

Notice of Final Agency Action

SUBJECT: MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, effective October 1, 2015

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

Introduction

Part I of this Notice provides a summary of the MassHealth out-of-state acute hospital payment methodologies (which are not changing), and sets forth MassHealth rates for out-of-state acute hospital services, effective October 1, 2015 (see Attachment A to Part I). *Part II* of this Notice describes and summarizes changes in MassHealth payment for services provided by in-state acute hospitals, effective for rate year 2016 (RY2016) which begins October 1, 2015. A complete description of the RY2016 MassHealth in-state acute hospital inpatient and outpatient payment methods and rates is attached to Part II (see Attachment B for RY2016 in-state acute hospital rates). For further information regarding RY2016 acute hospital payment methods and rates, you may contact Steven Sauter at the Executive Office of Health and Human Services, MassHealth Office of Providers and Plans, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or by email at steven.sauter@state.ma.us.

PART I: Out-of-State Acute Hospital Payment Methods

1.Out-of-State Acute Hospital Inpatient Services

The MassHealth out-of-state acute hospital payment methodologies for inpatient services are not changing. Except as provided in Section 3 of Part I, the payment methods are as follows.

- Out-of-state acute hospitals will continue to be paid an adjudicated payment amount per discharge (“Out-of-State APAD”), which will cover the MassHealth member’s entire acute inpatient stay from admission through discharge. The discharge-specific Out-of-State APAD equals the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals, multiplied by the MassHealth DRG Weight¹ assigned to the discharge by MassHealth using information contained on a properly submitted inpatient claim.
- For qualifying discharges, out-of-state acute hospitals will also continue to be paid an outlier payment in addition to the Out-of-State APAD if the calculated cost of the discharge, as determined by MassHealth, exceeds the discharge-specific outlier threshold (“Out-of-State Outlier Payment”). The Out-of-State Outlier Payment will equal the marginal cost factor in effect for in-state acute hospitals multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold, as determined by MassHealth. The “calculated cost of the discharge” equals the out-of-state acute hospital’s allowed charges for the discharge, as determined by MassHealth, multiplied by the applicable inpatient cost-to-charge ratio. For High MassHealth

¹ The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of All Patient Refined-Diagnostic Related Group (APR-DRG) and severity of illness.

Volume Hospitals,² the cost-to-charge ratio is hospital-specific; for all other out-of-state acute hospitals, the median in-state acute hospital inpatient cost-to-charge ratio in effect, based on MassHealth discharge volume, is used. The “discharge-specific outlier threshold” equals the sum of the hospital’s Out-of-State APAD for the discharge, and the inpatient fixed outlier threshold in effect for in-state acute hospitals.

- For MassHealth members transferred to another acute hospital, the transferring out-of-state acute hospital will continue to be paid at a transfer per diem rate (“Out-of-State Transfer Per Diem”), and no other payment methods will apply. The Out-of-State Transfer Per Diem will equal the sum of the transferring hospital’s Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by MassHealth, divided by the mean in-state acute hospital all payer length of stay for the particular APR-DRG assigned, as determined by MassHealth. Payments made on an Out-of-State Transfer Per Diem basis are capped.
- If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, the out-of-state acute hospital will continue to be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem in effect for in-state acute hospitals, and no other payment methods apply.

2.Out-of-State Acute Hospital Outpatient Services

The out-of-state acute hospital payment method for outpatient services is not changing. Except as provided in Section 3 of Part I, below, out-of-state acute hospitals will continue to be paid a payment per episode of care equal to the median outpatient payment amount per episode (“PAPE”) in effect for in-state acute hospitals on the date of service for those same services, based on episode volume, as determined by EOHHS, or according to the applicable fee schedules in regulations adopted by EOHHS for services for which in-state acute hospitals are not paid the PAPE.

3.Services Not Available In-State

This payment method is not changing. For medical services MassHealth determines are not available in-state, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid the rate of payment established for the medical service under the other state’s Medicaid program, as determined by MassHealth, or such other rate as MassHealth determines is necessary to ensure member access to services. For an inpatient service MassHealth determines is not available in-state, payment to the out-of-state acute hospital under this method will also include acute hospital outpatient services MassHealth determines are directly related to the service not available in-state.

² An out of state “High MassHealth Volume Hospital” is one that had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available, as determined by MassHealth at least 90 days prior to the start of the federal fiscal year.

ATTACHMENT A

Out-of-State Acute Hospital Rates

Effective October 1, 2015, out-of-state acute hospital rates are as follows:

I. INPATIENT:

Components of Out-of-State APAD, Outlier Payment, & Transfer Per Diem Rates									Other
	1. In-state Statewide Operating Standard Per Discharge	2. In-state Statewide Capital Standard Per discharge	Sum of Columns 1 and 2	MassHealth DRG Weight*	In-State Marginal Cost Factor	Cost- to- Charge Ratio	In-State Fixed Outlier Threshold	Mean In- State All- Payer Length of Stay*	Out-of- State Psych Per Diem
High MassHealth Volume Hospital:									
Rhode Island Hospital	\$9,391.96	\$631.63	\$10,023.59	See Chart 1*	80%	34.70%	\$24,000	See Chart 1*	\$883.52
All Other Out-of-State Acute Hospitals**	\$9,391.96	\$631.63	\$10,023.59	See Chart 1*	80%	46.97%	\$24,000	See Chart 1*	\$883.52

* See Chart 1 for the RY16 MassHealth DRG Weights and Mean All-Payer Lengths of Stay.

Click here: [Chart 1-Acute Hospital RY2016 MassHealth DRG Weights and Mean All-Payer Lengths of Stay](#)

II. OUTPATIENT PAPE:

All Out-of-State Acute Hospitals:** Out-of-State Payment Amount Per Episode -- \$313.24.

** For medical services payable by MassHealth that MassHealth determines are not available in-state, out-of-state acute hospitals that are not High MassHealth Volume Hospitals will be paid as described in Section 3 of Part I of this Notice, above.

PART II: Changes in In-State Acute Hospital Payment Methods

1. In-State Acute Hospital Inpatient Services

A. Summary of Rate Year 2016 (RY16) In-State Methodology for Calculating the Adjudicated Payment Amount per Discharge (APAD) and other Inpatient Hospital Service Payments

Except as otherwise indicated for Critical Access Hospitals (see below), in-state acute hospitals will be paid an adjudicated payment amount per discharge (“APAD”), which is an all-inclusive facility payment that will cover the MassHealth member’s entire acute inpatient stay from admission through discharge.³ The discharge-specific APAD is determined by the following steps: (1) adding the statewide operating standard per discharge, adjusted for the hospital’s wage area, to the statewide capital standard per discharge, (2) multiplying that sum by the MassHealth DRG Weight assigned to the discharge by MassHealth using information on a properly submitted inpatient claim, (3) adding to that product a Hospital-specific per discharge “pass-through” payment for malpractice and organ acquisition costs, and (4) adjusting that result, if applicable, by the hospital’s per discharge percentage payment reduction for potentially preventable readmissions (PPRs).

- The statewide operating standard per discharge is derived from the statewide average hospital cost per discharge using federal fiscal year (FFY) 2012 data, standardized for casemix differences and area wage variation. An efficiency standard is determined by capping hospital costs, weighted by FFY14 MassHealth discharges, at the 65% level of costs. The statewide average is adjusted for inflation and outliers. Certain costs are excluded (e.g., direct pass-through costs (malpractice and organ acquisition), capital costs). 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. For each hospital, this statewide average is then adjusted for each hospital’s wage area index.
- The statewide capital standard per discharge is derived from the statewide weighted average hospital capital cost per discharge using FFY 2012 data, standardized for casemix differences. An efficiency standard is determined by capping hospital casemix-adjusted capital costs, weighted by FFY14 MassHealth discharges, at the 50% level of costs. 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, and a statewide weighted average capital cost per discharge is calculated, and adjusted for inflation to the current year to produce the statewide capital standard per discharge.

³ For qualifying discharges, in-state hospitals will also receive an Outlier Payment in addition to the APAD. See below.

- The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness, using the 3M APR-DRG grouper version 30 and Massachusetts weights.
- The inpatient portion of hospital-specific costs for malpractice insurance and organ acquisition are treated as “pass-throughs” and are derived from the hospital’s FFY 2014 -403 cost report. The hospital-specific pass-through payment amount per discharge is derived by dividing the hospital’s inpatient portion of those costs by the hospital’s total volume of all-payer days, which is based on FFY12 data obtained by the Center for Health Information and Analysis (CHIA), and then multiplying the resulting cost per diem by the hospital-specific FFY14 MassHealth average length of stay, which is based on data obtained from Medicaid Management Information System (MMIS).
- Each hospital with an actual PPR volume which exceeds its expected PPR volume will be subject to a per-discharge percentage payment reduction, up to a maximum of 4.4%. The reduction will be proportional to the hospital’s ratio of excess PPR volume to its total discharge volume. The calculation also includes a multiplier of 3 as an incentive for hospitals to reduce PPRs. The per-discharge percentage reduction is partially offset if the hospital improved its PPR rate from its RY15 PPR rate.

For qualifying discharges, in-state acute hospitals will also be paid an outlier payment in addition to the APAD if the calculated cost of the discharge (the “discharge-specific case cost”), exceeds the discharge-specific outlier threshold. The outlier payment is calculated by multiplying the marginal cost factor of 80%, by the difference between the discharge-specific case cost and the discharge-specific outlier threshold. The discharge-specific case cost equals the hospital’s allowed charges for the discharge, as determined by MassHealth, multiplied by the hospital’s FFY14 inpatient cost-to-charge ratio. The discharge-specific outlier threshold is the sum of the hospital’s pre-adjusted APAD for the discharge (the amount prior to any PPR reduction), and the inpatient fixed outlier threshold, which is \$24,000. For discharges that qualify for an outlier payment, a hospital’s PPR adjustment (if applicable) is applied to the sum of the pre-adjusted APAD and the outlier payment amount.

EOHHS pays acute hospitals on a per diem basis under certain circumstances. Inpatient services delivered to individuals who transfer among hospitals or among certain settings within a hospital, are paid on a transfer per diem basis. The transfer per diem will equal the transferring hospital’s total case payment amount, calculated by MassHealth using the APAD and, if applicable, outlier payment methodologies corresponding to the period for which the hospital is being paid on a transfer per diem basis, divided by the mean acute hospital all payer length of stay for the particular APR-DRG assigned. Transfer per diem payments are subject to a total transfer case payment cap.

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 a rehabilitation per diem rate for services delivered in Rehabilitation Units. Administrative days are also paid a per diem rate.

Final payment to Critical Access Hospitals will be calculated to provide an amount equal to 101% of the Critical Access Hospital’s allowable costs as determined by EOHHS utilizing the Medicare

cost-based reimbursement methodology for both inpatient and outpatient services. Interim inpatient APAD, Outlier Payment and Transfer per Diem rates, and interim outpatient PAPE rates, will be paid to Critical Access Hospitals, which are calculated generally to approximate 101% of such costs utilizing the hospitals' FFY2014 CMS-2552-10 cost reports, and which are subject to final settlement. There is no adjustment for PPRs.

B.Summary of Changes

RY16 payment methods for in-state acute inpatient hospital services include the following changes from the RY15 payment methods:

(1)To calculate the APAD:

- An inflation update of 1.573% was applied to the statewide operating standard per discharge, and 1.3% to the statewide capital standard per discharge, to reflect price changes between RY15 and RY16.
- FFY14 discharges were used in weighting APAD Base Year costs for determining efficiency standards.
- FFY14 data was used for determining Hospital-specific “pass-throughs”.

(2)The PPR methodology is unchanged, but the data source is now MMIS claims data, rather than hospital discharge data reported to CHIA.

(3)Each Hospital's inpatient cost-to-charge ratio used in calculating any Outlier Payment was updated.

(4)The median nursing facility rate utilized in the calculation of the administrative day (AD) per diem rate was updated, and an inflation update of 1.659% was applied.

(5)An inflation update of 1.573% was applied to the psychiatric per diem rate.

(6)For critical access hospitals paid at 101% of allowable costs utilizing Medicare's cost-based reimbursement methodology, interim payment rates were derived utilizing cost data from the hospital's FFY14 CMS 2552-10 cost report, rather than the 403 cost report.

2.In-State Acute Hospital Outpatient Services

A.Summary of Rate Year 2016 (RY16) In-State Methodology for Calculating the Payment Amount per Discharge (PAPE) and other Outpatient Hospital Service Payments

The Payment Amount Per Episode (PAPE) methodology establishes a fixed hospital-specific episodic rate, which is payment in full for most MassHealth acute outpatient hospital services that are delivered to a member on a single calendar day. 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 in regulations adopted by EOHHS.

Except for Critical Access Hospitals, each hospital-specific RY16 PAPE is a blended rate that equally weights the hospital's RY15 PAPE in effect on September 30, 2015, and the hospital's

preliminary RY16 PAPE. The hospital-specific preliminary RY16 PAPE is calculated by multiplying the (1) hospital's outpatient casemix index by (2) the PAPE outpatient statewide standard (that product is the hospital's "PAPE base payment"), and then adding, if applicable, (3) a hospital-specific fixed outlier add-on. This calculation is based on PAPE Base Year data (FFY14), and the components are further summarized below.

- The hospital- specific outpatient casemix index is equal to the average of the hospital's twelve (12) monthly average Enhanced Ambulatory Patient Group (EAPG) weights per episode for the PAPE Base Year, determined by EOHHS based on FFY14 PAPE paid claims data in MMIS, and utilizing the 3M EAPG grouper (version 3.5).
- In determining the PAPE outpatient statewide standard, an average outpatient cost per episode is calculated for each hospital, utilizing the hospital's FFY14 outpatient cost-to-charge ratio from its 403 cost report, and allowed charges and episodes from FFY14 PAPE paid claims data in MMIS. Each hospital's average cost per episode is standardized for casemix differences, and an efficiency standard applied by capping hospital costs, weighted by FFY14 episodes, at the 65% level of costs. The weighted mean of the hospitals' capped costs per episode is adjusted by an outlier adjustment factor and inflation is applied, to result in the preliminary outpatient statewide standard. The preliminary outpatient statewide standard, divided by the RY16 conversion factor of 1.057 is the PAPE outpatient statewide standard.
- The fixed hospital-specific outlier add-on is equal to the sum of the hospital's episode-specific outlier values for all of the hospital's qualifying PAPE Base Year episodes, divided by the hospital's number of episodes in the PAPE Base Year. Each individual episode-specific outlier value is equal to the product of the Marginal Cost Factor of 80% and the amount by which the episode-specific cost exceeds the episode outlier threshold, as calculated by EOHHS. The episode-specific cost is the product of the hospital's allowed episode charges (based on MMIS paid claims data) and the hospital's FFY14 outpatient cost-to-charge ratio (from the hospital's 403 cost report). The episode outlier threshold is the sum of (i) the outlier base value, which is the product of the preliminary outpatient statewide standard and the hospital-specific outpatient case mix index, and (ii) the RY16 fixed outpatient outlier threshold of \$4,500.00.

For the hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the calculation of its preliminary RY16 PAPE is as set forth above, except that an adjusted PAPE outpatient statewide standard is applied.

Payment to Critical Access Hospitals for services for which a PAPE is paid will be calculated based on the methodology described in Part II, Section 1.A., above.

B. Summary of Changes

The RY16 payment method for in-state acute outpatient hospital services includes the following changes from the RY15 payment method:

- (1)The RY16 PAPE will be an equal blend of the hospital's RY15 PAPE and the preliminary RY16 PAPE calculation, but the 90% floor has been eliminated.

- (2) The preliminary RY16 PAPE is the product of the hospital's outpatient casemix index and the PAPE outpatient statewide standard ("PAPE Base Payment"), *plus* a hospital-specific fixed Outlier Add-On.
- (3) In calculating the PAPE outpatient statewide standard for the preliminary RY16 PAPE:
- The PAPE Base Year was updated to FFY14;
 - The prior payment-based method for calculating the standard has been replaced with a cost-based method, utilizing PAPE Base Year data;
 - Along with adjustments for casemix, outliers, and inflation, an efficiency standard and conversion factor were applied;
 - The inflation factor applied for price changes between RY15 and RY16 was 1.573%.
- (4) In determining the Hospital's casemix index for the preliminary RY16 PAPE, FFY14 data and 3M's EAPG grouper version 3.5 were utilized.
- (5) The hospital-specific fixed outlier add-on for the preliminary RY16 PAPE is a separate amount added to the PAPE Base Payment. The add-on equals the sum of the hospital's episode-specific outlier values for PAPE Base Year episodes divided by the hospital's number of episodes in the PAPE Base Year. Outlier values were calculated using an outlier threshold of \$4,500.00 and a marginal cost factor of 80%.
- (6) For the hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), its PAPE outpatient statewide standard is \$229.47.
- (7) For critical access hospitals paid at 101% of allowable costs utilizing Medicare's cost-based reimbursement methodology, the interim PAPE rate was derived utilizing cost data from the hospital's FFY14 CMS 2552-10 cost report, rather than the 403 cost report.

