# Notice of Final Agency Action

**SUBJECT:** MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, effective October 1, 2022

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

## Introduction

**Part I** of this notice describes and summarizes the MassHealth out-of-state acute hospital payment methodologies, and sets forth MassHealth rates and rate components for out-of-state acute hospital services for rate year 2023 (RY23), which begins October 1, 2022, and ends September 30, 2023 (see Attachment A to Part I). **Part II** of this notice describes and summarizes proposed changes in MassHealth payment for services provided by in-state acute hospitals, effective for RY23, which begins October 1, 2022, and ends September 30, 2023. A complete description of the RY23 MassHealth in-state acute hospital inpatient and outpatient payment methods is attached to Part II (see also Attachment B for RY23 in-state acute hospital rates and rate components). For further information regarding RY23 acute hospital payment methods and rates, or to provide written comments, contact Hai Nguyen at the Executive Office of Health and Human Services, MassHealth Office of Providers and Pharmacy Programs, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or by email at hai.nguyen@state.ma.us. EOHHS specifically invites comments regarding the impact of the proposed changes on member access to care.

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

### 1. Out-of-State Acute Inpatient Hospital Services

In RY23, the MassHealth out-of-state acute inpatient hospital payment methodologies are generally unchanged from RY22. However, as a result of changes to the in-state acute inpatient hospital rates and rate components described in Part II.1 of this notice, the corresponding out-of-state acute inpatient hospital rates and rate components will also be changing effective with RY23 (see Attachment A to Part I of this notice).

**Out-of-State Acute Inpatient Hospital Payment Methods**
Except as provided in Section 3 of Part I, the out-of-state acute inpatient hospital payment methods applicable to RY23 are as follows.

- **Out-of-State APAD.** 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 with the exception of long-acting reversible contraception (LARC) Devices, and APAD Carve-Out Drugs, as further described later in the document. 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 Diagnostic Related Group (DRG) Weight[1] assigned to the discharge by MassHealth using information contained on a properly submitted inpatient hospital claim.

[1] The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of All Patient Refined-Diagnostic Related Group and severity of illness (APR-DRG or DRG). The APR-DRG is assigned based on information on a properly submitted inpatient hospital claim by the 3M APR-DRG grouper.

- **Out-of-State Outlier Payment.** 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,[2] as determined by MassHealth, multiplied by the applicable inpatient cost-to-charge ratio. For High MassHealth Volume Hospitals,[3] 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.

- **Out-of-State Transfer per Diem.** 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. The Out-of-State Transfer Per Diem (similarly capped) will also be paid in certain other circumstances to generally align with the in-state method.

- **Out-of-State Psychiatric per Diem.** 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 most recently in effect for in-state acute hospitals on the date of service, and no other payment methods apply.

- **APAD Carve-Outs.** The Out-of-State APAD does not provide payment for LARC Devices or APAD Carve-Out Drugs. Instead, payment is as described next.

    - ***Long-Acting Reversible Contraception (LARC) devices (LARC Devices).*** Out-of-state acute inpatient hospitals will continue to be paid separately for a LARC Device if the LARC procedure occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay, and all other MassHealth acute inpatient hospital requirements are met. Payment will be in accordance with the fee schedule rates for such devices set forth in EOHHS regulations at 101 CMR 317.00 (Medicine). LARC Devices are defined specifically as intrauterine devices and contraceptive implants; they do not refer to the procedure itself.

[2] A hospital's charges for a LARC Device and for APAD Carve-Out Drugs will be excluded.
[3] In RY23, as in RY22, an out-of-state "High MassHealth Volume Hospital" is an out-of-state hospital that had at least 100 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. As in RY22, in RY23 the two High MassHealth Volume Hospitals will be Rhode Island Hospital and Women & Infants Hospital (RI).

- ***APAD Carve-Out Drugs.*** Out-of-state acute inpatient hospitals will be paid separately for APAD Carve-Out Drugs4 administered to a MassHealth member during an inpatient admission if all MassHealth requirements are met. In such circumstances, out-of-state acute inpatient hospitals will be reimbursed for the APAD Carve-Out Drug in accordance with the MassHealth payment method applicable to such drug as in effect for in-state acute inpatient hospitals on the date of service.

## 2. Out-of-State Acute Outpatient Hospital Services

In RY23, the MassHealth out-of-state acute outpatient hospital payment methodologies are generally unchanged from RY22. However, as a result of changes to the in-state acute outpatient hospital adjudicated payment per episode of care (APEC) rate components as described in Part II.2 of this notice, the Out-of-State APEC rate components will also be changing effective with RY23 (see Attachment A to Part I of this notice).

**Out-of-State Acute Outpatient Hospital Payment Methods**
Except as provided in Section 3 of Part I, and except for APEC-Carve-Out Drugs (as further described later in this document), out-of-state acute hospitals will continue to be paid for outpatient services utilizing an adjudicated payment per episode of care payment methodology ("Out-of-State APEC") for services for which in-state acute hospitals are paid the APEC ("APEC-covered services"), or according to the applicable fee schedules in regulations adopted by EOHHS for services for which in-state acute hospitals are not paid the APEC.

- **Out-of-State APEC.** The Out-of-State APEC is an episode-specific all-inclusive facility payment for all APEC-covered services provided in the episode. The Out-of-State APEC for each payable episode will equal the sum of the episode-specific total Enhanced Ambulatory Patient Group (EAPG) payment and the APEC outlier component (if applicable).
  - The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG[5] payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC outpatient statewide standard in effect for in-state acute hospitals on the date of service, and the claim detail line's adjusted EAPG weight. The 3M EAPG grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line MassHealth EAPG weights to produce the claim detail line's adjusted EAPG weight for this calculation. The "MassHealth EAPG weight" is the MassHealth relative weight developed by MassHealth for each unique EAPG.
  - The "APEC outlier component" equals the marginal cost factor in effect for in-state acute hospitals on the date of service, multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold. The "episode-specific case cost" is determined by MassHealth by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the applicable outpatient cost-to-charge ratio. For High MassHealth Volume Hospitals,[6] the cost-to-charge ratio is hospital-specific; for all other out-of-

[4] The MassHealth-designated APAD Carve-Out Drugs are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" page of the MassHealth Drug List, and may be updated from time to time. The MDHL is posted at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.
[5] EAPG refers to Enhanced Ambulatory Patient Group. EAPGs are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient hospital claim by the 3M EAPG grouper and refer to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix.
[6] See footnote 3 and accompanying text.

state acute hospitals, the median in-state acute hospital outpatient cost-to-charge ratio in effect, based on episode volume, is used. The "episode-specific outlier threshold" equals the sum of the episode-specific total EAPG payment corresponding to the episode (see above), and the fixed outpatient outlier threshold in effect for in-state acute hospitals. In no case is an "APEC outlier component" payable if the episode-specific total EAPG payment is $0.

- **APEC Carve-Out Drugs.** Out-of-state acute outpatient hospitals will be paid separately from the APEC for APEC Carve-Out Drugs[7] administered to a MassHealth member during an acute outpatient hospital visit if all MassHealth requirements are met. In such circumstances, out-of-state acute outpatient hospitals will be reimbursed for the APEC Carve-Out Drug in accordance with the MassHealth payment method applicable to such drug as in effect for in-state acute outpatient hospitals on the date of service.

**3. <u>Services Not Available In-State</u>**

For medical services MassHealth determines are not available in-state, an out-of-state acute hospital that is not a High MassHealth Volume Hospital[8] 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 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.

[7] The MassHealth-designated APEC Carve-Out Drugs will be identified on the "MassHealth Acute Hospital Carve-Out Drugs List" page of the MassHealth Drug List, and may be updated from time to time. The MHDL is posted at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.

[8] See footnote 3 and accompanying text.

## ATTACHMENT A

### Out-of-State Acute Hospital Rates

### I. INPATIENT — Effective 10/1/22

| Here are the out-of-state acute inpatient hospital rates/rate components for the Out-of-State APAD, Outlier Payment and Transfer Per Diem rates, as well as the Psychiatric Per Diem rate, effective for RY23. See Part I.1 for descriptions of the calculations of the out-of-state acute hospital inpatient payment methods. Payment for LARC Devices will be in accordance with the fee schedule rates for such devices at 101 CMR 317.00 (Medicine), and payment for APAD Carve-Out Drugs will be in accordance with the in-state acute hospital payment method for such drugs. **Components of Out-of-State APAD, Outlier Payment, & Transfer Per Diem Rates (applicable to admissions in Rate Year 2023)** | | | | | | | | | **Other (for dates of service in RY23)** |
|---|---|---|---|---|---|---|---|---|---|
| | 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 Hospitals:** | | | | | | | | | |
| *Rhode Island Hospital* | $11,566.32 | $799.07 | $12,365.39 | See Chart C* | 60% | 31.59% | $39,925.00 | See Chart C* | $954.59 |
| *Women & Infants Hospital (RI)* | $11,566.32 | $799.07 | $12,365.39 | See Chart C* | 60% | 44.40% | $39,925.00 | See Chart C* | $954.59 |
| **All Other Out-of-State Acute Hospitals:**** | $11,566.32 | $799.07 | $12,365.39 | See Chart C* | 60% | 47.62% | $39,925.00 | See Chart C* | $954.59 |

***See Chart C for the RY23 MassHealth DRG Weights and Mean All-Payer Lengths of Stay.**
Click here: Chart C- Acute Hospital RY23 MassHealth DRG Weights and Mean All Payer Lengths of Stay

****** 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.

**Out-of-State Acute Hospital Rates (continued)**

## II. OUTPATIENT APEC – Effective 10/1/22

Out-of-State Acute Hospitals will be paid an Out-of-State APEC for APEC-covered outpatient services, which is an episode-specific payment method. APEC rate components are as follows for the dates of service in RY23. (See description of this payment method in Part I.2 earlier in this document.) Payment for APEC Carve-Out Drugs will be in accordance with the in-state acute hospital payment method for such drugs.

**Components of Out-of-State APEC Rates**
**(applicable to dates of service in RY23)**

| | In-state APEC Outpatient Statewide Standard | MassHealth EAPG Weight | In-State Marginal Cost Factor | Cost-to-Charge Ratio | In-State Fixed Outpatient Outlier Threshold |
|---|---|---|---|---|---|
| **High MassHealth Volume Hospitals:** | | | | | |
| *Rhode Island Hospital* | $653.84 | See Chart D* | 60% | 22.86% | $4,200.00 |
| *Women & Infants Hospital (RI)* | $653.84 | See Chart D* | 60% | 35.54% | $4,200.00 |
| **All Other Out-of-State Acute Hospitals**** | $653.84 | See Chart D* | 60% | 34.86% | $4,200.00 |

***See Chart D for the RY23 MassHealth EAPG Weights.**
Click here: Chart D-Acute Hospital RY23 MassHealth EAPG Weights

**Note:** The 3M EAPG grouper's discounting, consolidation, and packaging logic is applied to each of the episode's claim detail MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight that is used in the APEC calculation.

****** 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.

## PART II: Proposed Changes to In-State Acute Hospital Payment Methods

### 1. In-State Acute Inpatient Hospital Inpatient Services

#### A. Summary of Proposed RY23 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 separate section later in this document), the following payment methods apply to in-state acute inpatient hospitals.

***Adjudicated Payment Amount per Discharge (APAD)***

In-state acute inpatient hospitals will continue to be paid an adjudicated payment amount per discharge (APAD) for each payable discharge. The APAD is an all-inclusive facility payment that will cover the MassHealth member's entire acute inpatient stay from admission through discharge, exclusive of LARC Devices and APAD Carve-Out Drugs for which payment separate from the APAD will continue to be made (described further later). The discharge-specific APAD is determined by the following steps: (1) adding the statewide operating standard per discharge, adjusted for the hospital's Massachusetts-specific wage area index, to the statewide capital standard per discharge (which sum is referred to as the "APAD Base Payment"), and (2) multiplying the APAD Base Payment by the MassHealth DRG Weight assigned to the discharge by MassHealth using information on a properly submitted inpatient claim.

The APAD Base Year is federal fiscal year (FY) 2019. The components of the APAD applicable to admissions in RY23 are described here.

- The statewide operating standard per discharge is derived from the statewide average hospital all payer cost per discharge using APAD Base Year data, standardized for casemix differences and area wage variation. An efficiency standard is determined by capping hospital costs, weighted by FY21 MassHealth discharges, at the 60% level of costs. The statewide average is adjusted for outliers and inflation. Certain costs are excluded (e.g., Excluded Units, capital costs, costs of LARC Devices). Malpractice and organ acquisition costs are included. 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, the statewide operating standard per discharge is then adjusted for that hospital's Massachusetts-specific wage area index.
- The statewide capital standard per discharge is derived from the statewide weighted average hospital capital cost per discharge using APAD Base Year data, standardized for casemix differences. An efficiency standard is determined by capping hospital casemix-adjusted capital costs, weighted by FY21 MassHealth discharges, at the 60% 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.
- 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 Corporation's APR-DRG grouper version 38 and Massachusetts weights.
- For discharges assigned a MassHealth DRG Weight of 3.0 or greater from Freestanding Pediatric Acute Hospitals,[9] the APAD Base Payment will be adjusted to include an additional 57%.

[9] "Freestanding Pediatric Acute Hospitals" is as defined in the RY23 RFA.

***Outlier Payment***

For qualifying discharges that correspond to admissions occurring in RY23, in-state acute hospitals will also continue to 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 60%, 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 FY20 inpatient cost-to-charge ratio. The discharge-specific outlier threshold is the sum of the hospital's APAD for the discharge, and the inpatient fixed outlier threshold, which is $39,925. Charges for a LARC Device and APAD Carve-Out Drugs (each defined later) are excluded during these calculations.

***Transfer Per Diem***

Inpatient services delivered to members 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 for 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. This payment method also applies in certain other circumstances when MassHealth is the responsible payer for only a portion of the acute hospital stay.

***Other Per Diems***

Behavioral health services delivered in DMH-licensed psychiatric beds of acute hospitals are paid a statewide psychiatric per diem rate, and acute hospitals are paid a statewide rehabilitation per diem rate for services delivered in Rehabilitation Units. Administrative days are also paid a per diem rate. All per diems are all-inclusive.

***LARC Device***

Long-Acting Reversible Contraception (LARC) devices are defined specifically as intrauterine devices and contraceptive implants and do not include the procedure itself. Acute inpatient hospitals may be paid separately from the APAD for the LARC Device if the LARC procedure occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay, and all other MassHealth requirements are met. Payment will be in accordance with the fee schedule rates for such devices set forth in EOHHS regulations at 101 CMR 317.00 (*Rates for Medicine Services*).

***APAD Carve-Out Drugs***

Acute inpatient hospitals will be paid separately from the APAD for APAD Carve-Out Drugs[10] administered to a MassHealth member during an acute inpatient hospital admission if MassHealth requirements are met. MassHealth payment for APAD Carve-Out Drugs will be the Hospital's actual acquisition cost of the drug.[11]

[10] The list of MassHealth designated "APAD Carve-Out Drugs" are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" of the MassHealth Drug List (MHDL), and may be updated from time to time. The MHDL is posted at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.

[11] References to "drugs" in this notice refers to drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

***Inpatient Admission Rates Payments***

For inpatient BH admissions in DMH-Licensed Beds for members who are not enrolled with the BH Contractor or an MCO, an inpatient admission rate will be paid in addition to the inpatient per diem rate. There are six categories, based on criteria met upon admission, with separate established rates.

***Critical Access Hospitals***

Final payment to Critical Access Hospitals (CAHs) for FY23 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 payments will be made subject to final reconciliation. The interim inpatient APAD, Outlier Payment and Transfer per Diem, and interim outpatient APEC rates and rate components effective as of RY23 have been updated utilizing more recent data (based on FY21 CMS 2552-10 cost reports), and the interim inpatient Outlier Payment and Transfer per Diem payments are otherwise calculated the same as they are for all other hospitals (except utilizing as part of those methodologies, the modified interim APAD calculations applicable to critical access hospitals). These interim rates are calculated generally to approximate 101% of costs.

***RY23 In-State Acute Inpatient Hospital Rates and Rate Components***

The in-state acute inpatient hospital rates and rate components applicable to RY23 are set forth in Attachment B.

## B. Summary of Proposed Changes

RY23 payment methods for in-state acute inpatient hospital services include changes from the RY22 payment methods, including the following.

(1) In calculating the APAD:
- The APAD Base Year remains FY19.
- APAD Base Year discharges from MMIS were used in weighting APAD Base Year costs for determining the efficiency standards for the statewide operating and capital standards per discharge; both efficiency standards were again set at the 60% level of costs.
- In calculating the statewide operating standard and the hospital's wage adjusted operating standard per discharge, the labor factor was updated consistent with CMS updates, and the method used to calculate the hospital's Massachusetts-specific wage area index remains the same.
- The outlier adjustment factor applied for the statewide operating standard per discharge remains 91.85%.
- For price changes between RY22 and RY23, an inflation update of 2.451% was applied to the statewide operating standard and 1.7% to the statewide capital standard per discharge.
- For discharges assigned a MassHealth DRG Weight of 3.0 or greater from Freestanding Pediatric Acute Hospitals, the APAD Base Payment is adjusted to include an additional 57%.

(2) To calculate the Outlier Payment (if any), the fixed outlier threshold was changed to $39,925, the marginal cost factor remains at 60%, and each hospital's inpatient cost-to-charge ratio was calculated based on the hospital's FY20 Massachusetts Hospital cost report.

(3) EOHHS utilized FY22 base median nursing facility rates when calculating the administrative day (AD) per diem rate for RY23.

(4) For critical access hospitals paid at 101% of allowable costs utilizing Medicare's cost-based reimbursement methodology, interim APAD rates for admissions in RY23 were derived utilizing cost

data from the hospital's FY21 CMS 2552-10 cost report. Final payment for the FY23 period will be made as described in Part II, Section 1.A.

## 2. In-State Acute Hospital Outpatient Services

### A. Summary of Proposed RY23 In-State Methodology for Calculating the Adjudicated Payment per Episode of Care (APEC), and other Outpatient Hospital Service Payments

Except as otherwise indicated for Critical Access Hospitals (see separate section later in this document), the following payment methods apply to in-state acute outpatient hospitals.

During RY23, hospitals will continue to receive a hospital-specific, episode-specific all-inclusive facility payment for each payable episode known as the adjudicated payment per episode of care (APEC). The APEC will be payment in full for most MassHealth acute outpatient hospital services that are delivered to a member on a single calendar day, or if the services extend past midnight in the case of emergency department or observation services, on consecutive days.[12] Outpatient services paid for by the APEC are referred to as "APEC-covered services." Certain services, including laboratory services, are carved out of the APEC calculation and payment. Laboratory services and other carve-out services (with the exception of APEC Carve-Out Drugs) are paid for in accordance with applicable fee schedules in regulations adopted by EOHHS. The APEC payment method, and the payment method for APEC Carve-Out Drugs, are each described further later.

***Adjudicated Payment per Episode of Care (APEC)***

The RY23 APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus (2) if applicable, an APEC Outlier Component, each as further described later. The APEC Base Year is calendar year (CY) 2019.

The "Episode-Specific Total EAPG Payment" is equal to the sum of all of the episode's claim detail line EAPG[13] payment amounts, where each claim detail line EAPG payment amount is equal to the product of the hospital's Wage Adjusted APEC Outpatient Standard and the claim detail line's Adjusted EAPG Weight.

- The Wage Adjusted APEC Outpatient Standard is the APEC Outpatient Statewide Standard, adjusted by the hospital's Massachusetts-specific wage area index.[14]
    - In determining the APEC Outpatient Statewide Standard, an average outpatient cost per episode is calculated for each hospital, utilizing the hospital's FY19 outpatient cost-to-charge ratio from its 403 cost report, and allowed charges and episodes based on CY19 APEC paid claims data in MMIS. Each hospital's average outpatient cost per episode was adjusted by the Hospital's Massachusetts-specific wage area index, and by the hospital's CY19 outpatient casemix index,

[12] In certain limited circumstances, APEC-covered services delivered to a member in a second distinct and independent visit on the same calendar day may be considered a separate episode.

[13] EAPG stands for Enhanced Ambulatory Patient Group, and refers to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix. EAPGs are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient hospital claim by the 3M EAPG grouper version 3.16 (configured for the MassHealth APEC methodology).

[14] The hospital's Massachusetts-specific wage area index used in the APEC calculation is determined the same way as it is determined for the inpatient APAD calculation.

as determined by EOHHS, to produce the hospital's standardized cost per episode. An efficiency standard was applied by capping standardized hospital costs, weighted by total statewide CY19 episodes, at the 60% level of costs. The weighted mean of the hospitals' capped costs per episode is adjusted by an outlier adjustment factor and inflation is applied, which result is then divided by a conversion factor to result in the APEC Outpatient Statewide Standard.

- Except for certain hospitals identified later in this document, for each hospital, the APEC Outpatient Statewide Standard is then adjusted for that hospital's Massachusetts-specific wage area index to produce the hospital's Wage Adjusted APEC Outpatient Standard. In calculating the APEC for a hospital that is (1) a PPS-exempt cancer hospital under 42 CFR 412.23(f) or (2) a Group 1 safety net hospital in Appendix N to the MassHealth 1115 waiver, EOHHS applied different Wage Adjusted APEC Outpatient Standards.

- EAPGs are assigned to the Episode's APEC-covered services based on information within a properly submitted outpatient Hospital claim, utilizing the 3M EAPG grouper version 3.16. EAPGs are assigned at the claim detail line level. The MassHealth EAPG weight is the MassHealth relative weight developed by MassHealth for each unique EAPG. The 3M EAPG grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG weights to produce the claim detail line's Adjusted EAPG Weight.

The APEC Outlier Component (if applicable) is equal to the product of the marginal cost factor of 60%, and the amount by which the episode-specific case cost exceeds the episode-specific outlier threshold, as calculated by EOHHS. The episode-specific case cost is the product of the episode's total allowed charges (which is the sum of the MassHealth allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay), and the hospital's FY20 outpatient cost-to-charge ratio (based on the hospital's FY20 Massachusetts Hospital cost report). The episode-specific outlier threshold is the sum of (1) the Episode-Specific Total EAPG Payment and (2) the RY23 fixed outpatient outlier threshold of $4,200. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.

***APEC-Carve-Out Drugs***

Acute outpatient hospitals will be paid separate from the APEC for APEC Carve-Out Drugs[15] administered to a MassHealth member during an acute outpatient hospital visit if MassHealth requirements are met. MassHealth payment for APEC Carve-Out Drugs will be the Hospital's actual acquisition cost of the drug.

***Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule***

Acute outpatient hospitals will be paid separate from the APEC for outpatient administration of certain physician administered drugs identified on the "Certain MassHealth Outpatient Physician Administered Drugs to be paid by fee schedule" section of the MassHealth Drug List (Fee Schedule Drugs). The list of Fee Schedule Drugs may be updated from time-to-time. Payment to hospitals for the outpatient administration of any Fee Schedule Drug shall be the amount as listed by the quarterly Medicare Part B Drug Average Sales Price for the Fee Schedule Drug, as set forth on CMS's website at www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2022-asp-drug-pricing-files.

[15] The list of MassHealth designated "APEC Carve-Out Drugs" are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" of the MassHealth Drug List (MHDL), and may be updated from time to time. The MHDL is posted at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.

***Reimbursement for CARES for Kids Program Services***

The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support for Kids Program (CARES program) is a targeted case management (TCM) service rendered by MassHealth-certified CARES program providers to members younger than 21 years of age in accordance with CARES program requirements. Effective for date of service on or after July 1, 2023, hospitals providing outpatient TCM services in accordance with the MassHealth CARES Program Services requirements at 130 CMR 410.482 will be reimbursed at individual consideration (I.C.) until appropriate rates can be developed to be listed in 101 CMR 317.00: *Rates for Medicine Services*.

***Update to Emergency Department Services***

Beginning on January 1, 2023, the hospital will offer Behavioral Health Crisis Evaluations. The hospital is responsible for disposition planning, including assisting in placement for fee-for-service members requiring inpatient psychiatric treatment or behavioral health diversionary services, in conjunction with the referring provider and MassHealth.

***Critical Access Hospitals***

The payment methodology for in-state Critical Access Hospitals is described in Part II, Section 1.A.

***RY23 In-State Acute Outpatient Hospital APEC Rate Components***

The in-state acute outpatient hospital APEC rate components applicable to RY23 are set forth in Attachment B.

## B. Summary of Proposed Changes

RY23 payment methods for in-state acute outpatient hospital services include changes from the RY22 payment methods, including the following.

(1) In calculating the APEC:

- For the Episode-Specific Total EAPG Payment, the individual claim detail line EAPG payment amounts will be determined by multiplying the hospital's Wage Adjusted APEC Outpatient Standard (which is the APEC Outpatient Statewide Standard, adjusted by the hospital's Massachusetts-specific wage area index) by the claim detail line's Adjusted EAPG Weight.
- In determining the APEC Outpatient Statewide Standard:
    - To produce each hospital's standardized costs per episode, an adjustment for each hospital's Massachusetts-specific wage area index was also applied, and the hospital's APEC Base Year outpatient casemix index was calculated utilizing the grouper and updated weights, as adjusted by EOHHS.
    - CY19 MassHealth episodes from MMIS were used in weighting APEC Base Year costs for determining the efficiency standard, which was set at the 60% level of costs.
    - The outlier adjustment factor applied was 93%.
    - An inflation update of 2.451% was applied to reflect price changes between RY22 and RY23.
    - The conversion factor applied was 1.160.
- For the APEC Outlier Component calculation, the fixed outpatient outlier threshold was set at $4,200, the marginal cost factor at 60%, and the hospital's outpatient cost-to-charge ratio was calculated based on the hospital's FY20 Massachusetts Hospital cost report.

(2) For critical access hospitals that are paid at 101% of allowable costs utilizing Medicare's cost-based reimbursement methodology, interim APEC rates for episodes with dates of service in RY23 were derived utilizing cost data from the hospital's FY21 CMS 2552-10 cost report. Final payment for the FY23 period will be made as set forth in Section II.1.A.

**3. <u>In-State Acute Hospital Supplemental Payments</u>**

In addition to the payments specified earlier, EOHHS makes state plan supplemental payments to qualifying in-state acute hospitals. The FY23 state plan methods for the following supplemental payments remain substantially similar to the FY22 methods for those payments, except utilizing more recent data: the High Public Payer Supplemental Payment, the Essential MassHealth Hospital Supplemental Payment, the Supplemental Payment for Acute Hospitals with High Medicaid Discharges, the Supplemental Payment for the High Medicaid Volume Freestanding Pediatric Acute Hospitals, the High Public Payer Behavioral Health Service Supplemental Payment, the Specialized Pediatric Service Hospital Supplemental Payment, the Medicaid Volume Safety Net Hospital Supplemental Payment, the Pediatric Inpatient BH Per Diem Supplemental Payment, Supplemental Payments for Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020, Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services, and Expansion of Inpatient Behavioral Health Capacity Supplemental Payment and Supplemental Payments to Support Staffing DMH Licensed Beds.

The following FY22 state plan supplemental payments have been discontinued: the Adult Inpatient BH Per Diem Supplemental Payment, Supplemental Payments for Fiscally Distressed Hospitals, Supplemental Payments to Support Hospital Financial Stability, and MassHealth Targeted Hospital Supplemental Payments.

The following supplemental payment methods have changed as follows: the High Medicaid Volume Safety Net Hospital HLHC supplemental payment for the High Medicaid Volume Safety Net Hospital (Boston Medical Center) to be transferred to its HLHC whose MassHealth annual outpatient volume exceeded 75,000 episodes (East Boston Neighborhood Health Center). The payment amount will be reduced to $1.05 million.

The following are new supplemental payment methods for RY23: Medicaid Base Rate Add-on Payments. EOHHS will make uniform dollar add-on payments per inpatient discharge and outpatient episode to in-state acute care hospitals, to be paid for through the proposed new hospital assessment structure. The inpatient add-on pool is $305.5 million, calculated by multiplying $650 million by 47%. The outpatient add-on pool is $344.5 million, calculated by multiplying $650 million by 53%.

**4. <u>In-State Pay for Performance (P4P)</u>**

There are substantive changes to the existing slate of P4P measures that affect each quality measure category (QMC) performance assessment method and payment approach. Such changes signal the start of a transition from the original P4P requirements to the expansion of the broader inpatient Clinical Quality Initiative (CQI_ Program description that follows this section.

- **<u>P4P Updated Total Allocated Amounts & Payment Approach:</u>** In RY23, the P4P Program retains a separate budget from the new CQI Program, described in a new section of the RFA (Section 7B). The total maximum P4P allocation in Section 7 will remain at $25M. Allocations are adjusted for removal of the health disparities category, HD2, as follows:
    - Perinatal Quality Measure Category ($7.5M) is allocated to (P4P). This includes:
        - Maternity measure
        - Newborn measure (to be discontinued as of Q1, 2023)
        - Perinatal morbidity structural measure (new)
    - Care Coordination Measure Category ($9.0M) is allocated to pay-for-reporting (P4R) (3 measures)

- Safety Outcome Measure Category ($4.5M) is allocated to modified P4P. This includes:
  - Patient safety and adverse events composite
  - Healthcare associated infections (HAI) (5 measures)
- Patient Experience Measure Category ($4.0M) is allocated to P4R (7 survey dimensions)

- Changes to the evaluation of measures are as follows:
  - **Perinatal Care Measure Category:** Hospitals must report full calendar year (CY) 2022 data on the cesarean birth and exclusive breast milk feeding measure. The exclusive breastmilk feeding measure is discontinued as of the first calendar quarter of 2023 reporting and replaced with the new perinatal morbidity structural measure (PMSM-1). All hospitals will be required to complete the new PMSM-1 five item survey that attests to CY2022 participation in a federally sponsored CDC or HRSA Perinatal Quality Collaborative Program and implementation of in-hospital safety practices to prevent severe maternal morbidity. Performance assessment methods for this category will add the new structural measure to the overall score.

