was:
 - (1) Preventable;
 - (2) Within the hospital’s control; and
 - (3) Did not result from:
 - (a) A failure to follow the provider’s policies and procedures; or
 - (b) Inadequate or non-existent provider policies and procedures; or
 - (c) Inadequate system design.

A failure to follow the provider’s policies and procedures will include, but not be limited to a failure to provide adequate training and supervision of staff.
- b. A hospital shall make a preventability determination for all SREs occurring on premises covered by its license.

2. No later than thirty days after the date of reporting of the SRE to DPH and MassHealth, the hospital shall:

- a. Complete a preventability determination, utilizing the criteria in **Section 8.3.C.1.a**, above;
- b. Provide to MassHealth’s Utilization Management Program:
 - (1) A copy of the updated SRE report issued to DPH describing the hospital’s preventability determination including, at a minimum, the following:
 - (a) Narrative description of the SRE;
 - (b) Analysis and identification of the root cause of the SRE;
 - (c) Analysis of the preventability criteria required by DPH;
 - (d) Description of any corrective measures taken by the hospital following discovery of the SRE; and
 - (e) Whether the hospital intends to charge or seek reimbursement from MassHealth for services provided at the hospital as a result of the SRE;
 - (2) Copies of the hospital policies and procedures related to SREs;

- (3) A copy of the member’s medical record for the inpatient Hospital admission or outpatient episode of care during which the SRE occurred, if the Hospital intends to charge or seek reimbursement for services provided at the Hospital during such admission or episode of care, or for follow-up care as a result of the SRE.

DPH regulations can be found at: www.mass.gov/dph.

Information on the *HealthyMass* initiative, including the Serious Reportable Events Task Force Policy Guidelines issued June 16, 2009, can be found at: www.mass.gov/healthymass.

D. Non-Payment for SREs

- 1. A Hospital may not charge or seek reimbursement for services in violation of 105 CMR 130.332 and the Policy Guidelines of the *HealthyMass* Task Force on Serious Reportable Events. Any payment to a Hospital that is obtained in violation of this **Section 8.3** shall constitute an overpayment under 130 CMR 450.235. Any charge or submission of a claim for payment by a Hospital in violation of this **Section 8.3** shall constitute a violation under 130 CMR 450.238 (B) and may be subject to administrative fines or other sanction under 130 CMR 450.238.
- 2. MassHealth shall make a determination regarding payment based on the criteria above and utilizing **Table 8-1**, below:

Table 8-1. MassHealth Non-Payment Methodology, Acute Hospitals

Payment Component that includes Preventable SRE	Resulting Non-payment
Inpatient acute admission	Non-payment of SPAD
Inpatient - Outlier Per Diem, Transfer Per Diem, Psychiatric Per Diem, or Acute Rehab Per Diem	Non-payment of all per diems associated with the inpatient stay
Outpatient Hospital Services	Non-payment of PAPE and any other outpatient services payable under the RFA
Hospital-Based Physician services	Non-payment of physician fees for care associated with the SRE

All applicable SRE reports shall be sent to the Utilization Management Program at the following address:

Manager, Hospital Utilization Management Programs
MassHealth
100 Hancock Street, 6th Floor
Quincy, MA 02171