3. In-State Supplemental Hospital Payments

In addition to the payments specified above, EOHHS makes supplemental payments to certain qualifying in-state hospitals. The RY16 state plan supplemental payment methods to hospitals that qualify as Essential MassHealth Hospitals, Acute Hospitals with High Medicaid Discharges, and High Medicaid Volume Freestanding Pediatric Acute Hospitals, are substantially similar to the RY15 supplemental payment methods, as are the payment methods for the High Public Payer (State-Defined Disproportionate Share) Hospital Supplemental Payment⁴, Freestanding Pediatric Acute Hospital High Complexity Supplemental Payment, and Pediatric Specialty Unit High Complexity Supplemental Payment, except that payments will be based on more recent data (FFY15).

EOHHS is eliminating the Disproportionate Share Hospital (state-defined) Behavioral Health Services Supplemental Payment that was in effect for RY15.

⁴ The "High Public Payer Hospital" supplemental payment method was formerly referred to as the state-defined Disproportionate Share Hospital Supplemental Payment method. Qualifying hospitals continue to be state-defined disproportionate share hospitals, which for RY16 are hospitals that received more than 63% of their gross patient service revenue in FFY14 from government payers and free care as determined by MassHealth based on the hospital's FFY14 - 403 cost report.

4. In-State 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 M.G.L. c. 118E, sec. 13B. The maximum allocated amount for P4P for RY16 remains at \$50.0M, which is planned to be paid in a subsequent rate year following finalization of RY15 P4P data. The Tobacco Treatment measure set will be eligible for pay-for-reporting incentive payments for RY16, and other updates made to quality measures from RY15.

Justification

Except as specified above, the acute hospital payment methods for Rate Year 2016 are substantially similar to those for Rate Year 2015. 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 annual aggregate acute hospital state plan expenditures resulting from these payment methods will increase by \$25.2 million overall, broken down as follows: an estimated \$28.1 million increase in estimated annual aggregate *in-state* acute inpatient and outpatient hospital state plan expenditures; and an estimated \$2.9 million decrease in estimated annual aggregate *out-of-state* acute inpatient and outpatient hospital state plan expenditures due to projected reduction in estimated utilization of out-of-state acute hospital services.

Statutory Authority: M.G.L. c. 118E; St. 2015, c. 46; St. 2012, c. 224; 42 USC 1396a; 42 USC 1396b.

Related Regulations: 130 CMR 410, 415, 450; 42 CFR Parts 431 and 447

In-State Acute Hospitals

Section 2: Definitions

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

Adjudicated Payment Amount Per Discharge (APAD) — a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge, which is the complete fee-for-service payment for such acute hospitalization, excluding the additional payment of any inpatient Hospital Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a per diem basis under this RFA (for example, Transfer per diem).

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.

All Patient Refined–Diagnostic Related Group (APR-DRG or DRG) – the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper, Version 30, unless otherwise specified.

APAD Base Year — the hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY12, using the FY12 -403 cost reports as screened and updated as of June 9, 2014.

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.

Center for Health Information and Analysis (CHIA) – the Center for Health Information and Analysis established under M.G.L. c. 12C.

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

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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 M.G.L. chapter 176Q, section 2.

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** attached hereto, and incorporates all of the provisions of this 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 this RFA and that enters into a Contract with EOHHS to meet the purposes specified in this 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, by October 1, 2015, was certified by CMS and designated as a Critical Access Hospital under 42 U.S.C. 1395i-4, and that continues to maintain that status.

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.

Discharge-Specific Case Cost — the product of the Hospital's MassHealth allowed charges for a specific discharge, as determined by EOHHS, and the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY 14 -403 cost report.

Discharge-Specific Outlier Threshold — the sum of the Pre-Adjusted APAD for a specific discharge, as determined by EOHHS, and the inpatient Fixed Outlier Threshold.

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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 bodily 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.

Enhanced Ambulatory Patient Group (EAPG) — a group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation's EAPG Grouper Version 3.5.

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-Specific Cost — the product of (1) the Hospital's MassHealth allowed outpatient charges for a specific PAPE Base Year Episode, as determined by EOHHS based on PAPE paid claims for PAPE Base Year Episodes residing in MMIS as of April 12, 2015, for which MassHealth was primary payer, and (2) the Hospital's outpatient cost-to-charge ratio, as calculated by EOHHS using the Hospital's FY14 403 cost report.

Episode Outlier Threshold — the sum of (1) the Hospital's Outlier Base Value, as determined by EOHHS, and (2) the Fixed Outpatient Outlier Threshold.

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.

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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.

Fixed Outlier Threshold (inpatient) — for RY16, the Fixed Outlier Threshold for purposes of calculating any inpatient Hospital Outlier Payment is \$24,000.00.

Fixed Outpatient Outlier Threshold – for RY16, the Fixed Outpatient Outlier Threshold is \$4,500.

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.

High Medicaid Volume Freestanding Pediatric Acute Hospital – a Freestanding Pediatric Acute Hospital with more than 1,000 Medicaid discharges in FY12 for which a SPAD was paid, as determined by paid claims in MMIS as of May 11, 2013, and for which MassHealth was the primary payer.

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 this 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 this 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) — Hospital discharge filings, as provided and verified by each hospital and submitted to CHIA, including FY12 Acute Hospital casemix data as screened and updated by CHIA as of June 9, 2014, for purposes of **Section 5.B.1**, on APAD rate development,

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 Administrative Days — an inflation factor that is a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factor for Administrative Days is as follows:

1.659% reflects the price changes between RY15 and RY16

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Inflation Factors for Capital Costs — the factors used by CMS to update capital payments made by Medicare, which is based on the CMS Capital Input Price Index. The Inflation Factors for Capital Costs between RY04 and RY16 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
- 1.2% reflects the price changes between RY12 and RY13
- 1.4% reflects the price changes between RY13 and RY14
- 1.5% reflects the price changes between RY14 and RY15
- 1.3% reflects the price changes between RY15 and RY16

Inflation Factors for Operating Costs — for price changes between RY04 and RY07, and between RY08 and RY16, 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 RY16 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
- 1.775% reflects the price changes between RY12 and RY13
- 1.405% reflects the price changes between RY13 and RY14
- 1.611% reflects the price changes between RY14 and RY15
- 1.573% reflects the price changes between RY15 and RY16

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 this RFA.

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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 include "traditional" MCOs, Senior Care Organizations (SCOs) and CarePlus MCOs. In addition, MCOs include One Care plans for all purposes under this RFA, except for **Section 4.A.2** and **Section 7**.

Marginal Cost Factor — for RY16, the Marginal Cost Factor is 80% (inpatient and outpatient).

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, 2013, through September 30, 2014, paid by MassHealth as determined utilizing MMIS paid claims where MassHealth is the primary payer, divided by the number of discharges using the casemix data residing in MMIS as of May 20, 2015.

MassHealth DRG Weight — the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness (SOI).

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 this RFA.

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One Care: MassHealth plus Medicare (One Care plan) – a health plan or provider-based organization contracted with EOHHS and CMS, and accountable for providing integrated care to individuals age 21 through 64 at the time of enrollment who are eligible for both Medicare and MassHealth Standard or CommonHealth and who do not have any other comprehensive public or private health care coverage. A One Care plan is also known as an Integrated Care Organization (ICO).

Outlier Add-On (outpatient) – a fixed Hospital-specific add-on amount, calculated in accordance with **Section 5.C.1.a.(1)(c)**, that is a component of a Hospital’s “preliminary RY16 PAPE” (see **Section 5.C.1.a.(1)**).

Outlier Base Value (outpatient) – the product of (1) the “preliminary outpatient statewide standard,” as determined by EOHHS (see **Section 5.C.1.a.(1)(b)**), and (2) the Hospital-Specific Outpatient Casemix Index, as determined by EOHHS (see **Section 5.C.1.a.(1)(a)**).

Outlier Payment (inpatient) – a hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section 5.B.2**.

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 this RFA.

PAPE Base Payment – the product of (1) the Hospital-Specific Outpatient Casemix Index, as determined by EOHHS (see **Section 5.C.1.a.(1)(a)**) and (2) the PAPE Outpatient Statewide Standard, as determined by EOHHS (see **Section 5.C.1.a.(1)(b)**). The PAPE Base Payment is added to the Hospital’s Outlier Add-On to determine the Hospital’s “preliminary RY16 PAPE” (see **Section 5.C.1.a.(1)**).

PAPE Base Year — the PAPE Base Year is FY14.

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 included in the calculation of the APAD.

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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.

Pre-Adjusted APAD — the amount calculated by EOHHS utilizing the APAD payment methodology set forth in **Section 5.B.1**, below, for a specific discharge, but excluding the final step of applying any adjustment for Potentially Preventable Readmissions pursuant to **Section 8.1**.

Primary Care — all health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, nurse practitioner, nurse midwife, or other eligible MassHealth primary care provider 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, Acute Hospital Outpatient Department, or other eligible MassHealth providers 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 FY04, using FY04 -403 cost reports as screened and updated as of March 10, 2006.

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.

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Rate Year (RY) — generally, the period beginning October 1 and ending the following September 30. RY16 will begin on October 1, 2015, and end on September 30, 2016.

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.

Standard Payment Amount Per Discharge (SPAD) — an inpatient payment methodology that was utilized in prior Acute Hospital RFAs. The SPAD was a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which was the complete fee-for-service payment for an acute episode of illness, excluding the additional payment of Outlier Days (as that term was defined in prior Acute Hospital RFAs), Transfer Per Diems, Administrative Days and Physician Payments. This payment methodology was replaced by the APAD payment methodology beginning in RY15.

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 Case Payment — the sum, as determined by EOHHS, of the Pre-Adjusted APAD and, if applicable, any inpatient Hospital Outlier Payment, adjusted for Potentially Preventable Readmissions pursuant to **Section 8.1**.

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Total Transfer Payment Cap – the Total Case Payment amount calculated by EOHHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in **Sections 5.B.1** and **5.B.2**, for the period for which the Transferring Hospital is being paid on a Transfer per diem basis under **Section 5.B.3**.

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.

Transferring Hospital –an Acute Hospital that is being paid on a Transfer per diem basis, pursuant to **Section 5.B.3**.

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

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Section 3: Eligible Applicants

- A.** In-state Acute Hospitals are eligible to apply for a Contract pursuant to this 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.5** and **5.C**.
- D.** For public state-owned hospitals that contract under the RFA, EOHHS may waive these or any other requirements and may, at its discretion, agree to requirements and conditions of participation that differ from those set forth in this RFA to address specific situations. Any such requirements and conditions of participation may be documented in any resulting contract or may be specified through other such means as may be agreed to by the parties.

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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 this 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 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 payment 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 payment solely by the BH Contractor. Such payment 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 payment 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 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.

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2. MCO Services

Hospitals that provide medically necessary MCO-covered services, including Emergency and Post-Stabilization Services, qualify for payment solely by the MCO for services to Members enrolled with the MCO pursuant to contracts between the MCO and each contracting Hospital.

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 payment 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 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. [RESERVED]

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 payment solely by the Health Plan for services to Members enrolled with the Health Plan pursuant to contracts between the Health Plan and each contracting Hospital.

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 MassHealth 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 payment 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.

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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. One Care Plan Services

Hospitals that provide medically necessary One Care plan-covered services, including Emergency and Post-Stabilization Services, qualify for payment solely by the One Care plan for services to Members enrolled with the One Care plan pursuant to contracts between the One Care plan and each contracting Hospital.

If a One Care plan offers to pay a non-network Hospital a rate equal to the amount allowed under original Medicare less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the One Care plan’s enrollees, that non-network Hospital must accept the One Care plan’s rate offer as payment in full. This requirement does not prohibit a One Care plan from negotiating to pay any non-network Hospital at rates lower than original Medicare less any amount for graduate medical education for Emergency and Post-Stabilization Services.

Hospitals are not entitled to any payment from EOHHS, and may not claim such reimbursement for any services that are One Care plan-covered services or are otherwise reimbursable by the One Care plan. Any such 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.

6. Air Ambulance Services

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

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

Unless otherwise specified in this RFA, EOHHS shall not reimburse Acute Hospitals through this 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**.

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8. Claims for Outpatient Professional Services (Primary Care Payment Reform (PCPR))

For any Hospital Outpatient Department, HLHC, or other Satellite Clinic site participating in the Primary Care Payment Reform (PCPR) initiative, outpatient Hospital-Based Physician services are governed by the site's executed MassHealth PCC Plan Provider contract or MCO provider agreement, and are not payable through this Acute Hospital RFA and Contract.

B. Program Initiatives

1. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives, other than those in this 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 this 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 this 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, and outpatient covered drugs processed through the Pharmacy On-Line Processing System (POPS). Hospitals must continue to conform to the separate provider participation and reimbursement requirements for those MassHealth programs.

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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 this 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, 2015.

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, 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.

A Hospital with a DMH-licensed inpatient psychiatric unit must accept into its DMH-licensed inpatient psychiatric unit all referrals of MassHealth members that meet the established admission criteria of the inpatient unit.

B. Payment for Inpatient Services

A Hospital will be paid in accordance with **Section 5.B** for Inpatient Services.

Except as otherwise provided in **Sections 5.B.2 through 5.B.8** and in **Section 5.D.7**, fee-for-service payments to Hospitals for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be an Adjudicated Payment Amount Per Discharge (APAD), calculated as described more fully in **Sections 5.B.1.a through g**, below.

For qualifying discharges, Hospitals may also be paid an Outlier Payment in addition to the APAD, under the conditions set forth in, and calculated as described in, **Section 5.B.2**.

For Critical Access Hospitals, payment for Inpatient Services is in accordance with **Section 5.D.7**.

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.4**).

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 Total Transfer Payment Cap (see **Sections 5.B.3 and 5.B.4**).

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For Inpatient Services paid on a per diem basis, MassHealth pays the lesser of (i) the per diem rate or (ii) 100% of the Hospital's actual charge submitted.

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

1. Adjudicated Payment Amount per Discharge

a. Overview

The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge. The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific wage area index; (2) the Statewide Capital Standard per Discharge; (3) the discharge-specific MassHealth DRG Weight; (4) a per-discharge, Hospital-specific payment amount for expenses related to malpractice and organ acquisition costs equal to the Hospital's Pass-Through Amount Per Discharge; and (5) a Hospital-specific adjustment, where applicable, for Potentially Preventable Readmissions (PPR) pursuant to **Section 8.1**. These components and the calculation of the APAD are described further below in **Sections 5.B.1.b** through **5.B.1.g**. For components calculated based on data from all Hospitals, the calculation included data for all currently operating Hospitals only.

b. Calculation of the Statewide Operating Standard per Discharge

In the development of the RY16 Statewide Operating Standard per Discharge, EOHHS used APAD Base Year all-payer costs and FY12 HDD as the primary sources of data to develop operating costs per discharge.

The Statewide Operating Standard per Discharge is based on the statewide average payment amount per discharge, which is derived from the actual statewide costs of providing Inpatient Services as reflected in the APAD Base Year cost report. The average payment amount per discharge for 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 labor portion of the average payment amount per discharge for each Hospital was adjusted by the Hospital's Massachusetts-specific wage area index, and the labor and non-labor portions were then adjusted by the Hospital-specific FY12 all-payer APR-

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DRG Version 30 Casemix Index that was determined by using FY12 discharges and APR-DRG version 30 of the 3M grouper and Massachusetts weights. Massachusetts Hospitals' wages and hours were determined based on CMS's FY_2016_Proposed_Rule_Wage_Index_PUFs file, downloaded May 14, 2015 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 May 8, 2015. 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. These steps result 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 FY14 MassHealth discharges for the Hospitals was produced from MMIS claims data on file as of May 20, 2015, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges and costs from Excluded Units were omitted. The efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 65% of the total number of statewide discharges in the MMIS. The RY16 efficiency standard is \$10,568.45.

The Statewide Operating Standard 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%; and by (c) the Inflation Factors for Operating Costs between RY12 and RY16. The resulting RY16 Statewide Operating Standard per Discharge is \$9,391.96.

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. EOHHS may make adjustments to assure budget neutrality for such grouper changes. EOHHS reserves the right to update to a new grouper.

c. Calculation of the Statewide Capital Standard per Discharge

In the development of the RY16 Statewide Capital Standard per Discharge, EOHHS used APAD Base Year all-payer costs and FY12 HDD as the primary sources of data to develop capital costs per discharge.