  - **Care Coordination Measure Category:** Hospitals must collect and report data on the newly modified data element specifications applicable to all three measures from the CY2022 period and first quarter of CY2023 period. Performance assessment method for this category will be based on meeting data reliability standard on the newly reported data elements (Pass = 100% and Failed = 0% score).

  - **Health Disparity Measure Category:** This category was removed. Refer to the CQI expanded health equity requirement description that follows below.

  - **Safety Outcome Measure (SOM) Category:** The Patient Safety Indicator (PSI-90) and Healthcare-Associated Infection (HAI) measure requirements were modified to remove eligible CY20 and CY21 data periods affected by COVID-19 pandemic that may affect performance results. The PSI-90 data period was shortened to 15 months, from 24 months, and the Agency for Healthcare Research and Quality (AHRQ) software calculations will exclude COVID-19 cases. The Healthcare-Associated Infection (HAI) measure periods were shortened to 12 months, from 24 months, to use CY2021 but remove eligible CY2020 data impacted by COVID-19 pandemic. Based on these COVID-19 provisions, the SOM performance assessment method will remove the minimum attainment threshold requirement and all hospitals will receive an incentive payment based on interquartile range scale.

  - **Patient Experience and Engagement Measure Category:** The Hospital Consumer Assessment of Healthcare Provider Systems Survey **(**HCAHPS) measure requirements were modified based on the CMS caveats on the eligible publicly reported CY2020 and CY2021 data impacted by COVID-19 pandemic. Performance assessment methods for this category is based on receive a score of 100% for HCAHPS posted data that meets the 100 minimum surveys completed for C20Y21 period**.**

**5. <u>Clinical Quality Incentive (CQI) program:</u>**

For RY23, EOHHS has adopted hospital quality performance measures for the CQI Program that incentivizes safe and high-quality care. The CQI program provides opportunities for hospitals to earn incentives (investments totaling $250 million, including fee-for-service and managed care payments) for quality reporting and performance on quality measures for CY2023, to be paid for through the proposed new hospital assessment structure. This is in addition to the MassHealth P4P Program described above.

- Measures included in the CQI are drawn from standard measures stewarded by nationally recognized quality measure developers. There are four core quality measure domains (referred to as "Core Quality Measure Domain(s)"). There are two specialty quality measure domains (referred to as "Specialty Quality Measure Domain(s)".

- Hospitals will be accountable to performance for all core quality measure domains, and may also be determined by EOHHS to be accountable to all measures in one or more specialty quality measure domains, based on type of hospital and domain service lines provided.

## 6. Part III: Justification

Except as specified earlier, the acute inpatient and outpatient hospital rate payment methods for RY23 are substantially similar to those for RY22. All changes to hospital payment rates and methods, including the updated rates and rate components effective with RY23, are in accordance with state and federal law, subject to all necessary state and federal approvals, and are within the range of reasonable payment levels to acute hospitals.

## 7. Estimated Fiscal Effect

EOHHS estimates that annual aggregate acute hospital state plan expenditures resulting from the FY23 (October 1, 2022 – September 30, 2023) rate payment methods will increase by approximately $51.9M overall, broken down as follows: an estimated $50.8M increase in estimated annual aggregate in-state acute inpatient and outpatient hospital state plan rate payment expenditures; and a $1.1M estimated annual aggregate impact to out-of-state acute inpatient and outpatient hospital state plan rate payment expenditures. Holding utilization constant, EOHHS estimates that the fiscal impact resulting from the changes in payment methods for rates to acute inpatient and outpatient hospitals applicable to FY23 will result in an increase, in the aggregate, of 3.4% to the rates on an annualized basis, compared to estimated annualized base year rate payments. These figures exclude payments funded by the American Rescue Plan Act of 2021 (Pub. L. 117-2), including the payments described in Sections 5.D.17 and 5.D.18 of the RY23 RFA. In addition to the rate payment method increases described herein, additional supplemental payment and add-on payments, expected to be funded through the proposed new hospital assessment structure, will result in a total additional investment of $900 million across both fee-for-service state plan expenditures and managed care expenditures. Such payments are subject to all necessary state and federal approvals.

**Statutory Authority:** M.G.L. c. 118E; St. 2022, c. 126; St. 2012, c. 224; 42 USC 1396a; 42 USC 1396b.

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

# 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.

**30-day Readmissions Policy (30-Day RP)** – the MassHealth Acute Hospital 30-day Readmissions Policy, which is a quality-based program intended to encourage participating in-state MassHealth Acute Hospital Providers to establish immediate measures and actions to improve performance in patient care and reduce potentially preventable readmissions.

**3M EAPG Grouper** – the 3M Corporation's EAPG Grouper Version 3.16, configured for the MassHealth APEC payment method.

**Accountable Care Organization (ACO)** – an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans (ACPPs), Primary Care ACOs, and MCO-Administered ACOs.

**Accountable Care Partnership Plan (ACPP)** – a type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO) and which is organized primarily for the purpose of providing health care services.

**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). The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in Section 5.B.8. The APAD is calculated as set forth in Section 5.B.1.

**Adjudicated Payment per Episode of Care (APEC)** – a Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in Section 4.C and Sections 5.C.3 through 5.C.14, as such services are excluded from the definitions of "APEC-Covered Services" and "Episode" under this RFA. The APEC is calculated as set forth in Section 5.C.1.

**Adjusted EAPG Weight** – the EAPG weight that is multiplied by the Hospital's Wage Adjusted APEC Outpatient Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating the Episode-Specific Total EAPG Payment. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the

Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight.

**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.

**Adult Mobile Crisis Intervention (AMCI)** - a community-based behavioral health service available 24 hours per day, 7 days per week, 365 days per year and providing short-term mobile, on-site, face-to-face crisis assessment, intervention, and stabilization to individuals 21 years of age and older experiencing a behavioral health crisis. Services may be provided by a Community Behavioral Health Center (CBHC) in community-based settings outside a CBHC, at a CBHC, or in emergency department sites of services when necessary. Services may also be provided via telehealth. The purpose is to identify, assess, treat, and stabilize the situation and reduce the immediate risk of danger to the individual or others consistent with the individual's risk management or safety plan, if any. AMCI service is not an outpatient hospital service and is not a payable service under this RFA.

**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 38, unless otherwise specified.

**APAD Base Year** – the hospital-specific base year for the APAD is FY19, using the FY19 Massachusetts Hospital cost reports as screened and updated as of August 11, 2021.

**APAD Carve-Out Drugs** – drugs designated by EOHHS that are carved out of the APAD payment and separately paid pursuant to Section 5.B.8.b.

**APEC Base Year** – the APEC Base Year is CY19.

**APEC Carve-Out Drugs** – drugs designated by EOHHS that are carved out of the APEC payment and are separately paid pursuant to Section 5.C.9.

**APEC-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.14.

**APEC Outlier Component** – A Hospital-specific, Episode-specific component of the APEC which is calculated by EOHHS as described in Section 5.C.1.b.(2), and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.

**APEC Outpatient Statewide Standard** – the outpatient statewide standard determined by EOHHS as described in Section 5.C.1.b.(1)(a)1, that is utilized in the calculation of the APEC.

**Baseline ED Psychiatric Services** – The following services:

1. Family support and education.
2. Screening for substance use disorder (i.e., Screening, Brief Intervention, and Referral to Treatment), including medication-assisted treatment initiation when appropriate.
3. Referring members to community-based providers for ongoing care after discharge, as necessary.
4. Observation for those with suicidal ideation and/or homicidal ideation.

**Behavioral Health (BH) Contractor** – the entity with which EOHHS contracts to provide, arrange for, and coordinate Behavioral Health Services to enrolled Members on a capitated basis.

**Behavioral Health Diversionary Services** – those mental health and substance use disorder services provided outside of this RFA as clinically appropriate alternatives to Behavioral Health Inpatient Services, to support an Enrollee returning to the community following a 24-hour acute placement, or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services: those services which are provided in a 24-hour facility, and those services which are provided in a non-24-hour setting or facility.

**Behavioral Health Emergency Department Crisis Evaluations –** An evaluation provided in an Emergency Department by qualified clinical professionals to members experiencing a behavioral health crisis. The evaluation includes the initial assessment of risk, diagnosis, and treatment needs, as well as the initial clinical stabilization interventions, and the determination and coordination of appropriate disposition.

**Behavioral Health Services (or Behavioral Health)** – services provided to Members who are being treated for psychiatric disorders or substance use disorders.

**Calendar Year (CY)** – the time period of 12 months beginning on January 1 of any given year and ending on December 31 of the same year.

**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 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.

**Community-Based Acute Treatment (CBAT) –** 24-hour-per-day, seven-day-per-week, staff-secure treatment settings for children and adolescents up to the age of 18 with serious behavioral health disorders that provide short-term crisis stabilization, therapeutic intervention, and specialized programming.

**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.

**Community Behavioral Health Center** (CBHC) **–** an entity that serves as a hub of coordinated and integrated behavioral health disorder treatment for individuals of all ages, including routine and urgent behavioral health outpatient services, mobile crisis intervention services for adults and youth, and community crisis stabilization services for adults and youth.

**Community Crisis Stabilization (CCS) –** A community-based program that serves as a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides short-term staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and treatment also include the capacity to provide induction onto and bridging for medication for the treatment of opioid use disorders (MOUD) and withdrawal management for opioid use disorders (OUD) as clinically indicated.

**Community Partners –** entities certified by EOHHS to work with ACOs to ensure integration of care, as further specified by EOHHS. There are two types of CPs – Long-Term Services and Supports CPs (LTSS CPs) and Behavioral Health CPs (BH CPs).

**Community Partner Assigned Member –** an ACO-enrolled Member who is assigned to a BH or LTSS CP.

**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, prior to October 1, 2021, 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 (1) the Hospital's MassHealth allowed charges for a specific discharge, as determined by EOHHS, and (2) the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY20 Massachusetts Hospital Cost Report. For applicable discharges, a Hospital's charges corresponding to LARC Devices or APAD Carve-Out Drugs are excluded in calculating the Discharge-Specific Case Cost.

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

**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.

**Drugs** – drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate Drug.

**ED-Presenting Psychiatric Member –** A Member who presents to a Hospital's ED for clinical psychiatric evaluation and treatment.

**Eligibility Verification System (EVS**) [**formerly known as the Recipient Eligibility Verification System (REVS**)] – the online and telephonic system Hospitals must access to verify eligibility, managed care enrollment, and available third-party liability information about Members.

**Emergency Aid to the Elderly, Disabled and Children (EAEDC)** – 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.

# In-State Acute Hospitals

**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, or at a separate site included in the Hospital's DPH license.

**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.

**Emergency Services Program (ESP) Services** – Medically necessary services provided through designated ESP providers, and which are available 7 days per week, 24 hours per day to provide treatment of any individual who is experiencing a mental health or substance use disorder crisis, or both. An ESP encounter includes, at a minimum, crisis assessment, intervention, and stabilization. ESP Services include Mobile Crisis Intervention for members under the age of 21.

**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 3.16.

**Enhanced ED Psychiatric Services** – Mental health or substance use disorder services provided to ED-Presenting Psychiatric Members in need of Inpatient Behavioral Health (BH) Services (including CBAT and CCS services), who need to remain in the Hospital's ED or one of the Hospital's non-psychiatric beds for at least 24 hours while awaiting transfer to an Inpatient Facility (whether located in that Hospital, another acute hospital, a psychiatric inpatient hospital, a CBAT unit, or a CCS unit).

These enhanced services may be provided by any hospital staff, whether employed or contracted, who is qualified to deliver such services within their scope of practice. Such services may be provided to assess an ED-Presenting Psychiatric Member's mental status or consult on such Member's behavioral health needs, including proper medications, with the Hospital's medical staff. Services should be provided according to applicable standards or best practices for the Member's age. Such services may include, as clinically indicated:

- Medication evaluation.
- Medication management.
- Stabilization interventions (e.g., solution-focused therapy, de-escalation strategies, peer supports, etc.).

- Specific services for children that may include:

    - Applied Behavior Analysis: A service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning.

    - Family Therapy: the psychotherapeutic treatment of more than one member of a family simultaneously in the same visit.

- Group therapy: the application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

- Partial Hospitalization Program Interventions: These services offer short-term day mental health programming available seven days per week, as an alternative to inpatient hospital services. These services include daily psychiatric management.

**Episode** – all MassHealth-covered Outpatient Services, except those described in Section 4.C and Sections 5.C.3 through 5.C.14, delivered to a MassHealth Member on a single calendar day, or if the services extend past midnight in the case of Emergency Department or Observation Services, on consecutive days. (See also definition of Observation Services). Additionally, in limited circumstances, APEC-Covered Services delivered to a MassHealth Member during a second distinct and independent visit on the same calendar day may be considered a separate Episode for payment purposes if the services are for unrelated purposes and conditions as determined by EOHHS.

**Episode's Total Allowed Charges** – the sum of the MassHealth allowed charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.

**Episode-Specific Case Cost** – the product of (1) the Episode's Total Allowed Charges, and (2) the Hospital's FY20 outpatient cost-to-charge ratio, as calculated by EOHHS using the Hospital's FY20 Massachusetts Hospital Cost Report.

**Episode-Specific Outlier Threshold** – the sum of (1) the Episode-Specific Total EAPG Payment, as determined by EOHHS, and (2) the Fixed Outpatient Outlier Threshold.

**Episode-Specific Total EAPG Payment** – an Episode-specific payment amount, which summed with the APEC Outlier Component (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in Section 5.C.1.b**.(1)**.

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

# In-State Acute Hospitals

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

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

**Fixed Outlier Threshold (inpatient)** – the Fixed Outlier Threshold for purposes of calculating any inpatient Hospital Outlier Payment is $39,925

**Fixed Outpatient Outlier Threshold** – the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $4,200.

**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.

**High Medicaid Volume Safety Net Hospital** – an Acute Hospital which had a ratio of Medicaid inpatient days to total inpatient days that was greater than 45% in FY14, based on the Hospital's FY14 403 cost report.

**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 at Home** – Inpatient Hospital Services provided in a Member's home or residence in accordance with MassHealth's Acute Inpatient Hospital Bulletin 180, or any successor bulletins thereto.

**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 for FY19 provided and verified by each hospital, submitted to CHIA and screened and updated by CHIA as of June 3, 2021. HDD is used for determining casemix as part of the APAD rate development, as set forth in Section 5.B.1.

# In-State Acute Hospitals

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

**Inflation Factors for Capital Costs** – for price changes between RY04 and RY18 and between RY19 and RY23, the inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index. For price changes between RY18 and RY19, the inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare and are based on the CMS Capital Input Price Index, plus a RY19 capital enhancement factor of 0.9%. The Inflation Factors for Capital Costs between RY04 and RY23 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
- 0.9% reflects the price changes between RY16 and RY17
- 1.3% reflects the price changes between RY17 and RY18
- 2.1108% reflects the price changes between RY18 and RY19
- 1.5% reflects the price changes between RY19 and RY20
- 1.5% reflects the price changes between RY20 and RY21
- 1.0% reflects the price changes between RY21 and RY22
- 1.7% reflects the price changes between RY22 and RY23

**Inflation Factors for Operating Costs** – for price changes between RY04 and RY07, and between RY08 and RY23, 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 RY23 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
- 1.937% reflects the price changes between RY16 and RY17
- 2.26% reflects the price changes between RY17 and RY18
- 2.183% reflects the price changes between RY18 and RY19
- 2.236% reflects the price changes between RY19 and RY20
- 1.854% reflects the price changes between RY20 and RY21
- 1.433% reflects the price changes between RY21 and RY22
- 2.451% reflects the price changes between RY22 and RY23

**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 or Hospital at Home services provided in a Member's home or residence in accordance with MassHealth's Acute Inpatient Hospital Bulletin 180, or any successor bulletins thereto. 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.

**I&R** – isolation and recovery.

**I&R Clinical Care Team** – collectively, the I&R Hospital staff that will provide I&R Services to guests at an I&R Site pursuant to the I&R Hospital's I&R Services-related special conditions addendum to its MassHealth Hospital Contract. The I&R Clinical Care Team may include physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses, certified nursing assistants, home health aides, social workers holding a masters of social work degree, licensed independent clinical social workers, and administrative support staff. In its discretion, EOHHS may approve I&R staff with qualifications differing from those set forth above to serve on the I&R Clinical Care Team. The required composition of each I&R Hospital's I&R Clinical Care Team (including any variation from the qualifications set forth above) will be memorialized in each I&R Hospital's I&R Services-related special conditions addendum to its MassHealth Hospital Contract.

**I&R Hospital** – a Hospital that has a fully executed I&R Services-related special conditions addendum to its MassHealth Hospital Contract to provide I&R Services at an I&R Site.

**I&R Services** – a type of Observation Service that the I&R Hospital's I&R Clinical Care Team will provide at an I&R Site pursuant to the I&R Hospital's I&R Services-related special conditions addendum to its MassHealth Hospital Contract. EOHHS will reimburse I&R Hospitals rendering I&R Services pursuant to **section 5.D.10** of this RFA and the I&R Hospital's I&R Services-related special conditions addendum to its MassHealth Hospital Contract.

**I&R Site** – a location that is neither an Acute Inpatient Hospital nor a Hospital Outpatient Department, such as a hotel or motel, that contracts with EOHHS to provide safe, isolated lodging for individuals with a COVID-19 diagnosis.

**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).

**Long-Acting Reversible Contraception (LARC) Device** –refers, specifically, to intrauterine devices and contraceptive implants. LARC Device does not refer to the procedure, itself.

**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 Accountable Care Partnership Plans (ACPPs). In addition, MCOs include One Care plans for all purposes under this RFA, except for Sections 4.A.2, 4.B.4, 5.D.1 and Section 7. When historical MCO data is used in a methodology, the term MCO will also include CarePlus MCOs, to the extent CarePlus MCOs existed during the period for which the MCO data is used in such methodology, as applicable.

**Marginal Cost Factor** – the Marginal Cost Factor is 60% (inpatient) and 60% (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 DRG Weight** – the MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). See Chart C to Appendix C for the MassHealth DRG Weights.

**MassHealth EAPG Weight** – the MassHealth relative weight developed by EOHHS for each unique EAPG (See Chart D to Appendix D for the RY23 MassHealth EAPG Weights for the APEC methodology). The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight as part of the APEC payment methodology. See also the definition of "Adjusted EAPG Weight."

**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.

**Mobile Crisis Intervention (MCI)** – services provided by designated ESP providers to members under age 21. MCI services include a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. MCI utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a week.

**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 Inpatient Hospital or Hospital Outpatient Department (a) to evaluate a Member's condition and determine the need for admission to an Acute Hospital; or (b) to assess or monitor the Member on the Hospital's premises following a discharge from a COVID-19-related Acute Inpatient Hospital admission, prior to relocating the Member home or to another non-hospital setting. 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.

**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 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, Remote Patient Monitoring 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 E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions, and this RFA.

**PAPE Covered Services** – MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, that were paid utilizing the PAPE payment methodology under prior Acute Hospital RFAs.

**Participating PCP** – See definition of Primary Care ACO Participating Primary Care Provider.

**Patient** – a person receiving health care services from a hospital.

**Pay-for-Performance Program for Acute Hospitals (P4P)** – for RY23, this refers to the pay-for-performance program set forth in Section 7 of the RFA.

**Payment Amount Per Episode (PAPE)** – an outpatient payment methodology that was utilized in prior Acute Hospital RFAs. The PAPE was a fixed Hospital-specific all-inclusive facility payment that was made for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode (as defined in prior Acute Hospital RFAs), with the exception of those services that were excluded from the PAPE payment methodology as described in those prior RFAs. The outpatient PAPE payment methodology was replaced by the APEC payment methodology during RY17 beginning with dates of service on and after December 30, 2016.

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

**Primary Care ACO** – a type of ACO with which the MassHealth agency contracts under its ACO program.

**Primary Care ACO Participating Primary Care Provider (Participating PCP)** – a physician, independent certified nurse practitioner, group practice organization, community health center, Hospital-Licensed Health Center, Acute Hospital Outpatient Department, or other eligible providers, who serve as a Participating PCP with a Primary Care ACO.

**Primary Care Clinician (PCC)** – a physician, independent certified 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 Behavioral Health 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.

**Rate Year (RY)** – generally, the period beginning October 1 and ending the following September 30. The RY23 will begin on October 1, 2022, and end on September 30, 2023.

**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 their ability to function with a reasonable expectation of significant improvement that will be of practical value to the Member measured against their 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.

**Remote Patient Monitoring** – Outpatient Hospital Services provided in a Member's home or residence to evaluate a Member's condition and determine the need for admission to an Acute Hospital in accordance with MassHealth Transmittal Letter AOH-47 (Corrected), MassHealth All Provider Bulletin 319, and 101 CMR 446.03(2), or any successors thereto.

**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.

**Specialized Pediatric Service Hospital** – a High Medicaid Volume Freestanding Pediatric Acute Hospital; or an Acute Hospital, other than a Freestanding Pediatric Acute Hospital, that maintains a DPH licensed pediatric unit and has a burn unit verified by the American Burn Association as of August 31, 2019, as determined by EOHHS.

**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 20 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 those 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.

**Tier 1 ED Psychiatric Provider** – A Hospital that attests pursuant to **Section 5.D.18.b.(1)** that it has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members according to the Tier 1 requirements during the period between November 1, 2022, and April 30, 2023.

**Tier 2 ED Psychiatric Provider** – A Hospital that attests pursuant to **Section 5.D.18.b.(1)** that it has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members according to the Tier 2 requirements during the period between November 1, 2022, and April 30, 2023.

**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 APAD and, if applicable, any inpatient Hospital Outlier Payment.

**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 for Inpatient Services provided to a Transfer Patient.

**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 Behavioral Health 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, or is eligible for MassHealth on the date of admission but becomes ineligible 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, or who becomes eligible for 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, Primary Care ACO or non-managed care to an MCO, or from an MCO to the PCC Plan, Primary Care ACO or non-managed care; or (7) is admitted following an outpatient surgery or procedure at the Acute Hospital.

**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.

**Wholesale Acquisition Cost (WAC)** – The wholesale acquisition cost (WAC) of the Drug as published by First Data Bank or other national price compendium designated by EOHHS.

**Youth Community Crisis Stabilization (YCCS) -** staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that provides active treatment that includes restoration of functioning; strengthening the resources and capacities of the youth, family, and other natural supports; and ensuring a timely return to previous living environment to individuals up to and including 18 years of age.

**Youth Mobile Crisis Intervention (YMCI)** – a community-based behavioral health service available 24 hours per day, seven days per week, and 365 days per year providing short-term mobile, on-site, face-to-face crisis assessment, intervention, and stabilization to individuals younger than 21 years of age experiencing a behavioral health crisis. Transition-aged youth older than 17 years of age and younger than 21 years of age may be served by adult-trained clinicians with a certified peer specialists instead of a family partner based on an individual's clinical needs. Services may be provided by CBHCs in community-based settings outside the CBHC or at the CBHC. Services may be provided via telehealth. The purpose is to identify, assess, treat, and stabilize the situation and reduce the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any.

# In-State Acute Hospitals

# 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.

# Section 4: Non-Covered Services, Program Initiatives, Non-RFA Ambulatory Services, and Requirements Regarding Hospital Notifications and Discharge Planning Coordination

## 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 payment from MassHealth or the BH Contractor for Members enrolled with the BH Contractor who receive BH Contractor-covered services, except in accordance with a service-specific agreement with the BH Contractor.

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.

### 2. MCO Services

**a.** 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.

**b.** 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.

**c.** For purposes of this Section 4.A.2.c, "MCO" refers to all MCOs as defined in Section 2, except Senior Care Organizations (SCOs), and One Care plans; and "non-Emergency services" means services that correspond to the types of Inpatient and Outpatient Services for which Hospitals are paid on a fee-for-service basis under Sections 5.B.1 through 5.B.3, 5.B.6, 5.B.7, 5.C.1 and 5.D.7 of this RFA (subject to Sections 8.2 and 8.3, as applicable), with the exception of (1) Emergency and Post-Stabilization Services (which are governed by Section 4.A.2.b., above) and (2) Behavioral Health Services.

If a Hospital (whether network or non-network) provides non-Emergency services to the MCO's MassHealth enrollees, and the MCO offers to pay the Hospital a rate that is equivalent to the Hospital's applicable fee-for-service RFA rate for such non-Emergency services, that Hospital must accept the MCO's rate offer as payment in full. This requirement does not prohibit an MCO from negotiating to pay a Hospital at rates other than the Hospital's MassHealth-equivalent fee-for-service RFA rate for non-Emergency services to the MCO's MassHealth enrollees, pursuant to the MCO's contract with EOHHS.

**d.** 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. Injectable Materials or Biologicals Provided by the Massachusetts Department of Public Health at No Charge**

EOHHS will not pay for the cost of injectable materials or biologicals that a Hospital received from the Massachusetts Department of Public Health free of charge. Hospitals administering such injectable materials or biologicals must bill the code for the injectable material or biological itself, with the modifier SL, as well as the code for the administration of the injectable material or biological.

**4. Former Section 4.A.4 was reserved in the RY23 RFA.**

**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.

### 8. Behavioral Health Diversionary Services

In order to receive reimbursement for Behavioral Health Diversionary Services, Hospitals must have a separate contract with EOHHS for such services.

## 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 need to conform to the MassHealth Drug List (see www.mass.gov/druglist) whenever medically appropriate for inpatients, outpatients, and upon discharge.

Hospitals are required to obtain prior authorization from the MassHealth Drug Utilization Review (DUR) Program for certain Drugs that will be administered to Members in an inpatient or outpatient Hospital setting. Drugs for which MassHealth requires Hospitals to obtain prior authorization will be specified on the MassHealth Acute Hospital Carve-Out Drugs List of the MassHealth Drug List (and any other section of the MassHealth Drug List applicable to Acute Hospitals that may be developed); Subchapter 6 of the Acute Outpatient Hospital Provider Manual (in the case of Acute Outpatient Hospitals); or other written statements of policy issued by EOHHS. The prior authorization requirements will be set forth in the MassHealth Drug List or in other written statements of policy issued by EOHHS. See also **Sections 5.B.8.b, 5.C.9**, and **6.A** of this RFA.

**4. MCO Offer of Contract**

For purposes of this **Section 4.B.4**, "MCO" refers to all MCOs as defined in **Section 2**, except Senior Care Organizations (SCOs) and One Care plans.

Effective as of October 1, 2022, all Hospitals that are parties to a Hospital Contract under this RFA must have a written contract with at least one MCO to participate as a network Hospital provider under the MCO's provider network (and continue to maintain at least one such MCO network provider contract), if offered a network Hospital provider contract by the MCO(s).

**5. MassHealth Behavioral Health, Substance Use Disorder, Autism Spectrum Disorder, and Intellectual and Developmental Disability Initiatives**

**a.** Hospitals with DMH-Licensed Beds must comply with all applicable Department of Mental Health regulations and subregulatory guidance, including, but not limited to, the following:

i. Department of Mental Health COVID Emergency Bulletin #22-01, Clinical Competencies/Operational Standards Related to Infection Control in Response to the COVID-19 Pandemic, as that document may be updated from time to time.

ii. Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards that follow, as they appear in DMH Licensing Division Bulletin #19-01 (or any amended or successor bulletin), when delivering Inpatient Psychiatric Services in those DMH-Licensed Beds:

(1) Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric Units within General Hospitals

(2) Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk
(3) Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)
(4) Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

For reference, excerpts of DMH Licensing Division Bulletin #19-01, including the relevant Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards, are reprinted in **Appendix G**. In the event that the Department of Mental Health amends or supersedes DMH Licensing Division Bulletin #19-01, the amended or superseding bulletin shall be controlling.

**b.** All Hospitals, including those that do not have DMH-Licensed Beds, must have the capability to treat, in accordance with professionally recognized standards of medical care, all individuals admitted to any unit or bed within the Hospital who present with co-occurring behavioral conditions, including, but not limited to, individuals with co-occurring Substance Use Disorders (SUD), Autism Spectrum Disorder, and Intellectual and Developmental Disabilities (ASD/ID/DD), and/or individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk. Consistent with DMH guidance, EOHHS recognizes that patients with significant maladaptive behavior, inability to maintain Activities of Daily Living (ADLs), as well as those with significant self-injurious or violent behavior due to their ASD/ID/DD, may have needs that exceed the expected capability of a general inpatient psychiatric unit.

## 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.

## D. Requirements for Hospital Notifications and Discharge Planning Coordination

### 1. Notification of Emergency Department (ED) Services

For Members enrolled in the PCC Plan or a Primary Care ACO, the Hospital must notify the Member's PCC or Participating PCP within one business day of the commencement of ED services for the Member. For Members that are identified in EVS as Community Partner (CP) Assigned Members, the Hospital must notify the Member's CP(s) within one business day of the commencement of ED services for the Member. Notification may

include a secure electronic notification of the visit. For the avoidance of doubt, Hospitals shall ensure that any such notification is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance. EOHHS reserves the right to specify the form and format for such notification.

**2. Notification of Inpatient Admission and Discharge Planning Activities**

**a.** For Members enrolled in the PCC Plan or a Primary Care ACO, the Hospital must notify the Member's PCC or Participating PCP within one business day of the Member's: (1) Inpatient Admission and (2) subsequent discharge (which includes, for purposes of this **section 4.D.2**, a transfer to another Acute Inpatient Hospital or to a 24-hour facility that provides Behavioral Health Diversionary Services). For members that are identified in EVS as Community Partner Assigned Members, the Hospital must notify the Member's CP(s) within one business day of the Member's: (1) Inpatient Admission and (2) subsequent discharge (which includes, for purposes of this **section 4.D.2**, a transfer to another Acute Inpatient Hospital or to a 24-hour facility that provides Behavioral Health Diversionary Services). Notification may include a secure electronic notification of the visit. For the avoidance of doubt, Hospitals shall ensure that any such notification is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance. EOHHS reserves the right to specify the form and format for such notification.