Public Notice

RY 12 Acute Hospital Inpatient Rates

Initial Acute Hospital Inpatient Rates-HRY12-RFA12 Effective October 1, 2011	Rate Code 25 UB92=X1 Standard Payment Amt per Discharge	Rate Code 61 UB92=X5 Standard Transfer Payment Amt	Rate Code 28 UB92=X3 Standard Outlier Payment Amt	Rate Code 90 UB92=Y4 Mental Health Payment Amt	Rate Code 27 UB92=X1 Standard Payment Amt per Discharge	Rate Code 63 UB92=X5 Standard Transfer Payment Amt	Rate Code 29 UB92=X3 Standard Outlier Payment Amt	Rate Code 84 UB92=Y1 MassHealth w/Medicare B AD payment Amt	Rate Code 85 UB92=Y2 MassHealth Only AD payment Amt	Rate Code 71 Rehab Per Diem
Hospital										
ANNA JAUQUES HOSPITAL	\$ 5,247.20	\$ 1,193.92	\$ 895.44	\$829.46				\$253.72	\$274.37	
ATHOL HOSPITAL	\$ 5,213.51	\$ 1,120.59	\$ 840.44	not applicable				\$253.72	\$274.37	
BAYSTATE MED. CTR.	\$ 9,151.33	\$ 1,889.05	\$ 1,416.79	\$829.46				\$253.72	\$274.37	
BERKSHIRE MED. CTR.	\$ 7,814.34	\$ 1,619.12	\$ 1,214.34	\$829.46				\$253.72	\$274.37	\$ 734.69
BETH ISRAEL DEAC-NEEDHAM CAMPUS	\$ 6,974.94	\$ 1,606.88	\$ 1,205.16	not applicable				\$253.72	\$274.37	
BETH ISRAEL DEACONESS MED CTR	\$ 9,647.51	\$ 2,087.62	\$ 1,565.71	\$829.46				\$253.72	\$274.37	
BEVERLY HOSPITAL	\$ 5,059.95	\$ 1,123.41	\$ 842.56	\$829.46				\$253.72	\$274.37	
BOSTON MEDICAL CENTER	\$ 8,343.15	\$ 1,759.61	\$ 1,319.71	not applicable				\$253.72	\$274.37	\$ 734.69
BRIGHAM & WOMEN'S HOSPITAL	\$ 9,648.36	\$ 2,122.96	\$ 1,592.22	not applicable				\$253.72	\$274.37	
BROCKTON HOSPITAL	\$ 5,769.28	\$ 1,235.50	\$ 926.63	\$829.46				\$253.72	\$274.37	
CAMBRIDGE HEALTH ALLIANCE	\$ 5,143.23	\$ 1,116.20	\$ 837.15	\$829.46				\$253.72	\$274.37	
CAPE COD HOSPITAL	\$ 7,181.75	\$ 1,521.83	\$ 1,141.37	\$829.46				\$253.72	\$274.37	
CARNEY HOSPITAL	\$ 7,491.06	\$ 1,570.08	\$ 1,177.56	\$829.46				\$253.72	\$274.37	
CHILDREN'S MEDICAL CENTER	\$ 13,770.33	\$ 2,941.19	\$ 2,205.89	\$829.46	\$13,770.33	\$2,941.19	\$2,205.89	\$253.72	\$274.37	
CLINTON HOSPITAL	\$ 6,254.54	\$ 1,375.57	\$ 1,031.68	\$829.46				\$253.72	\$274.37	
COOLEY-DICKINSON HOSPITAL	\$ 5,752.70	\$ 1,277.27	\$ 957.96	\$829.46				\$253.72	\$274.37	
DANA FARBER	\$ 14,817.10	\$ 3,137.88	\$ 2,353.41	not applicable				\$253.72	\$274.37	
EMERSON HOSPITAL	\$ 5,757.12	\$ 1,261.23	\$ 945.92	\$829.46				\$253.72	\$274.37	
FAIRVIEW HOSPITAL	\$ 7,655.60	\$ 1,708.57	\$ 1,281.43	not applicable				\$253.72	\$274.37	
FALMOUTH HOSPITAL	\$ 7,054.20	\$ 1,487.53	\$ 1,115.64	not applicable				\$253.72	\$274.37	
FAULKNER HOSPITAL	\$ 7,456.34	\$ 1,608.60	\$ 1,206.45	\$829.46				\$253.72	\$274.37	
FRANKLIN MED CTR	\$ 4,894.98	\$ 1,053.36	\$ 790.02	\$829.46				\$253.72	\$274.37	
GOOD SAMARITAN MED CTR	\$ 6,053.17	\$ 1,295.08	\$ 971.31	\$829.46				\$253.72	\$274.37	
HALLMARK HEALTH	\$ 5,887.21	\$ 1,296.75	\$ 972.56	\$829.46				\$253.72	\$274.37	
HARRINGTON MEM'L HOSPITAL	\$ 4,819.22	\$ 1,081.91	\$ 811.44	\$829.46				\$253.72	\$274.37	
HEALTH ALLIANCE	\$ 5,242.66	\$ 1,175.09	\$ 881.31	not applicable				\$253.72	\$274.37	
HENRY HEYWOOD HOSPITAL	\$ 4,594.12	\$ 1,061.78	\$ 796.33	\$829.46				\$253.72	\$274.37	
HOLY FAMILY HOSPITAL	\$ 5,755.42	\$ 1,271.69	\$ 953.77	\$829.46				\$253.72	\$274.37	
HOLYOKE HOSPITAL	\$ 6,285.02	\$ 1,340.79	\$ 1,005.59	\$829.46				\$253.72	\$274.37	
JORDAN HOSPITAL	\$ 5,995.34	\$ 1,318.12	\$ 988.59	not applicable				\$253.72	\$274.37	
LAHEY CLINIC	\$ 13,706.73	\$ 2,926.96	\$ 2,195.22	not applicable				\$253.72	\$274.37	
LAWRENCE GENERAL HOSPITAL	\$ 5,635.64	\$ 1,188.87	\$ 891.65	not applicable				\$253.72	\$274.37	