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 FY12 - 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 FY12 total inpatient hospital discharges net of Excluded Unit capital costs and discharges.

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The casemix-adjusted capital cost per discharge was determined by (a) dividing the cost per discharge by the All-Payer APR-DRG version 30 Casemix Index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of FY14 MassHealth discharges from MMIS claims data on file as of May 20, 2015, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges and costs from Excluded Units were omitted. 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 50% of the total number of discharges. The RY16 efficiency standard is \$682.42.

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 FY14 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 between RY12 and RY16. The resulting RY16 Statewide Capital Standard per Discharge is \$631.63.

d. Determination of MassHealth DRG Weight

The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). The discharge-specific MassHealth DRG Weight is assigned to the discharge based on information contained in a properly submitted inpatient Hospital claim and determined using the 3M APR-DRG version 30 and Massachusetts weights.

e. Calculation of the Pass-Through Amounts per Discharge

The inpatient portion of malpractice insurance and organ acquisition costs (Pass-Through Costs) was derived from each Hospital's FY14 -403 cost report as screened and updated by CHIA as of August 14, 2015. 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 APAD Base Year and then multiplying the resulting cost per diem by the Hospital-specific MassHealth Average Length of Stay. The costs and days associated with Excluded Units are omitted. The result is the Hospital's Pass-Through Amount per Discharge.

f. Potentially Preventable Readmissions (PPR).

See **Section 8.1** for the calculation of any PPR adjustment.

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g. Calculation of the APAD

Each APAD is determined by the following steps: (1) multiplying the labor portion of the Statewide Operating Standard per Discharge by Hospital's Massachusetts-specific wage area index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge, (3) adding this sum to the Statewide Capital Standard per Discharge, (4) multiplying the sum of these three amounts by the discharge-specific MassHealth DRG Weight, (5) adding to that product a Hospital-specific per discharge payment amount for expenses related to malpractice and organ acquisition costs equal to the Hospital's Pass-Through Amount Per Discharge; and (6) then adjusting that result, where applicable, for Potentially Preventable Readmissions under **Section 8.1**.

The Hospital's Massachusetts-specific wage area index which is used to adjust the Statewide Operating Standard per Discharge was derived from the CMS file referenced in **Section 5.B.1.b**.

The following is an illustrative example of the calculation of the Total Case Payment for a standard APAD claim that does not also qualify for an Outlier Payment under **Section 5.B.2**, below.

Table 1: Standard APAD claim			
(Values are for demonstration purposes only)			
Hospital:	Sample Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	Statewide Operating Standard per Discharge	\$9,391.96	Determined annually
2	Hospital wage area	1.0255	Varies by hospital, determined annually
3	Labor Factor	0.69587	Determined annually
4	Wage Adjusted Operating Standard per Discharge	\$9,558.61	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0-Line 3))
5	Statewide Capital Standard per Discharge	\$631.63	Determined annually
6	Sum of Wage Adj. Oper. Standard and Statewide Capital Standard per Discharge	\$10,190.24	Line 4 + Line 5
7	MassHealth DRG Weight	0.3668	Appendix C, Chart 1
8	Hospital's Pass-Through Amount per Discharge	\$25.30	Varies by hospital, determined annually
9	Pre-Adjusted APAD	\$3,763.08	((Line 6 * Line 7) + Line 8)
10	Potentially Preventable Readmission adjustment	-1.200%	Varies by hospital, determined annually
11	Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)	\$3,717.93	Line 9 * (100% + Line 10)

2. Outlier Payments

A Hospital qualifies for a discharge-specific Outlier Payment in addition to the APAD if *all* of the following conditions are met:

- a. The Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge;
- b. The Hospital continues to fulfill its discharge planning duties as required in MassHealth regulations;
- c. The patient is not a patient in a DMH-Licensed Bed for any part of the discharge; and

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- d. The patient is not a patient in an Excluded Unit within an Acute Hospital.

If a Hospital qualifies for an Outlier Payment, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold. In such a case, the adjustment under **Section 8.1** for Potentially Preventable Readmissions, if applicable, is applied against the sum of the Pre-Adjusted APAD and the Outlier Payment.

The following is an illustrative example of the calculation of the Total Case Payment for a claim involving *an* Outlier Payment.

Table 2: Claim with Outlier Payment			
(Values are for demonstration purposes only)			
Hospital:	Sample Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	Pre-Adjusted APAD	\$3,763.08	Table 1, Line 9, above
2	Allowed charges	\$50,000.00	Determined from claim
3	Hospital Cost-to-Charge Ratio	72.00%	Varies by hospital, determined annually
4	Discharge-Specific Case Cost	\$36,000.00	Line 2 * Line 3
5	Fixed Outlier Threshold	\$24,000	Determined annually
6	Discharge-Specific Outlier Threshold	\$27,763.08	Line 1 + Line 5
7	Does Discharge-Specific Case Cost exceed Discharge-Specific Outlier Threshold?	TRUE	Is Line 4 > Line 6
8	Marginal Cost Factor	80%	Determined annually
9	If Line 7 = True, then Outlier Payment is due Outlier Payment	\$6,589.53	(Line 4 - Line 6) * Line 8
10	Pre-Adjusted APAD + Outlier Payment	\$10,352.62	Line 1 + Line 9
11	Potentially Preventable Readmission adjustment	-1.200%	Varies by hospital, determined annually
12	Total Case Payment	\$10,228.39	Line 10 * (100% + Line 11)

3. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, a Hospital that transfers a patient to another Acute Hospital will be paid on a transfer per diem basis, capped at the Hospital's Total Transfer Payment Cap.

In general, the Hospital that is receiving the patient will be paid (a) on a per-discharge basis in accordance with the RY16 APAD, and, if applicable, Outlier Payment methodology(ies) specified in **Section 5.B.1** and **5.B.2**, if the patient is actually discharged from that Hospital; or (b) on a transfer per diem basis, capped at the Hospital's Total Transfer Payment Cap, if the Hospital transfers the patient to another Acute Hospital or back to the Acute Hospital from which it received the patient.

The RY16 payment per day for Transfer Patients (the Transfer per diem) shall equal the Transferring Hospital's Total Case Payment amount, as determined by EOHHS, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG version 30 Massachusetts-specific weight file. For purposes of this calculation, the Total Case Payment amount is calculated utilizing the APAD, and, if applicable,

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Outlier Payment methodology(ies) set forth in **Sections 5.B.1 and 5.B.2** for the period for which the Transferring Hospital is being paid on a Transfer per diem basis pursuant to this **Section 5.B.3**. In all cases, payment on a Transfer per diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap.

See **Table 3: Claim with Transfer (APAD only)** and **Table 4: Claim with Transfer (APAD and Outlier)**, respectively, for illustrative examples of the calculation of the Transfer per diem, Total Transfer Payment Cap, and corresponding Total Transfer Case Payment, that would apply to the case. These illustrative examples apply to all subsections of **Section 5.B.3**.

Table 3: Claim with Transfer (APAD only)			
(Values are for demonstration purposes only)			
Hospital:	Sample Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	APAD (Total Case Payment amount)	\$3,717.93	Table 1, line 11, above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	1.8	Appendix C, Chart 1
4	Transfer per diem	\$2,065.51	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	\$4,131.03	Line 4 * Line 2
6	Total Transfer Payment Cap	\$3,717.93	Table 3, Line 1
7	Total Transfer Case Payment	\$3,717.93	Lower of Line 5 or Line 6

Table 4: Claim with Transfer (APAD and Outlier)			
(Values are for demonstration purposes only)			
Hospital:	Sample Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	Total Case Payment amount (Claim with Outlier Payment)	\$10,228.39	Table 2, Line 12 above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	1.8	Appendix C, Chart 1
4	Transfer per diem	\$5,682.44	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	\$11,364.87	Line 4 * Line 2
6	Total Transfer Payment Cap	\$10,228.39	Table 4, Line 1
7	Total Transfer Case Payment	\$10,228.39	Lower of Line 5 or Line 6

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's Total Transfer Payment Cap. This section outlines reimbursement under some specific transfer circumstances.

(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's discharge

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specific APAD for the portion of the stay that preceded the patient's discharge 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, becomes eligible for managed care and is enrolled in an MCO or becomes ineligible for managed care and disenrolled 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's Total Transfer Payment Cap, or, if the patient is at the Administrative Day level of care, at the AD per diem rate, in accordance with **Section 5.B.6**.

(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's Total Transfer Payment Cap.

(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.3.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 rate capped at the Hospital's Total Transfer Payment Cap for the non-DMH-Licensed Bed portion of the stay, and at the psychiatric per diem rate for the DMH-Licensed Bed portion of the stay (see **Section 5.B.4**).

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 Total Transfer Payment Cap.

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(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 U.S.C. 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 Total Transfer Payment Cap, 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

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Transfer per diem rate, capped at the Total Transfer Payment Cap, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

4. 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 Psychiatric Per Diem Base Year is FY04. MassHealth utilizes the costs, statistics, and revenue reported in the FY04 -403 cost reports, as screened and updated as of March 10, 2006.

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

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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 Inpatient Psychiatric Overhead Costs, Direct Routine Costs, and Direct Ancillary Costs were updated by the Inflation Factors for Operating Costs between the Psychiatric Per Diem Base Year and RY07. The Standard for Inpatient Psychiatric Capital Costs was updated by the Inflation Factors for Capital Costs between the Psychiatric Per Diem Base Year and RY07.

The Inflation Factors for Operating Costs between RY08 and RY10 and between RY12 and RY16 were applied to the rate calculated above to determine the RY16 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 Total Transfer Payment Cap. See **Sections 5.B.3.b(4) and 5.B.3.b(5)** for payment rules involving transfers to and from DMH-Licensed Beds and BH managed care status.

5. 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 reimbursement shall be at the lower of (1) the fee established in 101 CMR 317.00 (Medicine), 114.3 CMR 16.00 (Surgery and Anesthesia), 114.3 CMR 18.00 (Radiology) and 101 CMR 320.00 (Clinical Laboratory Services), or successor regulations as applicable (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. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in **Section 2**.

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

For primary care physician services provided by Section 1202-eligible Hospital-Based Physicians, payment for the professional component is in accordance with **Section 5.O**.

Physician fee schedules are available at the State House Bookstore and at www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html.

6. 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 \$200.19, which represents the median nursing facility rate that was effective January 1, 2015 for all nursing home rate categories, as determined by EOHHS.

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 resulting AD rates (base and ancillary) were then updated by the Inflation Factor for Administrative Days. The resulting AD rates for RY16 are \$260.09 for Medicaid/Medicare Part B-eligible patients and \$281.25 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. Furthermore, the Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status in a single hospitalization.

7. 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 RY16 Rehabilitation Hospital rate for Chronic Disease and Rehabilitation (CDR) Hospitals. Acute Hospital Administrative Day rates will be paid in accordance with **Section 5.B.6** 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

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hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410 – 411.

8. 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.8.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

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cost that equals or exceeds the Hospital's own threshold defined in **Section 5.B.8.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:

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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.8.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 inpatient cost equals or exceeds the threshold defined in **Section 5.B.8.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 this RFA.*

A Hospital will be paid 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 fixed Hospital-specific payment for each Episode, known as the Payment Amount Per Episode (PAPE) (see **Section 5.C.1**, below).

For Critical Access Hospitals, payment for Outpatient Services is in accordance with **Section 5.D.7**.

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

The Hospital-specific RY16 PAPE is a set payment amount that remains constant for each payable Episode during RY16 for the Hospital. Each Hospital's RY16 PAPE is a blended rate that equally weights the Hospital's RY15 PAPE that was in effect on September 30, 2015, and the Hospital's preliminary RY16 PAPE, determined as calculated in this **Section 5.C.1.a.(1)**.

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- (1) **Hospital's preliminary RY16 PAPE** -- The Hospital's preliminary RY16 PAPE is the product of the Hospital-specific Outpatient Casemix Index and the PAPE Outpatient Statewide Standard (such product is referred to as the **PAPE Base Payment**), *plus*, if applicable, a Hospital-specific Outlier Add-On. These components are further described in **Sections 5.C.1.a(1)(a) through (c)**, below. For components of the calculation based on data from all Hospitals, the calculation includes data for all currently operating Hospitals only.

(a) Hospital-Specific Outpatient Casemix Index: The Hospital-specific Outpatient Casemix Index is equal to the average of the Hospital's twelve (12) monthly average EAPG weights per Episode, based on FY14 PAPE paid claims data residing in MMIS as of April 12, 2015, for which MassHealth was primary payer.

For each Hospital and month of FY14, an average EAPG weight per Episode was determined by (i) assigning individual EAPGs and associated weights to the Hospital's PAPE paid claims for the month (utilizing the 3M EAPG grouper), (ii) summing the individual EAPG weights together, and then (iii) dividing that sum by the Hospital's number of Episodes for the month.

The sum of the Hospital's twelve (12) monthly average EAPG weights per Episode for FY14 divided by 12 is the Hospital-specific Outpatient Casemix Index.

(b) PAPE Outpatient Statewide Standard — The PAPE Outpatient Statewide Standard is equal to the preliminary outpatient statewide standard, divided by a conversion factor. The preliminary outpatient statewide standard is the average outpatient cost per Episode for all Hospitals' Episodes for the PAPE Base Year, adjusted for casemix, an efficiency standard, an outlier adjustment factor, and inflation, as further described below.

For each Hospital, an average outpatient cost per Episode for the PAPE Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all PAPE paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. Each Hospital's CCR was calculated by EOHHS using the Hospital's FY14 -403 cost report. The Hospital-specific Episodes and related charges were determined by EOHHS based on paid claims for Episodes residing in MMIS as of April 12, 2015, for the PAPE Base Year, for which MassHealth was primary payer.

Each Hospital's average outpatient cost per Episode was then divided by the Hospital-Specific FY14 Outpatient Casemix Index as calculated in **Section 5.C.1.a(1)(a)**, to determine the Hospital's standardized cost per Episode. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY14 MassHealth Episodes for the Hospitals was produced from MMIS paid

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claims on file as of April 12, 2015, for which MassHealth was the primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 65% of the total number of statewide Episodes in MMIS. The RY16 PAPE efficiency standard is \$196.06.

The preliminary outpatient statewide standard was then determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 94%; and by (c) the Inflation Factors for Operating Costs between RY14 and RY16. The preliminary outpatient statewide standard divided by a conversion factor of 1.057 is the PAPE Outpatient Statewide Standard, which is \$164.47.

For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's PAPE Outpatient Statewide Standard will instead be \$229.47. The preliminary outpatient statewide standard for this Hospital is the same as it is for all other Hospitals.

For each Hospital, the PAPE Base Payment is equal to the product of the Hospital-Specific Outpatient Casemix Index and the PAPE Outpatient Statewide Standard.

(c) Outlier Add-On: For Hospitals with qualifying PAPE Base Year claims, a fixed Hospital-specific Outlier Add-On is added to the Hospital's PAPE Base Payment to calculate the Hospital's preliminary RY16 PAPE. The Hospital-specific Outlier Add-On is a fixed amount that serves as an additional payment amount for very high cost Episodes from the PAPE Base Year.

If applicable, a Hospital's Outlier Add-On is equal to the sum of the Hospital's Episode-Specific Outlier Values for all of the Hospital's PAPE Base Year Episodes, as determined by EOHHS, divided by the Hospital's number of Episodes in the PAPE Base Year. (See **Table 5.1**, below, for an illustrative example of how a Hospital's Outlier Add-On is calculated).

Each individual Episode-Specific Outlier Value is equal to the product of the Marginal Cost Factor and the amount by which the Episode-Specific Cost exceeds the Episode Outlier Threshold, as determined by EOHHS. (See **Table 5.2**, below, for an illustrative example of how a single Episode-Specific Outlier Value is calculated).

For each Hospital, each Episode-Specific Cost is determined by multiplying the Hospital's MassHealth allowed Episode charges by the Hospital's outpatient cost-to-charge ratio, as calculated by EOHHS using the Hospital's FY14 403 cost report. The Episode-Specific Cost is compared to the Episode Outlier Threshold, which is the sum of the Outlier Base Value and the RY16 Fixed Outpatient Outlier Threshold of \$4,500. The Hospital's Outlier Base Value is the product of the preliminary outpatient statewide

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standard (described in **Section 5.C.1.a.(1)(b))**, and the Hospital-Specific Outpatient Casemix Index (described in **Section 5.C.1.a.(1)(a)**).

If the Episode-Specific Cost exceeds the Episode Outlier Threshold, then an Episode-specific Outlier Value is computed equal to the Marginal Cost Factor for RY16 set at 80%, multiplied by the difference between the computed Episode-Specific Cost and the Episode Outlier Threshold. The Hospital's fixed Outlier Add-On is the sum of the Hospital's Episode-Specific Outlier Values for all of the Hospital's PAPE Base Year Episodes divided by the Hospital's total number of PAPE Base Year Episodes.