**b.** The Hospital, when possible, must begin formulating a discharge plan on the first day of a Member's Inpatient Admission.

**c.** In addition to satisfying all other requirements for discharge planning set forth in MassHealth regulations or other formal written statements of policy:

**(1)** For Members enrolled in the PCC Plan or a Primary Care ACO, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's PCC or Participating PCP within two business days of the discharge. For Members identified in EVS as Community Partner Assigned Members, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's CP(s) within two business days of the discharge. The discharge summary must include a copy of the Hospital's discharge instructions that were provided to the Member, and include details on the Member's diagnosis and treatment. For the avoidance of doubt, Hospitals shall ensure that any such transmission is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance.

**(2)** For all Members receiving Inpatient Services, the Hospital shall communicate with, as applicable, each of the Member's primary care provider, health plan, and CP(s) to ensure that, consistent with all applicable federal and state laws, regulations, and sub-regulatory guidance, all appropriate parties are included in the Member's discharge planning process. Such appropriate parties may include CPs, case managers, caregivers, and other critical supports for the Member.

Examples of these activities may include setting up appropriate consent and communication protocols, and protocols to allow staff from these parties onto hospital units to participate in discharge planning and care coordination. For the avoidance of doubt, Hospitals shall ensure that any such communications comply with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance.

**(3)** For Members admitted for childbirth and newborn care, the hospital's discharge planning process shall include, at a minimum, the following activities to help ensure appropriate follow-up care for the mother and newborn:

**(a)** Completing and submitting MassHealth's Notification of Birth form in accordance with MassHealth's instructions on that form;
**(b)** Advising the family to select a pediatrician if one has not yet been selected and, if requested by the family, assisting the mother in the selection of a pediatrician by, at a minimum, providing the mother with:

i. A paper copy of and/or web access to the MassHealth Enrollment Guide and MassHealthChoices.com website;
ii. The telephone number by which Members contact MassHealth's Customer Service;

**(c)** Advising the family to schedule an appointment with the pediatrician for the initial well baby visit and aftercare services as clinically appropriate and, if requested by the family, assisting in securing such an appointment. For any appointment that is critical to the patient's health and safety, the hospital shall strongly encourage and offer to assist the member in securing an appointment; and

**(d)** Advising the mother to schedule an appointment for a postpartum visit and any aftercare services (e.g. staple removal post cesarean section) as clinically appropriate and, if requested by the mother, assisting in securing such an appointment. For any appointment that is critical to the patient's health and safety, the hospital shall strongly encourage and offer to assist the member in securing an appointment.

**(4)** For all Members receiving Inpatient Services, Hospitals must comply with the Discharge Planning Procedures for Members Experiencing or at Risk of Homelessness set forth in **Appendix H.**

**d.** The Hospital must document in the Member's medical record all actions taken to satisfy the notification and discharge planning requirements set forth in this **Section 4.D.2**.

**e.** For the avoidance of doubt, Hospitals shall ensure that any such notification or discharge planning-related activities are made in compliance with applicable federal and state privacy laws and regulations.

### 3. Electronic Submission Requirements and Review for Pre-Admission Screening

Except as provided explicitly to the contrary in this **Section 4.D.3**, EOHHS conducts admission screening on elective admissions in accordance with 130 CMR 450.208(A). Notwithstanding that portion of 130 CMR 450.208(A)(1) that requires admitting providers to submit requests for admission screening for elective admissions via telephone or fax, the admitting provider must submit requests for admission screening via the Provider Online Service Center (POSC) at least seven calendar days before the proposed elective admission. For more information about the POSC or to register as a user, see https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal. In all other respects, the admitting provider shall submit requests for admission screening in accordance with 130 CMR 450.208(A).

# In-State Acute Hospitals

# 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, 2022.

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. Such Hospitals shall report all available DMH-Licensed Beds into the Massachusetts Behavioral Health Access website at a minimum three times per day, 7 days per week. Such updates shall occur, at a minimum, between 8am-10am, 12pm-2pm, and 6pm-8pm. EOHHS may designate an alternative frequency for such updates.

The Hospital is responsible for providing to EOHHS a report of fee-for-service Members admitted for inpatient psychiatric services, regardless of the inpatient location, in a format and frequency to be determined by EOHHS, for the purposes of supporting clinical management and care coordination of complex cases.

## 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.9** 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 5.B.1.e, 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**.

# In-State Acute Hospitals

Payment to Hospitals for LARC Devices and APAD Carve-Out Drugs, respectively, is as set forth in Sections 5.B.8.a and 5.B.8.b, respectively, and not pursuant to the APAD and Outlier Payment methodologies.

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

Payment for Behavioral Health 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**).

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 (APAD)**

**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 (exclusive of any separate payment for LARC Devices or APAD Carve-Out Drugs, if applicable, as described in Section 5.B.8, below). 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; and (3) the discharge-specific MassHealth DRG Weight. These components and the calculation of the APAD are described further below in **Sections 5.B.1.b** through **5.B.1.e**. For components calculated based on data from all Hospitals, the calculation included data for all Hospitals that were operating as of August 1, 2019.

**b. Calculation of the Statewide Operating Standard per Discharge**

**Primary sources of data:** In the development of the Statewide Operating Standard per Discharge, EOHHS used APAD Base Year all-payer costs and discharges and FY19 HDD as the primary sources of data to develop operating costs per discharge.

**Calculating the average cost per discharge for each Hospital*:*** The Statewide Operating Standard per Discharge is based on the statewide average cost 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 cost 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 and costs associated with postpartum LARC Devices. 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.

Capital costs and direct medical education costs were excluded from the calculation of the statewide average cost per discharge. Malpractice and organ acquisition costs were included.

**Wage area and casemix adjustments to calculate each hospital's standardized costs per discharge:**
The labor portion of the average cost 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 FY19 all-payer APR-DRG Version 38 Casemix Index that was determined by using FY19 discharges, APR-DRG version 38 of the 3M grouper, and MassHealth DRG Weights. Massachusetts Hospitals' wages and hours were determined based on CMS's FY 2022-April-30-2021-Wage-Index-PUF zip file, downloaded May 20, 2021 from the CMS web site at www.cms.hhs.gov. Each Hospital was assigned to a wage area according to CMS's FY 2021 IPPS FR and CN Impact File from the CMS web site at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2021-ipps-final-rule-home-page (FY2021 Impact File), except that:

- Brigham and Women's Hospital and Massachusetts General Hospital were assigned to the Boston wage area and their wages and hours included in the Boston area;
- The following four hospitals were redesignated as follows:
    - Baystate Medical Center from Springfield to Worcester;
    - North Shore Medical Center from Cambridge-Newton-Framingham to Boston;
    - Beverly Hospital from Cambridge-Newton-Framingham to Boston; and
    - Southcoast Hospitals Group from Providence-Warwick to Boston;
- PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined by EOHHS from the hospital's license (PPS-exempt hospitals are not included in the FY2021 Impact File).

Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. The area's wage index is the Massachusetts-specific wage area index for each Hospital assigned to the area, except for any Hospital that was redesignated to a different wage area in a written decision from CMS to the Hospital provided to EOHHS by March 28, 2022. For any such redesignated Hospital, its Massachusetts-specific wage area index was calculated based on the wages and hours, determined from the CMS File, of (i) the redesignated hospital, (ii) all other hospitals redesignated to that same area, and (iii) all hospitals assigned to that area, combined.

These steps result in the calculation of each Hospital's standardized costs per discharge.

**Determining the efficiency standard:** All Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of FY21 MassHealth discharges for the Hospitals was produced from MMIS claims data on file as of June 7, 2022, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges 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 60% of the total number of statewide discharges in the MMIS. The efficiency standard applicable to RY23 is $12,528.00.

**Final calculation of Statewide Operating Standard per Discharge:** 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 91.85%; by (c) the Inflation Factors for Operating Costs between RY19 and RY23, and by (d) 101.75%. The resulting Statewide Operating Standard per Discharge is $11,566.32

**c. Calculation of the Statewide Capital Standard per Discharge**

**Primary sources of data:** In the development of the Statewide Capital Standard per Discharge, EOHHS used APAD Base Year all-payer costs and discharges and FY19 HDD as the primary sources of data to develop capital costs per discharge.

**Calculating each hospital's capital cost per discharge:** For each Hospital, the total inpatient capital costs include the Building and Fixtures and Movable Equipment categories reported in the FY19 Massachusetts Hospital Cost report. Total capital costs for Buildings and Fixtures are allocated to inpatient services through the square-footage based allocation formula, and total capital costs for Movable Equipment are allocated to inpatient services through the dollar value based allocation formula, of the FY19 Massachusetts Hospital Cost Report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. For each Hospital, the capital cost per discharge was calculated by dividing the Hospital's total net inpatient capital costs by the Hospital's FY21 total inpatient hospital discharges net of Excluded Unit discharges.

**Determining the casemix-adjusted efficiency standard:** The casemix-adjusted capital cost per discharge was determined by (a) dividing the cost per discharge by the Hospital-specific FY19 All-Payer APR-DRG Version 38 Casemix Index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of FY21 MassHealth discharges from MMIS claims data on file as of June7, 2022, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges 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 60% of the total number of discharges. The efficiency standard is $869.05

**Calculation of statewide weighted average capital cost per discharge:** 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 was then multiplied by the Hospital's FY21 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.

**Calculation of final Statewide Capital Standard per Discharge:** The statewide weighted average capital cost per discharge was then updated by the Inflation Factors for Capital Costs between RY19 and RY23, and then multiplied by 101.75%. The resulting Statewide Capital Standard per Discharge is $799.07

**d. Determination of MassHealth DRG Weight**

The MassHealth DRG Weight is the MassHealth relative weight developed 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 grouper version 38 and Massachusetts weights (see Chart C to Appendix C for the MassHealth DRG Weights that apply to RY23).

**e. 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 the Hospital's Massachusetts-specific wage area index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to determine the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "**APAD Base Payment**"), and (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight.

For purposes of step (1), above, the Hospital's Massachusetts-specific wage area index which is multiplied by the labor portion of the Statewide Operating Standard per Discharge was derived as specified in **Section 5.B.1.b**.

For qualifying discharges from Freestanding Pediatric Acute Hospitals for which the MassHealth DRG Weight assigned to the discharge is 3.0 or greater, the APAD Base Payment will be adjusted to include an additional 57% for purposes of step (4), above, in the calculation of the APAD.

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. As noted, values are for demonstration purposes only.

| DRG Model Example - Massachusetts Hospitals | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| | | | |
| **Table 1: Standard APAD claim** | | | |
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Statewide Operating Standard per Discharge | $11,566.32 | RY23 RFA |
| 2 | Hospital's Massachusetts-specific wage area index | 1.0255 | Varies by hospital, determined annually |
| 3 | Labor Factor | 0.68257 | RY23 RFA |
| 4 | Hospital's Wage Adjusted Operating Standard per Discharge | $11,767.64 | (Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3)) |
| 5 | Statewide Capital Standard per Discharge | $799.07 | RY23 RFA |
| 6 | APAD Base Payment | $12,566.71 | Line 4 + Line 5 |
| 7 | MassHealth DRG Weight | 0.3972 | Appendix C, Chart C |
| **8** | **Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)** | **$4,991.50** | Line 6 * Line 7 |

## 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 amount of the APAD for the discharge, as calculated as set forth in Section 5.B.1 exceeds $0;

**b.** The Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge;

**c.** The patient is not a patient in a DMH-Licensed Bed for any part of the discharge; and

**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.

EOHHS reserves the right, as part of an audit, prepayment utilization review or similar process, to deny payment to the Hospital for an Outlier Payment(s), or initiate overpayment proceedings on a post-payment basis to recover an Outlier Payment(s) from the Hospital, if the Hospital fails to fulfill its discharge planning duties as required in MassHealth regulations, the RFA or other written statements of policy issued by EOHHS, or fails to meet generally accepted medical standards applicable to discharge planning.

The following is an illustrative examples of the calculation of the Total Case Payment for a claim involving an Outlier Payment. As noted, values are for demonstration purposes only.

| Table 2: Claim with Outlier Payment | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | APAD (must be >$0) | $4,991.50 | Table 1, Line 8 |
| 2 | Allowed Charges | $75,000.00 | Determined from claim |
| 3 | Hospital's Inpatient Cost-to-Charge Ratio | 72% | FY20 Massachusetts Hospital Cost Report |
| 4 | Discharge-Specific Case Cost | $54,000.00 | Line 2 * Line 3 |
| 5 | Fixed Outlier Threshold | $39,925.00 | RY23 RFA |
| 6 | Discharge-Specific Outlier Threshold | $44,916.50 | Line 1 + Line 5 |
| 7 | Does Discharge-Specific Case Cost exceed Discharge-Specific Outlier Threshold? | TRUE | Is Line 4 > Line 6? If TRUE, then Outlier Payment is due |
| 8 | Marginal Cost Factor | 60% | RY23 RFA |
| 9 | Outlier Payment | $5,450.10 | (Line 4 - Line 6) * Line 8 |
| **10** | **Total Case Payment = APAD plus Outlier Payment** | **$10,441.60** | Line 1 + Line 9 |

## 3. Transfer Per Diem Payments

### a. Transfer Between Hospitals

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.

The Hospital that is receiving the patient will be paid (a) on a per-discharge basis in accordance with the 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 **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 38 Massachusetts-specific weight file (**Chart C to Appendix C**). For purposes of this calculation, the Total Case Payment amount is calculated 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 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. This methodology applies to all subsections of Section 5.B.3, for admissions in RY23 that are paid on a Transfer Per Diem basis.

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**. As noted, values are for demonstration purposes only.

| Table 3: Claim with Transfer (APAD only) | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | APAD (Total Case Payment Amount) | $4,991.50 | Table 1, line 8 |
| 2 | Patient length of stay (# of days) | 2.00 | Determined from claim |
| 3 | Mean all-payer length of stay for DRG 203 | 2.39 | Appendix C, Chart C |
| 4 | Transfer per diem | $2,088.49 | Line 1 / Line 3 |
| 5 | Transfer per diem x Patient length of stay (# of days) | $4,176.98 | Line 4 * Line 2 |
| 6 | Total Transfer Payment Cap | $4,991.50 | Line 1 |
| **7** | **Total Transfer Case Payment** | **$4,176.98** | **Lower of Line 5 or Line 6** |

–

| Table 4: Claim with Transfer (APAD and Outlier) | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Total Case Payment Amount (Claim with Outlier Payment) | $12,601.60 | Table 2, line 10 |
| 2 | Patient length of stay (# of days) | 2.00 | Determined from claim |
| 3 | Mean all-payer length of stay for DRG 203 | 2.39 | Appendix C, Chart C |
| 4 | Transfer per diem | $5,272.64 | Line 1 / Line 3 |
| 5 | Transfer per diem x Patient length of stay (# of days) | $10,545.27 | Line 4 * Line 2 |
| 6 | Total Transfer Payment Cap | $12,601.60 | Line 1 |
| **7** | **Total Transfer Case Payment** | **$10,545.27** | **Lower of Line 5 or Line 6** |

### b. Transfers within a Hospital

Except as described below, 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 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 from the PCC Plan, a Primary Care ACO, or Non-Managed Care to an MCO during a Hospital Stay (or vice versa); or in the Event of Exhaustion of (or eligibility for) Other Insurance

When a patient becomes MassHealth-eligible (or loses MassHealth eligibility) after the date of admission and prior to the date of discharge, changes enrollment from the PCC Plan, a Primary Care ACO, or non-managed care to an MCO (or vice versa) during the course of a Hospital stay, or exhausts other insurance benefits (or becomes eligible for 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 at the Hospital, 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**).

When a Member who is 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 for the non-DMH-Licensed Bed portion of the stay at the Transfer Per Diem rate capped at the Hospital's Total Transfer Payment Cap.

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

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

Except as otherwise provided in section 4.A.1, Hospitals that are not in the BH Contractor's network do not qualify for payment from either MassHealth or the BH Contractor for BH Contractor-covered services rendered to a Member during a period in which the Member was enrolled with the BH Contractor.

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 Behavioral Health Services in a DMH-Licensed Bed or at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap, for Behavioral Health 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 a 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 Behavioral Health Services in a DMH-Licensed Bed; or at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-Licensed Bed.

**4. Payments for Behavioral Health Services**

Services provided to MassHealth Members in DMH-Licensed Beds during an inpatient BH admission who are not enrolled with the BH Contractor or an MCO shall be paid through a combination of a Psychiatric Per Diem and a per inpatient admission behavioral health rate, as described below. This payment mechanism does not apply to cases in which Behavioral Health Services are provided to Members enrolled with the BH Contractor or an MCO.

**a. Statewide Standard Psychiatric Per Diem**

The Statewide Standard Psychiatric Per Diem Rate is derived using the sum of the following: the Acute Hospital Standard for Inpatient Psychiatric Overhead Costs, the Acute Hospital Standard for Inpatient Psychiatric Direct Routine Costs, the Acute Hospital Standard for Inpatient Psychiatric Direct Ancillary Costs, the Acute Hospital Standard for Inpatient Psychiatric 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, in determining Base Year Operating Standards and the Base Year Capital Standards described in subsection 5.B.4.c and d, below.

**c. Determination of Base Year Operating Standards**

(1) The Standard for Inpatient Psychiatric Overhead Costs is the median of the Inpatient Psychiatric Overhead Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

(2) The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the Inpatient Psychiatric Direct Routine Costs Per Day (minus direct routine physician costs) for the array of acute hospitals providing mental health services

in DMH-licensed beds. The median is determined based upon inpatient psychiatric days.

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

**d. Determination of Base Year Capital Standard**

(1) Each hospital's base year capital costs consist of the hospital's actual Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the hospital's capital expenses.

(2) Each hospital's base year Psychiatric Capital Cost Per Day equals the base year psychiatric capital cost divided by the greater of: the actual base year psychiatric days or 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, between RY12 and RY19, and between RY21 and RY23 were applied to the rate calculated above to determine the RY23 Statewide Standard Psychiatric Per Diem rate.

**f. Inpatient Admission Rates Payments:**

For inpatient BH admissions in DMH-Licensed Beds for members who are not enrolled with the BH Contractor or an MCO, an inpatient admission rate will be paid in addition to the inpatient per diem rate. The inpatient admission rate is determined based on criteria met upon admission, as set forth below. Each admission may meet only one category below:

# In-State Acute Hospitals

| | (1) Category 1 Per Admission Inpatient Rate; OR | (2) Category 2 Per Admission Inpatient Rate; OR | (3) Category 3 Per Admission Inpatient Rate |
|---|---|---|---|
| **(A) Weekday Admission - Patient admission occurs Monday to Friday; OR** | The Member admission does not meet eligibility criteria for either Category 2 or Category 3 Per Inpatient Admission Rates. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 14 years old to 17 years old (inclusive); or<br>2. The Member has a diagnosis of Autism Spectrum Disorder or Intellection Disability Disorder (ASD/IDD);<br>3. The Member is homeless as indicated by diagnosis code Z59.0x, or housing unstable as indicated by diagnosis code Z59.1 or Z59.819; or<br>4. The member is admitted to a hospital identified by CHIA as a teaching hospital;<br>AND<br>The Member admission does not meet eligibility criteria for the Category 3 Per Inpatient Admission Rate. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 13 years old or below; or<br>2. The Member is aged 65 years old or above; or<br>3. The Member is affiliated (as indicated in MMIS) with one or more of the following Massachusetts human service agencies: DDS, DCF, DMH, or DYS. |
| **(B) Weekend Admission - Patient admission occurs Saturday or Sunday** | The Member admission does not meet eligibility criteria for either Category 2 or Category 3 Per Inpatient Admission Rates. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 14 years old to 17 years old (inclusive); or<br>2. The Member has a diagnosis of ASD/IDD;<br>3. The Member is homeless as indicated by diagnosis code 759.0x, or housing unstable as indicated by diagnosis code Z59.1 or Z59.819; or<br>4. The member is admitted to a hospital identified by CHIA as a teaching hospital;<br>AND<br>The Member admission does not meet eligibility criteria for the Category 3 Per Inpatient Admission Rate. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 13 years old or below; or<br>2. The Member is aged 65 years old or above; or<br>3. The Member is affiliated (as indicated in MMIS) with one or more of the following Massachusetts human service agencies: DDS, DCF, DMH, or DYS. |

The payment rates for inpatient behavioral health services described in the chart above are as follows:

(1) Psychiatric per diem rate - $954.59 per day
(2) Category A1 rate - $350 per admission
(3) Category B1 rate - $1,000 per admission
(4) Category A2 rate - $1,850 per admission
(5) Category B2 rate - $2,500 per admission
(6) Category A3 rate - $2,975 per admission
(7) Category C3 rate - $3,625 per admission

**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), 101 CMR 316.00 (Surgery and Anesthesia), 101 CMR 318.00 (Radiology) 101 CMR 320.00 (*Rates for Clinical Laboratory Services*), and 101 CMR 446.03(2) (COVID-19 Payment Rates for Certain Community Health Care Providers, Medicine), 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. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

Hospitals shall not be reimbursed for inpatient physician services provided by Community-Based Physicians.

Physician fee schedules are available at the State House Bookstore and at 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 $242.03, which represents the median nursing facility rate that was effective October 1, 2021, 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 are $316.90 for Medicaid/Medicare Part B-eligible patients and $342.68 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 and/or subregulatory guidance. Therefore, except as permitted in such regulations or subregulatory guidance, 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 in the Acute Hospital's Rehabilitation Unit.

The Rehabilitation Unit per diem rate for such Rehabilitation Services equals the median MassHealth RY23 Rehabilitation Hospital group per diem rate under the Chronic Disease and Rehabilitation (CDR) Hospital RFA and program, as determined by EOHHS. 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 hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410 – 411.

**8. Payment for APAD Carve-Out Items**

**a. Payment for LARC Devices**

A Hospital may be paid for a LARC Device separate from the APAD, if all of the following conditions are met:

(1) The member requests the LARC Device while admitted as an inpatient for a labor and delivery stay and, at the time of the procedure, is a clinically appropriate candidate for immediate post-labor and delivery LARC Device insertion;

(2) The practitioner has been properly trained for immediate post-partum LARC Device insertion, and performs the procedure immediately after labor and delivery during the same inpatient hospital stay; and

(3) The Hospital submits a separate claim for payment in accordance with applicable MassHealth billing instructions, including any special billing instructions for

Acute Inpatient Hospital claims for LARC Devices that MassHealth may publish under "Billing Tips" on the MassHealth website at www.mass.gov/service-details/billing-tips, or in other written statements of policy issued by EOHHS. (See also Section 5.G) EOHHS may update the billing instructions, from time to time.

If the Hospital qualifies for separate payment of a LARC Device, the Hospital will be reimbursed for the LARC Device according to the fee schedule rates for such devices set forth in EOHHS regulations at 101 CMR 317.00 (*Rates for Medicine Services*).

**b. APAD Carve-Out Drugs**

**(1) APAD Carve-Out Drugs and Prior Approval Requirements**

(a) The EOHHS-designated APAD Carve-Out Drugs are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" within the MassHealth Drug List. The MassHealth Drug List is published on the MassHealth website at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do. This list of APAD Carve-Out Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at the above website location.

(b) The APAD Carve-Out Drugs listed on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization through the MassHealth Drug Utilization Review (DUR) Program. The related inpatient stay(s) are also subject to separate MassHealth preadmission screening (PAS) requirements and approval through the MassHealth Acute Hospital Utilization Review vendor. (See also **Sections 4.B.3** and **6.A.**)

**(2) Payment for APAD Carve-Out Drugs**

(a) Payment to Hospitals for APAD Carve-Out Drugs administered to Members during an inpatient admission will be the Hospital's "actual acquisition cost" of the Drug. For this purpose, the Hospital's "actual acquisition cost" of the Drug is the Hospital's invoice price for the Drug, net of all on- or off- invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member while the Member was admitted in the Hospital, including any efficacy, outcome-, or performance-based guarantees (or similar arrangements), whether received pre- or post-payment.

(b) Payment to the Hospital for an APAD Carve-Out Drug is conditioned on and subject to all of the following:

i. The Hospital must have satisfied all applicable MassHealth prior authorization and other applicable prior approval requirements, and all other MassHealth conditions of payment (see also **Section 6.A**).
ii. The Hospital must provide timely reports to EOHHS on Member progress as a result of being treated with the APAD Carve-Out Drug as required in

the prior authorization approval criteria and billing instructions (or other written statements of policy issued by EOHHS).

iii. The Hospital must claim separate payment for APAD Carve-Out Drugs in accordance with applicable MassHealth billing instructions, including, without limitation, as set forth herein, in MassHealth billing instructions for 837P via DDE claims (unless otherwise indicated), and in any special billing instructions for Acute Inpatient Hospital claims for APAD Carve-Out Drugs that may be published under "Billing Tips" on the MassHealth website at https://www.mass.gov/service-details/billing-tips, EOHHS may update the billing instructions from time to time. See also **Section 5.G: Billing**.

iv. The Hospital's claim must be accompanied by a copy of the invoice (or invoices) for the APAD Carve-Out Drug from the drug manufacturer, supplier, distributor, or other similar party or agent, as well as any other documentation that is necessary for the Hospital to evidence that the amount listed on the claim is the Hospital's actual acquisition cost for the Drug (as defined in **Section 5.B.8.b.(2)(a)**). Hospitals must provide EOHHS with any additional documentation deemed necessary by EOHHS to establish or verify that the amount included on the claim is the Hospital's actual acquisition cost as defined in **Section 5.B.8.b.(2)(a)**, upon request.

v. In the event the drug manufacturer (or other party) offers any providers an efficacy-, outcome-, or performance-based guarantee (or similar arrangement) related to the APAD Carve-Out Drug in question, the Hospital shall make every effort to enter such an arrangement with the manufacturer (or other party), at least with respect to the Hospital's treatment of MassHealth Members, and shall make every effort to negotiate terms most favorable to the Hospital and MassHealth. Subject to the requirements of 130 CMR 450.309, in the event the terms of the arrangement allow the Hospital to pay in full or in part for the Drug only if certain conditions are met (e.g., Hospital only pays for the Drug if the Member goes into remission), the Hospital shall not submit a claim to MassHealth for the Drug until the Hospital actually remits the payment it will be required to make for the Drug (and shall not submit any claim for the Drug to MassHealth in the event it is not ultimately required to pay for the Drug). Subject to the above, in the event any other performance-based guarantee (or similar arrangement) is triggered to the benefit of the Hospital with respect to the Member's treatment with the Drug after the Hospital has submitted a claim for the Drug, the Hospital shall immediately notify EOHHS in writing and shall adjust or modify its claim for the Drug to account for the benefit, or otherwise pass the benefit back to MassHealth in the manner specified by EOHHS.

EOHHS may designate particular APAD Carve-Out Drugs as requiring the Hospitals to obtain a performance-based guarantee (or similar arrangement). In the event EOHHS designates an APAD Carve-Out Drug as requiring such an arrangement, it will so indicate on the MassHealth

Acute Hospital Carve-Out Drugs List within the MassHealth Drug List, and may require documentation or attestation that the Hospital has entered such an arrangement as part of the prior authorization process for the Drug.

(c) Any MassHealth payment made to the Hospital for an APAD Carve-Out Drug based on a claim or invoice submitted by a Hospital for an amount that exceeds the Hospital's actual acquisition cost of the Drug, as defined in **Section 5.B.8.b.(2)(a)**, or under circumstances in which EOHHS determines there was noncompliance with the requirements set forth in **Section 5.B.8.b.(2)(b)**, shall constitute an overpayment as defined by 130 CMR 450.235 and will be subject to recoupment. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

## 9. 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.9.a(2)(a), then the Hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants less than one year of age is calculated. If a Hospital has a Medicaid inpatient case with a cost that equals or exceeds the Hospital's own threshold defined in Section 5.B.9.a(2)(b) above, then the Hospital is eligible for an infant outlier payment.

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

**b. Pediatric Outlier Payment Adjustment**

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

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

**(1) Data Source:** The prior year's discharge data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.

**(2) Eligibility:** Eligibility for the adjustment is determined as follows:

**(a) Exceptionally Long Lengths of Stay:** First, a statewide weighted average Medicaid inpatient length of stay is calculated. This is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. Second, the statewide weighted standard deviation for Medicaid inpatient length of stay is calculated. Third, the statewide weighted standard deviation for Medicaid inpatient length of stay is multiplied by two and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

**(b) Exceptionally High Cost:** Exceptionally high cost is calculated for Hospitals providing services to children greater than one year of age and less than six years of age as follows:

1. The average cost per Medicaid inpatient discharge for each Hospital is calculated.

2. The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated.

3. The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two and added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.

**(c) Eligibility for a Pediatric Outlier Payment:** For Acute Hospitals providing services to children greater than one year of age and less than six years of age, eligibility for a pediatric outlier payment is calculated as follows:

1. The average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this Hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in **Section 5.B.9.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.9.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, or a contract between the Acute Hospital and an MCO, as applicable, and that are provided to MassHealth Members enrolled with EOHHS' BH Contractor or with the MCO, as applicable, shall be governed by terms agreed upon between the Acute Hospital and the BH Contractor, or between the Acute Hospital and the MCO (as applicable), as set forth in* ***Section 4.A.1, 4.A.2 or 4.A.5*** *(as applicable) 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 Section 4.C and Sections 5.C.3 through 5.C.14, Hospitals that are not Critical Access Hospitals will receive a Hospital-

specific, Episode-specific payment for each payable Episode, known as the Adjudicated Payment per Episode of Care (APEC), calculated as set forth in **Section 5.C.1**, below.

For Critical Access Hospitals, payment for Outpatient Services is set forth in **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. Adjudicated Payment per Episode of Care**

**a. Rate Year 2023 APEC**

For dates of service in RY23, Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services delivered to a Member on an outpatient basis in one Episode known as the Adjudicated Payment per Episode of Care (APEC). The APEC is calculated as set forth in **Section 5.C.1.b**, below.