Initial Acute Hospital Inpatient Rates-HRY12-RFA12 Effective October 1, 2011 Hospital	Rate Code 25 UB92=X1 Standard Payment Amt per Discharge	Rate Code 61 UB92=X5 Standard Transfer Payment Amt	Rate Code 28 UB92=X3 Standard Outlier Payment Amt	Rate Code 90 UB92=Y4 Mental Health Payment Amt	Rate Code 27 UB92=X1 Standard Payment Amt per Discharge	Rate Code 63 UB92=X5 Standard Transfer Payment Amt	Rate Code 29 UB92=X3 Standard Outlier Payment Amt	Rate Code 84 UB92=Y1 MassHealth w/Medicare B AD payment Amt	Rate Code 85 UB92=Y2 MassHealth Only AD payment Amt	Rate Code 71 Rehab Per Diem
LOWELL GENERAL HOSPITAL	\$ 5,233.25	\$ 1,164.28	\$ 873.21	not applicable				\$253.72	\$274.37	
MARLBOROUGH HOSPITAL	\$ 7,796.02	\$ 1,761.41	\$ 1,321.06	\$829.46				\$253.72	\$274.37	
MARTHA'S VINEYARD	\$ 5,787.57	\$ 1,307.49	\$ 980.62	not applicable				\$253.72	\$274.37	
MARY LANE HOSPITAL	\$ 6,548.46	\$ 1,461.12	\$ 1,095.84	not applicable				\$253.72	\$274.37	
MASS. EYE & EAR INFIRMARY	\$ 7,150.20	\$ 1,581.28	\$ 1,185.96	not applicable				\$253.72	\$274.37	
MASS. GENERAL HOSPITAL	\$ 10,603.07	\$ 2,265.68	\$ 1,699.26	\$829.46				\$253.72	\$274.37	
MERCY HOSPITAL	\$ 6,535.75	\$ 1,355.45	\$ 1,016.59	\$829.46				\$253.72	\$274.37	\$ 734.69
MERRIMACK VALLEY HOSPITAL	\$ 8,605.64	\$ 1,770.94	\$ 1,328.21	\$829.46				\$253.72	\$274.37	
METROWEST MED CTR	\$ 4,940.77	\$ 1,131.26	\$ 848.44	\$829.46				\$253.72	\$274.37	
MILFORD REGIONAL MEDICAL CENTER	\$ 5,585.22	\$ 1,242.39	\$ 931.79	not applicable				\$253.72	\$274.37	
MILTON HOSPITAL	\$ 6,851.01	\$ 1,555.62	\$ 1,166.72	not applicable				\$253.72	\$274.37	
MORTON HOSPITAL	\$ 5,597.00	\$ 1,215.19	\$ 911.39	\$829.46				\$253.72	\$274.37	
MOUNT AUBURN HOSPITAL	\$ 5,626.70	\$ 1,245.65	\$ 934.24	\$829.46				\$253.72	\$274.37	
NANTUCKET COTTAGE HOSPITAL	\$ 3,466.07	\$ 798.33	\$ 598.74	not applicable				\$253.72	\$274.37	