MassHealth allowed charges and Episodes for purposes of the Outlier Add-On calculation are based on PAPE paid claims for Episodes residing in MMIS as of April 12, 2015 for the PAPE Base Year, for which MassHealth was primary payer.

The Hospital-specific preliminary RY16 PAPE equals the sum of the Hospital's PAPE Base Payment, plus the Hospital-Specific Outlier Add-on.

(2) Transition

In the interest of transitioning from the PAPE methodology used in the RY15 RFA to the revised methodology used in this RY16 RFA, each Hospital's revised RY16 PAPE will be computed by blending 50/50 the Hospital's RY 15 PAPE that was in effect on September 30, 2015 with the Hospital's preliminary RY16 PAPE.

Table 5, below, is an illustrative example of the calculation of a Hospital's RY16 PAPE.

Table 5 -- Example of Hospital's RY16 PAPE Calculation			
(Values are for demonstration purposes only)			
Line	Description	Value	Notes/ Source
1	Preliminary Outpatient Statewide Standard	\$ 173.85	RY2016 RFA, based on PAPE Base Year data
2	Conversion Factor	1.057	RY2016 RFA
3	PAPE Outpatient Statewide Standard	\$ 164.47	Line 1 / Line 2
4	Hospital-Specific Outpatient Casemix Index	2.0402	Varies by Hospital, based on FY14 data
5	PAPE Base Payment	\$ 335.56	Line 3 * Line 4
6	Outlier Add-On (Note: Value could equal \$0)	\$9.11	Fixed amount that varies by Hospital (see example calculation from Table 5.1, below)
7	Hospital's Preliminary RY16 PAPE	\$ 344.67	Line 5 + Line 6
8	Hospital's RY15 PAPE	\$ 318.49	RY15 RFA and Contract, Hospital's Appendix D
9	Blend Rate Percentage	50%	RY16 RFA
10	Hospital's RY16 PAPE	\$ 331.58	(Line 7 + Line 8)/ 2

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Table 5.1 -- Example Calculation for Hospital's Outlier Add-On (for Table 5, Line 6, above)			
(Values are for demonstration purposes only)			
Line	Description	Value	Notes/ Source
1	Sum of Hospital's Episode-Specific Outlier Values for all of the Hospital's PAPE Base Year Episodes	\$ 61,535.97	Varies by Hospital (see example calculation for single Episode-Specific Outlier Value in Table 5.2, below)
2	Hospital's Total # of Episodes in PAPE Base Year	6,758	MassHealth MMIS claims data for PAPE Base Year
3	Hospital's Outlier Add-On (for Table 5, Line 6, above)	\$ 9.11	Line 1 / Line 2

Table 5.2 -- Example Calculation for a single Episode-Specific Outlier Value*			
(Values are for demonstration purposes only)			
Line	Description	Value	Notes/ Source
1	Preliminary Outpatient Statewide Standard	\$ 173.85	Table 5, Line 1, above
2	Hospital-Specific Outpatient Casemix Index	\$ 2.0402	Table 5, Line 4, above
3	Outlier Base Value	\$ 354.69	Line 1 * Line 2
4	Allowed Charges for Episode	\$ 12,000.00	Determined from PAPE Base Year claims in MMIS corresponding to the Episode
5	Hospital's Outpatient Cost-to-Charge Ratio	46.36%	Varies by Hospital (based on Hospital's FY14 403 cost report)
6	Episode-Specific Cost	\$ 5,563.20	Line 4 * Line 5
7	Fixed Outpatient Outlier Threshold	\$ 4,500.00	RY2016 RFA (same for all Hospitals)
8	Episode Outlier Threshold	\$ 4,854.69	Line 3 + Line 7
9	Does Episode-Specific Cost exceed Episode Outlier Threshold?	Yes	Is Line 6 > Line 8
10	Marginal Cost Factor	80%	RY2016 RFA (same for all Hospitals)
11	Episode-Specific Outlier Value	\$ 566.81	(Line 6 - Line 8) * Line 10 (Note: Value always = or > \$0)
* This calculation is repeated for each of the Hospital's PAPE Base Year Episodes, and the sum of the Hospital's Episode-Specific Outlier Values for all PAPE Base Year Episodes is the value for Table 5.1, Line 1.			

b. Payment System

MassHealth processes and pays clean outpatient claims in accordance with 130 CMR 450.000, 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.

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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.3.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. EOHHS reserves the right to specify the form and format for such notification. Said notice shall include, at a minimum, 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 this RFA.
- b.** Such reimbursement shall be the lower of (1) the fee established in 101 CMR 317.00 (Medicine), 114.3 CMR 16.00 (Surgery and Anesthesia), 114.3 CMR 18.00 (Radiology) and 101 CMR 320.00 (Clinical Laboratory Services), or successor regulations as applicable (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-

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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.
- g. For primary care physician services provided by Section 1202-eligible Hospital-Based Physicians, payment for the professional component is in accordance with **Section 5.O**.

Physician fee schedules are available at the State House Bookstore and at www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html.

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 Clinical Laboratory Services fee schedule at 101 CMR 320.00 and the Surgery & Anesthesia fee schedule at 114.3 CMR 16.00, or successor regulations as applicable (available at the State House Bookstore and at www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html).
- (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.

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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 fees established in 101 CMR 323.00 (Hearing Aid Dispensers).

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 fees established in 101 CMR 315.00 (Vision Care Services and Ophthalmic Materials).

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 fees established in 114.3 CMR 14.00 et seq., or successor regulations, 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.

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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. High Public Payer (State-Defined Disproportionate Share) Hospital Supplemental Payment

a. Qualification

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 Hospitals that received more than 63% of their Gross Patient Service Revenue in FY 2014 from government payers and free care as determined by the Hospital's FY 2014 - 403 cost report.

b. Payment 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 supplemental payments to each qualifying High Public Payer (State-Defined Disproportionate Share) Hospital equal to the sum of (i) 6 percent of its total FY15 inpatient APAD and Outlier Payments, and (ii) 1 percent of its total FY15 outpatient PAPE payments, based on Medicaid paid claims data on file as of March 31, 2016.

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.

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- (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 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 -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 costs, 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.

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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 High Medicaid Volume 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 High Medicaid Volume 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 High Medicaid Volume 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 High Medicaid Volume Freestanding Pediatric Acute Hospitals shall be determined by EOHHS.

5. Freestanding Pediatric Acute Hospital High Complexity Supplemental Payment

a. Qualification

In order to qualify for the Freestanding Pediatric Acute Hospital High Complexity Supplemental Payment, a Hospital must limit its admissions primarily to children and qualify as exempt from the Medicare prospective payment system.

b. Payment 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 Freestanding Pediatric Acute Hospitals, to account for the complex pediatric cases they provide care for.

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of \$11.8 million to qualifying hospitals on a pro-rata basis according to each qualifying hospital's number of inpatient discharges in FY 2015, based on Medicaid paid claims data on file as of March 31, 2016. Payments may be made in installments.

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6. Pediatric Specialty Unit High Complexity Supplemental Payment

a. Qualification

In order to qualify for the Pediatric Specialty Unit Payment High Complexity Supplemental Payment, a Hospital must have a Pediatric Specialty Unit as defined in **Section 2**.

b. Payment 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 Hospitals with Pediatric Specialty Units, to account for the complex pediatric cases they provide care for.

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of \$3 million to qualifying hospitals on a pro-rata basis according to each qualifying hospital's number of inpatient discharges in FY 2015, based on Medicaid paid claims data on file as of March 31, 2016. Payments may be made in installments.

7. Critical Access Hospitals

The payment methods set forth in this **Section 5.D.7** apply to Critical Access Hospitals. EOHHS will pay Critical Access Hospitals an amount equal to 101 percent of the Hospital's allowable costs, as determined by EOHHS utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services, as more fully described below. Interim payments will be made to Critical Access Hospitals based on the rates and methods set forth herein, which payments are provisional in nature and subject to the completion of a cost review and settlement for the time period October 1, 2015 through September 30, 2016, as described in **Section 5.D.7.c**. Subject to this **Section 5.D.7**, all sections of this RY16 RFA otherwise apply to Critical Access Hospitals. If the Hospital loses its designation as a Critical Access Hospital during this period, the payments for inpatient and outpatient services shall revert to the standard inpatient and outpatient rate methodologies set forth in **Sections 5.B** and **5.C**, as determined by EOHHS, and payments may be adjusted accordingly. In no event shall the reversion to any such rate methodologies affect the payment rates to other participating acute hospitals for the applicable rate year.

a. Payment for Inpatient Services

For Inpatient Admissions occurring in RY16, Critical Access Hospitals (CAHs) will be paid for Inpatient Services in accordance with **Section 5.B** with the following changes.

Critical Access Hospitals (CAH) will be paid an Adjudicated Payment Amount per Discharge (APAD) for those Inpatient Services for which all other in-state acute

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hospitals are paid an APAD. Notwithstanding **Section 5.B.1**, for Inpatient Admissions occurring in RY16, the APAD for each Critical Access Hospital is calculated as follows:

1. EOHHS calculated a cost per discharge for Inpatient Services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 1, line 40 of the Hospital's FY14 CMS-2552-10 cost report by the Hospital's number of FY14 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY14 paid claims data residing in MMIS as of May 27, 2015, for which MassHealth is the primary payer.
2. EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY14 and RY16, resulting in the RY16 cost per discharge for each Critical Access Hospital.
3. EOHHS then divided each Critical Access Hospital's RY16 cost per discharge by each Hospital's FY14 inpatient casemix index (CMI), as determined by EOHHS.
4. That result is the CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the Wage Adjusted Statewide Operating Standard per Discharge, the Statewide Capital Standard per Discharge, and the Hospital's Pass-Through Amount per Discharge, used in the APAD calculations for all other Hospitals.
5. The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the RY16 CAH-Specific Total Standard Rate per Discharge by the discharge-specific MassHealth DRG Weight.
6. Critical Access Hospitals will not be subject to any adjustment for Potentially Preventable Admissions under **Section 8.1**.

The following is an illustrative example of the calculation of the Total Case Payment for a CAH's standard APAD claim that does not also qualify for an Outlier Payment.

Table 6: Critical Access Hospital Standard APAD claim			
(Values are for demonstration purposes only)			
Hospital:	Sample Critical Access Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	RY16 CAH-Specific Total Standard Rate per Discharge (value for demonstration purposes only)	\$17,900.61	All Inclusive Rate (Operating & Capital)
2	MassHealth DRG Weight	0.3668	Appendix C, Chart 1
3	Pre-Adjusted APAD	\$6,565.94	Line 1 * Line 2
4	Potentially Preventable Readmission adjustment	0.0%	Not Applicable to CAHs
5	Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)	\$6,565.94	Line 3 * (100% + Line 4)

Outlier Payments and Transfer per diem rates for Critical Access Hospitals are calculated and paid as described in **Sections 5.B.2** and **Section 5.B.3**, respectively, except that the APAD used for purposes of those calculations is the CAH's APAD calculated as set forth **Section 5.D.7.a**, above, and that **Section 8.1** does not apply to CAHs.

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b. Payment for Outpatient Services

For dates of service in RY16, Critical Access Hospitals (CAHs) will be paid for Outpatient Services in accordance with **Section 5.C** with the following changes.

Critical Access Hospitals will be paid a hospital-specific Payment Amount Per Episode (PAPE) for those Outpatient Services for which all other in-state acute hospitals are paid a PAPE. Notwithstanding **Section 5.C.1**, the hospital-specific RY16 PAPE for each Critical Access Hospital was calculated as follows:

1. EOHHS calculated a cost per Episode for Outpatient Services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 40 of the Hospital's FY14 CMS-2552-10 cost report by the Hospital's number of FY14 Medicaid (MassHealth) Episodes. The Hospital's Medicaid (MassHealth) Episode volume was derived from FY14 paid claims data residing in MMIS as of May 27, 2015, for which MassHealth is the primary payer.
2. EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY14 and RY16, resulting in the Critical Access Hospital's RY16 PAPE for dates of service in RY16.
3. The Critical Access Hospital's RY16 PAPE will not be blended with the Critical Access Hospital's RY15 PAPE, but will be the result of the calculations set forth above.

c. Post-RY16 Cost Review and Settlement

Each Critical Access Hospital must timely complete all Medicaid (Title XIX) data worksheets on CMS-2552 cost reports for FY16 in accordance with the CMS Provider Reimbursement Manual - Part 2 (CMS publication 15-2) ("CMS-2552-10 cost reports"), and any additional instructions provided by MassHealth, and submit copies of such completed reports to EOHHS no later than February 28, 2017, or such date as otherwise determined necessary by EOHHS. Critical Access Hospitals shall also complete and provide to EOHHS upon request all such other information, and in such format, as EOHHS determines necessary to perform the review described below.

EOHHS will perform a post-RY16 review to determine whether the Critical Access Hospital received aggregate interim payments in an amount equal to 101% of allowable costs utilizing the Medicare cost-based reimbursement methodology for both inpatient and outpatient services for RY16, as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY16 CMS-2552-10 cost reports and such other information that EOHHS determines is necessary, to perform this post RY16 review. "Aggregate interim payments" for this purpose shall include all hospital payments under the RY16 RFA, as determined by EOHHS, but excluding any payments under **Section 5.D.1** and **Section 7**.

If EOHHS determines that the Critical Access Hospital was paid less than 101% of allowable costs, EOHHS will pay the Critical Access Hospital the difference

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between the amount that EOHHS determines is 101% of allowable costs and the aggregate interim payments. If EOHHS determines that the Critical Access Hospital was paid more than 101% of allowable costs, the Critical Access Hospital shall pay to EOHHS, or EOHHS may recoup or offset against future payments, the amount that equals the difference between the aggregate interim payments and the amount that EOHHS determines is 101% of allowable costs.

This post RY16 review and settlement will take place within approximately twelve (12) months after the close of RY16, subject to the availability of data, or, if later, at such other time as EOHHS determines the necessary documentation is available.

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 additional payments above the amounts specified in **Sections 5.B, 5.C, and 5.D** to Hospitals which qualify for payments under the SNCP. 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 this RFA, are eligible for SNCP payments.

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

F. Federal Financial Participation (FFP)

1. FFP Denials

If any portion of the RFA payment methodology or any amount paid pursuant to this RFA is not approved or is the basis of a disallowance by CMS, such payments made to the Hospital by EOHHS in excess of the federally approved methodology or amounts will be deemed an overpayment and EOHHS may recoup, or offset such overpayments against future payments.

2. Exceeding Limits

a. Hospital-Specific Limits

If any payments made pursuant to this 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, such amounts will be deemed an overpayment and EOHHS may recoup, or offset against future payments, any such overpayments.

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b. Aggregate Limits

If any payments made pursuant to this 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 disallowed amounts 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

1. Submission of Claims. The Provider shall submit claims for all non-professional services through an 837I or Direct Data Entry (DDE) and all professional components services for Hospital –Based Physician (Inpatient and Outpatient) Services through an 837P or DDE, 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 periodically. In the event that a provider's only means of submission is paper, the provider must meet the MassHealth requirements of a paper submission waiver request.
2. International Classification of Diseases (ICD) Version. To comply with the national conversion from ICD-9 to ICD-10 effective October 1, 2015, wherever ICD is used for billing, reporting, payment, or other relevant purposes, Hospitals must submit claims for Hospital services using the appropriate version, as follows.
 - a) For inpatient hospital services that are paid the APAD, Outlier Payment, or Transfer per diem: Claims for an inpatient stay with a date of discharge on or after October 1, 2015, must contain ICD-10 only codes (where ICD is required) for the entire claim regardless of the date of admission. Claims for an inpatient stay with a date of discharge before October 1, 2015, must contain ICD-9 only codes (where ICD is required).
 - b) For inpatient hospital services that are paid the Rehabilitation Services per diem, the Psychiatric per diem, or the Administrative Day per diem, or for outpatient hospital services that are paid the Payment Amount Per Episode (PAPE): Claims with dates of service on or after October 1, 2015, must contain ICD-10 only codes (where ICD is required). Claims with dates of services before October 1, 2015, must contain ICD-9 only codes (where ICD is required).

Detailed instructions for MassHealth providers regarding the ICD changes are available at www.mass.gov/masshealth/icd-10.

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

Except as described in the next paragraph, EOHHS shall reimburse participating Hospitals for services provided to MassHealth Members who are at acute inpatient status prior to October 1, 2015, and who remain at acute inpatient status on or after October 1, 2015, at the Hospital's MassHealth rates and payment methods established prior to this RY16 RFA, and at the Hospital's MassHealth rates and payment methods established in this RY16 RFA for inpatient services provided to MassHealth members who are admitted on or after October 1, 2015.