**b. Description of APEC Payment Method**

The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus, (2) if applicable, an APEC Outlier Component, each as described in more detail, below. For proper payment, Hospitals must include on a single claim all of the APEC-Covered Services that correspond to the Episode, and must otherwise submit properly completed outpatient hospital claims. For components of the APEC calculated based on data from all Hospitals, the calculation included data for all Hospitals that were operating as of August 1, 2019.

**(1)** Episode-Specific Total EAPG Payment
For each claim detail line containing APEC-Covered Services in the Episode, the Hospital's Wage Adjusted APEC Outpatient Standard (described below) is multiplied by the claim detail line's Adjusted EAPG Weight (described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.

**(a) Wage Adjusted APEC Outpatient Standard.**
The Wage Adjusted APEC Outpatient Standard is the APEC Outpatient Statewide Standard, adjusted by the Hospital's Massachusetts-specific wage area index, determined as follows.

**1. APEC Outpatient Statewide Standard**
The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for wage area index, casemix, an efficiency standard, an

outlier adjustment factor, inflation, and a conversion factor, as further described below.

***Calculating the average outpatient cost per Episode for each Hospital:*** For each Hospital, an average outpatient cost per Episode for the APEC 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 CY19 APEC-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 FY19 cost report. The Hospital-specific Episodes and related charges were determined by EOHHS based on paid claims for Episodes residing in MMIS as of July 21, 2021, for the APEC Base Year, for which MassHealth was primary payer.

***Wage area and casemix adjustments to calculate each hospital's standardized costs per episode:*** The labor portion of the average outpatient cost per Episode for each Hospital was adjusted by the Hospital's Massachusetts-specific wage area index, which was derived as specified in Section 5.B.1.b, and the labor and non-labor portions were then adjusted by the Hospital-Specific CY19 Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific CY19 Outpatient CMI was determined based on CY19 paid claims data residing in MMIS as of July 21, 2021, for which MassHealth was primary payer. EOHHS calculated each Hospital's CY19 Outpatient CMI by summing the Hospital's CY19 grouper-adjusted EAPG weights for each of its APEC-paid Episodes during CY19, as determined by EOHHS, and then dividing that sum by the Hospital's total number of APEC-paid Episodes in CY19, also as determined by EOHHS.

***Determining the efficiency standard:*** All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of CY19 MassHealth Episodes for the Hospitals was produced from MMIS paid claims on file as of July 21, 2021, 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 60% of the total number of statewide Episodes in MMIS. The APEC efficiency standard is $813.85.

***Final calculation of the APEC Outpatient Statewide Standard:*** The APEC Outpatient Statewide Standard was 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 93%; and by (c) the Inflation Factors for Operating Costs between RY19 and RY23, and then dividing that result by a conversion factor of 1.160. The APEC Outpatient Statewide Standard is $653.84. For Episodes that extend past midnight in the case of Emergency Department Services, Observation Services, or Remote Patient Monitoring Services, the APEC Outpatient

Statewide Standard that applied to the first date of service shall apply to the entire Episode.

**2. Wage Adjusted APEC Outpatient Standard**

Except as otherwise provided in this section, the Hospital's Wage Adjusted APEC Outpatient Standard is determined by: (1) multiplying the labor portion of the APEC Outpatient Statewide Standard by the Hospital's Massachusetts-specific wage area index, and (2) adding this amount to the non-labor portion of the APEC Outpatient Statewide Standard.

For this purpose, the Hospital's Massachusetts-specific wage area index which was multiplied by the labor portion of the APEC Outpatient Statewide Standard was derived as specified in Section 5.B.1.b.

For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's Wage Adjusted APEC Outpatient Standard will be $836.35. For Episodes that extend past midnight in the case of Emergency Department Services, Observation Services, or Remote Patient Monitoring Services, the Wage Adjusted APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode.

For the Acute Hospitals identified as Group 1 safety net hospitals in Appendix N to the MassHealth 1115 waiver, its Wage Adjusted APEC Outpatient Standard shall be as listed in the chart that follows:

| HOSPITAL | WAGE ADJUSTED APEC OUTPATIENT STANDARD |
|---|---|
| Group 1 Hospitals that are High Medicaid Volume Safety Net Hospitals | $714.59 |
| Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Boston | $743.59 |
| Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Springfield | $657.05 |
| Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Cambridge-Newton-Framingham | $705.54 |

For Episodes that extend past midnight in the case of Emergency Department Services, Observation Services, or Remote Patient Monitoring Services, the Wage Adjusted APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode.

**(b) Claim Detail Line's "Adjusted EAPG Weight"**

EAPG(s) are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted outpatient Hospital claim, utilizing the 3M EAPG Grouper. EAPGs are assigned at the claim detail line level. The MassHealth EAPG Weight is the MassHealth relative weight developed by EOHHS for each unique EAPG (see Chart D to Appendix D). The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce that claim detail line's "Adjusted EAPG Weight" for purposes of calculating the Episode-Specific Total EAPG Payment. This 3M EAPG Grouper logic recognizes the efficiencies and value created when multiple procedures or services are provided to the Member in the same Episode.

**(2) APEC Outlier Component**

The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then multiplied by the Marginal Cost Factor of 60%.

The Episode-Specific Case Cost is determined by multiplying the Episode's Total Allowed Charges by the Hospital's FY20 Outpatient CCR, calculated by EOHHS using the Hospital's FY20 Massachusetts Hospital Cost Report. The Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section 5.C.1.b.(1)**, above) and the Fixed Outpatient Outlier Threshold of $4,200. If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor set at 60%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0.

In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.

**(3) Calculation of the APEC**

The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section 5.C.1.b.(1)**, above) and the APEC Outlier Component (calculated as set forth in **Section 5.C.1.b.(2)**, above).

See **Table 5, and Tables 5.1 and 5.2**, below, for an illustrative example of the calculation of an APEC for an Episode claim with multiple EAPGs. As noted, values are for demonstration purposes only.

# In-State Acute Hospitals

| Table 5: Example of Hospital's RY23 APEC Calculation for a Single Episode | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| **Calculation of Episode-Specific Total EAPG Payment** | | | |
| 1 | Episode-Specific Total EAPG Payment | $3,389.71 | Sum of episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #s 1 through 5 from Table 5.2) |
| **Calculation of APEC Outlier Component (only calculated if Line 1 > $0)** | | | |
| 2 | Episode's Total Allowed Charges | $15,300.00 | Sum of episode's claim detail line MassHealth allowed charges (sum of Line 2 from claim detail lines #s 1 through 5 from Table 5.2) |
| 3 | Hospital's Outpatient Cost-to-Charge Ratio | 60.00% | Hospital's FY20 Massachusetts Hospital Cost Report |
| 4 | Episode-Specific Case Cost | $9,180.00 | Line 2 * Line 3 |
| 5 | Fixed Outpatient Outlier Threshold | $4,200.00 | RY23 RFA |
| 6 | Episode-Specific Outlier Threshold | $7,589.71 | Line 1 + Line 5 |
| 7 | Does Episode-Specific Cost exceed Episode-Specific Outlier Threshold ? | TRUE | Is line 4 > Line 6? If TRUE, then APEC Outlier component is due |
| 8 | Marginal Cost Factor | 60% | RY23 RFA |
| 9 | APEC Outlier Component | $ 954.17 | (Line 4 - Line 6) * Line 8 |
| **APEC for the Episode** | | | |
| 10 | APEC | $ 4,343.88 | Line 1 + Line 9 |

| Table 5.1: Hospital's Wage Adjusted APEC Outpatient Standard (Example) | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | APEC Outpatient Statewide Standard | $653.84 | RY23 RFA |
| 2 | Hospital's Massachusetts-specific wage area index | 1.0704 | Varies by hospital, determined annually |
| 3 | Labor factor | 0.6000 | RY23 RFA |
| 4 | Hospital's Wage Adjusted APEC Outpatient Standard | $681.46 | (Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3)) |

| Table 5.2: Claim Detail Line EAPG Payment Amounts (Example) | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Claim Detail Line #1 EAPG Payment Amount Calculation** | | | |
| **EAPG:** | **290, PET SCANS** | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Hospital's Wage Adjusted APEC Outpatient Standard | $681.46 | Table 5.1, Line 4 |
| 2 | Claim detail line allowed charges | $5,000.00 | Determined from claim |
| 3 | Claim detail line MassHealth EAPG weight | 2.3680 | Appendix D, Chart D |
| 4 | Claim detail line Adjusted EAPG weight | 2.3680 | Determined by 3M EAPG Grouper logic |
| 5 | Claim detail line EAPG payment amount | $1,613.69 | Line 1 * Line 4 |
| | | | |
| **Claim Detail Line #2 EAPG Payment Amount Calculation** | | | |
| **EAPG:** | **220, LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP** | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Hospital's Wage Adjusted APEC Outpatient Standard | $681.46 | Table 5.1, Line 4 |
| 2 | Claim detail line allowed charges | $4,000.00 | Determined from claim |
| 3 | Claim detail line MassHealth EAPG weight | 1.7244 | Appendix D, Chart D |
| 4 | Claim detail line Adjusted EAPG weight | 1.7244 | Determined by 3M EAPG Grouper logic |
| 5 | Claim detail line EAPG payment amount | $1,175.11 | Line 1 * Line 4 |
| | | | |
| **Claim Detail Line #3 EAPG Payment Amount Calculation** | | | |
| **EAPG:** | **220, LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP** | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Hospital's Wage Adjusted APEC Outpatient Standard | $681.46 | Table 5.1, Line 4 |
| 2 | Claim detail line allowed charges | $4,000.00 | Determined from claim |
| 3 | Claim detail line MassHealth EAPG weight | 1.7244 | Appendix D, Chart D |
| 4 | Claim detail line Adjusted EAPG weight | 0.8622 | Determined by 3M EAPG Grouper logic |
| 5 | Claim detail line EAPG payment amount | $587.55 | Line 1 * Line 4 |
| | | | |
| **Claim Detail Line #4 EAPG Payment Amount Calculation** | | | |
| **EAPG:** | **299, LEVEL I COMPUTED TOMOGRAPHY** | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Hospital's Wage Adjusted APEC Outpatient Standard | $681.46 | Table 5.1, Line 4 |
| 2 | Claim detail line allowed charges | $2,000.00 | Determined from claim |
| 3 | Claim detail line MassHealth EAPG weight | 0.1170 | Appendix D, Chart D |
| 4 | Claim detail line Adjusted EAPG weight | - | Determined by 3M EAPG Grouper logic |
| 5 | Claim detail line EAPG payment amount | $0.00 | Line 1 * Line 4 |
| | | | |
| **Claim Detail Line #5 EAPG Payment Amount Calculation** | | | |
| **EAPG:** | **400, LEVEL I CHEMISTRY TESTS** | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Hospital's Wage Adjusted APEC Outpatient Standard | $681.46 | Table 5.1, Line 4 |
| 2 | Claim detail line allowed charges | $300.00 | Determined from claim |
| 3 | Claim detail line MassHealth EAPG weight | 0.0196 | Appendix D, Chart D |
| 4 | Claim detail line Adjusted EAPG weight | 0.0196 | Determined by 3M EAPG Grouper logic |
| 5 | Claim detail line EAPG payment amount | $13.36 | Line 1 * Line 4 |

### c. 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

(1) 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.

(2) For dates of service through January 2, 2023, the Hospital shall offer Emergency Services Program (ESP) Services to all Members presenting with a mental health and/or substance use disorder crisis in the Emergency Department or dedicated

emergency department as defined in 42 CFR 489.24. Furthermore, the Hospital is responsible for assisting in placement for fee-for-service Members requiring inpatient psychiatric treatment, in conjunction with the referring provider, MassHealth, and/or ESP.

(3) For dates of service on or after January 3, 2023, the Hospital shall offer Behavioral Health Crisis Evaluations as outlined in **Appendix I** to all Members presenting with a mental health and/or substance use disorder crisis in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24. Furthermore, the Hospital is responsible for disposition planning, including assisting in placement for fee-for-service Members requiring inpatient psychiatric treatment or behavioral health diversionary services, in conjunction with the referring provider and MassHealth.

(4) The Hospital shall offer substance use evaluations, treatment, and notification in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24 in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.

**b. Payment for Emergency Services**

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

**3. Outpatient Hospital Services Payment Limitations**

**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.

**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 (*Rates for Medicine Services*), 101 CMR 316.00 (*Rates for Surgery and Anesthesia*

*Services*), 101 CMR 318.00 (*Rates for Radiology Services*), 101 CMR 320.00 (*Rates for Clinical Laboratory Services*), and 101 CMR 446.03(2) (COVID-19 Payment Rates for Certain Community Health Care Providers, Medicine), 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-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 or Remote Patient Monitoring, the reasons for the Observation Services or Remote Patient Monitoring, the start and stop time of the Observation Services or Remote Patient Monitoring, and the name of the physician ordering the Observation Services or Remote Patient Monitoring, must be documented in the Member's medical record.

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 101 CMR 316.00, 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. §1395*l*(h) for tests performed for a person with Medicare Part B benefits.

**b. Physician Services**

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

**6. Audiology Dispensing**

**a. Payment for Audiology Dispensing Services**

Hospitals will be reimbursed for services designated as hearing aid services in Subchapter 6 of the MassHealth *Audiologist Manual* for providers under 130 CMR 426.000. These services will be performed 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 (*Rates for Hearing Services*).

**b. Physician Payment**

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

**7. Dispensing of Ophthalmic Materials**

**a. Payment for Ophthalmic Materials Dispensing**

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 ophthalmic materials dispensing 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 101 CMR 314.00 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.

**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 APEC 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-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

**9. APEC Carve-Out Drugs**

**a. APEC Carve-Out Drugs and Prior Approval Requirements**

(1) The EOHHS-designated APEC Carve-Out Drugs are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" within the MassHealth Drug List. The MassHealth Drug list is published on the Mass Health website at: https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do. The list of APEC Carve-Out Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at this website location.

(2) The APEC Carve-Out Drugs listed on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization through the MassHealth Drug Utilization Review (DUR) Program. See also **Sections 4.B.3 and 6.A**.

**b. Payment for APEC Carve-Out Drugs**

(1) Payment to Hospitals for APEC Carve-Out Drugs administered to Members during an acute outpatient hospital visit will be the Hospital's "actual acquisition cost" of the Drug. For this purpose, the Hospital's "actual acquisition cost" of the Drug is the Hospital's invoice price for the Drug, net of all on- or –off invoice reductions, discounts, rebates, charge backs, and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member during an Acute Outpatient Hospital visit, including any efficacy-, outcome, or performance-based guarantees (or similar arrangements), whether received pre- or post-payment.

(2) Payment to the Hospital for an APEC Carve-Out Drug is conditioned on and subject to all of the following:

(a) The Hospital must have satisfied all applicable MassHealth prior authorization and other applicable prior approval requirements (if any), and all other conditions of payment (see also **Section 6.A**).

(b) The Hospital must provide timely reports to EOHHS on Member progress as a result of being treated with the APEC Carve-Out Drug as required in the prior authorization approval criteria and billing instructions (or other written statements of policy issued by EOHHS).

(c) The Hospital must claim payment for APEC Carve-Out Drugs in accordance with applicable MassHealth billing instructions, including without limitation, as set forth herein, in MassHealth billing instructions for 837I via DDE claims (unless otherwise indicated) and in any special billing instructions for Acute Outpatient Hospital claims for APEC Carve-Out Drugs that may be published under "Billing Tips" on the MassHealth website at https://www.mass.gov/service-details/billing-tips. EOHHS may update the billing instructions from time to time.

(d) The Hospital's claim must be accompanied by a copy of the invoice (or invoices) for the APEC Carve-Out Drug from the drug manufacturer, supplier, distributor, or other similar party or agent, as well as any other documentation that is necessary for the Hospital to evidence that the amount listed on the claim is the Hospital's actual acquisition cost for the Drug (as defined in **Section 5.C.9.b.(1)**). Hospitals must provide EOHHS with any additional documentation deemed necessary by EOHHS to establish or verify that the amount included on the claim is the Hospital's actual acquisition cost as defined in **Section 5.C.9.b.(1)**, upon request.

(e) In the event the drug manufacturer (or other party) offers any providers an efficacy-, outcome-, or performance-based guarantee (or similar arrangement) related to the APEC Carve-Out Drug in question, the Hospital shall make every effort to enter such an arrangement with manufacturer (or other party), at least with respect to the Hospital's treatment of MassHealth Members, and shall make every effort to negotiate terms most favorable to the Hospital and MassHealth. Subject to the requirements of 130 CMR 450.309, in the event the terms of the arrangement allow the Hospital to pay for the Drug in full or in part only if certain conditions are met (e.g., Hospital only pays for the Drug if the Member goes into remission), the Hospital shall not submit a claim to MassHealth for the Drug until the Hospital actually remits the payment it will be required to make for the Drug (and shall not submit any claim for the Drug to MassHealth in the event it is not ultimately required to pay for the Drug). Subject to the above, in the event any other performance-based guarantee (or similar arrangement) is otherwise triggered to the benefit of the Hospital with respect to the Member's treatment with the Drug after the Hospital has submitted a claim for the Drug, the Hospital shall immediately notify EOHHS in writing and shall adjust or modify its claim for the Drug to account for the benefit, or otherwise pass the benefit back to MassHealth in the manner specified by EOHHS.

EOHHS may designate particular APEC Carve-Out Drugs as requiring the Hospitals to obtain a performance-based guarantee (or similar arrangement). In the event EOHHS designates an APEC Carve-Out Drug as requiring such an arrangement, it will so indicate on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List, and may require documentation or attestation that the Hospital has entered such an arrangement as part of the prior authorization process for the Drug.

(3) Any MassHealth payment made to the Hospital for an APEC Carve-Out Drug based on a claim or invoice submitted by a Hospital for an amount that exceeds the Hospital's actual acquisition cost of the Drug, as defined in **Section 5.C.9.b.(1)**, or under circumstances in which EOHHS determines there was noncompliance with the requirements set forth in **Section 5.C.9.b.(2)**, shall constitute an overpayment as defined by 130 CMR 450.235 and will be subject to recoupment. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

**10. Emergency Department-Dispensed Nasal Naloxone Packages**

**a. Payment for Emergency Department-Dispensed Nasal Naloxone Packages**

Hospitals will be reimbursed for the dispensing of nasal naloxone packages through their emergency departments at the rate of $125 per nasal naloxone package. A single nasal naloxone package consists of two nasal spray inhalers, with each inhaler containing 4 mg of naloxone. This payment is in addition to any payment that the Hospital may receive pursuant to Section 5.C for services rendered to the member.

**b. Physician Payment**

Hospitals may not bill for Hospital-Based Physician services related to the dispensing of nasal naloxone packages through their Emergency Departments.

**11. Behavioral Health Crises Evaluations in the Emergency Department**

Until January 2, 2023, Hospitals providing Emergency Service Program (ESP) services in the Emergency Department for Members experiencing Behavioral Health crises in accordance with All Provider Bulletin 291, or any successor bulletin thereto, will be reimbursed in accordance with the fees set forth in 101 CMR 306.00, et seq. This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the member as part of the Emergency Department visit.

For dates of service on or after January 3, 2023, hospitals providing Behavioral Health Crisis Evaluations to Members experiencing behavioral health crises in accordance with **Appendix I** will be reimbursed at a rate of $632.08 using HCPCS code S9485, without code modifiers. This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the member as part of the Emergency Department visit.

Hospitals shall demonstrate readiness to provide crisis evaluations by January 3, 2023, to the satisfaction of EOHHS. By October 14, 2022, Hospitals must indicate their readiness to perform these evaluations to MassHealth using a form to be provided by EOHHS. Hospitals shall submit any additional information as requested by EOHHS as necessary for EOHHS to evaluate the Hospital's readiness to provide BH crisis evaluations. MassHealth will only pay Hospitals that are determined by MassHealth to be ready to provide such services for Behavioral Health Crisis Evaluations.

### 12. COVID-19 Vaccine Administration

Hospitals will be reimbursed for the administration of COVID-19 vaccines in accordance with the fee schedule set forth in 101 CMR 446.03(2). This payment is in addition to any payment that the Hospital may receive pursuant to Section 5.C for services rendered to the member.

### 13. COVID-19 Monoclonal Antibody Product Infusion

Hospitals will be reimbursed for the administration of COVID-19 monoclonal antibody products in accordance with the fee schedule set forth in 101 CMR 446.03(2). This payment is in addition to any payment that the Hospital may receive pursuant to Section 5.C for services rendered to the member.

### 14. Reimbursement for Outpatient Administration of Certain Physician Administered Drugs

Hospitals will be reimbursed for the outpatient administration of certain physician administered drugs identified on the "Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule" section of the MassHealth Drug List (Fee Schedule Drugs) in accordance with this **Section 5.C.14**. The MassHealth Drug list is published on the MassHealth website at: https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do. The list of Fee Schedule Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at this website location.

Payment to hospitals for the outpatient administration of any Fee Schedule Drug shall be the amount as listed by the quarterly Medicare Part B Drug Average Sales Price for the Fee Schedule Drug, as set forth on CMS's website at www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2021-asp-drug-pricing-files.

This payment is in addition to any payment that the Hospital may receive pursuant to Section 5.C for services rendered to the member.

### 15. Reimbursement for CARES for Kids Program Services

The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support for Kids Program (CARES program) is a targeted case management (TCM) service rendered by MassHealth-certified CARES program providers to members under the age of 21 in accordance with CARES program requirements. Effective for dates of service on or after July 1, 2023, Hospitals providing outpatient TCM services in accordance with the MassHealth CARES Program Services requirements at 130 CMR 410.482 will be reimbursed at individual consideration (I.C.) until appropriate rates can be developed to be listed in 101 CMR 317.00 (*Rates for Medicine Services*).

## D. Reimbursement for Unique Circumstances

### 1. High Public Payer Hospital Supplemental Payment

#### a. Qualification

In order to qualify for the High Public Payer Hospital Supplemental Payment, a Hospital's FY21 public payer percentage, which is the ratio of the Hospital's FY21 Gross Patient Service Revenue from government payers and free care to the Hospital's FY21 Gross Patient Service Revenue ("FY21 Public Payer Percentage"), must exceed 63% ("High Public Payer Threshold"), as determined by EOHHS based on the Hospital's FY21 Massachusetts Hospital 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 $13 million in total aggregate supplemental payments to High Public Payer Hospitals satisfying the eligibility criteria set forth in **Section 5.D.1.a** (each an "Eligible Hospital" for purposes of this **Section 5.D.1**), allocated $6.5 million to inpatient and $6.5 million to outpatient.

For purposes of this **Section 5.D.1**, references to "MCOs" include only "traditional" MCOs, and exclude ACPPs, SCOs, and One Care plans.

The inpatient portion of the supplemental payment amount for each Eligible Hospital will be determined by apportioning a total of $6.5 million to Eligible Hospitals on a pro-rata basis, as follows:

- First, EOHHS will calculate each Eligible Hospital's Weighted Discharge Volume by summing 60% of the Hospital's FY23 Accountable Care Partnership Plan (ACPP) and Primary Care ACO discharge volume, 20% of the Hospital's FY23 MCO discharge volume, and 20% of the Hospital's FY23 PCC Plan discharge volume;
- Second, EOHHS will calculate each Eligible Hospital's Pro-Rata Discharge Volume by dividing its Weighted Discharge Volume by the sum of all Eligible Hospitals' Weighted Discharge Volumes;
- Third, EOHHS will calculate each Eligible Hospital's HPP Ratio by:
    - Subtracting the 63% High Public Payer Threshold from that Hospital's FY20 Public Payer Percentage;
    - Multiplying that difference by 12%; and
    - Adding 2% to that product;
- Fourth, EOHHS will calculate each Eligible Hospital's Inpatient HPP Distribution Percentage by multiplying its Pro-Rata Discharge Volume by its HPP Ratio;
- Fifth, EOHHS will calculate each Eligible Hospital's Inpatient HPP Payment Factor by dividing its Inpatient HPP Distribution Percentage by the sum of all Inpatient HPP Distribution Percentages for all Eligible Hospitals; and

- Sixth, EOHHS will calculate the inpatient portion of each Eligible Hospital's supplemental payment by multiplying its Inpatient HPP Payment Factor by $6.5 million.

The outpatient portion of the supplemental payment amount for each Eligible Hospital will be determined by apportioning a total of $6.5 million to Eligible Hospitals on a pro-rata basis, as follows:

- First, EOHHS will calculate each Eligible Hospital's Weighted Episode Volume by summing 60% of the Hospital's FY23 ACPP and Primary Care ACO episode volume, 20% of the Hospital's FY23 MCO episode volume, and 20% of the Hospital's FY23 PCC Plan episode volume;

- Second, EOHHS will calculate each Eligible Hospital's Pro-Rata Episode Volume by dividing its Weighted Episode Volume by all Eligible Hospitals' Weighted Episode Volume;

- Third, EOHHS will calculate each Eligible Hospital's HPP Ratio in the same fashion as it did for the inpatient portion of the supplemental payment – namely, by:

    - Subtracting the 63% High Public Payer Threshold from that Hospital's FY20 Public Payer Percentage;

    - Multiplying that difference by 12%; and

    - Adding 2% to that product;

- Fourth, EOHHS will calculate each Eligible Hospital's Outpatient HPP Distribution Percentage by multiplying its Pro-Rata Episode Volume by its HPP Ratio;

- Fifth, EOHHS will calculate each Eligible Hospital's Outpatient HPP Payment Factor by dividing its Outpatient HPP Distribution Percentage by the sum of all Outpatient HPP Distribution Percentages for all Eligible Hospitals; and

- Sixth, EOHHS will calculate the outpatient portion of each Eligible Hospital's supplemental payment by multiplying its Outpatient HPP Payment Factor by $6.5 million.

For purposes of this calculation, FY23 ACPP, Primary Care ACO, MCO, and PCC plan discharge volume refers to paid inpatient discharges from the qualifying Hospital for MassHealth Members enrolled in an ACPP, a Primary Care ACO, an MCO, or the PCC plan, and FY23 ACPP, Primary Care ACO, MCO, and PCC plan episode volume refers to paid outpatient episodes of care delivered by the qualifying Hospital to MassHealth Members enrolled in an ACPP, a Primary Care ACO, an MCO, or the PCC plan, each as determined by EOHHS. EOHHS will make these determinations utilizing, for the ACPP and MCO discharges and episodes, ACPP and MCO

encounter data submitted by each ACPP or MCO for FY23, respectively, and residing in the MassHealth Data Warehouse as of March 31, 2024, and for the PCC plan and Primary Care ACO discharges and episodes, Medicaid paid claims data for FY23 residing in MMIS as of March 31, 2024 for which MassHealth is primary payer. Only MCO and ACPP encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section 5.D.1.a**) are considered in determining the pro rata share. Payments to qualifying Hospitals under this **Section 5.D.1** may be made in installments.

**2. Essential MassHealth Hospitals**

**a. Qualification**

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

**(1)** The Hospital is a non-state-owned public Acute Hospital.

**(2)** The Hospital meets the current MassHealth definition of a non-profit teaching hospital affiliated with a Commonwealth-owned medical school.

**(3)** The Hospital has at least 7% of its total patient days as Medicaid days.

**(4)** The Hospital is an acute-care general Hospital located in Massachusetts that provides medical, surgical, Emergency and obstetrical services.

**(5)** The Hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

**b. Reimbursement Methodology**

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Essential 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 Massachusetts Hospital Cost Report by the total statewide Medicaid discharges for all Hospitals, as determined by EOHHS.

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.

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, state plan and waiver provisions, 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. High Public Payer Behavioral Health Service Supplemental Payment

### a. Qualifications

In order to qualify for the High Public Payer Hospital Behavioral Health Supplemental Payment, an Acute Care Hospital must (1) qualify for a RY23 High Public Payer Supplemental Payment pursuant to **Section 5.D.1** of this RFA, (2) operate at least one DMH-Licensed Bed throughout RY23, and (3) have provided Inpatient Behavioral Health Services to MassHealth members in FY21. Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

### b. Reimbursement Methodology

(1) 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 meet the qualifications described in **Section 5.D.5.a**, in the aggregate amount of $9,000,000, to support access to Inpatient Behavioral Health Services for MassHealth Members, with particular emphasis on supporting access to such services for child and adolescent Members, using the APAD payment methodology to develop a proxy that takes into account the various acuity levels such Members present. EOHHS will pay qualifying hospitals in accordance with the formula set forth in **Section 5.D.5.b.2,** below.

(2) Each qualifying Hospital receives an amount as calculated by the following methodology:

**Step A. Calculate Hospital Specific Payment Amount based on Share of IP BH Days, weighted toward pediatric/adolescent days.**

$$\left[\left[\left[\left[\frac{\text{Hospital Specific IP Pedi Adol BH Days}}{\text{Total IP Pedi Adol BH Days for all Hospitals}} * 0.6\right] + \left[\frac{\text{Hospital Specific IP Adult BH Days}}{\text{Total IP Adult BH Days for all Hospitals}} * 0.4\right]\right] * \$9{,}000{,}000\right] = A$$

**Step B. Calculate Hospital Specific Relative Acuity Adjusted Proxy Payment Amount, determined by APAD grouper methodology.**

$$\left[\left[\frac{\text{Hospital specific relative acuity adjusted payment proxy}}{\text{Total relative acuity adjusted proxy payments}}\right] * \$9{,}000{,}000\right] = B$$

**Step C. Blend Hospital Specific Payment Amount based on Share of IP BH Days and Hospital Specific Payment Amount based on Relative Acuity Complexity**

$$\left[\left[\frac{A}{\$9{,}000{,}000} * 0.5\right] + \left[\frac{B}{\$9{,}000{,}000} * 0.5\right]\right] * \$9{,}000{,}000 = \text{Hospital Specific Supplemental Payment}$$

***Glossary***: As used in this **Section 5.D.5**, the following terms shall have the meanings that follow:

"BH days" refers to the total number of days in which MassHealth Members (whether fee for service or enrolled in managed care or MBHP) received Inpatient Behavioral Health Services in FY21, using data residing in MMIS and/or the Data Warehouse as of March 31, 2022.