NASHOBA VALLEY MED CTR	\$ 7,830.02	\$ 1,776.21	\$ 1,332.16	not applicable				\$253.72	\$274.37	
NEW ENGLAND BAPTIST HOSPITAL	\$ 12,562.69	\$ 2,732.47	\$ 2,049.35	not applicable				\$253.72	\$274.37	
NEWTON-WELLESLEY HOSPITAL	\$ 6,694.27	\$ 1,486.65	\$ 1,114.99	\$829.46				\$253.72	\$274.37	
NOBLE HOSPITAL	\$ 6,833.04	\$ 1,453.85	\$ 1,090.39	\$829.46				\$253.72	\$274.37	\$ 734.69
NORTH ADAMS HOSPITAL	\$ 5,846.19	\$ 1,272.39	\$ 954.29	\$829.46				\$253.72	\$274.37	
NORTH SHORE MEDICAL CENTER	\$ 6,977.72	\$ 1,467.21	\$ 1,100.41	\$829.46				\$253.72	\$274.37	
NORWOOD HOSPITAL	\$ 6,120.59	\$ 1,385.78	\$ 1,039.33	\$829.46				\$253.72	\$274.37	
QUINCY MEDICAL CENTER	\$ 7,372.80	\$ 1,563.26	\$ 1,172.45	\$829.46				\$253.72	\$274.37	
SAINTS MEM MED CTR	\$ 8,257.27	\$ 1,734.71	\$ 1,301.03	not applicable				\$253.72	\$274.37	
SOUTH SHORE HOSPITAL	\$ 6,063.68	\$ 1,356.22	\$ 1,017.16	not applicable				\$253.72	\$274.37	
SOUTHCOAST	\$ 6,225.54	\$ 1,326.68	\$ 995.01	\$829.46				\$253.72	\$274.37	\$ 734.69
ST. ANNE'S OF F.R. HOSPITAL	\$ 6,892.95	\$ 1,463.07	\$ 1,097.30	\$829.46				\$253.72	\$274.37	
ST. ELIZABETH'S HOSPITAL	\$ 8,038.93	\$ 1,697.82	\$ 1,273.36	\$829.46				\$253.72	\$274.37	
ST. VINCENT'S HOSPITAL	\$ 6,407.98	\$ 1,374.41	\$ 1,030.81	\$829.46				\$253.72	\$274.37	
STURDY MEMORIAL HOSPITAL	\$ 5,547.06	\$ 1,252.59	\$ 939.45	not applicable				\$253.72	\$274.37	
TUFTS MEDICAL CENTER	\$ 10,520.45	\$ 2,337.16	\$ 1,752.87	\$829.46	\$ 14,192.61	\$ 3,035.62	\$ 2,276.71	\$253.72	\$274.37	
UMASS MEMORIAL MED. CTR.	\$ 9,711.31	\$ 2,097.70	\$ 1,573.28	\$829.46				\$253.72	\$274.37	
WINCHESTER HOSPITAL	\$ 5,256.87	\$ 1,163.54	\$ 872.65	not applicable				\$253.72	\$274.37	
WING MEMORIAL HOSPITAL	\$ 6,099.35	\$ 1,296.22	\$ 972.17	\$829.46				\$253.72	\$274.37	