For services that qualify for the Rehabilitation Services per diem, the Psychiatric per diem, the Administrative Day per diem, or the Payment Amount Per Episode (PAPE), the Hospital's MassHealth rates and payment methods established prior to this RY16 RFA apply to dates of service prior to October 1, 2015, and the Hospital's RY16 RFA rates and payment methods apply to dates of service on or after October 1, 2015.

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.

All provisions of the RFA requiring continuing performance shall survive the termination of such RFA.

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 415.000 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

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responsible for determining, through the MassHealth Eligibility Verification System (EVS), that the Member meets the conditions stated herein on each discrete date of service.

L. Errors in Calculation of Pass-Through Amounts, Outpatient Casemix or Potentially Preventable Readmissions

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

A Hospital must meet the particular conditions of the applicable subsection set forth below in order to request a correction to an error. Hospitals are not allowed to combine the effect of an error under one subsection to the effect of an error under another subsection in order to meet a required threshold.

1. Errors in Calculation of Pass-Through Costs

- a.** If EOHHS makes a transcription error or if EOHHS transcribes the incorrect line in the calculation of the RY16 Pass-Through Costs used in the calculation of its APAD, 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 to EOHHS by hand delivery or mail, postmarked no later than February 1, 2016, copies of the relevant report(s), as referenced in **Sections 5.B.1.e**, highlighting items found to be in error, using the following address:

Executive Office of Health and Human Services
MassHealth Office of Providers and Plans
Attention: Acute Hospital Program
100 Hancock Street, 6th Floor
Quincy, MA 02171

2. Incorrect Determination of Outpatient Casemix

- a.** Casemix shall be calculated on claims for outpatient Episodes as described in **Section 5.C.1.a.(1)(a)**. In the event of an error in the calculations of casemix made by EOHHS, for Outpatient Services, resulting in an amount not consistent with the methodology and where the effect of the error is a decrease in the Hospital's PAPE of 2% or more, a Hospital may request a correction to its RY16 casemix, which shall be at the sole discretion of EOHHS.
- b.** To qualify for a correction, Hospitals must contact EOHHS in writing by hand delivery or mail, postmarked no later than February 1, 2016, 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

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occurred. Requests for corrections that do not include all necessary documentation will not be considered.

Please contact the Acute Hospital Program at the following address:

Executive Office of Health and Human Services
MassHealth Office of Providers and Plans
Attention: Acute Hospital Program
100 Hancock Street, 6th Floor
Quincy, MA 02171

3. Incorrect Determination of 30-Day Potentially Preventable Readmissions (PPR)

- a. PPR calculations shall be made as described in **Section 8.1**. In the event of an error in the calculations of PPR made by EOHHS, resulting in an amount not consistent with the methodology and where the effect of the error is a decrease in the Hospital's estimated total RY16 inpatient APAD and Outlier Payments of 2% or more, a Hospital may request a correction to its RY16 PPR calculations, which shall be at the sole discretion of EOHHS.
- b. To qualify for a correction, Hospitals must contact EOHHS in writing by hand delivery or by mail, postmarked no later than February 1, 2016, and must include with their request for a correction all of the necessary documentation for each and every contested discharge used in the finalized PPR calculations. Hospital reporting errors in claims used in PPR calculations, as well as changes in claims status in MMIS that took place after the date the claims data was extracted for purposes of determining the Hospital's PPR reduction under **Section 8.1** are not subject to correction. Requests for corrections that do not include all necessary documentation will not be considered.

Please contact the Acute Hospital Program at the following address:

Executive Office of Health and Human Services
MassHealth Office of Providers and Plans
Attention: Acute Hospital Program
100 Hancock Street, 6th Floor
Quincy, MA 02171

M. Data Sources

If data sources specified by this RFA are not available, or if other factors do not permit precise conformity with the provisions of this 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 this RFA, EOHHS, in its sole discretion, shall determine on a case-by-case basis: (1) whether the Hospital qualifies for reimbursement under this RFA; and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of this RFA to the extent that EOHHS deems possible. EOHHS' determination shall be

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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**, and **Appendix B, item 11**, for requirements in the event of Hospital change of ownership.

O. Primary Care Physician Payments Pursuant to Section 1202 of the Affordable Care Act

Notwithstanding **Section 5.B.5, Physician Payment** (inpatient services) and **Section 5.C.4, Physician Payments** (outpatient services), for primary care physician services provided by Section 1202-eligible Hospital-Based Physicians to MassHealth patients in calendar years 2013 and 2014, the Hospital will be paid for the professional component of such physician services in accordance with, and subject to, the regulations at 101 CMR 317.03(11) (Medicine) (or successor regulations), and any other applicable federal and state laws, regulations, rules, policies, and contract requirements regarding implementation of Section 1202 of the Affordable Care Act.

Hospitals will be paid the Section 1202 rate for the professional component of such physician services only if the Section 1202-eligible Hospital-Based Physician completes MassHealth's enrollment and attestation form for Hospital-Based Physicians and otherwise satisfies the applicable MassHealth requirements for payment at the Section 1202 rate. Hospitals must ensure that the Section 1202-eligible Hospital-Based Physicians for whose services the Hospitals are billing receive the direct benefit of the entire payment increase for each of the Section 1202 primary care services they provide.

The Hospital shall comply with, and shall assist EOHHS in complying with the requirements of any audits related to the implementation of Section 1202, including but not limited to audits conducted by EOHHS, CMS, and other state and federal authorities. Such assistance may include, but is not limited to, providing all documentation reasonable and necessary for EOHHS and CMS to determine Section 1202 rates were paid and administered in accordance with Section 1202 and all applicable federal and state laws, regulations, rules, policies, and contract requirements related to the implementation of Section 1202 of the Affordable Care Act.

For additional requirements for Hospital-Based Physicians, see **Section 5.B.5, Physician Payment** (inpatient services) and **Section 5.C.4, Physician Payments** (outpatient services).

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Section 6: Payment and Reporting Provisions

All payments under this 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

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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 this RFA.

E. Reporting Requirements

All Acute Hospitals must furnish ownership, licensure, financial, and statistical documents relating to MassHealth participation, services, and payment, as required by EOHHS and other governmental entities. This shall include, but is not limited to, state and federal cost reports, charge books, merged billing and discharge filings, audited financial statements, and provider enrollment information. In addition, Critical Access Hospitals must timely complete and furnish all Medicaid (Title XIX) data worksheets on CMS-2552-10 cost reports in accordance with the CMS Provider Reimbursement Manual - Part 2 (CMS publication 15-2) (see **Section 5.D.7**). If a Hospital does not furnish required information within the applicable time period, or within a reasonable extension of time approved in writing by EOHHS, such Hospital may have a 5% reduction applied to its APAD and inpatient Outlier Payments 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 APAD and Outlier Payments for the first month would equal 5%; if the requested documentation is not received for another month, the downward adjustment to the Hospital's APAD and Outlier Payments for the second month shall equal 10%. The adjustment shall not, in any case, exceed 50% of the APAD and Outlier Payments. If a Hospital is not in full compliance with the submission of the aforementioned information at such time as the Hospital's rates are subject to change (i.e., at the start of a new Rate Year, or upon commencement of an amendment that affects the rates), at no time can the new rates exceed the adjusted current rates. If, however, the new rates are less than the rates currently in effect, then the new rates will become effective and potentially subject to further adjustment.

Hospitals must separately identify in the state cost report any costs associated with Rehabilitation Units, in accordance with all applicable instructions.

All Acute Hospitals must report their costs and payments using the Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR), in accordance with the requirements of the federally approved cost limit protocol and instructions by EOHHS. Such cost reporting will be based on the provider's CMS-2552-10 cost report and will result in reconciliation and recovery of any overpayments.

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

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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 this 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.

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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 RFA16, incentive 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 Program Requirements

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 for RFA16 incentive payments, using quality measures for maternity, care coordination, emergency department, tobacco treatment, and health disparities as set forth in **Section 7.3**.
- C.** Assess Hospital performance for the applicable year, 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 this RFA. As specified in **Section 7.5**, P4P incentive payments for RY16 will be based on both pay-for-performance and pay-for-reporting, as specified therein.
- E.** To be eligible to receive P4P incentive 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**;
 - 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. Meet data submission deadlines set forth in **Section 7.6.A**. 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 this RFA;
 - 4. Identify and authorize individuals to conduct electronic data transactions, via the EOHHS designated secure portal, on the Hospital's behalf;
 - 5. Meet the minimum reliability standards for data elements and pass data validation as defined in **Section 7.4.B**; and
 - 6. Achieve quality standards and performance benchmarks on reported measures data.

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- F. 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 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* per instructions in **Section 7.6.E** by the due date set forth in **Section 7.6.A**.

7.3 Hospital Quality Performance Measures

Hospitals are required to collect and submit data on all quality measures for which they are eligible to report based on the measure's patient population definitions, treatment of conditions and types of services provided. **Table 7-1** identifies the specific hospital quality measures by measure ID number and name that apply for RFA16 reporting.

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Table 7-1. Hospital Quality Performance Measures

Measure ID #	Measure Set and Name	Measure Reporting Status
MAT-1 MAT-2a MAT-2b MAT-3 MAT-4 MAT-5	Maternity Measure Set Intrapartum Antibiotic Prophylaxis for Group B Streptococcus Perioperative Antibiotics for Cesarean Section –Antibiotic Timing Perioperative Antibiotics for Cesarean Section – Antibiotic Selection Elective Delivery Prior to 39 Completed Weeks Gestation Cesarean Birth, Nulliparous term singleton vertex Appropriate deep vein thrombosis prophylaxis for cesarean sections	Discontinue MAT-1, 2a and 2b with Q1-2016 data No change to MAT-3 Begin MAT-4 with Q1-2015 data Begin MAT-5 with Q1-2016 data
HD-2	Health Disparities Composite Measure Composite of Maternity and Care Coordination measures	No change
CCM-1 CCM-2 CCM-3	Care Coordination Measure Set Reconciled medication list received at discharge (inpatient) Transition record with specified data received at discharge (inpatient) Timely transmission of transition record (inpatient)	No change
ED-1 ED-2	Emergency Department Measure Set Median time from ED arrival to ED departure for admitted ED patient Median time from admit decision to ED departure for admitted patients	No change
TOB-1 TOB-2 TOB-3	Tobacco Treatment Measure Set Tobacco use screening Tobacco use treatment provided or offered Tobacco use treatment provided or offered at discharge	Begin with Q1-2015 data Begin with Q1-2015 data Begin with Q1-2015 data
NEWB-1 NEWB-2	Newborn Measure Set Exclusive breast milk feeding Newborn Bilirubin screening	Begin with Q1-2016 data Begin with Q1-2016 data

A. Quality Performance Measure Sets. The quality performance measure sets listed in **Table 7-1** include individual measures that are part of a measure set and one composite measure (HD-2). In RY16, Hospitals must continue to collect and report calendar year 2015 and 2016 data on certain measures introduced in previous RFA(s), and also incorporate reporting status updates for certain measures, including ones that are being newly introduced, as follows:

1. *Maternity Measure Set:* In RY16, Hospitals must continue to collect and report on the MAT-1, MAT-2a, and MAT-2b measures listed in **Table 7-1** through all four quarterly data submission cycles for calendar year 2015 data (Q1-2015, Q2-2015, Q3-2015 and Q4-2015), in accordance with the due dates in **Section 7.6.A**. The MAT-1, MAT-2a, and MAT-2b measures will then be retired, and Hospitals should discontinue collecting and reporting on those measures beginning with the Q1-2016 (Jan. 1, 2016 – March 31, 2016) data cycle.

There is no change to the reporting status for the MAT-3 measure listed in **Table 7-1**, and Hospitals must continue to collect and report on that measure in RY16. Hospitals must also collect and report on the new MAT-4 measure listed in **Table 7-1** (Cesarean Birth, Nulliparous term singleton vertex), as announced in the previous RFA, beginning with the Q1-2015 (Jan 1, 2015 – March 31, 2015) data submission cycle due date in **Section 7.6.A**, and on the newly introduced MAT-5 measure listed in **Table 7-1** (Appropriate deep vein thrombosis prophylaxis for cesarean sections) beginning with the Q1-2016 (Jan 1, 2016 – March 31, 2016) data submission cycle due date in **Section 7.6.A**.

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2. *Care Coordination Measure Set:* No changes apply to the reporting status for the individual care coordination measures listed in **Table 7-1**. Hospitals must continue to collect and report on these measures in RY16.
 3. *Emergency Department Measure Set:* No changes apply to the reporting status for the individual ED measures listed in **Table 7-1**. Hospitals must continue to collect and report on the entire ED-1 and ED-2 measure population strata in RY16, as referenced in the applicable *EOHHS Technical Specifications Manual*. However, performance evaluation will be based on ED-1b and ED-2b measures only.
 4. *Tobacco Treatment Measure Set.* In RY16, Hospitals must begin reporting on the new tobacco treatment measure category (TOB-1, TOB-2 and TOB-3 measures listed in **Table 7-1**), as announced in the prior RFA. Hospitals are required to collect and report on these new measures beginning with Q1-2015 (Jan 1, 2015 – March 31, 2015) data submission cycle due date in **Section 7.6.A**.
 5. *Newborn Measure Set.* In RFA16, EOHHS is introducing reporting requirements for the new newborn care measure category that includes the measures listed in **Table 7-1** (NEWB-1 and NEWB-2). Hospitals are required to collect and report on these new measures beginning with Q1-2016 (Jan 1, 2016 - March 31, 2016) data submission cycle due date in **Section 7.6.A**.
 6. *Health Disparities Composite Measure:* This composite measure will be comprised of aggregate data from specific individual measures (i.e., the maternity and care coordination measure sets, only), listed in **Table 7-1**, on which the Hospital reports. Hospitals must ensure that all quality measures data that they collect include Race, Hispanic Indicator, and Ethnicity codes and allowable values, as referenced in the applicable *EOHHS Technical Specifications Manual*. 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 quality measures data files.
- B. **EOHHS Measure Specifications.** All Hospitals must adhere to the data collection and reporting guidelines contained in the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6**, for the reporting of all measures listed in **Table 7-1**. This comprehensive manual contains technical details on data element definitions, ICD-10-CM and ICD-10-PCS code reporting requirements, clinical algorithms for inclusion and exclusions that apply to numerators/denominators, sampling guidelines, data abstraction tools, XML schema, data dictionary, portal system requirements, Medicaid payer source code instructions, race/ethnicity codes, and more. EOHHS updates the *EOHHS Technical Specifications Manual* regularly and changes to reporting become effective with quarter reporting periods as specified in **Table 7-1** of this RFA. Refer to **Section 7.6.A** of this RFA for the appropriate updated versions of the *EOHHS Technical Specifications Manual* for the applicable quarterly data reporting cycle.
- C. **All Medicaid Payer Data Collection.** Hospital quality reporting for the measures listed in **Table 7-1** must be collected on all Medicaid payer data. Detailed instructions on all Medicaid payer data reporting requirements, including all relevant and new Medicaid payer codes resulting from the implementation of the Affordable Care Act, are included in the applicable version of the *EOHHS Technical Specifications Manual* referred to in **Section 7.6.A**.

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- D. **Data Accuracy and Completeness Requirements.** Hospitals are required to submit complete data on all 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 include all cases that meet the inclusion criteria for each measure's eligible patient population, and 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 version of *EOHHS Technical Specifications Manual*, by submission deadlines listed in **Table 7-4 of Section 7.6.A**. Each Hospital is required to sign and submit a data accuracy and completeness attestation form, per instructions in **Section 7.6.E** by the due date set forth in **Section 7.6.A**.

7.4 Performance Assessment Methods

Hospital performance will be determined by assessing performance on each measure the Hospital reports on. Performance assessment methods include computing measure rates, data validation scores, performance thresholds, assignment of quality points, and total performance scores, as described below.

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

1. *Individual Measure Rate:* Except for the individual ED measures, a measure rate is calculated for each individual measure by dividing the numerator by the denominator, to obtain a percentage for the individual measure. The numerators and denominators for the applicable individual measures are further defined in the applicable *EOHHS Technical Specifications Manual* listed in **Section 7.6.A**. The ED measure rates are calculated using a median time outcome from all patient level time data reported.
2. *Health Disparities Composite Measure:* The HD-2 measure is calculated by dividing the composite numerator rate by the composite denominator rate for each racial/ethnic group. The composite numerator rate is created by summing the numerators of individual measures and the composite denominator rate is created by summing the denominators of individual measures the Hospital reports on. A separate reference group composite rate is calculated by combining all racial/ethnic groups from the Hospitals' reported data. Each racial/ethnic group composite rate for an individual Hospital is then compared to the reference group composite rate and a between group variance (BGV) statistic is calculated for each racial/ethnic composite group. Each of the racial/ethnic group BGV statistics are summed to yield the final disparity composite value BGV statistic. The composite measure and disparity composite 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 further defined in the applicable *EOHHS Technical Specifications Manual* listed in **Section 7.6.A**. As noted in **Section 7.3.A.6**, only the following two individual measure sets—maternity and care coordination—will be included in the HD-2 composite calculation. The ED measure set will not be included in the HD-2 measure calculation because a median time outcome cannot be combined with a composite rate outcome.