"Hospitals" refers to qualifying Hospitals that meet the requirements of **Section 5.D.5.a**, above.

"Pedi Adol" is short for "pediatric and adolescent" and refers to MassHealth members under age 18.

"Adult" refers to MassHealth members age 18 and older.

"Relative Acuity Adjusted Proxy Payment" refers to a relative acuity adjusted proxy payment calculated as follows. To develop a relative acuity adjusted proxy payment, EOHHS processed all Hospital IP BH claims (whether for fee for service members or members enrolled in managed care or MBHP) residing in MMIS and/or the Data Warehouse as of March 31, 2022, using the APAD methodology (used to price medical IP claims). The APAD methodology assigns relative acuity to each discharge and then multiplies the acuity by a base rate to establish an acuity adjusted proxy payment. EOHHS will then take the ratio of each qualifying hospital's total average relative acuity adjusted proxy payment to the sum of all qualifying hospitals' acuity adjusted proxy payments to establish each hospital's pro rata share of such total payments.

"IP" refers to inpatient.

**6. Specialized Pediatric Service Hospital Supplemental Payment**

**a. Qualification**

In order to qualify for the Specialized Pediatric Service Hospital Supplemental Payment, a Hospital must be a Specialized Pediatric Service Hospital, as defined in **Section 2**. Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

**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 $5.5 million in total aggregate supplemental payments to Specialized Pediatric Service Hospitals, with payment to each hospital based on its pro rata share of all Specialized Pediatric Service Hospitals' acute inpatient discharges of Members meeting certain criteria, according to the methodology that follows.

EOHHS will first calculate each Specialized Pediatric Service Hospital's pro rata share of all Specialized Pediatric Service Hospitals' acute inpatient discharges of members under

the age of 21 and enrolled in either an ACPP or a Primary Care ACO during the period from October 1, 2021 through September 30, 2022. EOHHS will then multiply that ratio by $5.5 million to determine that Specialized Pediatric Service Hospital's supplemental payment.

**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, 2022 through September 30, 2023, as described in **Section 5.D.7.c**. Subject to this **Section 5.D.7**, all sections of this RY23 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 RY23, 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 hospitals are paid an APAD.

Notwithstanding **Section 5.B.1**, for Inpatient Admissions occurring in RY23, 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 21 of the Hospital's FY21 CMS-2552-10 cost report, by the Hospital's number of FY21 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY20 paid claims data residing in MMIS as of May 4, 2022, for which MassHealth is the primary payer.

2. EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY21 and RY23, resulting in the inflation-adjusted cost per discharge for each Critical Access Hospital.

3. EOHHS then divided each Critical Access Hospital's inflation-adjusted cost per discharge by each Hospital's FY21 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 APAD Base Payment, used in the APAD calculations for all other Hospitals for admissions in RY23.

5. The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the CAH-Specific Total Standard Rate per Discharge by the discharge-specific MassHealth DRG Weight from **Chart C to Appendix C**.

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. As noted, values are for demonstration purposes only.

| | | | |
|---|---|---|---|
| **DRG Model Example - Massachusetts Critical Access Hospitals** | | | |
| (Values are for demonstrative purposes only) | | | |
| | | | |
| **Table 6: Critical Access Hospital Interim APAD claim** | | | |
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Critical Access Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | RY23 CAH-Specific Total Standard Rate per Discharge | $16,000.00 | RY23 RFA |
| 2 | MassHealth DRG Weight | 0.3966 | Appendix C, Chart C |
| **3** | **Total Case Payment = Adjudicated Payment Amount per Discharge (Interim APAD)** | **$6,345.60** | Line 1 * Line 2 |

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.

### b. Payment for Outpatient Services

Critical Access Hospitals (CAHs) will be paid for Outpatient Services in accordance with Section 5.C with the following changes.

For dates of service in RY23, Critical Access Hospitals will be paid a Hospital-specific, Episode-Specific Adjudicated Payment per Episode of Care (APEC) for those Outpatient Services for which all other in-state hospitals are paid an APEC.

Notwithstanding **Section 5.C.1**, for dates of service in RY23, the Hospital-specific, Episode-specific APEC 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 21 of the Hospital's FY21 CMS-2552-10 cost report by the

Hospital's number of FY21 Medicaid (MassHealth) Episodes. The Hospital's Medicaid (MassHealth) Episode volume was derived from FY21 paid claims data residing in MMIS as of May 4, 2022, 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 RY21 and RY23, resulting in the Critical Access Hospital's inflation-adjusted cost per Episode.

3. EOHHS then divided each Critical Access Hospital's inflation-adjusted cost per Episode by each Hospital's FY21 outpatient casemix index (CMI), as determined by EOHHS.

4. That result is the CAH-Specific Outpatient Standard Rate per Episode. For Episodes that extend past midnight in the case of Emergency Department Services, Observation Services, or Remote Patient Monitoring Services, the CAH-Specific Outpatient Standard Rate per Episode that applied to the first date of service shall apply to the entire Episode.

5. The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the CAH-Specific Outpatient Standard Rate per Episode in place of the Wage Adjusted APEC Outpatient Standard, and calculating a CAH APEC payment as otherwise described in **Section 5.C.1.b**.

**c. Post-RY23 Cost Review and Settlement**

Each Critical Access Hospital must timely complete all Medicaid (Title XIX) data worksheets on CMS-2552 cost reports for FY23 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, 2024, 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-RY23 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 FY23, as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY23 CMS-2552-10 cost reports and such other information that EOHHS determines is necessary, to perform this post RY23 review. "Aggregate interim payments" for this purpose shall include all hospital payments made under (i) the RY22 RFA corresponding to the one-month period in FY23 from October 1, 2022 through October 31, 2022, and (ii) the RY23 RFA for the remainder of FY23, as determined by EOHHS, but excluding any payments under **Section 5.D.1** and **Section 7** under each of the RY22 RFA and the RY23 RFA.

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 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 RY23 review and settlement will take place within approximately twelve (12) months after the close of RY23, subject to the availability of data, or, if later, at such other time as EOHHS determines the necessary documentation is available.

In the case of a Critical Access Hospital that does not comply with the reporting requirements set forth in **Section 6.E** and this **Section 5.D.7.C.**, the amount of any reduction(s) to such hospital's APAD and inpatient Outlier Payments pursuant to **Section 6.E** will also be deducted from such hospital's allowable costs, as calculated by EOHHS pursuant to this **Section 5.D.7.C.**, for purposes of the post-RY23 review and settlement described in this **Section 5.D.7.C.**

**8. High Medicaid Volume Safety Net Hospital Supplemental Payment**

**a. Qualification**

In order to qualify for a High Medicaid Volume Safety Net Hospital supplemental payment, a Hospital must be a High Medicaid Volume Safety Net Hospital as defined in Section 2, and must enter into a separate payment agreement with EOHHS relating to payment as a High Medicaid Volume Safety Net 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 a High Medicaid Volume Safety Net Hospital. The payment amount will be (i) determined by EOHHS using data filed by the 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 a qualifying High Medicaid Volume Safety Net Hospital 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 a High Medicaid Volume Safety Net Hospital shall be determined by EOHHS.

**9. High Medicaid Volume Safety Net Hospital HLHC Supplemental Payment**

In order to qualify for a High Medicaid Volume Safety Net Hospital HLHC supplemental payment, a Hospital must be a High Medicaid Volume Safety Net Hospital that operates an HLHC that experienced a volume of at least 75,000 outpatient episodes in fiscal year

2018, as determined by EOHHS through a review of MMIS claims ("Qualifying HLHC"). Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

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 $1.05 million in total aggregate supplemental payments to Hospitals that qualify for this payment pursuant to the preceding paragraph, divided equally among all qualifying Hospitals, provided that each such Hospital agrees to spend such funds solely for the benefit of its Qualifying HLHC. The payment amount will be specified in an agreement between EOHHS and each qualifying Hospital.

**10. Reimbursement for I&R Hospitals Rendering I&R Services at an I&R Site**

I&R Hospitals rendering I&R Services at an I&R Site will be paid for those services through a weekly, I&R Hospital-specific, all-inclusive rate established pursuant to the payment methodology described below. This rate will be memorialized in the I&R Hospital's I&R Services-related special conditions addendum to its MassHealth Hospital Contract. This rate shall be sufficient to cover the following allowable costs associated with the provision of I&R Services, as agreed to by EOHHS for each I&R Hospital:

a. The direct labor costs for the I&R Clinical Care Team, staffed appropriately to meet the clinical and administrative needs of the I&R Site.

b. The costs to acquire and maintain sufficient quantities of medical supplies necessary to provide I&R Services at the I&R Site.

c. Appropriate set-up and other one-time costs associated with the provision of I&R Services at the I&R Site, which may include information technology equipment and services, and office supplies.

To constitute an allowable cost, the costs described in paragraphs (a), (b), and (c) must, at a minimum, be reasonable, directly related to the provision of I&R Services, and identified in the I&R Hospital's I&R Services-related special conditions addendum to its MassHealth Hospital Contract.

No additional payment shall be made for any physician service provided in connection with an I&R Hospital's provision of I&R Services at an I&R Site. Payment pursuant to this **Section 5.D.10** represents payment in full for all I&R Services rendered by an I&R Hospital at an I&R Site.

A Hospital rendering services which are reimbursed through this RFA, and which are not I&R Services, will not be reimbursed through this **Section 5.D.10**. Instead, such Hospitals will be reimbursed for those services pursuant to the applicable methodology(ies) set forth elsewhere in this RFA.

## 11. Pediatric Inpatient BH Per Diem Supplemental Payment

### a. Definitions

For purposes of this **Section 5.D.11**, the following terms shall have the following meanings:

(1) Pediatric – a Member under 18 years of age.

(2) Pediatric Inpatient BH Bed-Days Baseline - the adjusted CY19 Pediatric Inpatient BH Bed-Days for a given performance period, calculated in accordance with **Section 5.D.11.b.2.**

(3) Pediatric Inpatient BH Bed-Days Volume - Pediatric inpatient BH bed-days utilization equal to the Hospital's Pediatric Inpatient BH Bed-Days for a particular period.

(4) Pediatric Inpatient BH Bed-Day – a day on which a Hospital provided Inpatient Behavioral Health Services to a Pediatric Member for which payment was made by MassHealth or a Managed Care Entity, as determined by EOHHS. Pediatric Inpatient BH Bed-Days shall include each day of utilization for each Pediatric Member to whom Inpatient Behavioral Health Services were rendered.

(5) Managed Care Entity (MCE) – An MCO or the BH Contractor.

(6) First RY23 Performance Period – the period beginning on October 1, 2022, and ending on March 31, 2023.

(7) Second RY23 Performance Period – the period beginning on April 1, 2023, and ending on September 30, 2023.

(8) RY23 Performance Period – either the First RY23 Performance Period or the Second RY23 Performance Period.

### b. Eligibility Criteria

(1) A Hospital is eligible for a Pediatric Inpatient BH Per Diem Supplemental Payment or Payments if its Pediatric Inpatient BH Bed-Days Volume for an RY23 Performance Period, calculated in accordance with **Section 5.D.11.b.3**, exceeds its Pediatric Inpatient BH Bed-Days Baseline for that RY23 Performance Period, calculated in accordance with **Section 5.D.11.b.2**. EOHHS shall determine a Hospital's eligibility to receive payment pursuant to this **Section 5.D.11.b**.

(2) EOHHS shall calculate a Hospital's Pediatric Inpatient BH Bed-Days Baseline for an RY23 Performance Period as follows:

a. If the Hospital had at least one Pediatric Inpatient BH Bed-Day during each calendar month in CY2019, EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume during Calendar Year 2019 ("CY19 Pediatric Inpatient BH Bed-Days") by summing all of the

Hospital's Pediatric Inpatient BH Bed-Days during CY19, determined based on CY2019 fee-for-service MMIS paid claims and encounter data submitted to EOHHS by Managed Care Entities as of September 11, 2020.

b. If the Hospital had zero Pediatric Inpatient BH Bed-Days during at least one calendar month in CY2019, EOHHS will calculate the Hospital's CY19 Pediatric Inpatient BH Bed-Days Volume as follows:

i. If the Hospital had zero Pediatric Inpatient BH Bed-Days during at least one calendar month in the second half of CY19 (July to December), EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume during Calendar Year 2019 ("CY19 Pediatric Inpatient BH Bed-Days"), by summing all of the Hospital's Pediatric Inpatient BH Bed-Days during CY19, determined based on CY2019 fee-for-service MMIS paid claims and encounter data submitted to EOHHS by Managed Care Entities as of September 11, 2020.

ii. If a Hospital not described in **section 5.D.11.b.2.b.i** had zero Pediatric Inpatient BH Bed-Days during at least one calendar month in the first half of CY19 (January to June), EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume during the second half of Calendar Year 2019, by summing all of the Hospital's Pediatric Inpatient BH Bed-Days during the second half of CY19, determined based on CY2019 fee-for-service MMIS paid claims and encounter data submitted to EOHHS by Managed Care Entities as of September 11, 2020. The Hospital's CY19 Pediatric Inpatient BH Bed-Days shall equal 200% of the Hospital's Pediatric Inpatient BH Bed-Days Volume during the second half of CY19.

c. EOHHS will multiply the Hospital's CY19 Pediatric Inpatient BH Bed-Days (as calculated pursuant to **Section 5.D.11.b.2.a, 5.D.11.b.2.b.i,** or **5.D.11.b.2.b.ii**) by 80%, resulting in the Hospital's Pediatric Inpatient BH Bed-Days Baseline.

d. The Hospital's Pediatric Inpatient BH Bed-Days Baseline for the First RY23 Performance Period shall equal 52.5% of the amount calculated in **Section 5.D.11.b.2.c**.

e. The Hospital's Pediatric Inpatient BH Bed-Days Baseline for the Second RY23 Performance Period shall equal 47.5% of the amount calculated in **Section 5.D.11.b.2.c**.

(3) A Hospital's Pediatric Inpatient BH Bed-Days Volume during an RY23 Performance Period shall be calculated as follows:

a. The Hospital's Pediatric Inpatient BH Bed-Days Volume for an RY23 Performance Period shall equal the sum of the Hospital's Pediatric Inpatient BH Bed-Days during that RY23 Performance Period.

b. EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume for the first RY23 Performance Period utilizing RY23 fee-for-service MMIS paid claims and managed care encounter data submitted to EOHHS by Managed Care Entities by September 30, 2023.

c. EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume for the Second RY23 Performance Period utilizing RY23 fee-for-service MMIS paid claims and managed care encounter data submitted to EOHHS by Managed Care Entities by March 31, 2024.

**c. Methodology**

(1) 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, for each Hospital eligible for a Pediatric Inpatient BH Per Diem Supplemental Payment for an RY23 Performance Period in accordance with **Section 5.D.11.b**, the Hospital's payment shall equal $330 multiplied by the number of days by which the Hospital's Pediatric Inpatient BH Bed-Days Volume for an RY23 Performance Period, calculated in accordance with **Section 5.D.11.b.3**, exceeds the Hospital's Pediatric Inpatient BH Bed-Days Baseline for that RY23 Performance Period, calculated in accordance with **Section 5.D.11.b.2**. This payment is in addition to any other payment to which the Hospital may be entitled pursuant to this RFA for services rendered during a Performance Period.

(2) EOHHS may make partial payments to eligible Hospitals under this Section at the close of an RY23 Performance Period or at other times as determined appropriate by EOHHS in its sole discretion. Any partial payment made by EOHHS that exceeds amounts owed to the Hospital under **Section 5.D.11.c.1** shall be reconciled against future payments owed to the Hospital or recouped through other means, as determined by EOHHS.

**12. Medicaid Rate Add-on Payments**

EOHHS will make uniform dollar add-on payments per inpatient discharge and outpatient episode to in-state acute care hospitals.

**(a)** ***Inpatient Discharge Add-on***

(1) The inpatient add-on pool is $305.5 million, calculated by multiplying $650 million by 47%.

(2) To determine each in-state acute care hospital's final adjusted inpatient discharge add-on amount, EOHHS will:

a. First, divide the inpatient add-on pool by the total number of RY23 in-state acute care hospital inpatient discharges, inclusive of both MassHealth fee-for-service and managed care discharges, as determined by EOHHS based on paid claims and encounters on file as of March 31, 2024, to determine the final inpatient add-on amount per discharge.

b. Second, multiply the total number of RY23 inpatient discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2024, by the final inpatient add-on amount per discharge, to determine the hospital-specific final inpatient add-on payment amounts.

c. Third, for each hospital, subtract the total hospital-specific interim inpatient add-on payments received in RY23, calculated as described in **Section 5.D.12.a(3)**, from hospital-specific final inpatient add-on payment amounts, calculated as described in **Section 5.D.12.a(2)(c)** and, (i) if the amount is less than $0.00, make a final true-up payment equal to the difference; or (ii) if the amount is more than $0.00, complete a recoupment equal to the difference. The total final amount after true-up or recoupment, as applicable, is the final adjusted inpatient discharge add-on amount for each hospital calculated pursuant to this **Section 5.D.12.a(2)**.

(3) EOHHS will make interim inpatient add-on payments in RY23. For each interim inpatient add-on payment, a new inpatient add-on amount per discharge will be calculated by dividing the pool of funding available for that payment, as determined by EOHHS, by the total number of in-state acute care hospital inpatient discharges in a historical period as determined by EOHHS ("interim dataset"). To determine interim inpatient add-on payment amounts pursuant to this **Section 5.D.12.a(2)**, EOHHS will multiply each in-state acute care hospital inpatient discharge from the interim dataset by the interim payment inpatient add-on amount per discharge.

**(b)** ***Outpatient Episode Add-on***

(1) The outpatient add-on pool is $344.5 million, calculated by multiplying $650 million by 53%.

(2) To determine each in-state acute hospital's final adjusted outpatient episode add-on payment amount, EOHHS will:

(a) First, divide the outpatient add-on pool by the total number of RY23 in-state acute care hospital outpatient episodes, inclusive of both MassHealth fee-for-service and managed care episodes, as determined by EOHHS based on paid claims and encounters on file as of March 31, 2024, to calculate the final outpatient add-on payment amount per episode.

(b) Second, multiply the total number of RY23 outpatient episodes for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2024, by the final outpatient add-on payment amount per episode, to calculate the final outpatient add-on payment amount.

(c) Third, for each hospital, subtract the total hospital-specific interim outpatient add-on payments received in RY23, as calculated as described in **Section 5.D.12.b(3)**, from hospital-specific final outpatient add-on payment amounts, calculated in **Section 5.D.12.b(2)(b)**, and (i) if the amount is less than $0.00, make a final true-up payment equal to the difference; or (ii) if the amount is more than $0.00, complete a recoupment equal to the difference. The total final amount after true-up or recoupment, as applicable is the final adjusted outpatient episode add-on amount for each hospital, calculated pursuant to this **Section 5.D.12.b(2)**.

(3) EOHHS will make interim outpatient episode add-on payments in RY23. For each interim outpatient episode add-on payment, a new outpatient add-on amount per episode will be calculated by dividing the pool of funding available for that payment, as determined by EOHHS, by the total number of in-state acute care hospital outpatient episodes in a historical period , as determined by EOHHS ("interim dataset"). To determine interim outpatient add-on payment amounts pursuant to this **Section 5.D.12.b(3)**, EOHHS will multiply each in-state acute care hospital outpatient episode from the interim dataset by the interim payment outpatient episode add-on amount.

**13. Former Section 5.D.13 was reserved in the RY23 RFA.**

**14. Former Section 5.D.14 was reserved in the RY23 RFA.**

**15. Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services**

*a.* ***Definitions***

For the purposes of this payment, the following defined terms have been added to **Section 2**:

- Baseline ED Psychiatric Services
- Community-Based Acute Treatment (CBAT)
- Community Crisis Stabilization (CCS)
- ED-Presenting Psychiatric Member
- Enhanced ED Psychiatric Services
- Tier 1 ED Psychiatric Provider
- Tier 2 ED Psychiatric Provider
- Youth Community Crisis Stabilization (YCCS)

***b. Eligibility Criteria***

A Hospital is eligible for a Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services if the Hospital:

(1) Attests no later than November 1, 2022, in a form and format to be prescribed by EOHHS:

(a) To the number of bed days within calendar year 2021 (CY21) on which an ED-Presenting Psychiatric Member remained in the Hospital's ED or one of the Hospital's non-psychiatric beds while awaiting transfer to an inpatient psychiatric hospital licensed by DMH, CBAT, CCS, or YCCS, provided that, for purposes of this calculation, the Hospital shall exclude any bed-day(s) in which such Member arrived in the ED and was transferred to an Inpatient BH Bed or who otherwise leaves the hospital within 24 hours of presentation to the ED;

(b) That the hospital has the capacity to provide Baseline ED Psychiatric Services to all ED-Presenting Psychiatric Members; and

(c) That the hospital is self-designating during the period from November 1, 2022, through April 30, 2023, as either a Tier 1 Provider or a Tier 2 Provider:

1) By self-designating as a Tier 1 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced ED Psychiatric Services to each of its of its ED-Presenting Psychiatric Members, at least once within 48 hours of each such Member's presentation to the hospital's ED, and then at least once every 3 days thereafter until each such Member transfers to an Inpatient BH Bed or otherwise leaves the hospital.

2) By self-designating as a Tier 2 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced ED Psychiatric Services at least once each day to each of its ED-Presenting Psychiatric Members until each such Member transfers to an Inpatient BH Bed or otherwise leaves the hospital.

(2) Has the capacity to provide any of the Enhanced ED Psychiatric Services via telehealth when those services are clinically appropriate. The services must follow all applicable laws, regulations, and subregulatory guidance. MassHealth members may decline to receive services via telehealth in order to receive such services in person. See M.G.L. c. 118E, § 79(d).

(3) Enters into a separate payment agreement with EOHHS relating to receipt of such payment. Among other things, such Hospital must agree:

(a) Regardless of its designation as a Tier 1 or Tier 2 provider, that it has the capacity to provide Baseline ED Psychiatric Services to all ED-Presenting Psychiatric Members.

(b) If self-designating as a Tier 1 Provider, that the hospital has the capacity to provide Enhanced ED Psychiatric Services to each of its ED-Presenting

Psychiatric Members as described in **Section 5.D.15.b.(1)(c).1**. For purposes of this **Section 5.D.15.b.(3)(b)**, a Tier 1 Provider has the required capacity if at least 90% of ED-Presenting Psychiatric Members receive at least one Enhanced Service at the frequencies set forth above during the period from November 1, 2022, through April 30, 2023.

(c) If self-designating as a Tier 2 Provider, that the hospital has the capacity to provide Enhanced ED Psychiatric Services to each of its ED-Presenting Psychiatric Members as described in **Section 5.D.15.b.(1)(c).2**. For purposes of this **Section 5.D.15.b.(3)(c)**, a Tier 2 Provider has the required capacity if at least 90% of ED-Presenting Psychiatric Members receive at least one Enhanced Service at the frequency set forth above during the period from November 1, 2022, through April 30, 2023.

(d) That any supplemental payments made pursuant to this **Section 5.D.15** are subject to recoupment, in whole or in part, if the Hospital fails to comply with any terms of this **Section 5.D.15** or such payment agreement.

(e) To produce, upon request, all data or documents that, in EOHHS's sole discretion, are necessary to validate the Hospital's attestation or its compliance with any requirements set forth in this **Section 5.D.15** or such payment agreement.

(f) compliance with this **Section 5.D.15** and such payment agreement will be subject to auditing and validation by EOHHS.

(g) To satisfy any conditions of such payment agreement.

***c. 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 one or more supplemental payments to each Hospital that qualifies for this payment pursuant to **Section 5.D.15.b**, in accordance with the methodology that follows:

(1) EOHHS will pay each self-designating Tier 1 Provider $300 multiplied by half of the number of bed-days identified in the Hospital's attestation pursuant to **Section 5.D.15.b.(1)(c).1**. EOHHS will pay each self-designating Tier 2 Provider $500 multiplied by half of the number of bed-days identified in the Hospital's attestation pursuant to **Section 5.D.15.b.(1)(c).2**.

(2) The amount of each such qualifying Hospital's supplemental payment pursuant to this **Section 5.D.15** will be specified in the payment agreement between EOHHS and that Hospital. EOHHS reserves the right to make all payments pursuant to this **Section 5.D.15** in installments.

**16. Former Section 5.D.16 was reserved in the RY23 RFA.**

**17. Former Section 5.D.17 was reserved in the RY23 RFA.**

**18. Former Section 5.D.18 was reserved in the RY23 RFA.**

**19. Supplemental Payments for Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020**

**a. Eligibility Criteria**

In order to qualify for a Supplemental Payment for Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020, a Hospital must satisfy each of the following criteria:

1. the Hospital has a statewide relative price less than 0.90, as calculated by CHIA according to data from the most recent available year;

2. the Hospital has a public payer mix equal to or greater than 60 percent, as calculated by CHIA according to data from the most recent available year; and

3. the Hospital is not owned, financially consolidated or corporately affiliated with a provider organization, as defined by G.L. c. 6D, § 1:

    a. that owns or controls 2 or more acute care hospitals licensed under section 51 of chapter 111; and

    b. for which the total net assets of all affiliated acute care hospitals within the provider organization is greater than $600,000,000, as calculated CHIA according to data from the most recent available year.

For purposes of this **Section 5.D.19.a**, a Hospital's mere clinical affiliation with a provider organization, absent ownership, financial consolidation or corporate affiliation, shall not disqualify an eligible Hospital from payments authorized under this section.

In addition, to qualify for a Supplemental Payment for Hospitals Eligible for Payments Pursuant to Section 63 of Chapter 260 of the Acts of 2020, a Hospital meeting the eligibility criteria set forth above must enter into a separate payment agreement with EOHHS relating to payment under this provision. Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

**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 monthly payments within RY23 to each Hospital satisfying the eligibility criteria set forth in **Section 5.D.19.a**. Pursuant to section 63 of Chapter 260 of the Acts of 2020, EOHHS shall calculate each such qualifying Hospital's monthly payment by:

- First, determining each such Hospital's average monthly Medicaid payments for inpatient and outpatient acute hospital services for the preceding year or the

most recent year for which data is available (Average Monthly Medicaid Payment). This figure shall be as determined by EOHHS.

- Second, calculating each such Hospital's supplemental monthly payment by multiplying such Hospital's Average Monthly Medicaid Payment by 5 percent (Supplemental Monthly Payment).

In accordance with section 63 of the Chapter 260 of the Acts of 2020, in the event that the sum of all Supplemental Monthly Payments to all qualifying Hospitals in FY23 (including payments made by EOHHS during FY23 pursuant to Section 5.D.16 of the Rate Year 2022 Acute Hospital Request for Applications and Contract, as amended) exceeds $35 million, each qualifying Hospital's Supplemental Monthly Payment shall be reduced on a pro rata basis. Each qualifying Hospital's Supplemental Monthly Payment shall be specified in an agreement between EOHHS and the qualifying Hospital.

**20. Former Section 5.D.20 was reserved in the RY23 RFA.**

**21. Former Section 5.D.21 was reserved in the RY23 RFA.**

**22. Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services**

*a.* ***Definitions***

For purposes of this **Section 5.D.22**, the following terms shall have the following meanings:

(1) Community-Based Acute Treatment (CBAT) – 24-hour-per-day, seven-day-per-week, staff-secure treatment settings for children/adolescents up to the age of 18 with serious behavioral health disorders that provide short-term crisis stabilization, therapeutic intervention, and specialized programming.

(2) ED-Presenting Psychiatric Member – A Member who presents to a Hospital's ED in need of Inpatient Behavioral Health (BH) Services (including CBAT services), and needs to remain in the Hospital's ED or one of the Hospital's non-psychiatric beds for at least 24 hours while awaiting transfer to an Inpatient BH Bed (whether located in that Hospital, another acute hospital, a psychiatric inpatient hospital, or a CBAT unit).

(3) Inpatient BH Bed – A DMH-Licensed Bed located in an acute hospital, a bed located in a DMH-licensed psychiatric inpatient hospital, or a bed located in a CBAT unit.

(4) Baseline Services – The following services:

(a) Family support and education.

(b) Screening for substance use disorder (i.e., Screening, Brief Intervention, and Referral to Treatment), including medication-assisted treatment initiation when appropriate.

(c) Referring members to community-based providers for ongoing care after discharge, as necessary.

(d) Observation for those with suicidal ideation and/or homicidal ideation.

(5) Tier 1 Provider – A Hospital that attests pursuant to **Section 5.D.22.b.(1)** that it has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members according to the Tier 1 requirements during the period between May 1, 2022, and October 31, 2022.

(6) Tier 2 Provider – A Hospital that attests pursuant to **Section 5.D.22.b.(1)** that it has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members according to the Tier 2 requirements during the period between May 1, 2022, and October 31, 2022.

(7) Enhanced Services – Mental health or substance use disorder services provided to ED-Presenting Psychiatric Members by any hospital staff, whether employed or contracted, who is qualified to deliver such services within their scope of practice. Such services may be provided to assess such individual's mental status or consult on a member's behavioral health needs, including proper medications, with the Hospital's medical staff. Such services may include, as clinically indicated:

(a) Medication evaluation.

(b) Medication management.

(c) Stabilization interventions (e.g., solution-focused therapy, de-escalation strategies, peer supports, etc.).

(d) Specific services for children that may include:

1) Applied Behavior Analysis: A service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning.

2) Family Therapy: the psychotherapeutic treatment of more than one member of a family simultaneously in the same visit.

