Notice of Final Agency Action

SUBJECT: MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, Effective October 1, 2026

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 2027 (RY27), which begins October 1, 2026, and ends September 30, 2027 (see Chart A on the MassHealth "Special Notices for Acute Hospitals" webpage, under the heading "Federal Fiscal Year 2027 Notices"). **Part II** of this notice describes and summarizes changes in MassHealth payment for services provided by in-state acute hospitals, effective for RY27, which begins October 1, 2026, and ends September 30, 2027. A complete description of the RY27 MassHealth in-state acute hospital inpatient and outpatient payment methods is provided in Part II (see also Chart B for RY27 in-state acute hospital rates and rate components on the MassHealth "Special Notices for Acute Hospitals" webpage, under the heading "Federal Fiscal Year 2027 Notice"). For further information regarding RY27 acute hospital payment methods and rates, or to provide written comments, contact Jin Pantano at the Executive Office of Health and Human Services, MassHealth Office of Provider Networks, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171, or by email at AcuteHospitalRFA@mass.gov. EOHHS specifically invites comments regarding the impact of the changes on member access to care.

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

1. Out-of-State Acute Inpatient Hospital Services

In RY27, the MassHealth out-of-state acute inpatient hospital payment methodologies are generally unchanged from RY26.

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 RY27 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.

- **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.

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[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 Solventum APR-DRG grouper.
[2] A hospital's charges for a LARC Device and for APAD Carve-Out Drugs will be excluded.
[3] In RY27, as in RY26, an out-of-state "High MassHealth Volume Hospital" is an out-of-state hospital that had at least 300 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 RY26, in RY27 the two High MassHealth Volume Hospitals will be Rhode Island Hospital and Women & Infants Hospital (RI).

- ***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.

- ***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 RY27, the MassHealth out-of-state acute outpatient hospital payment methodologies are generally unchanged from RY26.

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 Solventum EAPG grouper's discounting, consolidation, and packaging logic is applied to

[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 MHDL is posted at mass.gov/druglist.
[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 Solventum EAPG grouper and refer to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix.

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-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. Services Not Available In State

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.

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[6] See footnote 3 and accompanying text.
[7] The MassHealth-designated APEC 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 MHDL is posted at mass.gov/druglist.
[8] See footnote 3 and accompanying text.

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

1. In-State Acute Inpatient Hospital Inpatient Services

A. Summary of RY27 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) 2021, unchanged from RY26. The components of the APAD applicable to admissions in RY27 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 case mix differences and area wage variation. An efficiency standard is determined by capping hospital costs, weighted by FY22 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 FY22 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 Solventum's APR-DRG grouper version 43 and Massachusetts weights.

Outlier Payment

For qualifying discharges that correspond to admissions occurring in RY27, 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 FY22 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 $42,430. 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[9] 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.[10]

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 FY27 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 RY27 continue to be based on FY22 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.

Other Payments for BH Services

Inpatient Admission Rates Payments—Addition of Eating Disorder to the list of Category 2 Conditions that would trigger the existing add-on rate.

BH Crisis Evaluation Policy—Expands the BH Crisis Evaluation policy to include members admitted to med/surg units. Clarifies that BH Crisis Evaluation can only be billed ONCE per admission. Reimbursed outside of the APAD and paid at the same rate as service when rendered in outpatient setting.

BH Crisis Management Services Rate—Implements a tiered per diem BH crisis management rate in acute medical settings, including the emergency department and medical/surgical floors, following the initial BH Crisis Evaluation for members requiring management of an ongoing BH crisis. Reimbursed outside of the APAD and paid at the same rate as service when rendered in outpatient setting.

Emergency Department MOUD Support—Establishes an add-on code for MOUD induction in the ED with member consent for induction. Reimbursed outside of the APAD and paid at the same rate as service when rendered in outpatient setting.

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[9] The 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 mass.gov/druglist.

[10] References to "drugs" in this notice refer 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.

Recovery Support Navigator—Establishes reimbursement for Recovery Support Navigator (RSN) services to support discharge and ongoing treatment for SUD. Reimbursed outside the APAD and paid at the same rate as service when rendered in outpatient setting.

Specialty IP ASD/IDD—Implements a Specialty IP Psych service and per diem rate in the Acute Hospital RFA for members under 21 with severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions.

RY27 In-State Acute Inpatient Hospital Rates and Rate Components

The in-state acute inpatient hospital rates and rate components applicable to RY27 are set forth in Chart B on the MassHealth "Special Notices for Acute Hospitals" webpage, under the heading "Federal Fiscal Year 2027 Notices".

B. Summary of Changes

RY27 payment methods for in-state acute inpatient hospital services are mostly unchanged from the RY26 payment methods, including the following.