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B. Data Validation Requirements. All reported measures (including newly reported measures and sub-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, based on all quarters of data required for performance evaluation, 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 Measures Performance Assessment. Each individual 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 on each individual measure to earn attainment points. The attainment threshold is defined as the median performance (50th percentile) of all hospitals in the previous reporting year.
- b. *Improvement Range:* represents the minimum level of performance achieved above the previous year, but below the benchmark, that must be achieved on each individual measure to earn improvement points; and
- c. *Benchmark Threshold:* represents the highest level (exemplary) performance achieved on each individual measure to earn the maximum amount of quality points. The benchmark performance level is set at the mean of 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 and benchmarks on each individual measure. Performance thresholds for the MassHealth-specific measures (maternity, care coordination, and tobacco treatment) are calculated using the previous year All Medicaid payer reported data. Performance thresholds on the nationally reported measures (emergency department) are calculated using previous year state-level data obtained from the CMS Hospital Compare website. For the Tobacco Treatment measure set, in RY16, this calculation will only be used to set baseline performance thresholds for pay-for-performance. No incentive payments are available for the Tobacco Treatment set for pay-for-performance under **Section 7.5.A.1** for RY16, and no quality points or performance scores will be calculated for those measure sets under **Section 7.4.C.2** or **Section 7.4.C.3** below, for RY16. The Tobacco Treatment measure set will only be eligible for incentive payments for pay-for-reporting under **Section 7.5.A.2** for RY16.

2. Quality Points System. A Hospital’s performance on each individual measure reported will be calculated using a quality point system. Hospitals can earn a range of quality points (from 0-10 points) based on where the Hospital’s measure rate falls, relative to the attainment, improvement and the benchmark as follows:

- a. *Attainment 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:

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- i. *Equal to or less than* the attainment threshold, it will receive zero (0) points for attainment.
 - ii. *Within the attainment range (greater than the attainment threshold but below benchmark)* it will receive anywhere from 1 to 9 points for attainment.
 - iii. *Equal to or greater than* the benchmark, it receives 10 points for attainment.
- b. *Improvement Points.* A Hospital can earn points for improvement based on how much the Hospital's measure rate has improved from the previous reporting year period. If a Hospital's rate 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 to 9 points for improvement.

3. Quality Scoring Criteria. The following criteria apply to awarding quality points for individual measures the Hospital reports on:

- a. 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 comparative year performance. Therefore, the Hospital would not be eligible for improvement points. However, the Hospital may be eligible for attainment points on each individual measure, based on calculation of calendar year 2015 data reported on the measure in RY16, if it passed validation in RY16 and also met the criteria in **Section 7.4.C.3.b** below.
- b. Attainment or improvement points are awarded only after the hospital has established an initial baseline rate for each eligible measure. The initial baseline rate serves as the starting point that will be used to compare future performance data. Attainment or improvement points are not awarded to a newly reported measure category or when a new sub-measure is reported under an existing category.
- c. Newly reported measures data is used to set the attainment and benchmark thresholds for all hospitals. When the attainment and benchmark thresholds for all hospitals indicate suboptimal performance, then no attainment points will be assigned for any hospital (e.g.: when improvement would be indicated by an increase in score, but the attainment or benchmark threshold is 0%; or when improvement would be indicated by a decrease in score, but the attainment or benchmark threshold is 100%).

D. Health Disparities Composite Measure Performance Assessment. The health disparities composite measure performance will be assessed using the following methods:

1. Setting Performance Thresholds

- a. *Decile Ranking Method.* Performance will be assessed using a method that determines the Hospital's rank, relative to other hospitals, based on the decile

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ranking system. Hospitals that meet the measure calculation criteria, per **Section 7.4.A.2**, are divided into ten groups (deciles) based on their disparity composite value, so that approximately the same number of hospitals fall within each decile.

- 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 composite value that falls above the 2nd decile group, as shown in **Table 7-2** below.

2. Disparity Composite Scoring Method.

- a. *Disparity Composite Value Ranking.* All Hospital disparity composite values, computed per **Section 7.4.A.2**, are rounded to six decimal places. All composite values are ranked from highest to lowest so approximately the same number of hospitals fall in each decile group. Hospitals that do not meet data validation standards set forth in **Section 7.4.B** are excluded from decile ranking.
- 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
<i>Target Attainment</i>		
Lower Deciles	2 nd decile	(zero)
	1 st decile	(zero)

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

E. Performance Score Calculations. A Hospital's performance score for the individual and health disparities composite measures will be computed using the methods described below:

- 1) **Individual Measures.** A Hospital's performance score, for each individual measure it is eligible to report on, is calculated based on the quality point system methods outlined in **Section 7.4.C** of this RFA. The following methods apply to computing the points earned:

- i. *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

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the attainment threshold divided by the difference between the *benchmark* and the *attainment threshold*. This ratio is multiplied by 9 and increased by 0.5. The Hospital's "attainment points" will be calculated based on the following formula:

Hospital's Measure Rate – Attainment	$\times 9 + 0.5 = \text{Hospital's Attainment Points Earned}$
Benchmark – Attainment	

- ii. **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 and decreased by 0.5. The Hospital's "improvement points" will be calculated based on the following formula:

Current Measure Rate – Previous Year's Measure Rate	$\times 10 - 0.5 = \text{Hospital's Improvement Points Earned}$
Benchmark – Previous Year's Measure Rate	

All attainment and improvement points earned will be rounded to the nearest whole number (e.g., 3.3 = 3.0 and 3.5 = 4.0).

- iii. **Total Performance Score.** The total performance score, for the individual 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. 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:

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

- 2) **Health Disparities Composite Measure Performance Score.** The performance score for the health disparities measure reflects the equivalent of the assigned conversion factor, per **Section 7.4.D**, that is calculated based on the following formula:

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

F. Performance Evaluation Periods. In RY16, the following performance evaluation periods apply:

1. **Individual Measures:** Individual measures will be evaluated using calendar year measures data reported for the comparison year (January 1, 2015 to December 31, 2015 discharge period) and previous year's reported data (January 1, 2014 to December 31, 2014 discharge period). For detailed information about comparative

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performance periods that apply to individual measures, refer to the applicable *EOHHS Technical Specifications Manual* version listed in **Section 7.6.A**.

2. **Health Disparities Composite Measure:** each Hospital's performance score will be evaluated using all applicable measures data reported, pursuant to **Section 7.4.A.2**, for the calendar year (January 1, 2015 to December 31, 2015) discharge periods *only*. The decile ranking method evaluates performance on a year-by-year basis and does not use comparison year data. Each year the Hospital's performance rank will be determined using the decile ranking method described in **Section 7.4.D**.

7.5 Pay-for-Performance (P4P) Incentive Payment Calculation Methods

As set forth in **Section 7.4** of this RFA, a Hospital may qualify to earn P4P incentive payments if it meets data completeness requirements, data validation requirements and achieves performance thresholds for measures listed in **Section 7.3** of this RFA. Each measure set's performance is calculated from the calendar year reported data, using the methods outlined in **Section 7.4** to produce performance scores that are converted into incentive payments. This section describes the methods used to convert individual and composite measure performance scores into hospital incentive payments.

A. Incentive Payment Approach. In RY16, incentive payment approaches will be based on both pay-for-performance and pay-for-reporting as described below:

1. **Pay-for-Performance Incentive:** Incentive payments for the ongoing reported measure sets, listed in **Table 7-1** (maternity, care coordination, emergency department, and health disparities), will be contingent on meeting data completeness, data validation standards and achieving performance thresholds set forth under **Section 7.4** of this RFA.
2. **Pay-for-Reporting Incentive:** For RY16, pay-for-reporting applies solely to the tobacco treatment measure set. Incentive payments for the new tobacco treatment measure set reported will be contingent on meeting the data validation standard (.80) as set forth in **Section 7.4.B**. Performance scoring for a new measure set is on a "Pass/Fail" criterion based *solely* on meeting the data validation standard for the measure set's required data elements. Hospitals that fail validation will receive a performance score of 0%, and Hospitals that pass validation will receive a performance score of 100%.

B. Payment Calculation. Incentive payments for each quality measure category will be calculated using methods described below.

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.

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Table 7-3. Payment Calculation Components

Quality Measure Category	Maximum Allocated Amount	Estimated Eligible Medicaid Discharges*	Estimated Per Discharge Amount*
Maternity	\$ 22,000,000	11,349	\$ 1,938.50
Care Coordination	\$ 11,000,000	47,326	\$ 232.43
Health Disparities Composite	\$ 2,500,000	58,675	\$ 42.61
Emergency Department	\$ 7,000,000	27,564	\$ 253.95
Tobacco Treatment (pay-for-reporting)	\$ 7,500,000	18,812	\$ 398.68
TOTAL	\$50,000,000	--	--

* The estimated eligible Medicaid discharges and estimated per-discharge amount for each measure category, listed in **Table 7-3**, are calculated based on FY13 hospital discharge data submitted by Hospitals to CHIA. The final numbers for these two columns will be determined based on FY15 MMIS Discharge Data, as follows:

2. *Eligible Medicaid Discharges.* The final eligible Medicaid discharges for each quality measure category listed in **Table 7-3** will be calculated based on FY15 MMIS Discharge Data, using the methods set forth in subsections a. and b., below, as applicable. For purposes of **Section 7.5**, “FY15 MMIS Discharge Data” refers to acute inpatient hospital discharge data from MMIS paid claims for FY15 PCC Plan and Fee-for-Service discharges only, for which MassHealth is the primary payer, as of a date to be determined by EOHHS.
 - a. **Individual Measure Categories.** For the applicable individual measures listed in **Table 7-1** (i.e., maternity, care coordination, emergency department and tobacco treatment), the eligible Medicaid discharges are determined based on the number of Hospital discharges in the FY15 MMIS Discharge Data for which an APAD or Transfer per diem was paid, as determined by EOHHS, and which meet the International Classification of Diseases (ICD) population requirements referenced in the EOHHS *Technical Specifications Manual* for each measure category the hospital reported on, pursuant to **Section 7.3**.
 - b. **Health Disparities Composite Measure Category.** For the health disparities composite measure, the eligible Medicaid discharges are based *only* on the sum of discharges for the two specific underlying individual measure categories (maternity and care coordination) that the hospital reported on, and that meet the criteria for the composite measure calculation per **Section 7.4.A.2**.
3. *Quality Measure Category per Discharge Amount.* **Table 7-3** above estimates the per-discharge amount based on FY13 hospital discharge data reported to CHIA. The final per-discharge amounts will be determined based upon FY15 MMIS P4P Discharge Data for each measure category. To determine these amounts, EOHHS will use the following formula:

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Maximum Allocated Amount	= Quality Measure Category per-Discharge Amount
Statewide Eligible Medicaid Discharges	

For each quality measure category, EOHHS has established a maximum allocated amount, specified in **Table 7-3**. The maximum allocated amount will be divided by the statewide eligible Medicaid discharges across all Hospitals eligible to report on that measure category, to determine the per-discharge amount for each measure category.

C. Incentive Payment Formulas. Payments for each quality measure category will be calculated based on the following formulas:

- a. Individual Measure Categories:** Incentive payments will be calculated by multiplying the Hospital's eligible Medicaid discharges by quality measure category per-discharge amount by the total performance score, per **Section 7.4.E** using the following formula:

(Hospital's Eligible Medicaid discharges) x (Quality Measure Category per-Discharge Amount) x (Total Performance Score)	= Hospital P4P Payment Individual Measure Category
---	---

- b. Health Disparities Composite Measure:** Incentive payments will be calculated by multiplying the Hospital's eligible Medicaid discharges by quality measure category per-discharge amount by the composite performance score per **Section 7.4.E** using the following formula:

(Hospital's Eligible Medicaid discharges) x (Quality Measure Category per-Discharge Amount) x (Composite Performance Score)	= Hospital P4P Payment Health Disparity Measure Category
---	---

A Hospital's total incentive payment will be the sum of the P4P incentive payments for each quality measure category for which the Hospital qualifies for payment. This aggregate sum is also referred to as the "Hospital's Final RY16 RFA Total P4P Payment Amount".

7.6 Pay-for-Performance Reporting Requirements

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. Data Submission Timelines.** All measures data for the hospital quality performance measures listed in **Section 7.3** must be submitted in quarter reporting cycles on the due dates noted in **Table 7-4**. The hospital hard-copy forms must be submitted per instructions set forth below under **Section 7.6.E**.

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Table 7-4. Data Submission Timelines

Submission Due Date	Data Submission Requirement	Data Reporting Format	Reporting Instructions
October 1, 2015	<ul style="list-style-type: none"> •Hospital Quality Contacts Form •Hospital Data Accuracy and Completeness Attestation Form 	HospContact_2016 Form HospDACA_2016 Form	RFA Section 7.2.D RFA Section 7.6.E
Nov 13, 2015	<ul style="list-style-type: none"> •Q1-2015 (Jan – Mar 2015) •Q1-2015 ICD population data •Q2-2015 (Apr – June 2015) •Q2-2015 ICD population data 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specs Manual (Version 8.0 and 8.1)
Feb 12, 2016	<ul style="list-style-type: none"> •Q3-2015 (July – Sept 2015) •Q3-2015 ICD population data 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specs Manual (Version 8.0 and 8.1)
May 13, 2016	<ul style="list-style-type: none"> •Q4-2015 (Oct – Dec 2015) •Q4-2015 ICD population data 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specs Manual Release Notes (Version 8.1a)
August 12, 2016	<ul style="list-style-type: none"> •Q1-2016 (Jan – Mar. 2016) •Q1-2016 ICD population data 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specs Manual (Version 9.0)

B. Data Reporting Format. All electronic data must be submitted using the following formats:

- 1. MassHealth Quality Exchange (MassQEX) Portal.** EOHHS has designated the MassQEX website as the secure portal for the submission of all electronic data files 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:
www.mass.gov/eohhs/provider/insurance/masshealth/massqex/
- 2. 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*.

C. Technical Specifications Manual. EOHHS publishes a comprehensive manual as a supplement to this RFA, which contains technical instructions, as described in **Section 7.3**, 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

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downloading and using the appropriate versions of EOHHS Technical Specifications Manual 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. All versions of the manuals are available on the MassQEX website at www.mass.gov/eohhs/provider/insurance/masshealth/massqex/ – click on the “EOHHS Technical Specifications Manual” link.

D. 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 this 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.

E. Hard Copy Reporting Forms

1. **Hospital Quality Contact Form.** Each Hospital must complete and submit information on all staff involved in quality reporting using the HospContact_2016.pdf fillable form. This form is due at the beginning of the rate year and must be resubmitted when any change in key quality representatives and MassQEX portal users listed occurs.
2. **Hospital Data Accuracy and Completeness Attestation Form.** Each Hospital must submit this form to acknowledge data completeness requirements pursuant to **Section 7.3.D** using the HospDACA_2016.pdf fillable form. This form must be signed by the Hospital’s chief executive officer and is due at the beginning of each rate year and must be resubmitted when any change to Hospital CEO occurs.

Electronic versions of these forms are posted on the Mass.gov page titled “MassHealth Quality Exchange” at www.mass.gov/eohhs/provider/insurance/masshealth/massqex/. The forms can also be obtained by sending a request to the EOHHS business mailbox at Masshealthhospitalquality@state.ma.us.

Hospitals must mail **one** hard copy of the Hospital Quality Contacts Form and the Hospital Data Accuracy and Completeness Attestation Form, with a typed cover letter using Hospital stationery that identifies content enclosed, to EOHHS using the following address:

Executive Office of Health and Human Services
MassHealth Office of Providers and Plans
Attention: Acute Hospital P4P Program
100 Hancock Street, 6th Floor
Quincy, MA 02171

Hard-copy submissions must be postmarked by close of business on the due date specified in **Table 7-4**.

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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 30-day Potentially Preventable Readmissions (PPRs)

Hospitals with a greater number of Actual Potentially Preventable Readmission (PPR) Chains than Expected PPR Chains, based on data specified in **8.1.B** will be subject to a percentage payment reduction per discharge calculated using the methodology described below. This reduction will be applied to Hospitals identified using the methodology described below.

A. Definitions

Actual PPR Chains: The actual number of PPR Chains for a specific Hospital.

Actual PPR Volume: The number of Actual PPR Chains for the time period.