3) Group Therapy: the application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

4) Partial Hospitalization Program interventions (either in person or via telehealth). These services offer short-term day mental health programming available seven days per week, as an alternative to inpatient hospital services. These services include daily psychiatric management.

*b.* ***Eligibility Criteria***

A Hospital is eligible for a Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services if the Hospital:

(1) Attests no later than June 10, 2022, in a form and format to be prescribed by EOHHS:

(a) To the number of bed days within calendar year 2021 (CY21) on which an ED-Presenting Psychiatric Member remained in the Hospital's ED or one of the Hospital's non-psychiatric beds while awaiting transfer to an Inpatient BH Bed, even if such Member is ultimately discharged without being admitted to an Inpatient BH Bed, provided that, for purposes of this calculation, the Hospital shall exclude any bed-day(s) in which such Member arrived in the ED and was either discharged within 24 hours of presentation to the ED or transferred to an Inpatient BH Bed within 24 hours of presentation to the ED;

(b) That the hospital has the capacity to provide Baseline Services to all ED-Presenting Psychiatric Members; and

(c) That the hospital is self-designating during the period from May 1, 2022, through October 31, 2022, as either a Tier 1 Provider or a Tier 2 Provider.

i. By self-designating as a Tier 1 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced Services to each of its of its ED-Presenting Psychiatric Members, once within 48 hours of each such Member's presentation to the hospital's ED, and then at least once every 3 days thereafter until each such Member transfers to an Inpatient BH Bed or is discharged without being admitted to an Inpatient BH Bed.

ii. By self-designating as a Tier 2 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced Services each day to each of its ED-Presenting Psychiatric Members until each such Member transfers to an Inpatient BH Bed or is discharged without being admitted to an Inpatient BH Bed.

(2) Enters into a separate payment agreement with EOHHS relating to receipt of such payment. Among other things, such Hospital must agree:

(a) Regardless of its designation, that it has the capacity to provide Baseline Services to all ED-Presenting Psychiatric Members.

(b) If self-designating as a Tier 1 Provider, that the hospital has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members as described in **Section 5.D.22.b.(1)(c).1**. For purposes of this **Section 5.D.22.b.(2)(b)**, a Tier 1 Provider has the required capacity if at least 90% of ED-Presenting Psychiatric Members receive at least one Enhanced Service at the frequencies set forth above during the period from May 1, 2022, through October 31, 2022.

(c) If self-designating as a Tier 2 Provider, that the hospital has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members as described in **Section 5.D.22.b.(1)(c).2**. For purposes of this **Section 5.D.22.b.(2)(c)**, a Tier 2 Provider has the required capacity if at least 90% of ED-Presenting Psychiatric Members receive at least one Enhanced Service at the frequency set forth above during the period from May 1, 2022, through October 31, 2022.

(d) That any supplemental payments made pursuant to this **Section 5.D.22** are subject to recoupment, in whole or in part, if the Hospital fails to comply with any terms of this **Section 5.D.22** or such payment agreement.

(e) To produce, upon request, all data or documents that, in EOHHS's sole discretion, are necessary to validate the Hospital's attestation or its compliance with any requirements set forth in this **Section 5.D.22** or such payment agreement.

(f) The Hospital's compliance with this **Section 5.D.22** and such payment agreement will be subject to auditing and validation by EOHHS.

(g) To satisfy any conditions of such payment agreement.

*c.* ***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 one or more supplemental payments to each Hospital that qualifies for this payment pursuant to **Section 5.D.22.b**, in accordance with the methodology that follows. EOHHS will pay each self-designating Tier 1 Provider $300 multiplied by half of the number of bed-days identified in the Hospital's attestation pursuant to **Section 5.D.22.b.(1)(a)**. EOHHS will pay each self-designating Tier 2 Provider $500 multiplied by half of the number of bed-days identified in the Hospital's attestation pursuant to **Section 5.D.22.b.(1)(a)**.

The amount of each such qualifying Hospital's supplemental payment pursuant to this **Section 5.D.22** will be specified in the payment agreement between EOHHS and that Hospital. EOHHS reserves the right to make all payments pursuant to this **Section 5.D.22** in installments.

## 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.

#### 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

Hospitals shall submit claims for non-professional services through an 837I and for the professional component of Hospital–Based Physician (Inpatient and Outpatient) Services through an 837P, 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. Until further notice, inpatient Hospital claims for LARC Devices pursuant to **Section 5.B.8.a** and APAD Carve-Out Drugs pursuant to **Section 5.B.8.b** must be separately submitted through an 837P via DDE and in compliance with applicable MassHealth 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.

## 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, 2022, and who remain at acute inpatient status on or after October 1, 2022, at the Hospital's MassHealth rates and payment methods established prior to this RY23 RFA, and at the Hospital's MassHealth rates and payment methods established in this RY23 RFA for inpatient services provided to MassHealth members who are admitted on or after October 1, 2022.

For services that qualify for the Rehabilitation Unit per diem, the Psychiatric Per Diem, the Administrative Day per diem, or the Adjudicated Payment Per Episode of Care (APEC), the Hospital's MassHealth rates and payment methods established prior to this RY23 RFA apply to dates of service prior to October 1, 2022, and the Hospital's RY23 RFA rates and payment methods apply to dates of service on or after October 1, 2022. As an exception, for Episodes that extend past midnight in the case of Emergency Department or Observation Services, if the Episode's first date of service occurs in RY22, then the APEC methodology under the RY22 RFA applies to the entire Episode.

## 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 MCO or EOHHS' Behavioral Health contractor that covers the service. Each day of an inpatient Hospital stay constitutes a discrete "date of service." A Member who meets the foregoing conditions on a given date of service may not meet such conditions on all dates of service comprising a Hospital stay. The Hospital is responsible for determining, through the MassHealth Eligibility Verification System (EVS), that the Member meets the conditions stated herein on each discrete date of service.

## L. Updating Groupers

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.

## 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 based on the totality of the circumstances. Any such rate may, in EOHHS' sole discretion, affect computation of any statewide average or statewide standard and/or any cost standard or component of such 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. Headings

The headings and subheadings used in this RFA are for convenience of reference only, and shall not define or limit any of the terms or provisions hereof.

# In-State Acute Hospitals

# 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 Prior Approval

1. **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.

2. **Services Requiring Hospital Prior Approval:** Services for which MassHealth requires Hospitals to obtain prior approval or prior authorization may be set forth in MassHealth regulations, Subchapter 6 of the Acute Outpatient Hospital Provider Manual (in the case of Acute Outpatient Hospitals), the MassHealth Acute Hospital Carve-Out Drug List of the MassHealth Drug List (and any other Acute Hospital section of the MassHealth Drug List that may be developed), Provider bulletins, or other written statements of policy issued by EOHHS. EOHHS will not reimburse a Hospital for services provided when the Hospital is required to, but fails to obtain prior authorization, referrals or other required approvals for the service.

3. **Effect of Prior Authorization:** MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, program restrictions, other MassHealth utilization management or control requirements and approvals, and all other MassHealth conditions of payment.

## 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 through 450.321.

3. Subject to compliance with all conditions of payment, for members who have other health insurance in addition to MassHealth, the MassHealth agency's liability **is the lesser of:**

    a. the member's liability, including coinsurance, deductibles, and copayments, as reported on the explanation of benefits or remittance advice from the insurer; or

    b. the provider's charges or maximum allowable amount payable under the MassHealth agency's payment methodology, whichever is less, minus the insurance payments.

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

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

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

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

## D. Sterilization

EOHHS will pay for an inpatient stay for a sterilization or for outpatient sterilization services only when the Hospital meets all requirements regarding Member consent and service delivery as set forth in MassHealth regulations and subregulatory guidance. 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 in effect October 1, 2016, increased by the Inflation Factors for Operating Costs between Rate Year 2017 and Rate Year 2022, 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 any Acute 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 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
Third Party Liability Unit
P.O. Box 15205

Worcester, MA 01615-0205
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.

# 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 the RY23 RFA. RY23 Incentive payments described in **Section 7.E** are contingent upon the Hospital's performance of all applicable requirements specified in **Section 7**. This is in addition to the new MassHealth Clinical Quality Incentives Program described in **Section 7B**. The MassHealth Health Equity Incentives (HEI) Program, which is further described in **Section 8**, is also being implemented in RY23, and is anticipated to begin January 1, 2023.

## A. Pay-for-Performance Program Requirements

The MassHealth P4P program shall operate under the following principles:

1. Reward Hospitals for excelling in and improving quality of care delivered to MassHealth members.

2. Evaluate Hospital performance for RY23 incentive payments, using the quality measures in **Section 7.C** and the performance assessment methods in **Section 7.D**.

3. Calculate incentive payments in accordance with the methods set forth in **Section 7.E**.

4. To be eligible for incentive payments, Hospitals must adhere to the following standards:

   *a. Data Requirements:*

   (1) Data Accuracy and Completeness: Hospitals shall ensure that all submitted data is complete and accurate, as described in **Section 7.C**;

   (2) Measure Specifications: Hospitals shall comply with all data collection and submission guidelines, for all measures listed in **Table 7-1**, as published in the applicable EOHHS Technical Specifications Manual version listed in **Table 7-5**, to ensure completeness and accuracy of data submitted;

   (3) Reporting Deadlines: Hospitals shall meet data submission deadlines set forth in **Section 7.F.1**. Failure to timely submit all data and reporting in the formats required by EOHHS may render the Hospital ineligible for some or all payments under **Section 7** of this RFA;

   (4) Portal Transactions: Hospitals shall identify and authorize individuals to conduct electronic data transactions via the EOHHS designated secure portal per **Section 7.B.2** and **Section 7.F.2.a** on the Hospital's behalf;

   *b. Data Validation:* Hospitals shall meet the minimum data reliability standards and pass data validation as defined in Section 7.D.2; and

   *c. Performance:* Hospitals shall achieve quality standards and performance benchmarks, as defined in Section 7.D, on all quality measures data.

5. 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.

B. **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:

1. Serve as the primary contact for all correspondence pertinent to the Hospital's quality performance reports and incentive payment annual reports, including responding to all inquiries and requests made by EOHHS, in accordance with the timeframes and format specified by EOHHS.

2. Identify the key staff responsible for obtaining and responding to quarterly medical record request lists and for accessing annual report results pertaining to all measures listed on **Table 7-1** of **Section 7.C**, via the EOHHS designated secure portal, on the Hospital's behalf;

3. Notify EOHHS of any changes in the key quality representatives and MassHealth Quality Exchange (MassQEX) Portal users that occur during the Contract period as soon as the information becomes available, using the Hospital Quality Contacts Form;

4. Use the EOHHS mailbox address, Masshealthhospitalquality@mass.gov, 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:

    a. 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 submitted via email to the EOHHS mailbox address.

    b. 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.

    c. 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.

5. **Reporting Requirement.** Each Hospital must complete and submit program participation forms that include information on all staff involved in quality reporting using the Hospital Quality Contacts Form per instructions in **Section 7.F.3** by the due date(s) set forth in **Section 7.F.1**.

C. **Hospital Quality Performance Measures**

For RY23, EOHHS has modified hospital performance measures aimed at ensuring members receive safe and high-quality care. There are four inpatient quality measure categories (referred to as "Quality Measure Category(ies)" or "Measure Category(ies)"). EOHHS has designated one or more inpatient measures that it will use to assess performance in accordance with each Quality Measure Category. Table 7-1, below, displays (a) each Quality Measure Category (four in total) and (b) the inpatient measure(s), identified by unique Measure ID# and Measure name, that correspond to each Quality Measure Category.

**Table 7-1. Hospital Quality Performance Measures**

| Quality Measure Category | Measure ID# | Measure Name |
|---|---|---|
| Perinatal | MAT-4 | Cesarean Birth, NTSV |
| Perinatal | NEWB-1 | Exclusive breast milk feeding (to be discontinued as of Q1 of 2023) |
| Perinatal | PMSM-1 | Perinatal Morbidity Structural Measure |
| Care Coordination | CCM-1 | Reconciled medication list received by discharged patient |
| Care Coordination | CCM-2 | Transition record with specified data elements received by discharge patient |
| Care Coordination | CCM-3 | Timely transmission of transition record within 48 hours at discharge |
| Safety Outcome | PSI-90 | Patient Safety and Adverse Events Composite |
| Safety Outcome | HAI-1 | Central Line-Associated Bloodstream Infection |
| Safety Outcome | HAI-2 | Catheter-Associated Urinary Tract Infection |
| Safety Outcome | HAI-3 | Methicillin-Resistant Staphylococcus Aureus bacteremia |
| Safety Outcome | HAI-4 | Clostridium Difficile Infection |
| Safety Outcome | HAI-5 | Surgical Site Infections: Colon and abdominal hysterectomy procedures |
| Patient Experience and Engagement | HCAHPS | Hospital Consumer Assessment of Healthcare Provider Systems Survey Composite |

1. **Quality Measure Categories.** The Quality Measure Categories, and the performance measures under each Quality Measure Category listed in **Table 7-1,** are further described below.

   a. **Perinatal Category:** This category consists of two individual chart-based measures, and one maternity structural measure, as described below:

(1) **Chart-Based Measures:** In RY23, EOHHS announces a transition to chart-based perinatal measure reporting requirements, as described below. Chart-based measures must be reported on all relevant Medicaid payer codes further outlined in the applicable EOHHS Technical Specifications Manual version listed in **Table 7.5**.

(a) Hospitals must report the cesarean birth (MAT-4) measure data listed in Table 7-1, for CY2022 (January 1, 2022 – December 31, 2022) and the first quarter of CY2023 (January 1, 2023 – March 31, 2023), in accordance with the data submission cycle due dates set forth in **Section 7.F.1**.

(b) Hospitals must report the exclusive breast milk feeding (NEWB-1) measure data listed in **Table 7-1**, for CY2022 (January 1, 2022 – December 31, 2022) in accordance with the data submission cycle due dates set forth in Section 7.F.1. The NEWB-1 measure reporting requirement is being discontinued as the first quarter of CY2023 (January 1, 2023).

(2) **Structural Measure:** In RY23, EOHHS introduces a new perinatal morbidity structural measure (PMSM-1) that requires Hospitals to participate in a federally sponsored CDC or Health Resource Service Administration (HRSA) Perinatal Quality Collaborative Program and implement in-hospital safety practices to prevent severe maternal morbidity. All Hospitals must complete the five-item survey to attest participation and implementation activity taken during CY2022. Item responses must be submitted annually using the web-based data collection tool, in accordance with **Section 7.F.4**, by the submission cycle due date set forth in **Section 7.F.1**. Details on reporting requirements are further described in the EOHHS Technical Specifications Manual version listed in **Table 7.5.**

b. **Care Coordination Quality Measure Category:** This category consists of three individual chart-based measures -- reconciled medication list (CCM-1), transition record with specified data elements (CCM-2), and timely transition of transition record (CCM-3), listed in **Table 7-1**. For each of these three measures, in RY23, Hospitals must collect and report data on the newly applicable modified data element specifications from CY2022 (January 1, 2022 – December 31, 2022) and the first quarter of CY2023 (January 1, 2023 – March 31, 2023), in accordance with the data submission cycle due dates set forth in **Section 7.F.1**.

c. **Safety Outcome Measure Category.** This category is comprised of the following inpatient safety outcome measures:

(1) **Patient Safety and Adverse Events Composite Measure:** PSI-90 consists of ten component patient safety indicators (PSI-3, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14, and PSI-15) that represent potentially preventable complications and adverse events resulting from in-hospital surgical and medical procedures. This claims-based measure will be collected by EOHHS, per **Section 7.C.3.b**, using methods further described in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required.

(2) **Healthcare-Associated Infections Measures:** EOHHS has retained in RY23 the five Healthcare-Associated Infections (HAI) measures that are reported by

Hospitals to the NHSN registry surveillance tracking system developed and maintained by the CDC. The five measures, which are also listed in **Table 7-1**, are: central line-associated bloodstream infection (HAI-1), catheter-associated urinary tract infection (HAI-2), methicillin-resistant staphylococcus aureus bacteremia (HAI-3), clostridium difficile infection (HAI-4), and surgical site infections for colon and abdominal hysterectomy procedures (HAI-5). EOHHS will access the relevant HAI measures all payer data directly from the CDC's NHSN registry surveillance tracking system database to which Hospitals previously conferred rights to EOHHS during the RY2019 MassHealth NHSN Group one-time enrollment process. Further details on data collection methods are further outlined in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required.

d. **Patient Experience and Engagement Measure Category:** In RY23, this quality category includes the HCAHPS measure, which is comprised of seven (7) survey dimensions developed by AHRQ for the Centers for Medicare and Medicaid Services (CMS), which include: nurse communication, doctor communication, responsiveness of hospital staff, communication about medicines, discharge information, overall rating, and 3-item care transition. EOHHS will collect the Hospitals' archived all payer HCAHPS measure data results from the CMS Provider Data Catalog website. Details on each survey dimension are further outlined in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required.

2. **EOHHS Technical Specifications Manual.** EOHHS publishes a comprehensive manual as a supplement to this RFA, that Hospitals must adhere to for data collection and reporting, and that applies to all quality measures listed in **Table 7-1**. The EOHHS Technical Specifications Manual contains detailed instructions on clinical and administrative data element specifications, sampling guidelines, data abstraction tools, XML schema tools, data dictionary, portal user system requirements, and more. The EOHHS Manual is regularly updated and Hospitals are responsible for downloading and using the appropriate versions of the EOHHS Manual that apply to each quarterly reporting data period noted in **Section 7.F.1**. EOHHS Manual versions are posted on the Mass.Gov website at https://www.mass.gov/masshealth-quality-exchange-massqex.

3. **Medicaid and Other Payer Data Collection.** The source of the payer data for each quality measure category is described below.

   a. ***Chart-Abstracted Measures Data.*** The individual process measures listed in **Table 7-1** and identified in **Section 7.C.1.a** are chart-abstracted and must be collected and reported by Hospitals on all Medicaid payer data. Detailed instructions on all Medicaid payer data reporting requirements, including all relevant Medicaid payer codes, are included in the applicable version of the EOHHS Technical Specifications Manual referred to in **Table 7-6**.

   b. ***Claims-Based Measures Data.*** The data for the PSI-90 composite measure listed in **Table 7-1**, are claims-based and will be collected on all Medicaid payer data by EOHHS from the Medicaid Management Information System (MMIS) fee-for-service claims and from MCO encounter data in the MassHealth Data Warehouse, using the

criteria and methods outlined in the EOHHS Technical Specifications Manual. EOHHS will extract all Medicaid payer data that reflect a six month run-out period after the end of the applicable performance evaluation period, per **Section 7.D.7.c**.

c. ***National Registry-Based Measures Data.*** The data for the HAI measures listed in Table 7-1, are national registry-based and are reported by Hospitals on all payer data to the CDC's NHSN registry surveillance tracking system, and the relevant data will be accessed by EOHHS via the MassHealth NHSN Group, per **Section 7.C.1.b.(2)**.

d. ***National Survey-Based Measures Data.*** The data for the seven survey dimensions of the HCAHPS measure listed in **Table 7-1**, are national survey-based and are reported by Hospitals on all payer data to CMS, and relevant archived data will be obtained by EOHHS from the CMS Provider Data Catalog website, per **Section 7.C.1.c.**

4. **Data Accuracy and Completeness Requirements.** Hospitals must meet data accuracy and completeness requirements for all quality measures listed in **Table 7-1** as described below.

   a. ***Chart-Abstracted Measures Data.*** Hospitals are required to submit complete data on all chart-based measures listed in **Table 7-1**, including Race and Hispanic Indicator, in the form of electronic data files, aggregate ICD patient population data, and proper documentation for chart validation purposes, pursuant to **Section 7.D.2**, for each quarterly discharge period being reported. The Hospital 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 **Section 7.F.1**.

   b. ***Claims-Based Measures Data.*** The PSI-90 composite measure data extracted from Medicaid claims, per **Section 7.C.3.b**, are subject to meeting data accuracy and completeness requirements as further described in the EOHHS Technical Specifications Manual.

   c. ***National Registry-Based Measures Data.*** EOHHS relies on the completeness and accuracy of the HAI data, as collected and reported by Hospitals to the CDC's NHSN registry surveillance tracking system, to ensure reliability and comparability of results across facilities. Hospitals must adhere to all NHSN required collection and reporting protocols for the HAI measures listed on **Table 7-1, including and in accordance with all requirements further outlined in the EOHHS Technical Specifications Manual**. Reporting incorrect data or failing to report timely data as required by NHSN protocols and CMS reporting criteria will affect the Hospital's eligibility for quality scoring per **Section 7.D**.

   d. ***National Survey-Based Measures Data.*** EOHHS relies on the completeness and accuracy of nationally reported HCAHPS archived data posted on the CMS Provider Data Catalog website, per **Section 7.C.1.c**, to ensure reliability and comparability of results across facilities. Hospitals must adhere to the survey data collection and

reporting protocols in applicable versions of the quality assurance guidelines posted on the CMS sponsored website http://www.hcahpsonline.org/. A Hospital's failure to adhere to these CMS requirements will affect the Hospital's eligibility for quality scoring per **Section 7.D**.

e. ***Web-Based Measures Data***. The perinatal morbidity structural measure listed in **Table 7-1**, which is required to be reported via the EOHHS-approved web-based data entry tool method, per **Section 7.F.4**, must meet data accuracy and completeness requirements further outlined in the applicable version of the EOHHS Technical Specifications Manual.

Each Hospital is required to sign and submit the MassHealth Hospital Data Accuracy and Completeness Attestation (DACA) Form that acknowledges specific quality reporting exceptions for measures listed in Table 7-1 based on a non-existing service line or other federal CMS IPPS granted exemption, per instructions in **Section 7.F.3**, by the due date set forth in **Section 7.F.1**.

D. **Performance Assessment Methods**

Hospital performance assessment and calculation methods that apply to all measures identified in **Section 7.C** are described below.

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

   a. **Chart-Based Measure Rate Result:** A measure rate is calculated by dividing the numerator by the denominator, to obtain a percentage for each individual chart-based measure. The numerators and denominators for the applicable individual chart-based measures listed in **Table 7-1 and described in Section 7.C.1(c)(1),** are further defined in the applicable EOHHS Technical Specifications Manual listed in **Table 7-6**. All measure rate results are rounded to the nearest integer (e.g., 3.3 is rounded to 3.0; 3.5 is rounded to 4.0).

   b. **PSI-90 Composite Measure Result.** The PSI-90 composite value for the PSI-90 composite measure is calculated as a weighted average of the scaled risk-adjusted and reliability-adjusted rates for the ten indicators combined, listed in **Section 7.C.1.c.(1)**, using the applicable version of AHRQ Quality Indicators Software. The Hospital measurement data period, per **Section 7.D.7**, must have a minimum volume of three or more eligible discharges for at least one component indicator to calculate a PSI-90 composite measure value. If the number of eligible discharges is fewer than three for the ten PSI-90 indicators combined, the PSI-90 composite value is not calculated by the AHRQ software due to insufficient data. Details on the calculation methods and AHRQ software versions used to compute the PSI-90 composite value are further described in the applicable EOHHS Technical Specifications Manual listed in **Table 7-6**.

   c. **Healthcare-Associated Infection Measures Results.** EOHHS will obtain each Hospital's standard infection ratio (SIR) output value for each HAI measure listed in **Table 7-1**, as calculated by the CDC, from the CDC's NHSN registry surveillance tracking system via the MassHealth NHSN Group per **Section 7.C.1.c**. EOHHS will

not calculate independent SIR output values but will rely on the CDC's calculations. The SIR output value is only calculated by the CDC for an HAI when the number of predicted infections is at least 1.0, and is not computed by CDC when the predicted number of infections is less than 1.0. Details regarding the calculations of SIR output values are further described in the applicable EOHHS Technical Specifications Manual listed in **Table 7-5**.

**d. Patient Experience and Engagement Measure Result:** EOHHS will obtain the archived HCAHPS measure "top box" raw results directly from the CMS Provider Data Catalog website that are posted in rounded integer format. The "top-box" raw score for each of the seven survey dimensions represents the percentage of a Hospital's patients who chose the most positive, or "top-box," response to a survey item. The "top box" raw result calculation includes a AHRQ patient-mix adjustment and survey-mode adjustment. If a Hospital has completed fewer than 100 surveys pertinent to the measurement year period, per **Section 7.D.7**, then it is deemed as not having sufficient data to calculate results for this measure.

**e. Perinatal Structural Measure Result:** The PMSM-1 measure result is calculated using the number of valid responses reported by Hospitals in the required 5-item survey, described in **Section 7.C.1.a.(2)**, compared to the total number of available valid responses to such 5-item survey. The Hospitals' attestation to the perinatal quality collaborative participation is calculated using one or more valid responses reported on survey items 1 through 4. The Hospitals attestation to the implementation of in-hospital safety practices to prevent maternal morbidity is calculated using one or more the valid responses reported on survey item 5. A valid response is the usable answer provided from those listed on each survey item that represents the practical action taken. Hospital item responses are subject to verification by EOHHS using methods further outlined in the applicable version of EOHHS Technical Specifications Manual listed in **Table 7-5**.

**2. Data Validation Requirements.** All reported chart-based 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 rate of 80 percent has been met, based on the data from the first three quarters of CY2022 (Q1-2022, Q2-2022 and Q3-2022) that the Hospital must collect and report during RY23 (see **Sections 7.C.1.a and 7.F.1**). Passing data validation is required prior to computing a Hospital's performance scores on each chart-based measure category pursuant to **Section 7.D.8**. The applicable EOHHS Technical Specifications Manual version, listed in **Table 7-5**, provides detailed information on data validation methods.

**3. Attainment and Improvement Performance Assessment.** Each Hospital's performance for measures in the Perinatal, Care Coordination, and Patient Experience and Engagement Quality Categories will be assessed on levels for attainment, improvement and benchmark defined as follows:

**a. Setting Performance Thresholds**

(1) ***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.

(2) ***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

(3) ***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 for each chart-based measure are derived from hospital reported data. Attainment and benchmark performance thresholds are calculated using relevant previous year all Medicaid payer hospital-reported data, as determined by EOHHS.

**b. Quality Points System.** A Hospital's performance on each chart-based 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:

1. **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:
   (a) Equal to or less than the attainment threshold, it will receive zero (0) points for attainment.

   (b) Within the attainment range (greater than the attainment threshold but below benchmark) it will receive anywhere from 1 to 9 points for attainment.

   (c) Equal to or greater than the benchmark, it receives 10 points for attainment.

2. **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.

**c. Quality Points Criteria.** The following criteria apply to awarding quality points for each individual process measure on which the Hospital reports:

(1) **Data Validation Standard:** If the Hospital has failed validation 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 chart-based measure, based on calculation of calendar year 2022

data reported on the measure in RY23, if it passed validation in RY23 and also met the criteria in **Section 7.D.3.c.(2)**, below.

(2) **Awarding Points:** 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 for a newly reported measure. Data for newly reported measures are used to set the all- hospital attainment and benchmark thresholds for the following year.

(3) **Case Minimum: To be included in EOHHS's Section 7.D.3 performance assessment for a particular chart-based measure, the Hospital's reported data for that measure must contain at least 25 cases in the measure denominator population. Hospitals that do not meet the case minimum for a particular chart-based measure are not eligible for quality performance scoring or incentive payments for that measure.**

**4. Safety Outcomes Measure Category Performance Assessment.** Each Hospital's performance on the safety outcomes measures will be assessed using methods described below.

**a. Scoring Eligibility.** The Hospital's safety outcomes measure category will be evaluated using both the Hospital's PSI-90 composite value calculated as described in **Section 7.D.1.c**, as well as the Hospital's SIR output values for each of the five HAI measures, calculated in accordance with **section 7.D.1.d**. Each Hospital must meet the criteria for having sufficient data, as defined in **Section 7.D.1.c or 7.D.1.d,** as applicable, to be eligible for the Winsorized z-scoring method described below.

**b. Winsorization Method**. Each Hospital's performance will be assessed in comparison to all eligible Hospitals' values using the Winsorization method, which transforms each Hospital's measure value into a standardized Winsor z-score using the steps described below. Details on the Winsor z-scoring methods are further described in the EOHHS Technical Specifications Manual.

(1) A Winsorized measure result is obtained by creating a continuous rank distribution of all eligible Hospitals' raw values, defined in **Section 7.D.5.a**, that are truncated at the 5th and 95th percentiles to determine the relative position of where each measure value falls in the distribution. Each Hospital's Winsorized measure result is determined separately for the PSI-90 composite measure and for each of the five HAI measures, as follows:

(a) If the Hospital's measure value falls between the minimum and the 5th percentile, then the Hospital's Winsorized measure result is equal to the measure value that corresponds to the 5th percentile.

(b) If the Hospital's measure value falls between the 95th percentile and the maximum, then the Hospital's Winsorized measure result is equal to the measure value that corresponds to the 95th percentile.

(c) If the Hospital's measure value falls between the 5th and 95th percentiles, then the Hospital's Winsorized measure result is equal to the Hospital's measure value.

A Winsor Z-score ($Z_i$) is calculated for each Hospital safety outcomes measure as the difference between the Hospital's Winsorized measure result ($X_i$) and the mean Winsorized measure result across all eligible Hospitals ($\bar{X}$)x. Such calculated difference is divided by the standard deviation of the Winsorized measure result from all eligible Hospitals' data (**SD ($x_i$)**) using the following formula:

$$\textbf{Measure } Z_i \textbf{ score} = ((X_i) - (\bar{X})) / \text{SD } (x_i)$$

**c. Safety Outcomes Measure Category Performance Scoring.** The Hospital's Safety Outcome Measure Category performance will be evaluated using the z-scores assigned, per **Section 7.D.5.b,** and is calculated as the equally weighted average of the combined PSI-90 composite measure z-score and each HAI measure that has a z-score, using the methods described below.

(1) **Equal Measure Weights Method.** The assigned weights that will apply to each safety measure z-score under the equal measure weights method are shown in **Table 7-2** below.