Public Notice
Hospital-Specific PAPE Rates Effective 10/1/11

PROVIDER NAME	PAPE HRY 2012
ANNA JACQUES HOSPITAL	\$237.22
ATHOL_MEMORIAL_HOSPITAL	\$212.89
BAYSTATE MEDICAL CENTER INC	\$268.59
BERKSHIRE MEDICAL CENTER	\$370.49
BETH ISRAEL DEAC NEEDHAM CAMPUS	\$260.20
BETH ISRAEL DEACONESS MED CTR	\$387.97
BEVERLY HOSPITAL	\$261.93
BOSTON_MEDICAL_CENTER	\$269.91
BRIGHAM WOMEN'S HOSPITAL	\$232.53
BROCKTON HOSPITAL INC	\$239.42
CAMBRIDGE HEALTH ALLIANCE	\$292.81
CAPE COD HOSPITAL	\$300.00
CARNEY HOSPITAL	\$251.83
CHILDRENS MEDICAL CENTER	\$545.81
CLINTON HOSPITAL	\$183.87
COOLEY DICKINSON HOSPITAL	\$296.49
DANA FARBER CANCER INSTITUTE	\$1,753.32
EMERSON HOSPITAL	\$285.33
FAIRVIEW HOSPITAL	\$312.92
FALMOUTH HOSPITAL	\$314.70
FAULKNER HOSPITAL INC	\$376.52
FRANKLIN MEDICAL CENTER	\$252.22
GOOD SAMARITAN MEDICAL	\$328.26
HALLMARK HEALTH	\$293.37
HARRINGTON MEMORIAL HOSPITAL	\$276.32
HEALTH ALLIANCE HOSPITALS	\$233.56
HEYWOOD HOSPITAL	\$232.72
HOLY FAMILY HOSPITAL INC	\$251.26
HOLYOKE HOSPITAL INC	\$283.87
JORDAN HOSPITAL INC	\$282.49
LAHEY CLINIC HOSPITAL INC	\$371.15
LAWRENCE GENERAL HOSPITAL	\$260.81
LOWELL GENERAL HOSPITAL	\$323.14
MARLBOROUGH HOSPITAL	\$200.90
MARTHAS VINEYARD HOSPITAL	\$289.68
MARY LANE HOSPITAL	\$211.55
MASS EYE EAR_INFIRMARY	\$507.83
MASS GENERAL HOSPITAL	\$310.56
MERCY HOSPITAL	\$210.26
MERRIMACK VALLEY HOSPITAL	\$309.28

PROVIDER NAME	PAPE HRY 2012
METROWEST MEDICAL CENTER COL	\$210.24
MILFORD WHITINSVILLE HOSPITAL	\$265.67
MILTON MEDICAL CENTER	\$237.21
MORTON HOSPITAL INC	\$225.95
MOUNT AUBURN HOSPITAL	\$304.67
NANTUCKET COTTAGE HOSPITAL	\$234.63
NASHOBA VALLEY MEDICAL CENTER	\$231.14
NEW ENGLAND BAPTIST HOSPITAL	\$399.85
NEWTON WELLESLEY HOSPITAL	\$221.40
NOBLE HOSPITAL	\$216.04
NORTH ADAMS REGIONAL HOSPITAL	\$283.03
NORTH SHORE MEDICAL CENTER	\$317.14
NORWOOD HOSPITAL	\$282.59
QUINCY MEDICAL CENTER	\$247.87
SAINT VINCENT HOSPITAL	\$278.75
SAINTS MEMORIAL MEDICAL CENTER	\$309.15
SOUTH SHORE HOSPITAL	\$365.76
SOUTHCOAST TOBEY HOSPITAL	\$257.13
ST ANNES HOSPITAL	\$289.02
ST ELIZABETH HOSPITAL	\$467.09
STURDY MEMORIAL HOSPITAL	\$256.39
TUFTS NEW ENGLAND MEDICAL	\$279.37
UMASS MEMORIAL MEDICAL	\$281.67
WINCHESTER HOSPITAL	\$255.63
WING MEMORIAL HOSPITAL	\$172.01