Actual PPR Rate: The number of Initial Admissions with one or more qualifying Clinically Related PPRs within a 30-day period divided by the total number of At-risk Admissions.

APR-DRG: The All Patient Refined-Diagnostic Related Group and Severity of Illness (SOI) combination assigned using the 3M PPR Grouper, version 30.

At-risk Admissions: The number of Total Admissions considered at risk for readmission, as determined by the 3M PPR methodology, excluding mental health and substance abuse primary diagnoses.

Clinically Related: A requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior Hospital admission.

Expected PPR Chains: The number of PPR Chains a Hospital, given its mix of patients as defined by APR-DRG category, would have experienced had its rate of PPRs been identical to that experienced by a reference or normative set of Hospitals.

Expected PPR Rate: The number of Expected PPR Chains divided by the total number of At-risk Admissions. The expected rate for each APR-DRG is the statewide average Actual PPR Rate for that APR-DRG.

Excess PPR Volume: The number of Actual PPR Chains above the number of Expected PPR Chains, as calculated by the 3M PPR methodology, for a specific Hospital. For a Hospital for which the number of Actual PPR Chains is equal to or less than the number of Expected PPR Chains, there is no Excess PPR Volume.

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Hospital Discharge Volume: The number of Hospital discharges in FY14 for which a SPAD was paid, as determined by EOHHS based on claims residing in MMIS as of March 31, 2015 and for which MassHealth is the primary payer.

Initial Admission: An admission that is followed by a Clinically Related readmission within a specified readmission time interval. Subsequent readmissions relate back to the care rendered during or following the Initial Admission. The Initial Admission initiates a PPR Chain.

Potentially Preventable Readmission (PPR): A readmission (return hospitalization within the specified readmission time interval) that is Clinically Related to the Initial Admission.

PPR Chain: A PPR or a sequence of PPRs. A PPR Chain can extend beyond 30 days, as long as the time between each discharge and subsequent readmission is within the 30-day time frame. Therefore, if Patient X is admitted on September 4th, readmitted on September 20th, and readmitted again on October 18th, that sequence is calculated as one (1) PPR Chain.

Readmission: A return hospitalization to an acute care Hospital that follows a prior Initial Admission from an acute care Hospital. Intervening admissions to non-acute care facilities are not considered readmissions. A readmission may be to an in-state or out-of-state acute care Hospital.

Total Admissions: The total number of Medicaid FFS/PCC Plan admissions for the time period.

B. Determination of Readmission Rates and Volumes

PPRs are identified in adjudicated and paid inpatient Hospital claims residing in MMIS as of March 31, 2015, for which MassHealth is the primary payer, by using the 3M PPR software version 30.0. The time period for identifying Total and At-risk Admissions was from September 1, 2013 to August 31, 2014, based on date of discharge. The time period for identifying PPRs associated with these At-risk Admissions was from September 1, 2013 to September 30, 2014 based on date of admission. To calculate the hospital-specific Expected PPR Rates, the At-risk Admissions and Actual PPR Chains from the Hospitals from North Adams, MA and Quincy, MA, that ceased operations in FY14 and FY15 respectively were excluded; furthermore, the At-risk Admissions and Actual PPR Chains for the specialty hospitals of Dana Farber Cancer Institute and the Massachusetts Eye and Ear Infirmary and those at out-of-state hospitals were not included in the calculation of the Expected PPR Rate.

1. Statewide Average PPR Rate

The statewide average Actual PPR Rate for each APR-DRG is calculated and represents the PPR benchmark for that APR-DRG.

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2. Hospital-specific Actual PPR Volume

Each Hospital's Actual PPR Volume is the number of PPR Chains in the specified time period.

3. Hospital-specific Expected PPR Volume

In order to derive the Hospital-specific Expected PPR Volume, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions by APR-DRG for the time period specified above and summed across all of the Hospital's APR-DRGs.

The Expected PPR Volume therefore reflects how a given Hospital should have performed on each APR-DRG recorded in their MMIS claims, as specified in **Section 8.1.B**.

4. Hospital-specific Excess PPR Volume

The Hospital-specific Excess PPR Volume is calculated as the number of Actual PPR Chains in excess of the number of Expected PPR Chains, as calculated by the 3M PPR methodology, for a specific Hospital. For a Hospital for which the number of Actual PPR Chains is equal to or less than the number of Expected PPR Chains, there is no Excess PPR Volume.

5. Hospital-specific Actual PPR Rate

Each Hospital's Actual PPR Rate is derived by dividing the number of Actual PPR Chains in the specified time period by the total number of At-risk Admissions.

6. Hospital-specific Expected PPR Rate

In order to derive the Hospital-specific Expected PPR Rate, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions by APR-DRG casemix. The Expected PPR Rate is therefore risk-adjusted and reflects how a given Hospital should have performed on each APR-DRG for the time period specified above.

7. Hospital-specific Actual-to-Expected PPR Ratio

Each Hospital's Actual-to-Expected (A:E) ratio is calculated as:

$\text{Actual PPR Rate} / \text{Expected PPR Rate}$

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C. Calculation of PPR Percentage Payment Reduction Per Discharge

1. General Initial Calculation

Hospitals with Excess PPR Volume are subject to a PPR Percentage Payment Reduction per Discharge, applied as set forth in **Section 8.1.F**, below. This per discharge reduction is expressed as a percentage. Only Hospitals with more than 40 At-Risk Admissions are subject to a PPR Percentage Payment Reduction per Discharge, if applicable.

Each Hospital's PPR Percentage Payment Reduction per Discharge will initially be calculated as follows:

$$\frac{[(\text{Hospital-Specific Excess PPR Volume}) \times (\text{Adjustment Factor})]}{(\text{Hospital Discharge Volume})} = \text{Hospital's Non-Improvement-Adjusted PPR Percentage Payment Reduction per Discharge}$$

The "Adjustment Factor" for RY16 is 3 and is a multiplier intended to provide incentive for Hospitals to identify and implement methods to reduce PPRs.

The remainder of the calculation depends on whether a Hospital qualifies for an Improvement Adjustment in accordance with **Section 8.1.D** below.

2. Hospitals not Qualifying for Improvement Adjustment

A Hospital with Excess PPR Volume that does not qualify for an Improvement Adjustment in accordance with **Section 8.1.D**, below, will be subject to a "PPR Percentage Payment Reduction per Discharge" equal to the amount calculated as the Hospital's Non-Improvement-Adjusted PPR Payment Reduction per Discharge under **Section 8.1.C.1** above.

3. Hospitals Qualifying for Improvement Adjustment

A Hospital with Excess PPR Volume that does qualify for an Improvement Adjustment in accordance with **Section 8.1.D**, below, will be subject to a "PPR Percentage Payment Reduction per Discharge" that is calculated as follows:

$$\frac{\text{Actual to Expected PPR Ratio RY 16}}{\text{Actual to Expected PPR Ratio RY15}} \times \text{Hospital's Non-Improvement-Adjusted PPR Percentage Payment Reduction per Discharge}$$

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= Hospital's PPR Percentage Payment Reduction per Discharge

D. Improvement Adjustment

If a Hospital has Excess PPR Volume for RY16 but has achieved an improvement as indicated by a decrease to its Actual-to-Expected PPR Ratio in RY16 compared to RY15, EOHHS shall adjust downward the PPR Percentage Payment Reduction per Discharge that the Hospital would otherwise receive. This "Improvement Adjustment" is calculated by applying the percent decrease in the Hospital's RY16 Actual-to-Expected PPR Ratio from RY15 to the Hospital's Non-Improvement-Adjusted PPR Percentage Payment Reduction per Discharge. For example, if a Hospital had a RY15 Actual-to-Expected PPR Ratio of 1.30 and a RY16 Actual-to-Expected PPR Ratio of 1.17, which is a decrease of 10%, and a RY16 Non-Improvement-Adjusted PPR Percentage Payment Reduction per Discharge of 3%, its RY16 PPR Percentage Payment Reduction per Discharge would be adjusted as follows:

Hospital's PPR Percentage Payment Reduction per Discharge = $1.17/1.30 \times 3\% = 90\% \times 3\%$
= 2.7% per Discharge

E. Maximum per-Discharge Adjustment

Notwithstanding **Sections 8.1.C** and **8.1.D**, a Hospital's PPR Percentage Payment Reduction per Discharge due to the Hospital's Excess PPR Volume is capped at 4.4%.

F. Application of PPR Percentage Payment Reduction per Discharge

The Hospital's PPR Percentage Payment Reduction per Discharge is applied against the sum of the Pre-Adjusted APAD and Outlier Payment for discharges that qualify for an Outlier Payment (see **Section 5.B.2**). It is applied against the Pre-Adjusted APAD for discharges that do not qualify for an Outlier Payment (see **Section 5.B.1**). These reductions apply when calculating the Transfer per diem rate, and when capping the Transfer per diem at the Total Transfer Payment Cap under **Section 5.B.3**.

G. Monitoring and Future Refinement of Actual PPR Volume

To assist each Hospital in monitoring and improving performance in PPRs, and to refine future determinations of Actual PPR Rates for RFA17 and beyond, EOHHS may provide each Hospital with periodic reports of its Actual PPR Volume in subsequent time periods after calculating the Hospital's RY16 Actual PPR Volume.

In addition, each Hospital may identify within these same time periods those At-risk Admissions for which readmissions within 30 days are planned. EOHHS at its discretion will determine the means by which planned readmissions data will be collected and the methods by which such data will be incorporated into future year rate adjustments.

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8.2 Provider Preventable Conditions

A. Introduction

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111.-148) (the ACA), and corresponding federal regulations at 42 C.F.R. 447.26, Hospitals must report “provider preventable conditions” to Medicaid agencies; and Medicaid agencies are prohibited from paying Hospitals for services resulting from a “provider preventable condition” in violation of the federal requirements. EOHHS has implemented policies that conform to the federal requirements. The following provisions and payment methods governing “provider preventable conditions” apply to the Hospital, and the Hospital must comply with such provisions.

As part of the MassHealth “provider preventable condition” policy, certain of the “serious reportable events” designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332, as they pertain to MassHealth members, shall be excepted from the requirement that the Hospital shall not charge or seek reimbursement for the event, as described in **Section 8.3**, below. The excepted “serious reportable events” are any “serious reportable events” designated by DPH pursuant to its regulations at 105 CMR 130.332 which are not identified in *Appendix U* of the Hospital’s Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals. The Hospital shall bill and report, and related payment adjustments shall be made for, these excepted “serious reportable events” as “provider preventable conditions” in accordance with this **Section 8.2** governing Provider Preventable Conditions. The Hospital also shall continue to perform the documented review process and determination for these events, as further described in **Section 8.2.F**, below, solely for the purposes of reporting to DPH. The remaining “serious reportable events” identified in *Appendix U* of the Hospital’s Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals shall be governed entirely by the Serious Reportable Events provisions in **Section 8.3**, below.

B. Definitions

The following definitions apply to this **Section 8.2**:

1. Provider Preventable Condition (PPC) – a condition that meets the definition of a “Health Care Acquired Condition” or an “Other Provider Preventable Condition” as defined by CMS in federal regulations at 42 C.F.R. 447.26(b).
2. Health Care Acquired Conditions (HCACs) – conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
3. Other Provider Preventable Condition (OPPC) – a condition that meets the requirements of an “Other Provider Preventable Condition” pursuant to 42 C.F.R. 447.26(b). OPPCs may occur in any health care setting and are divided into two sub-categories:

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- a) National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:

- A. Wrong surgical or other invasive procedure performed on a patient;
- B. Surgical or other invasive procedure performed on the wrong body part; and
- C. Surgical or other invasive procedure performed on the wrong patient.

For each of A. through C., above, the term “surgical or other invasive procedure” is as defined in CMS Medicare guidance on NCDs.

- b) Additional Other Provider Preventable Condition (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as Additional OPPCs.

C. Hospital Reporting of PPCs to EOHHS

1. *Appendix V* of the Hospital’s Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals identifies those PPCs that apply to the Hospital for inpatient and outpatient hospital services and hospital-based physician services, respectively. EOHHS may also provide this information to Hospitals through provider bulletins, or other written statements of policy, and all such documentation, including without limitation *Appendix V*, may be amended from time to time.
2. Hospitals must report the occurrence of a PPC and PPC-related services through MMIS claims submissions to MassHealth. Hospital reporting of PPCs, and related claims submissions, must be conducted in accordance with applicable MassHealth regulations, provider manuals and billing instructions, including without limitation as set forth in *Appendix V* of the MassHealth Acute Inpatient Hospital and Acute Outpatient Hospital provider manual, respectively. EOHHS may also provide such instructions through provider bulletins, or other written statements of policy, and all such documentation, including without limitation, *Appendix V*, may be amended from time to time.
3. In accordance with state and federal statutes, rules, and regulations governing the MassHealth program, including but not limited to 130 CMR 415.000 et seq. (Acute Inpatient Hospitals); 130 CMR 410.000 et seq. (Acute Outpatient Hospitals) and 130 CMR 450.000, et seq. (administrative and billing instructions), EOHHS may request additional information from the Hospital which EOHHS deems necessary to facilitate its review of any PPC or to carry out payment, provider enrollment, quality or other routine functions of the MassHealth program, and the Hospital must comply with the request. EOHHS may use this information, as well as the reports provided pursuant to **Section 8.2.F**, in reviewing any PPC, and in applying any payment adjustment as set forth in **Section 8.2.D**, below.

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D. Payment Adjustments to Hospitals for Provider Preventable Conditions

1. **Inpatient Hospital Services** – For inpatient hospital services, when a Hospital reports a PPC that the Hospital indicates was not present on admission, EOHHS will reduce payments to the Hospital as follows:
 - a. APAD, Outlier Payment and Transfer per diem payments. For inpatient services for which the Hospital would otherwise be paid an APAD, Outlier Payment or Transfer per diem payment:
 - i. MassHealth will not pay the APAD, Outlier Payment, or Transfer per diem payment if the Hospital reports that only PPC-related services were delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - ii. MassHealth will pay the APAD, Outlier Payment or Transfer per diem payment, in each case as adjusted to exclude PPC-related costs/services, if the Hospital reports that non-PPC-related services were also delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - b. Psychiatric, Rehabilitation, or Administrative Day Per Diem payments. For inpatient services for which the Hospital would otherwise be paid a psychiatric, rehabilitation or Administrative Day per diem:
 - i. MassHealth will not pay the per diem if the Hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - ii. MassHealth will pay the per diem if the Hospital reports that non-PPC related services were also delivered on that day, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - c. Inpatient Hospital Payments for Hospital-Based Physician Services: MassHealth will not pay for inpatient Hospital-based physician services reported as PPC-related services.
 - d. Follow-up Care in Same Hospital: If a hospital reports that it provided follow-up inpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the Hospital reports that non-PPC-related services were provided during the follow-up stay, payment will be made, but adjusted in the case of APAD, Outlier Payment or Transfer per diem payments to exclude the PPC-related costs/services,

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and MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

- 2. Outpatient Hospital Services** – For outpatient hospital services, when a Hospital reports that a PPC occurred during treatment at the Hospital (including its satellite clinics), MassHealth will reduce payments to the Hospital as follows:
 - a. PAPE. For outpatient services for which the Hospital would otherwise be paid the PAPE:
 - i. MassHealth will not pay the PAPE if the Hospital reports that only PPC-related services were delivered during the episode of care, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - ii. MassHealth will pay the PAPE if the Hospital reports that non-PPC related services were also delivered during the same episode of care, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - b. Outpatient Hospital Payments for Hospital-Based Physician Services: MassHealth will not pay for outpatient Hospital-based physician services reported as PPC-related services.
 - c. Follow-Up Care in Same Hospital: If a Hospital reports that it provided follow-up outpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided during the follow-up episode of care, payment will be made, but MassHealth will exclude all PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
- 3.** For each of subsection **D.1** and **D.2**, above, the PPC non-payment provisions also apply to third-party liability and crossover payments by MassHealth.
- 4.** Hospitals are prohibited from charging members for PPCs and PPC-related services, including without limitation co-payments or deductibles. Hospitals are also prohibited from seeking reimbursement for identified PPC-related services through the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.
- 5.** In the event that individual cases are identified throughout the MassHealth PPC implementation period, EOHHS may adjust reimbursement according to the methodology above.

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E. Additional Requirements

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, without limitation, Section 2702 of the ACA. In addition, should EOHHS, in its sole discretion, deem it necessary to further amend this RFA and Contract to implement any such laws, the Hospital agrees that, notwithstanding any other provision in this 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.