**Table 7-2 Safety Outcome Equal Measure Weights**

| Total Number of Measures with a z-score | Weight assigned to each Measure z-score |
|---|---|
| 6 | 16.7 |
| 5 | 20.0 |
| 4 | 25.0 |
| 3 | 33.3 |
| 2 | 50.0 |
| 1 | 100.0 |

As shown in **Table 7-2**, the equal measure weights method assigns the same weight to each Safety Outcome Measure z-score based on the total number of Safety Outcome Measures for which the Hospital has a z-score. If the Hospital has no z-scores for any of the safety outcome measures listed in **Table 7-1**, then it will not receive a safety outcome measure overall z-score.

(2) **Safety Outcomes Measure Category Overall z-score**: The Hospital's Safety Outcome Measure Category overall z-score (Z) is calculated as the equally weighted average of all measure z-scores, as indicated by the following formula:

$$(PSI90\ z\ score + \sum_{i=1}^{Number\ of\ HAI} HAI\ z\ Score_i) \,/ (Number\ of\ HAI + Number\ of\ PSI\ 90)$$

The overall z-score is calculated as the sum of the PSI-90 z-score and each of the HAI z-scores, divided by the number of all available HAI z-scores plus the PSI-90 z-score. The overall z-score is rounded to six decimal places.

**d. Setting Threshold**. The Hospital's performance on the Safety Outcomes Measure Category z-score is assessed using the methods described below.

(1) **Interquartile Rank Method.** Performance is assessed using a method that determines the Hospital's rank, relative to other hospitals, and divides the ranked results into four approximately equal quartile groups. The Hospitals' Safety Outcomes Measure Category z-score values are rounded to six decimal places and ranked highest (worse) to lowest (best) in performance.

(2) **Minimum Attainment Threshold.** The Safety Outcomes Measure Category z-score threshold represents the minimum level of performance that must be attained to earn incentive payments, except as described in **Section 7.D.4.d**, below. The minimum attainment threshold is defined as the lower boundary for the overall safety outcomes measure z-score values that fall above the 1st quartile group.

(3) **Conversion Factor.** Each quartile group is assigned a conversion factor as shown in **Table 7-3** below.

**Table 7-3 Quartile Group Thresholds**

| Quartile Group Threshold | Conversion Factor |
|---|---|
| 4th Quartile (Lower z-scores) | 1.0 |
| 3rd Quartile | .75 |
| 2nd Quartile (Minimum attainment threshold) | .50 |
| 1st Quartile (Higher z-scores) | .25 |

To meet the minimum attainment threshold, the Hospital's overall Safety Outcomes Measure Category z-score must be above the upper boundary of the 1st quartile (i.e., fall into the 2nd, 3rd, or 4th quartile). A lower z-score represents better performance and a higher z-score represents worse performance. All values that fall within the same quartile group are assigned the same conversion factor.
Notwithstanding the provisions above, for RY23, EOHHS removes the minimum attainment threshold for the performance evaluation data periods set forth in **Section 7.D.7**, due to the impacts of COVID-19.

**5. Patient Experience and Engagement Measure Category Performance Assessment.**

a. Except as described in **Section 7.D.5.b**, below, A Hospital's performance score on the seven HCAHPS survey dimension measures, described in **Section 7.C.1.c,** is calculated based on the attainment and improvement quality point system methods referenced in **Sections 7.D.1.a**, **7.D.6**, and **7.D.8.** All attainment and improvement points earned on

each of the seven dimensions are rounded to the nearest integer (e.g., 3.3 is rounded to 3.0 and 3.5 is rounded to 4.0). The total awarded points are divided by the total possible points, and then multiplied by 100% to obtain the total performance score for the Quality Measure Category, based on the following formula:

**Total Performance Score = (Total Awarded Points / Total Possible Points) x 100%**

b. For RY23, EOHHS has modified the performance assessment method for the Patient Experience Quality Measure Category and will not compute attainment or improvement points or a total performance score on the HCAHPS data obtained from the CMS Provider Data Catalog website, due to the impacts on data reporting and publicly available data resulting from COVID-19. Instead, Hospitals will receive credit for reporting, provided the available HCAHPS data has been posted and meets the annual minimum surveys required to be completed, as described in **Section 7.D.8**.

6. **Perinatal Structural Measure Performance Assessment.** Performance for this measure is assessed based on meeting both participation in a perinatal quality collaborative, as well as implementation of the in-hospital practice requirement. Each Hospital's verified valid item responses to the 5-item survey, described in Section 7.C.1.a.(2), are assigned a "Yes" or a "No" code. A Hospital must have a valid response for survey items 1 and 2 to meet the participation requirement and be assigned a "Yes" code. A Hospital determined not to have a valid response for either or both survey items 1 and 2, the Hospital will not meet the participation requirement and will be assigned a "No" code. In addition, the Hospital must have one or more valid responses for item 5 to meet the in-hospital implementation practice requirement. Participation is further confirmed through valid responses to survey items 3 and 4. However, a Hospital's overall result is assigned a "Yes" code only if it obtained a "Yes" code on participation (items 1 and 2) plus implementation (item 5). Details on item coding are further described in the applicable EOHHS Technical Specifications Manual listed in **Table 7-5.**

7. **Performance Evaluation Periods.** In RY23, the following performance evaluation periods apply to each performance measure listed in **Table 7-1**:

   a. **Perinatal Measures:** The MAT-4 and NEWB-1 measures performance will be evaluated using data reported for the comparison year discharge period (January 1, 2022, to December 31, 2022). The new perinatal morbidity structural measure (PMSM-1) performance evaluates participation and implementation activity during CY2022 (January 1, 2022, to December 31, 2022).

   b. **Care Coordination Measures:** The CCM-1, CCM-2 and CCM-3 measures performance will be evaluated on newly reported data specifications in the comparison year discharge period (January 1, 2022 – December 31, 2022) contingent on meeting data reliability standards in accordance with **Section 7.D.2.**

   c. **PSI-90 Composite Measure:** Each Hospital's PSI-90 composite measure performance will be evaluated using a two-part, 15-month discharge period (October 1, 2019, to December 31, 2019, and January 1, 2021, to December 31, 2021) collected from all Medicaid paid claims data, using the methods described in the EOHHS Technical Specifications Manual.

d. **Healthcare-Associated Infection Measures.** Each Hospital's HAI measure performance will be evaluated using a 12-month period (January 1, 2021 – December 31, 2021) of data collected from the CDC's NHSN registry surveillance tracking system, per **Section 7.C.1.b.(2)**

e. **Patient Experience and Engagement Measure.** For RY23, each Hospital's Patient Experience and Engagement Measure Score will be determined using the Hospital's publicly reported HCAHPS data from the CY2021 data period (January 1, 2021, to December 31, 2021) collected from the CMS Provider Data Catalog website.

For detailed information about performance measurement periods that apply to all quality measures, refer to the applicable EOHHS Technical Specifications Manual version listed in **Table 7-5**.

**8. Performance Score Calculations.** A Hospital's performance score for the performance measures listed in **Table 7-1** and described in **Section 7.C** will be computed using the methods described below.

**a. Attainment and Improvement Performance Score.** A Hospital's performance score, for each measure on which it is eligible to report, is calculated based on the quality point system methods outlined in **Section 7.D.3.** The following methods apply to computing the points earned for the individual process measures:

(1) **Attainment Points.** The number of "attainment points" a Hospital receives is determined by the ratio of the difference between the Hospital's measure rate and the attainment threshold divided by the difference between the benchmark and the attainment threshold. This ratio is multiplied by 9 and increased by 0.5. The Hospital's "attainment points" will be calculated based on the following formula:

| | |
|---|---|
| Hospital's Measure Rate – Attainment | × 9 + 0.5 = Hospital's Attainment Points Earned |
| Benchmark – Attainment | |

(2) **Improvement Points.** The number of "improvement points" a Hospital receives is determined by the ratio of the difference between the Hospital's Current Measure Rate and the Previous Year's Measure Rate divided by the difference between the benchmark and the Previous Year's Measure Rate. This ratio is multiplied by 10 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 | × 10 - 0.5 = Hospital's Improvement |
| Benchmark – Previous Year's Measure Rate | Points Earned |

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).

(3) **Total Performance Score.** The total performance score for the Perinatal Quality Measure Category and the Care Coordination Measure Category is a percentage of quality points earned out of the total possible points. For each measure, the quality points earned are calculated using the higher of the attainment or the improvement points earned. Those quality points earned for each measure are summed to yield the total awarded quality points for each Quality Measure Category; the total awarded quality points are then divided by the total possible points, and then multiplied by 100% to obtain the total performance score for the Quality Measure Category, based on the following formula:

| | |
|---|---|
| Total Awarded Points | × 100% = Perinatal and Care Coordination Measures Categories Total Performance Score |
| Total Possible Points | |

**b. Perinatal Structural Morbidity Measure.** In RY23, the performance score for the perinatal structural morbidity measure is based on the overall result code per **Section 7.D.6**. An overall result coded "Yes" is assigned a 100% score and an overall result coded "No" is assigned a 0% score. The perinatal structural morbidity measure score will contribute to the overall Perinatal Quality Measure Category performance score.

**c. Safety Outcomes Measure Category Performance Score.** The performance score for the Safety Outcomes Measure Category reflects the equivalent of the assigned conversion factor, per **Section 7.D.5**, that is calculated based on the following formula:

**(Conversion Factor) x 100% = Safety Outcomes Measure Category Performance Score**

**d. Patient Experience and Engagement Quality Measure Category Score.** For RY23, A Hospital's score on the Patient Experience and Engagement Quality Measure Category will be based on whether the Hospital reported HCAHPS survey data to CMS for the data periods referenced in **Section 7.D.7.e**. Specifically, the Hospital will receive a Patient Experience and Engagement Quality Measure Category Score of 100% if the CMS Provider Data Catalog website posts 100 or more surveys for the Hospital for the combined data periods referenced in **Section 7.D.7.e.** The Hospital will receive a Patient Experience and Engagement Quality Measure Category Score of 0% if the CMS Provider Data Catalog website posts fewer than 100 surveys for the Hospital for the combined data periods referenced in **Section 7.D.7.e.**

E. **Incentive Payment Calculation Methods**

As set forth in **Section 7.D**, a Hospital may qualify to earn incentive payments if it meets data completeness requirements, data validation and reliability requirements, and achieves performance thresholds for measures listed in **Section 7.C.**

# In-State Acute Hospitals

1. **Incentive Payment Approach.** In RY23, incentive payment approaches will be based on each of the following:

   a. Pay-for-performance (P4P) for all measures listed in **Table 7-1**. A hospital may receive an incentive payment for the measures listed in Table 7-1 if it achieved performance thresholds for the applicable evaluation periods set forth under Section 7.D.

   b. Pay-for-reporting (P4R) for the Patient Experience and Engagement Quality Measure Category. As described in **Section 7.D**, each Hospital will receive a Patient Experience and Engagement Quality Measure Category Total Score of 100% or 0%, depending upon whether it met the reporting benchmarks set forth in that section. A Hospital with a Patient Experience and Engagement Quality Measure Category Total Score of 100% will receive a P4R incentive payment for the Patient Experience and Engagement Quality Measure Category. A Hospital with a Patient Experience and Engagement Quality Measure Category Total Score of 0% will not receive a P4R incentive payment for Patient Experience and Engagement Quality Measure Category.

   c. P4R for the Care Coordination Quality Category. Incentive payments for the newly reported care coordination measure set (CCM-1, CCM-2, CCM-3) data specifications will be based solely on Pass/Fail criteria for meeting the data reliability standard (.80) set forth in **Section 7.4.B.** The pay-for-reporting (P4R) approach designates a fixed score. Hospitals that pass validation will receive a score of 100% and incentive payment. Hospitals that fail validation will receive a score of 0% and no incentive payment.

2. **Payment Calculations.** Incentive payments will be calculated using the methods described below.

   a. **Maximum Allocated Amount**. Incentive payments under this **Section 7** may cumulatively total no more than the maximum amount allotted by EOHHS for each Quality Measure Category in **Table 7-4** below.

**Table 7-4. Payment Calculation Components**

| Quality Measure Category | Maximum Allocated Amount | Estimated Eligible Medicaid Discharges | Estimated Per Discharge Amount |
|---|---|---|---|
| Perinatal | $ 7,500,000 | 32,633 | $ 229.83 |
| Care Coordination | $ 9,000,000 | 46,835 | $ 192.16 |
| Safety Outcome | $ 4,500,000 | 31,516 | $ 142.78 |
| Patient Experience and Engagement | $ 4,000,000 | 38,116 | $ 104.94 |
| TOTAL | $25,000,000 | -- | -- |

   b. **Eligible Medicaid Discharges.** For purposes of **Section 7.E**, "MMIS Discharge Data" refers to acute inpatient hospital discharge data from MMIS paid claims for PCC Plan, Primary Care ACO, and Fee-for-Service discharges only, for which MassHealth is the primary payer, as of a date to be determined by EOHHS. The estimated eligible Medicaid discharges and estimated per-discharge amount for each Quality Measure Category, listed in **Table 7-4,** are calculated based on FY21 Revised MMIS Discharge

Data. The actual final eligible Medicaid discharges and final per-discharge amount for each Quality Measure Category listed in **Table 7-4** will be calculated based on FY22 MMIS Discharge Data, using the methods set forth in **Sections 7.E.2.b.(1) through 7.E.2.b.(4)**, below, as applicable.

(1) **Perinatal and Care Coordination Quality Measure Categories:** For the Perinatal and Care Coordination Quality Measure Categories referenced in **Table 7-4**, the final eligible Medicaid discharges will be determined based on the number of Hospital discharges in the FY22 MMIS Discharge Data (described in **Section 7.E.2.b**), as determined by EOHHS, which meet the International Classification of Diseases (ICD) population requirements referenced in the EOHHS Technical Specifications Manual corresponding to the individual process measures on which the hospital reported, pursuant to **Section 7.C**, and that are included in the applicable Quality Measure Category. For the perinatal morbidity structural measure, the final eligible Medicaid discharges will be adjusted based on the Hospitals' total FY22 discharges, which meet the International Classification of Diseases (ICD) population requirements for cesarean birth measure.

(2) **Safety Outcomes Quality Measure P4P Category.** For the Safety Outcomes Quality Measure Category referenced in **Table 7-4**, the final eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY22 MMIS Discharge Data, as described in **Section 7.E.2.b**, which meet the medical and surgical All Payer Refined Diagnosis Related Group (APR-DRG) codes associated with AHRQ clinical measure specification manuals referenced in the EOHHS Technical Specifications Manual.

(3) **Patient Experience and Engagement Quality Measure P4P Category.** For the Patient Experience and Engagement Quality Measure Category referenced in **Table 7-4**, the final eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY22 MMIS Discharge Data, as described in **Section 7.E.2.b**, which meet the medical, surgical, vaginal deliveries, and cesarean APR-DRG service line codes as referenced in the EOHHS Technical Specifications Manual.

c. **P4P Quality Measure Category per-Discharge Amount. Table 7-4** above estimates the per-discharge amount for each Quality Measure Category based on FY21 MMIS Discharge Data. The final per-discharge amounts will be determined based upon FY22 MMIS Discharge Data for each Quality Measure Category listed in **Table 7-4**. To determine these amounts, EOHHS will use the following formula:

| | |
|---|---|
| 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 7-5**. The maximum allocated amount will be divided by the statewide eligible Medicaid discharges for that Quality Measure Category across all Hospitals eligible to report on measures in that Quality Measure Category, to determine the per-discharge amount for that Quality Measure Category.

3. **Incentive Payment Formulas.** Payments for each Quality Measure Category listed in **Table 7-4** will be calculated based on the following formulas:

   a. **Perinatal and Care Coordination Quality Measure Categories:** Separately for the Perinatal Quality Measure Categories, EOHHS will calculate incentive payments by multiplying the Hospital's eligible Medicaid discharges for each Quality Measure Category, per **Section 7.E.2.b.(1)**, by the Quality Measure Category per-discharge amount, and by the Hospital's total performance score for the Quality Measure Category, per **Section 7.D.8**, using the following formula:

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

   b. **Safety Outcomes Quality Measure Category:** EOHHS will calculate incentive payments for the Safety Outcomes Quality Measure Category listed in **Table 7-4** by multiplying the Hospital's eligible Medicaid discharges, per **Section 7.E.2.b.(3)**, by the Quality Measure Category per-discharge amount, and by the Hospital's Safety Outcomes Quality Measure Category performance score, per **Section 7.D.8**, using the following formula:

      (Hospital's Eligible Medicaid Discharges) x (Quality Measure Category per-Discharge Amount) x (Hospital's Safety Outcomes Quality Measure Category Performance Score) = Hospital P4P Payment for Safety Outcomes Quality Measure Category

   c. **Patient Experience and Engagement Quality Measure Category:** EOHHS will calculate incentive payments for the Patient Experience and Engagement Quality Measure Category listed in **Table 7-4** by multiplying the Hospital's eligible Medicaid discharges, per **Section 7.E.2.b.(4)**, by the Quality Measure Category per-discharge amount, and by the Hospital's Patient Experience and Engagement Quality Measure Category score, per **Section 7.D.8**, using the following formula:

      (Hospital's Eligible Medicaid discharges) x (Quality Measure Category per-Discharge Amount) x (Hospital's Patient Experience and Engagement Measure Category Score) = Hospital P4P Payment for Patient Experience and Engagement Measure Category

   A Hospital's total incentive payment will be the sum of the P4P incentive payments for each Quality Measure Category listed in **Table 7-4** for which the Hospital qualifies for payment. This aggregate sum is also referred to as the "Hospital's Final RY23 RFA Total P4P Payment Amount".

F. **Pay-for-Performance Reporting Requirements**

Each Hospital must comply with all data reporting requirements, portal registration requirements, and participant forms submission requirements as set forth below.

1. **Data Submission Timelines.** All electronic data files for the hospital quality performance measures listed in **Section 7.C** must be submitted by the due dates noted in **Table 7-5** below.

**Table 7-5. Hospital Data Submission Timelines**

| Submission Due Date | Data Submission Requirement | Data Reporting Format | Reporting Instructions |
|---|---|---|---|
| **October 28, 2022** | • Hospital Quality Contacts Form<br>• Hospital Data Accuracy and Completeness Attestation Form | HospContact_2023<br>HospDACA_2023 | RFA Section 7.2.E<br>RFA Section 7.3.D |
| **November 11, 2022** | • Q2-2022 (April – June 2022)<br>• Q2-2022 ICD population sample<br>• Q2-2022 Medical records DUE | XML Data Files; and ICD online data entry form (via MassQEX Portal) | EOHHS Technical Specifications Manual (Version 15.0 and 15.1) |
| **February 10, 2023** | • Q3-2022 (July – Sept 2022) data<br>• Q3-2022 ICD population sample<br>• Q3-2022 Medical records DUE<br>• Perinatal Structural Measure | XML Data Files and ICD online data entry form; Web-based data entry tool; (via MassQEX Portal) | EOHHS Technical Specifications Manual (Version 16.0) |
| **May 12, 2023** | • Q4-2022 (Oct – Dec 2022) data<br>• Q4-2022 ICD population sample<br>• NO medical records due | XML Data Files; and ICD online data entry form; (via MassQEX Portal) | EOHHS Technical Specifications Manual (Version 16.0) |
| **August 11, 2023** | • Q1-2023 (Jan – Mar 2023) data<br>• Q1-2023 ICD population sample<br>• Q1-2023 Medical records DUE | XML Data Files; and ICD online data entry form; (via MassQEX Portal) | EOHHS Technical Specifications Manual (Version 16.0 or TBD) |

2. **Data Reporting Format. All electronic data for the individual chart-based and web-based measures must be submitted using the following formats:**

   a. **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.C** 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 and downloading all medical record request lists, year-end results, and performance reports of the applicable quality measures listed in **Section 7.C.1**, per instructions set forth in the EOHHS Technical Specifications Manual as

described in **Section 7.C.2** in this RFA. The MassQEX web portal can only be accessed by registered users through the following URL: https://www.mass.gov/service-details/massqex-portal

b. **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 as described in **Section 7.C.2**.

c. **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.

d. **Web-Based Data Collection Tool**. EOHHS has expanded the secure MassQEX portal to include an online web-based data entry tool approved for Hospitals to report on specific measures identified in **Section 7.3.A.** Only Hospitals, and not third-party data vendors, can access the web-based data entry tool, per **Section 7.6.B.1**. Measures that require using the web-based entry format cannot be submitted via an XML file or any other electronic format. Detailed instructions to specific web-based measures data reporting requirements are provided in the EOHHS Technical Specifications Manual listed in **Table 7-5.**

e. **Medical Record Submissions:** Hospitals must use the MassQEX portal website to submit medical records requested for data validation purposes on the specified quarterly reporting cycles set forth in **Table 7-5**. All Hospitals must identify and authorize staff that will upload copies of medical records requested for validation, via the MassQEX secure file transfer procedures. Detailed instructions on how to prepare records for upload via secure file transfer are provided in the EOHHS Technical Specifications Manual.

3. **Program Participant Reporting Forms.** Each Hospital is required to submit the MassHealth Hospital P4P Program participation forms electronically, per the instructions set forth below:

a. **MassHealth Hospital Quality Contacts Form.** Each Hospital must complete and submit information on all staff involved in quality reporting, pursuant to **Section 7.B.5**, using the HospContact_2023 pdf fillable form. This form is due at the beginning of the rate year (by the due date set forth in **Table 7-5**) and must be

resubmitted when any change in key quality representatives and MassQEX portal users listed occurs.

b. **MassHealth Hospital Data Accuracy and Completeness Attestation Form.** Each Hospital must submit this form to acknowledge data completeness requirements pursuant to **Section 7.C.3** using the HospDACA_2023 pdf fillable form. This form must be signed by the Hospital's chief executive officer (CEO) and is due at the beginning of each rate year (by the due date set forth in **Table 7-5**).

Electronic versions of forms are posted on the Mass.gov webpage entitled "MassHealth Quality Exchange" at: http://www.mass.gov/masshealth-quality-exchage-massqex.

# Section 7B: Other Pay-for-Performance Quality Reporting Requirements and Payment Methods

## A. Clinical Quality Incentive Program

This section sets forth a MassHealth Clinical Quality Incentive (CQI) program. For RY2023, the CQI program provides opportunities for hospitals to earn incentives for quality reporting and performance on quality measures. **This is in addition to the MassHealth Pay-for-Performance (P4P) Program described in Section 7.**

The Clinical Quality Incentive (CQI) program described in this **Section 7B** describes quality reporting requirements and performance payment methods for the RY23 RFA. In future years, starting in RY2024, the CQI program Section 7B will replace the Hospital P4P program in Section 7.

Important Note: The following section is intended for general guidance and may be subject to change. EOHHS anticipates finalizing additional details through an amendment to this RY23 RFA in late Fall of 2022. Hospitals will have opportunity to provide feedback prior to finalizing the late Fall amendment. EOHHS anticipates holding at least one Special Bidder's Conference, as noted in the timetable in **Section 13**, presenting additional details on the CQI Program and soliciting feedback from all Hospitals. This feedback may be used to finalize the CQI Program details to be included in the late Fall amendment.

### 1. Clinical Quality Incentive (CQI) Program Requirements

The MassHealth CQI program aims to incentivize Hospitals to meet, excel or improve quality of care delivered to MassHealth members. It will be used to:

a. Evaluate Hospital performance for the purpose of determining RY23 incentive payments, using the quality performance measures in **Section 7B.A.1** and the performance assessment methods in **Section 7B.A.4.**

b. Calculate incentive payments in accordance with the methodological principles set forth in **Section 7B.A.5**.

To be eligible for incentive payments, Hospitals will be required to adhere to data accuracy, completeness and validation standards to be determined further in amendment and technical specifications.

### 2. Hospital Key Quality Representative Requirements

Each Hospital must identify and designate two key quality representatives, per **Section 7.B** with the appropriate expertise to inform, coordinate and communicate with EOHHS on all aspects of the Quality P4P Program (**Section 7)** and Clinical Quality Incentive Program **(Section 7B)** requirements and associated amendments during the Contract period.

## 3. Hospital CQI Program Performance Measures

For RY23, EOHHS has adopted hospital quality performance measures for the CQI program that incentivize safe and high-quality care. Measures included in the CQI are drawn from standard measures stewarded by nationally recognized quality measure developers. Measures are specified according to the standard specification, with few exceptions necessary for implementation in the context of the CQI program. Any differences to the standard measures shall be identified and noted in the annual technical specifications and any relevant release notes.

There are four core quality measure domains (referred to as "Core Quality Measure Domain(s)". There are two specialty quality measure domains (referred to as Specialty Quality Measure Domain(s)".

### *a. Core Quality Measure Domains*

All hospitals are accountable to performance on all measures in the Core Quality Measure Domains.

**Table 7B-1**, below, displays (a) each Core Quality Measure Domain (four in total) and (b) the measure(s), identified by Measure ID# and Measure name, that correspond to each Quality Measure Domain.

**Table 7B-1. Hospital Quality Performance Measures**
**(see next page)**

# In-State Acute Hospitals

| Core Quality Measure Domain | Measure ID# | Measure Steward: Measure Name | Data and Measure Type | Population |
|---|---|---|---|---|
| Care Coordination / Integration | CCM-1 | CMS: Reconciled medication list received by discharged patient | Chart-Abstracted Process Measures | All Medicaid payer |
| | CCM-2 | CMS: Transition record with specified data elements received by discharge patient | Chart-Abstracted Process Measures | All Medicaid |
| | CCM-3 | CMS: Timely transmission of transition record within 48 hours at discharge | Chart-Abstracted Process Measures | All Medicaid |
| | PCR | NCQA: Plan All-Cause Readmissions Adult (7-Day and 30-Day) | Claims-based Outcome Measure | All Medicaid |
| | TBD (No ID) | Pediatric All-Condition Readmission Measure (NQF2393) | Claims-Based Outcome Measure | All Medicaid |
| | FUH | NCQA: Follow-up After Hospitalization for Mental Illness (NQF 0576) (7-Day and 30-Day) | Claims-Based Process Measure | All Medicaid |
| | FUM | NCQA: Follow-up After ED Visit for Mental Illness (NQF 3489) (7-Day and 30-Day) | Claims-based Process Measures | All Medicaid |
| | FUA | NCQA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (NQF 3488) (7-Day and 30-Day) | Claims-based Process Measures | All Medicaid |
| Care for Acute and Chronic Conditions | SUB-2 | TJC: Alcohol Use – Brief Intervention Provided or Offered (NQF 1664) | Chart Abstracted Process Measures | All Medicaid |
| | SUB-3 | TJC: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge (NQF 1663) | Chart-Abstracted Process Measures | All Medicaid |
| | 506v5 | CMS: Safe Use of Opioids – Concurrent Prescribing (NQF 3316e) | EHR e-measure | All Medicaid |
| | | TBD: Pediatric measure in lieu of adult SUB-2 and SUB-3 | TBD | |
| Patient Safety | PSI-90 | AHRQ: Patient Safety and Adverse Events Composite | Claims-Based Measure | All Medicaid |
| | HAI-1 | CDC: Central Line-Associated Bloodstream Infection (CLABSI) | National Registry-Based Measures | All-Payer |

| | | | | |
|---|---|---|---|---|
| | **HAI-1** | **CMS: CLABSI – Pediatric ICU** | **National Registry-Based Measures** | |
| | **HAI-2** | **CDC: Catheter-Associated Urinary Tract Infection (CAUTI)** | **National Registry-Based Measures** | |
| | **HAI-3** | **CDC: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)** | **National Registry-Based Measures** | |
| | **HAI-4** | **CDC: Clostridium Difficile Infection (CDI)** | **National Registry-Based Measures** | |
| | **HAI-5** | **CDC: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)** | **National Registry-Based Measures** | |
| **Patient Experience** | **HCAHPS** | **AHRQ: HCAHPS This measure includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition.** | **National Survey-Based Measure<br><br>Patient Experience** | **All-Payer** |
| | **TBD** | **Member Experience** | **Survey Patient Experience** | **TBD** |

*b.* ***Specialty Quality Measure Domains***

In addition to being accountable to performance for all measures in core measure domains, Hospitals may also be determined by EOHHS to be accountable to all measures in one or more specialty domains. Specialty domain accountability will be determined by EOHHS based on type of Hospital and domain service lines provided (e.g., birthing Hospitals will be accountable for perinatal care domain measures, acute hospitals providing inpatient psychiatric care will be accountable for behavioral health care domain measures). EOHHS shall also take into consideration overall burden, patient population, and other factors in determining whether one or more specialty domains are applied at the individual Hospital level.

In limited cases, EOHHS anticipates a Hospital may provide primarily specialty care that is not represented in the Specialty Quality Measure Domains included in **Table 7B-2**. EOHHS or a Hospital providing specialty care may request further consultation to determine alternative options for Specialty Quality Measure Domain accountability. EOHHS shall make the final determination of each Hospital's Specialty Quality Measure Domain accountability.

**Table 7B-2**, below, displays (a) each Specialty Quality Measure Domain (three in total) and (b) the measure(s), identified by Measure ID# and Measure name, that correspond to each Specialty Quality Measure Domain.