- In calculating the APAD,
  - APR-DRG grouper updated to v43.
  - The APAD Base Year remains unchanged from FY21.
  - 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, no changes were made to the labor factor and the method used to calculate the hospital's Massachusetts-specific wage area index.
  - The outlier adjustment factor applied for the statewide operating standard per discharge remains 91.85%.
  - 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 67%, which is unchanged from RY26.
  - For Massachusetts Acute Hospitals that are not Freestanding Pediatric Acute Hospitals and that maintain between 1 and 15 pediatric beds, the APAD Base Payment for pediatric patients will continue to be adjusted to include an additional 25% for discharges of patients who are under 21 years of age.
  - For Massachusetts Acute Hospitals that are not Freestanding Pediatric Hospitals or Massachusetts Acute Hospitals and that do not maintain between 1 and 15 pediatric beds, the APAD Base Payment for pediatric patients will continue to be adjusted to include an additional 6% for discharges of patients who are under 21 years of age.
  - To calculate the Outlier Payment (if any), the fixed outlier threshold remained at $42,430, the marginal cost factor remains at 60%, and each hospital's inpatient cost-to-charge ratio continued to be calculated based on the hospital's FY22 Massachusetts Hospital cost report.
  - EOHHS continued to use FY24 base median nursing facility rates when calculating the administrative day (AD) per diem rate for RY27.
  - For critical access hospitals paid at 101% of allowable costs using Medicare's cost-based reimbursement methodology, interim APAD rates for admissions in RY27 were derived

using cost data from the hospital's FY22 CMS 2552-10 cost report, as they were for RY26. Final payment for the FY27 period will be made as described in Part II, Section 1.A.

2. In-State Acute Hospital Outpatient Services

A. Summary of RY27 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 RY27, 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.[11] 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 RY27 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 fiscal year (FY) 2021.

The "Episode-Specific Total EAPG Payment" is equal to the sum of all of the episode's claim detail line EAPG[12] 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.[13]
    - In determining the APEC Outpatient Statewide Standard, an average outpatient cost per episode is calculated for each hospital, utilizing the hospital's FY21 outpatient cost-to-

[11] 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.

[12] 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 Solventum EAPG grouper version 3.18 (configured for the MassHealth APEC methodology).

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

charge ratio from its 403 cost report, and allowed charges and episodes based on FY21 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 FY21 outpatient casemix index, 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 FY21 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 freestanding 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 Solventum EAPG grouper version 3.18. 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 Solventum 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 FY22 outpatient cost-to-charge ratio (based on the hospital's FY22 Massachusetts Hospital cost report). The episode-specific outlier threshold is the sum of (1) the Episode-Specific Total EAPG Payment and (2) the RY27 fixed outpatient outlier threshold of $4,460. 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[14] 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.

[14] The 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 mass.gov/druglist.

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 web page cms.gov/medicare/medicare-part-b-drug-average-sales-price/asp-pricing-files (2026 ASP Drug Pricing).

BH Outpatient Initiatives

BH Crisis Management Services Rate—Implements a tiered per diem BH crisis management rate. Reimbursed outside of the APEC.

Emergency Department MOUD Support—Establishes an add-on code for MOUD induction in the ED with member consent for induction. Reimbursed outside of the APEC.

Recovery Support Navigator—Establishes reimbursement for Recovery Support Navigator (RSN) services to support discharge and ongoing treatment for SUD. Reimbursed outside the APEC.

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

RY27 In-State Acute Outpatient Hospital APEC Rate Components
The in-state acute outpatient hospital APEC rate components applicable to RY27 are set forth in Chart B on the MassHealth "Special Notices for Acute Hospitals" webpage, under the heading "Federal Fiscal Year 2027 Notices".

B. Summary of Changes

RY27 payment methods for in-state acute outpatient hospital services are mostly unchanged from the RY26 payment methods, including the following.

(1) In calculating the APEC,
- The EAPG grouper remains v3.18.
- For the Episode-Specific Total EAPG Payment, the individual claim detail line EAPG payment amounts will continue to 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 for RY27, the following is unchanged from RY26.
    - 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.
    - FY21 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%.
    - The conversion factor applied was 1.2303.
- For the APEC Outlier Component calculation, the fixed outpatient outlier threshold remained at $4,460, the marginal cost factor remained at 60%, and the hospital's outpatient cost-to-charge ratio continued to be calculated based on the hospital's FY22 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 RY27 continue to be derived utilizing cost data from the hospital's FY22 CMS 2552-10 cost report. Final payment for the FY27 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 FY27 state plan methods for the following supplemental payments remain substantially similar to the FY26 methods for those payments, except utilizing more recent data or adjusting total amounts to be paid out: 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 High Medicaid Volume Safety Net Hospital Supplemental Payment, and the Inpatient Psychiatric Supplemental Payment.
- The FY27 state plan methods for the following supplemental payments have been deleted and reserved: the High Medicaid Volume Safety Net Continuation of Access Supplemental Payment, the Supplemental Payment for Continuity of Access of High Public Payer Acute Hospitals, and the MassHealth Targeted Hospital Supplemental Payments.

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

- The inpatient add-on is paid from two pools. Pool 1 is $225.6 million, calculated by multiplying $480 million by 47%. Pool 2 is $41.36 million, calculated by multiplying $88 million by 47%.
- The outpatient add-on pool is paid from two pools. Pool 1 is $254.4 million, calculated by multiplying $480 million by 53%. Pool 2 is $46.64 million, calculated by multiplying $88 million by 53%.