F. Reporting to the Massachusetts Department of Public Health

In addition to complying with **Sections 8.2.A** through **E**, above, for any PPC that is also a "serious reportable event (SRE)" as designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332, the Hospital must also continue to report the occurrence of the PPC as an SRE to DPH, and perform the documented review process as set forth in and in accordance with DPH regulations at 105 CMR 130.332(B) and (C). The Hospital must also provide copies of such reports to EOHHS and any other responsible third-party payer and inform the patient as required by and in accordance with DPH regulations at 105 CMR 130.332(B) and (C). The copies to MassHealth must be sent to:

PPC/Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

Notwithstanding such reporting and documented review process as set forth in 105 CMR 130.332(B) and (C), provider claims to MassHealth and related payment methods for PPCs, including without limitation, those that also constitute a DPH-designated SRE, are governed by this **Section 8.2** and not **Section 8.3**, below.

8.3 Serious Reportable Events

A. Applicability

1. "Serious Reportable Events (SREs)" for purposes of this **Section 8.3** shall mean those serious reportable events (SREs) listed in *Appendix U* of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals. All references to SREs in **Sections 8.3.B** through **8.3.D**, below, are subject to this **Section 8.3.A**.

From time to time, EOHHS may update the list of SREs that are subject to this **Section 8.3** through issuing provider bulletins or updates to provider manuals, or through other written statements of policy.

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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 this 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 and Preventability Determination

1. In accordance with DPH regulations at 105 CMR 130.332(B) and (C), as may be amended, Hospitals must (i) timely report the occurrence of an SRE to DPH and provide copies of the report to required parties, as specified in such regulations, (ii) establish policies for making and documenting preventability determinations following the occurrence of an SRE, (iii) timely make preventability determinations for all SREs occurring on premises covered by the Hospital’s license, and (iv) timely submit the preventability determination report to DPH (“updated SRE report”), with copies to all other required parties, as specified in such regulations.

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2. A Hospital shall notify the MassHealth program of the occurrence of an SRE by mailing a copy of the report as filed with DPH pursuant to **Section 8.3.C.1** to:

Serious Reportable Event Coordinator
MassHealth
Utilization Management Department
100 Hancock Street, 6th Floor
Quincy, MA 02171

Hospitals shall also use this address to send MassHealth a copy of the updated SRE report as submitted to DPH containing the information as specified under DPH regulations at 105 CMR 130.332.

3. No later than thirty days after the date of initial reporting of the SRE to DPH and MassHealth, if upon completing a preventability determination following the occurrence of an SRE pursuant to **Section 8.3.C.1**, above, the Hospital seeks payment for Inpatient Services or Outpatient Services to a MassHealth member, the Hospital shall submit the following required documentation to MassHealth, using the address set forth in **Section 8.3.C.2**, above, so it can review the circumstances of the SRE;
 - (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.

D. Non-Payment for SREs

1. MassHealth will review the circumstances of the SRE and shall make a determination regarding payment based on the criteria set forth in DPH regulations at 105 CMR 130.332 and above, and utilizing **Table 8-1**, below:

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

Payment Component that includes Preventable SRE	Resulting Non-payment
Inpatient acute admission	Non-payment of APAD and Outlier Payments
Inpatient - Transfer Per Diem, Psychiatric Per Diem, Acute Rehab Per Diem, or Administrative Day 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

2. In accordance with state and federal statutes, rules, and regulations governing the MassHealth program, including but not limited to 130 CMR 415.000 *et seq.* (Acute Inpatient Hospitals); 130 CMR 410.000 *et seq.* (Acute Outpatient Hospitals) and 130 CMR 450.000, *et seq.* (administrative and billing instructions), EOHHS may request additional information from the Hospital which EOHHS deems necessary to facilitate its review of any SRE or to carry out payment, quality or other routine functions of the MassHealth program, and the Hospital must comply with the request.

Attachment B – Public Notice
RY 16 In-State Acute Hospital Inpatient Rates – Effective 10/1/15

	Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates* (*See link at end for Chart 1: RY16 MassHealth DRG Weights and Mean All Payer Lengths of Stay)											Other Per Diem Rates			
In-State Provider	Statewide Operating Standard per Discharge	Hospital Wage Area	Labor Factor	Wage Adjusted Operating Standard per Discharge	Statewide Capital Standard per Discharge	Payment for Organ Acquisition	Payment for Malpractice	Hospital Cost-to- Charge Ratio	Potentially Preventable Readmission Adjustment %	Fixed Outlier Threshold	Marginal Cost Factor	Admin Day	Admin Day w. Medicare Part B	Psych per Diem	Rehab per Diem
Anna Jaques Hospital	\$ 9,391.96	0.9062	0.69587	\$ 8,778.92	\$ 631.63	\$ -	\$ 25.26	63.41%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Baystate Franklin Medical Center	\$ 9,391.96	0.9412	0.69587	\$ 9,007.66	\$ 631.63	\$ -	\$ 43.58	63.16%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Baystate Mary Lane Hospital	\$ 9,391.96	0.8515	0.69587	\$ 8,421.42	\$ 631.63	\$ -	\$ 89.19	92.64%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Baystate Medical Center	\$ 9,391.96	0.8922	0.69587	\$ 8,687.42	\$ 631.63	\$ 52.07	\$ 152.74	50.21%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Baystate Noble Hospital	\$ 9,391.96	0.8515	0.69587	\$ 8,421.42	\$ 631.63	\$ -	\$ 33.62	47.00%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ 754.24
Baystate Wing Hospital	\$ 9,391.96	0.8515	0.69587	\$ 8,421.42	\$ 631.63	\$ -	\$ 9.81	42.55%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Berkshire Medical Center	\$ 9,391.96	0.8993	0.69587	\$ 8,733.82	\$ 631.63	\$ -	\$ 88.32	67.33%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ 754.24
Beth Israel Deaconess Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 178.43	\$ 102.92	53.10%	1.405%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Beth Israel Deaconess Hospital -Milton	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 65.90	53.70%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Beth Israel Deaconess Hospital -Needham	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 44.61	69.42%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Beth Israel Deaconess Hospital - Plymouth	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 25.10	62.92%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Beverly Hospital	\$ 9,391.96	0.9062	0.69587	\$ 8,778.92	\$ 631.63	\$ -	\$ 114.56	66.02%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Boston Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 81.77	\$ 144.36	64.68%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Brigham & Women's Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 404.93	\$ 187.60	31.46%	1.807%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Brockton Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 140.58	45.08%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Cambridge Health Alliance	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 141.02	75.19%	1.641%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Cape Cod Hospital	\$ 9,391.96	1.1193	0.69587	\$10,171.65	\$ 631.63	\$ -	\$ 61.01	65.36%	0.846%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Carney Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 92.22	113.90%	1.193%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Children's Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 473.41	\$ 145.24	58.89%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Clinton Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 4.00	47.86%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -

R^Y 16 In-State Acute Hospital Inpatient Rates – Effective 10/1/15

	Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates* (*See link at end for Chart 1: RY16 MassHealth DRG Weights and Mean All Payer Lengths of Stay)											Other Per Diem Rates			
In-State Provider	Statewide Operating Standard per Discharge	Hospital Wage Area	Labor Factor	Wage Adjusted Operating Standard per Discharge	Statewide Capital Standard per Discharge	Payment for Organ Acquisition	Payment for Malpractice	Hospital Cost-to- Charge Ratio	Potentially Preventable Readmission Adjustment %	Fixed Outlier Threshold	Marginal Cost Factor	Admin Day	Admin Day w. Medicare Part B	Psych per Diem	Rehab per Diem
Cooley Dickinson Hospital	\$ 9,391.96	0.8515	0.69587	\$8,421.42	\$ 631.63	\$ -	\$ 47.17	52.89%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Dana Farber Cancer Institute	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 74.14	31.69%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Emerson Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 67.66	54.54%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Falmouth Hospital	\$ 9,391.96	1.1193	0.69587	\$10,171.65	\$ 631.63	\$ -	\$ 66.12	67.16%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Faulkner Hospital	\$ 9,391.96	1.0255	0.69587	\$9,558.61	\$ 631.63	\$ -	\$ 82.47	48.11%	3.022%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Good Samaritan Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 47.53	74.83%	2.303%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Hallmark Health Systems	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 3.75	69.74%	1.134%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Harrington Memorial Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 53.01	74.02%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Health Alliance Hospitals	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 2.93	52.47%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Heywood Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 59.53	61.60%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Holy Family Hospital	\$ 9,391.96	0.9062	0.69587	\$ 8,778.92	\$ 631.63	\$ -	\$ 54.45	63.66%	2.256%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Holyoke Medical Center	\$ 9,391.96	0.8515	0.69587	\$ 8,421.42	\$ 631.63	\$ -	\$ 118.79	70.36%	2.981%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Lahey Hospital and Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 368.39	\$ 29.04	52.77%	4.298%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Lawrence General Hospital	\$ 9,391.96	0.9062	0.69587	\$ 8,778.92	\$ 631.63	\$ -	\$ 85.01	69.50%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Lowell General Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 25.24	45.23%	2.119%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Marlborough Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 1.35	45.47%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Massachusetts Eye & Ear Infirmary	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 88.73	48.48%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -
Massachusetts General Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 323.54	\$ 101.26	30.16%	0.141%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Mercy Medical Center	\$ 9,391.96	0.8515	0.69587	\$ 8,421.42	\$ 631.63	\$ -	\$ 101.46	47.68%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ 754.24
MetroWest Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 108.05	72.39%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Milford Regional Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 51.88	54.31%	2.024%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ -	\$ -

R^Y 16 In-State Acute Hospital Inpatient Rates – Effective 10/1/15

	Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates* (*See link at end for Chart 1: RY16 MassHealth DRG Weights and Mean All Payer Lengths of Stay)											Other Per Diem Rates			
In-State Provider	Statewide Operating Standard per Discharge	Hospital Wage Area	Labor Factor	Wage Adjusted Operating Standard per Discharge	Statewide Capital Standard per Discharge	Payment for Organ Acquisition	Payment for Malpractice	Hospital Cost-to- Charge Ratio	Potentially Preventable Readmission Adjustment %	Fixed Outlier Threshold	Marginal Cost Factor	Admin Day	Admin Day w. Medicare Part B	Psych per Diem	Rehab per Diem
Morton Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 43.51	75.22%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Mount Auburn Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 16.18	58.31%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Nantucket Cottage Hospital	\$ 9,391.96	0.9412	0.69587	\$ 9,007.66	\$ 631.63	\$ -	\$ 101.94	108.14%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Nashoba Valley Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 77.15	54.03%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
New England Baptist Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 25.09	51.92%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Newton-Wellesley Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 135.49	41.52%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
North Shore Medical Center	\$ 9,391.96	0.9062	0.69587	\$ 8,778.92	\$ 631.63	\$ -	\$ 28.77	45.59%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Norwood Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 49.37	69.23%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Saint Vincent Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 102.49	61.96%	1.597%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Shriners - Boston	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ -	128.98%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Shriners - Springfield	\$ 9,391.96	0.8515	0.69587	\$ 8,421.42	\$ 631.63	\$ -	\$ -	158.73%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
South Shore Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 35.46	52.57%	2.169%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Southcoast Hospitals Group	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 22.56	47.76%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ 754.24
St. Anne's Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 41.18	71.50%	4.100%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
St. Elizabeth's Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 151.13	64.85%	0.910%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Sturdy Memorial Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 53.36	67.48%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Tufts Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 437.61	\$ 198.84	43.73%	2.044%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Umass Memorial Medical Center	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ 334.71	\$ 16.52	40.33%	0.000%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -
Winchester Hospital	\$ 9,391.96	1.0255	0.69587	\$ 9,558.61	\$ 631.63	\$ -	\$ 38.86	72.97%	0.343%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09	\$ 883.52	\$ -

*See Chart 1 for the RY16 MassHealth DRG Weights and Mean All Payer Lengths of Stay. Click here: [Chart 1-Acute Hospital RY2016 MassHealth DRG Weights and Mean All-Payer Lengths of Stay](#)

R Y 16 In-State Acute Hospital Inpatient Rates – Effective 10/1/15

	Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates*				Other Per Diem Rates	
Critical Access Hospitals** In-State Provider	R Y16 CAH-Specific Total Standard Rate per Discharge	Hospital Cost-to-Charge Ratio	Fixed Outlier Threshold	Marginal Cost Factor	Administrative Day	Administrative Day w. Medicare Part B
Athol Memorial Hospital**	\$ 15,471.84	82.42%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09
Berkshire Fairview Hospital**	\$ 26,192.76	128.20%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09
Martha's Vineyard Hospital**	\$ 23,461.94	58.44%	\$ 24,000.00	80%	\$ 281.25	\$ 260.09

*See Chart 1 for the RY16 MassHealth DRG Weights and Mean All Payer Lengths of Stay. Click here: [Chart 1-Acute Hospital RY2016 MassHealth DRG Weights and Mean All-Payer Lengths of Stay](#)

** For Critical Access Hospitals – subject to reconciliation.

Public Notice – In-State Hospitals

Outpatient Payment Amount per Episode (PAPE) Rates –RY16 Effective 10/01/15

PROVIDER NAME	PAPE RY 2016
ANNA JAKUES HOSPITAL	\$331.19
ATHOL MEMORIAL HOSPITAL **	\$433.99
BAYSTATE FRANKLIN MEDICAL CENTER	\$320.64
BAYSTATE MARY LANE HOSPITAL	\$293.17
BAYSTATE MEDICAL CENTER	\$301.43
BAYSTATE NOBLE HOSPITAL	\$328.67
BAYSTATE WING HOSPITAL	\$227.80
BERKSHIRE FAIRVIEW HOSPITAL **	\$502.70
BERKSHIRE MEDICAL CENTER	\$402.99
BETH ISRAEL DEACONESS MEDICAL CENTER	\$369.71
BETH ISRAEL DEACONESS HOSPITAL - MILTON	\$356.57
BETH ISRAEL DEACONESS HOSPITAL - NEEDHAM	\$461.26
BETH ISRAEL DEACONESS HOSPITAL - PLYMOUTH	\$358.92
BEVERLY HOSPITAL	\$317.43
BOSTON MEDICAL CENTER	\$254.88
BRIGHAM & WOMEN'S HOSPITAL	\$313.24
BROCKTON HOSPITAL	\$342.98
CAMBRIDGE HEALTH ALLIANCE	\$248.02
CAPE COD HOSPITAL	\$376.63
CARNEY HOSPITAL	\$300.49
CHILDREN'S HOSPITAL	\$445.55
CLINTON HOSPITAL	\$239.71
COOLEY DICKINSON HOSPITAL	\$348.08
DANA FARBER CANCER INSTITUTE	\$1,115.79
EMERSON HOSPITAL	\$300.86
FALMOUTH HOSPITAL	\$343.50
FAULKNER HOSPITAL	\$390.66
GOOD SAMARITAN MEDICAL CENTER	\$405.48
HALLMARK HEALTH SYSTEMS	\$331.69
HARRINGTON MEMORIAL HOSPITAL	\$318.34
HEALTHALLIANCE HOSPITALS	\$271.52
HEYWOOD HOSPITAL	\$301.73

PROVIDER NAME	PAPE RY 2016
HOLY FAMILY HOSPITAL	\$329.84
HOLYOKE MEDICAL CENTER	\$339.75
LAHEY HOSPITAL AND MEDICAL CENTER	\$394.24
LAWRENCE GENERAL HOSPITAL	\$351.15
LOWELL GENERAL HOSPITAL	\$399.27
MARLBOROUGH HOSPITAL	\$317.54
MARTHA'S VINEYARD HOSPITAL **	\$544.41
MASSACHUSETTS EYE & EAR INFIRMARY	\$455.89
MASSACHUSETTS GENERAL HOSPITAL	\$315.18
MERCY MEDICAL CENTER	\$296.71
METROWEST MEDICAL CENTER	\$284.26
MILFORD REGIONAL MEDICAL CENTER	\$303.97
MORTON HOSPITAL	\$277.99
MOUNT AUBURN HOSPITAL	\$431.48
NANTUCKET COTTAGE HOSPITAL	\$266.02
NASHOBA VALLEY MEDICAL CTR	\$306.07
NEW ENGLAND BAPTIST HOSPITAL	\$382.57
NEWTON-WELLESLEY HOSPITAL	\$326.89
NORTH SHORE MEDICAL CENTER	\$376.85
NORWOOD HOSPITAL	\$392.10
SAINT VINCENT HOSPITAL	\$364.03
SHRINERS - BOSTON	\$817.41
SHRINERS - SPRINGFIELD	\$436.54
SOUTH SHORE HOSPITAL	\$359.79
SOUTHCOAST HOSPITALS GROUP	\$354.84
ST. ANNE'S HOSPITAL	\$375.41
ST. ELIZABETH'S HOSPITAL	\$444.00
STURDY MEMORIAL HOSPITAL	\$325.47
TUFTS MEDICAL CENTER	\$298.40
UMASS MEMORIAL MEDICAL CENTER	\$309.21
WINCHESTER HOSPITAL	\$294.94

** Subject to reconciliation- for Critical Access Hospitals