**Table 7B-2. Hospital Quality Performance Measures**

| Specialty Quality Measure Domain | Measure ID# | Measure Name | Measure Type | Population |
|---|---|---|---|---|
| Perinatal Care | PC-02 | TJC: Cesarean Birth, NTSV (NQF 0471) | Outcome Measure | All Medicaid |
| | PC-06 | TJC: Unexpected Newborn Complications in Term Infants (NQF 0716) | Chart-abstracted or e-measure Outcome measure | All Medicaid |
| | PMSM-1 | EOHHS: Perinatal Morbidity Structural Measure (*Note: PMSM-1 includes a survey question that aligns with the CMS (00418) Maternal Morbidity Structural Measure) | Survey | NA |
| | TBD in future years | CMS: Maternal Morbidity | TBD Outcomes Measure | TBD |
| | TBD in future years PCO-7 | CMS: Severe Obstetric Complications | TBD Outcomes Measure | TBD |
| Behavioral Health Care | TBD (No ID) | CMS IPFQR: Medication Continuation Following Inpatient Psychiatric Discharge (NQF3205) | Claims-Based Process Measure | All Payer |
| | HBIPS-5 | CMS IPFQR: Patients Discharged on Multiple Antipsychotic Medications (with Appropriate Justification) | Chart-Abstracted Process Measure | All Payer |
| | SMD | CMS IPFQR: Screening for Metabolic Disorders | Chart-Abstracted Process Measure | All Payer |

## 4. Performance Assessment Methodology (PAM)

This section sets forth the Performance Assessment Methodology (PAM) for the CQI program.

***Finalized details will be included in an amendment to this RFA, anticipated to be published in late Fall of 2022, inclusive of measure benchmarks and improvement targets to determine hospital measure performance, and consequently the PAM to determine measure, domain and overall quality scores. Below are design principles and examples of key design components to provide guidance on anticipated elements of the PAM. This section is intended for general guidance and subject to change.***

### *a. Performance Assessment Methodology (PAM) Design Principles*

EOHHS is taking into consideration the following design principles as it designs relevant quality performance assessment methodology (PAM):

(1) Standard practices should be used wherever possible to measure performance calculations and data validation;

(2) Each Hospital should have the opportunity to achieve its full eligible quality incentive amount for excellent quality performance. This may be achieved through design approaches such as:

(a) Establishing clear threshold and goal benchmarks for measures over a multi-year time period (e.g., five years) rather than for a single performance year only;

(b) Providing opportunity to earn incentive for year-over-year self-improvement (e.g., gap to goal targets); and

(c) Providing opportunity to earn incentive payments for each measure based on attainment (e.g., meeting threshold, goal or in-between threshold and goal performance), and/or for meeting targets for improvement.

(3) Simplified scoring and payment. This may be achieved through design approaches such as:

(a) Utilizing measures that roll up to a domain score (e.g., sum of the points earned for each measure/the maximum number of points)

(b) Weighting domain scores to calculate a single overall quality score:

1) 100% weighting of measure domains available to Hospitals.

2) Not excluding Hospitals from payments if they are not eligible for a measure domain. Instead, if a hospital is not eligible for a measure domain, the weighting is redistributed.

(c) Applying a single quality score to the total eligible incentive payment available for each Hospital.

(4) Alignment with PAM approach with other EOHHS programs where possible and as appropriate (e.g., ACO, other hospital programs, CMS approaches), such as aligning practices for introducing new measures or payments.

(5) Flexibility to address extenuating circumstances. Examples may include:

(a) Applying rules or safeguards to re-evaluate and reset benchmarks that are set too low or too high.

(b) PHE or other unforeseen events impacting performance. (e.g., COVID allowances).

**5. CQI Program Initiative Payment Calculation Methodology**

As set forth in **Section 7B.4**, a hospital may qualify to earn a CQI program incentive, through its overall quality score calculated and based on their quality measure performance.

The maximum CQI payment amount that each Hospital is eligible to earn will be determined by a pro-rata share of $250 million, across both MassHealth fee-for-service and managed care. The CQI payment amount for each Hospital is determined by dividing each Hospital's hospital-reported Medicaid gross patient service revenues (charges) by all hospital-reported Medicaid gross patient service revenues (charges) within a quality pool of incentive dollars.

Each Hospital's eligible CQI payment amount will be multiplied by the single hospital-specific quality score or ratio (0-1) assessed through the PAM to determine the actual earned Hospital CQI payment amount.

***Details TBD and anticipated to be included in an amendment to this RFA in late Fall of 2022***

**6. CQI Reporting Requirements**

***EOHHS anticipates including data reporting and submission requirements in an amendment to this RFA in late Fall of 2022.***

# Section 8: Other Quality- and Performance-Based Payments

## A. Health Equity Incentives Program & Health Equity Requirements

***EOHHS anticipates including details on the Health Equity Incentives (HEI) Program and its requirements in an amendment to this RFA in late Fall of 2022.***

## B. Provider Preventable Conditions

The following provisions regarding Provider Preventable Conditions (PPCs), as well as the provisions regarding Serious Reportable Events (SREs) in **Section 8.C**, 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.

### 1. 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.C**, 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.B** 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.B.6**, 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.C**, below.

### 2. Definitions

The following definitions apply to this **Section 8.B**:

a. **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).

b. **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.

c. **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:

(1) **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.

(2) **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.

**3. Hospital Reporting of PPCs to EOHHS**

a. Appendix V of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals identify 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.

b. 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.

c. 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.B.6**, in reviewing any PPC, and in applying any payment adjustment as set forth in **Section 8.B.4**, below.

**4. Payment Adjustments to Hospitals for Provider Preventable Conditions**

a. **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:

(1) **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:

(a) 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.

(b) 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.

(2) **Psychiatric, Rehabilitation Unit, or Administrative Day Per Diem payments.** For inpatient services for which the Hospital would otherwise be paid a Psychiatric, Rehabilitation Unit or Administrative Day per diem:

(a) 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.

(b) 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.

(3) **Inpatient Hospital Payments for Hospital-Based Physician Services:** MassHealth will not pay for inpatient Hospital-based physician services reported as PPC-related services.

(4) **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, 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.

b. **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:

(1) **APEC**. For outpatient services for which the Hospital would otherwise be paid the APEC:

(a) MassHealth will not pay the APEC 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.

(b) MassHealth will pay the APEC, 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 same 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.

(2) **Outpatient Hospital Payments for Hospital-Based Physician Services:** MassHealth will not pay for outpatient Hospital-based physician services reported as PPC-related services.

(3) **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 adjusted in the case of an APEC payment to exclude PPC-related costs/services, and 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.

c. For each of **subsection 4.a** and **4.b**, above, the PPC non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

d. 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.

e. In the event that individual cases are identified throughout the MassHealth PPC implementation period, EOHHS may adjust reimbursement according to the methodology above.

**5. 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.

**6. Reporting to the Massachusetts Department of Public Health**

In addition to complying with **Sections 8.B.1** through **5**, 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 via secure e-mail to:

PPC/Serious Reportable Event Coordinator
MassHealth Quality Office
MQO@mass.gov
Subject Line: PPC/SRE Report

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.B** and not **Section 8.C**, below.

## C. Serious Reportable Events

The following provisions regarding Serious Reportable Events (SREs), as well as the provisions regarding Provider Preventable Conditions (PPCs in **Section 8.B**, 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.

**1. Applicability**

a. "Serious Reportable Events (SREs)" for purposes of this **Section 8.C** 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.C.2** through **8.C.4**, below, are subject to this **Section 8.C.1**.

From time to time, EOHHS may update the list of SREs that are subject to this **Section 8.C** through issuing provider bulletins or updates to provider manuals, or through other written statements of policy.

b. 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.

**2. Scope of Non-Reimbursable Services**

a. MassHealth's SRE policy applies to both Hospitals and Hospital-Based Physicians.

b. 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 and unambiguously the result of a system failure, as described in DPH regulations ("preventable SRE"). Non-reimbursable Hospital and Hospital-based physician services include:

(1) All services provided during the inpatient admission or outpatient visit during which a preventable SRE occurred; and

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

(a) At a facility under the same license as the hospital at which a non-billable SRE occurred; or

(b) On the premises of a separately licensed hospital or ambulatory surgery center with common ownership or a common corporate parent of the hospital at which a non-billable SRE occurred.

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

(4) The non-payment provision of this RFA also applies to third-party liability and/or crossover payments by MassHealth.

(5) A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in **Section 8.C.2.b.(2)**, 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.

**3. Required Reporting and Preventability Determination**

a. 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.

b. A Hospital shall notify the MassHealth program of the occurrence of an SRE by securely emailing a copy of the report as filed with DPH pursuant to **Section 8.C.3.a** to:

PPC/Serious Reportable Event Coordinator
MassHealth Quality Office
MQO@mass.gov
Subject Line: PPC/SRE Report

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.

c. 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.C.3.a**, 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.C.3.b**, 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.

**4. Non-Payment for SREs**

a. 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:

**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 |

| Payment Component that includes Preventable SRE | Resulting Non-payment |
|---|---|
| Inpatient - Transfer Per Diem, Psychiatric Per Diem, Acute Rehabilitation Unit Per Diem, or Administrative Day Per Diem | Non-payment of all per diems associated with the inpatient stay |
| Outpatient Hospital Services | Non-payment of APEC and any other outpatient services payable under the RFA |
| Hospital-Based Physician services | Non-payment of physician fees for care associated with the SRE |

b. 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

## In-State Acute Inpatient Hospital Rates

## RY23 – *Effective 10/1/22*

**Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates***
**(*See link at end for Chart C - DRG Weights and Mean All Payer Lengths of Stay)**

| In-State Provider | Statewide Operating Standard per Discharge | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Operating Standard per Discharge | Statewide Capital Standard per Discharge | APAD Base Payment | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|---|---|
| Anna Jaques Hospital | $11,566.32 | 0.9661 | 0.68257 | $11,298.69 | $799.07 | $12,097.76 | 91.30% | $39,925.00 | 60% |
| Baystate Franklin Medical Center | $11,566.32 | 0.8425 | 0.68257 | $10,322.89 | $799.07 | $11,121.96 | 57.22% | $39,925.00 | 60% |
| Baystate Medical Center | $11,566.32 | 0.9371 | 0.68257 | $11,069.74 | $799.07 | $11,868.81 | 44.20% | $39,925.00 | 60% |
| Baystate Noble Hospital | $11,566.32 | 0.8425 | 0.68257 | $10,322.89 | $799.07 | $11,121.96 | 70.15% | $39,925.00 | 60% |
| Baystate Wing Hospital | $11,566.32 | 0.8425 | 0.68257 | $10,322.89 | $799.07 | $11,121.96 | 42.68% | $39,925.00 | 60% |
| Berkshire Medical Center | $11,566.32 | 0.9210 | 0.68257 | $10,942.63 | $799.07 | $11,741.70 | 56.14% | $39,925.00 | 60% |
| Beth Israel Deaconess Hospital - Milton | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 58.11% | $39,925.00 | 60% |
| Beth Israel Deaconess Hospital - Needham | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 65.35% | $39,925.00 | 60% |
| Beth Israel Deaconess Hospital - Plymouth | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 54.97% | $39,925.00 | 60% |
| Beth Israel Deaconess Medical Center | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 56.49% | $39,925.00 | 60% |
| Beverly Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 56.65% | $39,925.00 | 60% |
| Boston Children's Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 51.27% | $39,925.00 | 60% |
| Boston Medical Center | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 53.11% | $39,925.00 | 60% |
| Brigham & Women's Faulkner Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 43.78% | $39,925.00 | 60% |
| Brigham & Women's Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 30.83% | $39,925.00 | 60% |
| Cambridge Health Alliance | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 92.23% | $39,925.00 | 60% |
| Cape Cod Hospital | $11,566.32 | 1.0750 | 0.68257 | $12,158.43 | $799.07 | $12,957.50 | 47.43% | $39,925.00 | 60% |
| Carney Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 113.69% | $39,925.00 | 60% |
| Cooley Dickinson Hospital | $11,566.32 | 0.9371 | 0.68257 | $11,069.74 | $799.07 | $11,868.81 | 52.43% | $39,925.00 | 60% |
| Dana-Farber Cancer Institute | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 29.77% | $39,925.00 | 60% |
| Emerson Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 65.15% | $39,925.00 | 60% |
| Falmouth Hospital | $11,566.32 | 1.0750 | 0.68257 | $12,158.43 | $799.07 | $12,957.50 | 50.73% | $39,925.00 | 60% |

# RY23 In-State Acute Hospital Inpatient Rates

| In-State Provider | Statewide Operating Standard per Discharge | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Operating Standard per Discharge | Statewide Capital Standard per Discharge | APAD Base Payment | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|---|---|
| Good Samaritan Medical Center | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 61.36% | $39,925.00 | 60% |
| Heywood Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 74.86% | $39,925.00 | 60% |
| Holy Family Hospital | $11,566.32 | 0.9661 | 0.68257 | $11,298.69 | $799.07 | $12,097.76 | 69.67% | $39,925.00 | 60% |
| Holyoke Medical Center | $11,566.32 | 0.8425 | 0.68257 | $10,322.89 | $799.07 | $11,121.96 | 65.88% | $39,925.00 | 60% |
| Lahey Hospital & Medical Center | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 47.81% | $39,925.00 | 60% |
| Lawrence General Hospital | $11,566.32 | 0.9661 | 0.68257 | $11,298.69 | $799.07 | $12,097.76 | 71.92% | $39,925.00 | 60% |
| Lowell General Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 49.87% | $39,925.00 | 60% |
| Massachusetts Eye & Ear Infirmary | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 51.08% | $39,925.00 | 60% |
| Massachusetts General Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 29.99% | $39,925.00 | 60% |
| Melrose Wakefield Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 67.63% | $39,925.00 | 60% |
| Mercy Medical Center | $11,566.32 | 0.8425 | 0.68257 | $10,322.89 | $799.07 | $11,121.96 | 67.97% | $39,925.00 | 60% |
| MetroWest Medical Center | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 33.45% | $39,925.00 | 60% |
| Milford Regional Medical Center | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 73.84% | $39,925.00 | 60% |
| Morton Hospital | $11,566.32 | 0.9326 | 0.68257 | $11,034.21 | $799.07 | $11,833.28 | 83.94% | $39,925.00 | 60% |
| Mount Auburn Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 82.12% | $39,925.00 | 60% |
| Nantucket Cottage Hospital | $11,566.32 | 1.1904 | 0.68257 | $13,069.49 | $799.07 | $13,868.56 | 131.05% | $39,925.00 | 60% |
| Nashoba Valley Medical Center | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 64.24% | $39,925.00 | 60% |
| New England Baptist Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 62.12% | $39,925.00 | 60% |
| Newton-Wellesley Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 49.26% | $39,925.00 | 60% |
| North Shore Medical Center | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 45.69% | $39,925.00 | 60% |
| Norwood Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 74.80% | $39,925.00 | 60% |
| Saint Anne's Hospital | $11,566.32 | 0.9326 | 0.68257 | $11,034.21 | $799.07 | $11,833.28 | 47.37% | $39,925.00 | 60% |
| Saint Vincent Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 22.44% | $39,925.00 | 60% |
| Shriners Hospitals for Children - Boston | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 193.57% | $39,925.00 | 60% |
| Shriners Hospitals for Children - Springfield | $11,566.32 | 0.8425 | 0.68257 | $10,322.89 | $799.07 | $11,121.96 | 266.73% | $39,925.00 | 60% |
| Signature Healthcare Brockton Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 41.82% | $39,925.00 | 60% |
| South Shore Hospital | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 62.37% | $39,925.00 | 60% |
| Southcoast Hospitals Group | $11,566.32 | 1.0298 | 0.68257 | $11,801.59 | $799.07 | $12,600.66 | 44.31% | $39,925.00 | 60% |

# RY23 In-State Acute Hospital Inpatient Rates

| In-State Provider | Statewide Operating Standard per Discharge | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Operating Standard per Discharge | Statewide Capital Standard per Discharge | APAD Base Payment | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|---|---|
| St. Elizabeth's Medical Center | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 63.56% | $39,925.00 | 60% |
| Sturdy Memorial Hospital | $11,566.32 | 0.9326 | 0.68257 | $11,034.21 | $799.07 | $11,833.28 | 66.17% | $39,925.00 | 60% |
| Tufts Medical Center | $11,566.32 | 1.0631 | 0.68257 | $12,064.48 | $799.07 | $12,863.55 | 39.17% | $39,925.00 | 60% |
| UMass Memorial - Harrington Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 62.01% | $39,925.00 | 60% |
| UMass Memorial - HealthAlliance-Clinton Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 42.59% | $39,925.00 | 60% |
| UMass Memorial - Marlborough Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 45.64% | $39,925.00 | 60% |
| UMass Memorial Medical Center | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 39.19% | $39,925.00 | 60% |
| Winchester Hospital | $11,566.32 | 1.0257 | 0.68257 | $11,769.22 | $799.07 | $12,568.29 | 62.06% | $39,925.00 | 60% |

## Other Per Diem Rates

| In-State Provider | Administrative Day without Medicare Part B | Administrative Day with Medicare Part B | Psychiatric per Diem | Rehabilitation Unit per Diem |
|---|---|---|---|---|
| Anna Jaques Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Baystate Franklin Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Baystate Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Baystate Noble Hospital | $342.68 | $316.90 | $954.59 | $1,310.50 |
| Baystate Wing Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Berkshire Medical Center | $342.68 | $316.90 | $954.59 | $1,310.50 |
| Beth Israel Deaconess Hospital - Milton | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Beth Israel Deaconess Hospital - Needham | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Beth Israel Deaconess Hospital - Plymouth | $342.68 | $316.90 | $954.59 | Not Applicable |
| Beth Israel Deaconess Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Beverly Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Boston Children's Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Boston Medical Center | $342.68 | $316.90 | Not Applicable | Not Applicable |

# RY23 In-State Acute Hospital Inpatient Rates

| In-State Provider | Administrative Day without Medicare Part B | Administrative Day with Medicare Part B | Psychiatric per Diem | Rehabilitation Unit per Diem |
|---|---|---|---|---|
| Brigham & Women's Faulkner Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Brigham & Women's Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Cambridge Health Alliance | $342.68 | $316.90 | $954.59 | Not Applicable |
| Cape Cod Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Carney Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Cooley Dickinson Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Dana-Farber Cancer Institute | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Emerson Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Falmouth Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Good Samaritan Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Heywood Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Holy Family Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Holyoke Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Lahey Hospital & Medical Center | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Lawrence General Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Lowell General Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Massachusetts Eye & Ear Infirmary | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Massachusetts General Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Melrose Wakefield Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Mercy Medical Center | $342.68 | $316.90 | Not Applicable | $1,310.50 |
| MetroWest Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Milford Regional Medical Center | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Morton Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Mount Auburn Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Nantucket Cottage Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Nashoba Valley Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| New England Baptist Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Newton-Wellesley Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| North Shore Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Norwood Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Saint Anne's Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Saint Vincent Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| Shriners Hospitals for Children - Boston | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Shriners Hospitals for Children - Springfield | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Signature Healthcare Brockton Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |

# RY23 In-State Acute Hospital Inpatient Rates

| In-State Provider | Administrative Day without Medicare Part B | Administrative Day with Medicare Part B | Psychiatric per Diem | Rehabilitation Unit per Diem |
|---|---|---|---|---|
| South Shore Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Southcoast Hospitals Group | $342.68 | $316.90 | $954.59 | $1,310.50 |
| St. Elizabeth's Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Sturdy Memorial Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |
| Tufts Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| UMass Memorial - Harrington Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| UMass Memorial - HealthAlliance-Clinton Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| UMass Memorial - Marlborough Hospital | $342.68 | $316.90 | $954.59 | Not Applicable |
| UMass Memorial Medical Center | $342.68 | $316.90 | $954.59 | Not Applicable |
| Winchester Hospital | $342.68 | $316.90 | Not Applicable | Not Applicable |

***See Chart C** for RY23 MassHealth DRG Weights and Mean All Payer Lengths of Stay.

Click here: Chart C- Acute Hospital RY23 MassHealth DRG Weights and Mean All Payer Lengths of Stay

**#** For Freestanding Pediatric Acute Hospitals — for discharges assigned a MassHealth DRG Weight of 3.0 or greater, the APAD Base Payment will be $20,195.78 for Boston Children's Hospital and Shriner's Hospital for Children-Boston; and $17,461.47 for Shriner's Hospital for Children-Springfield.

## Critical Access Hospitals

**Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates***

| Critical Access Hospitals** In-State Provider | CAH-Specific Total Standard Rate per Discharge | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|
| Athol Memorial Hospital | $16,246.66 | 80.84% | $39,925.00 | 60% |
| Fairview Hospital | $18,792.61 | 94.63% | $39,925.00 | 60% |
| Martha's Vineyard Hospital | $24,145.99 | 113.74% | $39,925.00 | 60% |

# RY23 In-State Acute Hospital Inpatient Rates

**Other Per Diem Rates**

| Critical Access Hospitals** In-State Provider | Administrative Day without Medicare Part B | Administrative Day with Medicare Part B | Psychiatric per Diem |
|---|---|---|---|
| Athol Memorial Hospital | $342.68 | $316.90 | Not Applicable |
| Fairview Hospital | $342.68 | $316.90 | Not Applicable |
| Martha's Vineyard Hospital | $342.68 | $316.90 | Not Applicable |

***See Chart C** for RY23 MassHealth DRG Weights and Mean All Payer Lengths of Stay.

Click here: Chart C- Acute Hospital RY23 MassHealth DRG Weights and Mean All Payer Lengths of Stay

** For Critical Access Hospitals—subject to reconciliation.

# Public Notice – In-State Acute Hospitals (Outpatient)

## In-State Acute Outpatient Hospital Adjudicated Payment per Episode of Care (APEC)
## RY23 – *Effective 10/1/22*

## Components of Adjudicated Payment per Episode of Care (APEC)*
## (*See link at end for Chart D – RY2023 EAPGs and MassHealth EAPG Weights)

| In-State Provider | APEC Outpatient Statewide Standard | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Outpatient Standard | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|
| Anna Jaques Hospital | $653.84 | 0.9661 | 0.60000 | $640.54 | 36.89% | $4,200.00 | 60% |
| Baystate Franklin Medical Center | $653.84 | 0.8425 | 0.60000 | $592.05 | 34.57% | $4,200.00 | 60% |
| Baystate Medical Center | $653.84 | 0.9371 | 0.60000 | $629.16 | 42.26% | $4,200.00 | 60% |
| Baystate Noble Hospital | $653.84 | 0.8425 | 0.60000 | $592.05 | 42.99% | $4,200.00 | 60% |
| Baystate Wing Hospital | $653.84 | 0.8425 | 0.60000 | $592.05 | 46.27% | $4,200.00 | 60% |
| Berkshire Medical Center | $653.84 | 0.921 | 0.60000 | $622.85 | 42.19% | $4,200.00 | 60% |
| Beth Israel Deaconess Hospital - Milton | $653.84 | 1.0631 | 0.60000 | $678.59 | 39.39% | $4,200.00 | 60% |
| Beth Israel Deaconess Hospital - Needham | $653.84 | 1.0631 | 0.60000 | $678.59 | 47.10% | $4,200.00 | 60% |
| Beth Israel Deaconess Hospital - Plymouth | $653.84 | 1.0631 | 0.60000 | $678.59 | 34.50% | $4,200.00 | 60% |
| Beth Israel Deaconess Medical Center | $653.84 | 1.0631 | 0.60000 | $678.59 | 38.86% | $4,200.00 | 60% |
| Beverly Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 30.96% | $4,200.00 | 60% |
| Boston Children's Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 52.53% | $4,200.00 | 60% |
| Boston Medical Center | $653.84 | 1.0631 | 0.60000 | $714.59 | 48.50% | $4,200.00 | 60% |
| Brigham & Women's Faulkner Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 26.14% | $4,200.00 | 60% |
| Brigham & Women's Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 27.69% | $4,200.00 | 60% |

# In-State Hospitals – RY23 Outpatient APEC

| In-State Provider | APEC Outpatient Statewide Standard | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Outpatient Standard | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|
| Cambridge Health Alliance | $653.84 | 1.0257 | 0.60000 | $663.92 | 68.44% | $4,200.00 | 60% |
| Cape Cod Hospital | $653.84 | 1.075 | 0.60000 | $683.26 | 38.02% | $4,200.00 | 60% |
| Carney Hospital | $653.84 | 1.0631 | 0.60000 | $743.59 | 52.21% | $4,200.00 | 60% |
| Cooley Dickinson Hospital | $653.84 | 0.9371 | 0.60000 | $629.16 | 33.47% | $4,200.00 | 60% |
| Dana-Farber Cancer Institute | $805.84 | 1.0631 | 0.60000 | $836.35 | 28.33% | $4,200.00 | 60% |
| Emerson Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 35.69% | $4,200.00 | 60% |
| Falmouth Hospital | $653.84 | 1.075 | 0.60000 | $683.26 | 29.14% | $4,200.00 | 60% |
| Good Samaritan Medical Center | $653.84 | 1.0631 | 0.60000 | $678.59 | 34.99% | $4,200.00 | 60% |
| Heywood Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 42.11% | $4,200.00 | 60% |
| Holy Family Hospital | $653.84 | 0.9661 | 0.60000 | $640.54 | 38.48% | $4,200.00 | 60% |
| Holyoke Medical Center | $653.84 | 0.8425 | 0.60000 | $657.05 | 38.95% | $4,200.00 | 60% |
| Lahey Hospital & Medical Center | $653.84 | 1.0257 | 0.60000 | $663.92 | 38.65% | $4,200.00 | 60% |
| Lawrence General Hospital | $653.84 | 0.9661 | 0.60000 | $705.54 | 43.68% | $4,200.00 | 60% |
| Lowell General Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 29.01% | $4,200.00 | 60% |
| Massachusetts Eye & Ear Infirmary | $653.84 | 1.0631 | 0.60000 | $678.59 | 41.93% | $4,200.00 | 60% |
| Massachusetts General Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 27.10% | $4,200.00 | 60% |
| Melrose Wakefield Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 30.96% | $4,200.00 | 60% |
| Mercy Medical Center | $653.84 | 0.8425 | 0.60000 | $657.05 | 40.57% | $4,200.00 | 60% |
| MetroWest Medical Center | $653.84 | 1.0257 | 0.60000 | $663.92 | 13.34% | $4,200.00 | 60% |
| Milford Regional Medical Center | $653.84 | 1.0257 | 0.60000 | $663.92 | 27.37% | $4,200.00 | 60% |
| Morton Hospital | $653.84 | 0.9326 | 0.60000 | $627.40 | 42.83% | $4,200.00 | 60% |

# In-State Hospitals – RY23 Outpatient APEC

| In-State Provider | APEC Outpatient Statewide Standard | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Outpatient Standard | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|
| Mount Auburn Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 42.97% | $4,200.00 | 60% |
| Nantucket Cottage Hospital | $653.84 | 1.1904 | 0.60000 | $728.53 | 63.55% | $4,200.00 | 60% |
| Nashoba Valley Medical Center | $653.84 | 1.0257 | 0.60000 | $663.92 | 35.34% | $4,200.00 | 60% |
| New England Baptist Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 53.28% | $4,200.00 | 60% |
| Newton-Wellesley Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 30.89% | $4,200.00 | 60% |
| North Shore Medical Center | $653.84 | 1.0257 | 0.60000 | $663.92 | 24.67% | $4,200.00 | 60% |
| Norwood Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 37.35% | $4,200.00 | 60% |
| Saint Anne's Hospital | $653.84 | 0.9326 | 0.60000 | $627.40 | 32.07% | $4,200.00 | 60% |
| Saint Vincent Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 14.03% | $4,200.00 | 60% |
| Shriners Hospitals for Children - Boston | $653.84 | 1.0631 | 0.60000 | $678.59 | 88.95% | $4,200.00 | 60% |
| Shriners Hospitals for Children - Springfield | $653.84 | 0.8425 | 0.60000 | $592.05 | 66.10% | $4,200.00 | 60% |
| Signature Healthcare Brockton Hospital | $653.84 | 1.0631 | 0.60000 | $743.59 | 32.21% | $4,200.00 | 60% |
| South Shore Hospital | $653.84 | 1.0631 | 0.60000 | $678.59 | 44.01% | $4,200.00 | 60% |
| Southcoast Hospitals Group | $653.84 | 1.0298 | 0.60000 | $665.53 | 31.48% | $4,200.00 | 60% |
| St. Elizabeth's Medical Center | $653.84 | 1.0631 | 0.60000 | $678.59 | 43.00% | $4,200.00 | 60% |
| Sturdy Memorial Hospital | $653.84 | 0.9326 | 0.60000 | $627.40 | 45.09% | $4,200.00 | 60% |
| Tufts Medical Center | $653.84 | 1.0631 | 0.60000 | $678.59 | 42.75% | $4,200.00 | 60% |
| UMass Memorial - Harrington Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 31.15% | $4,200.00 | 60% |
| UMass Memorial - HealthAlliance-Clinton Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 25.51% | $4,200.00 | 60% |
| UMass Memorial - Marlborough Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 24.95% | $4,200.00 | 60% |
| UMass Memorial Medical Center | $653.84 | 1.0257 | 0.60000 | $663.92 | 29.46% | $4,200.00 | 60% |

# In-State Hospitals – RY23 Outpatient APEC

| In-State Provider | APEC Outpatient Statewide Standard | Hospital's Massachusetts-specific wage area index | Labor Factor | Wage Adjusted Outpatient Standard | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|---|---|---|
| Winchester Hospital | $653.84 | 1.0257 | 0.60000 | $663.92 | 42.27% | $4,200.00 | 60% |

***See Chart D** for the RY2023 EAPGs and MassHealth EAPG Weights.
Click here: Chart D-Acute Hospital RY23 MassHealth EAPG Weights

**Note:** The 3M EAPG grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight that is used in the APEC calculation.

## Critical Access Hospitals**

## Components of Adjudicated Payment per Episode of Care (APEC)*
## RY23 Outpatient

| In-State Provider | CAH-Specific Outpatient Standard Rate per Episode | Hospital Cost-to-Charge Ratio | Fixed Outlier Threshold | Marginal Cost Factor |
|---|---|---|---|---|
| Athol Memorial Hospital | $1,092.69 | 34.73% | $4,200.00 | 60% |
| Fairview Hospital | $1,721.85 | 53.21% | $4,200.00 | 60% |
| Martha's Vineyard Hospital | $1,811.19 | 50.58% | $4,200.00 | 60% |

***See Chart D** for the RY2023 EAPGs and MassHealth EAPG Weights.
Click here: Chart D-Acute Hospital RY23 MassHealth EAPG Weights

**Note**: The 3M EAPG grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight that is used in the APEC calculation.

** For Critical Access Hospitals—subject to reconciliation