4. <u>Performance Incentive Programs</u>

Clinical Quality Incentive (CQI) Program—Section 7B
In RY27, the CQI Program is updated to revise the optional eCQM bonus opportunity section to indicate intent to continue the opportunity in RY27 with additional information to be released in an amendment.

Hospital Quality and Equity Incentive Program (HQEIP)—Section 8.A
The Hospital Quality and Equity Initiative Program (HQEIP) is updated to include references to the HQEI technical specifications manual in the Program Requirements and Performance Assessment Methodology sections.

5. New Initiatives and Requirements

- **Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members**
    - Expansion of Perinatal Recovery Support Navigator Services (RSN-PP) from the Emergency Department to the Outpatient Department.

Part III: Justification

Except as specified earlier, the acute inpatient and outpatient hospital rate payment methods for RY27 are substantially similar to those for RY26. All changes to hospital payment rates and methods, including the updated rates and rate components effective with RY27, 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.

6. Estimated Fiscal Effect

EOHHS estimates that annual aggregate acute hospital state plan expenditures resulting from the RY27 (October 1, 2026–September 30, 2027) payment methods will decrease by approximately $116M overall, as compared to RY26 (October 1, 2025–September 30, 2026). The estimated decrease is entirely attributable to a reduction in supplemental payments in RY27 as compared to RY26. There is no reduction in rates, and therefore no amount of the decrease is attributable to estimated annual aggregate in-state and out-of-state acute inpatient and outpatient hospital rate payments. Holding utilization constant, EOHHS estimates that the fiscal impact resulting from the changes in rate payments, not including supplemental payments, to acute inpatient and outpatient hospitals applicable to FY27 will result in a 0% decrease, in the aggregate, on an annualized basis, compared to estimated annualized RY26 rate payments. All rate and supplemental payment methodologies are subject to all necessary state and federal approvals.

Statutory Authority: M.G.L. c. 118E; St. 2021, c. 24; 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 the 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.

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 the 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.18, as such services are excluded from the definitions of "APEC-Covered Services" and "Episode" under the 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 Solventum (formerly known as 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.

Administrative Psychiatric Day—An Administrative Day that is a day of inpatient hospitalization on which a Member's clinical presentation would typically call for discharge to a lower level of care (e.g., an appropriate community-based location), but an appropriate placement has not yet been secured, the

clinical barriers to discharge have been sufficiently addressed and the discharge plan is ready to be executed when an appropriate discharge placement has been secured, and the patient does not require a high degree of clinical resources daily. Administrative Psychiatric Day does not include a day on which a Member is receiving active stabilization efforts or requires inpatient hospital care to prevent further regression of the Member's condition.

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 the 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 Solventum APR-DRG Grouper, Version 43, unless otherwise specified.

APAD Base Year—The hospital-specific base year for the APAD is FY21, using the FY21 Massachusetts Hospital cost reports as screened and updated as of March 14, 2023.

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 FY21.

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.18.

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 Crisis—A situation in which an individual demonstrates signs or symptoms of a mental health disorder, substance use disorder, co-occurring mental health and substance use disorder, or co-occurring behavioral health and medical condition that led to significant impairment in the individual's functioning and/or to behavior that puts the individual at risk of harming themselves, harming others, or being unable to appropriately care for themselves.

Behavioral Health Crisis Management Services—A set of services provided in an Emergency Department or on a medical/surgical floor by qualified clinical professionals to members experiencing a Behavioral Health Crisis and in need of ongoing supports on days after they received the initial Behavioral Health Crisis Evaluation. The crisis management services include ongoing crisis interventions, ongoing determination and coordination of appropriate disposition, and ongoing required reporting and community collaboration activities.

Behavioral Health Diversionary Services—Those mental health and substance use disorder services provided outside of the 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 provided in a 24-hour facility and those provided in a non-24-hour setting or facility.

Behavioral Health Crisis Evaluations—An evaluation provided in an Emergency Department or on a medical/surgical floor by qualified clinical professionals to members experiencing a Behavioral Health Crisis during the first calendar day of their readiness to receive such an evaluation. The evaluation includes the initial comprehensive assessment of risk, diagnosis, and treatment needs; the initial crisis interventions; the initial determination and coordination of appropriate disposition; and required reporting and community collaboration activities.

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

Behavioral Health Treatment and Referral Platform (BHTRP)—Technology to support automation of the ED Behavioral Health referral screening, evaluation and referral process, enables the electronic transmission of standardized admissions information, and creates a real-time, transparent view of patients seeking behavioral health treatment for participant organizations.
Calendar Year (CY)—The time period of 12 months beginning January 1 of any given year and ending 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.

Certified Event Notification Service Vendor or Certified ENS Vendor—An ENS vendor that is certified by EOHHS in compliance with 101 CMR 20.00: *Health Information Exchange*.

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 the RFA. Unless the context indicates that the term "RFA" refers exclusively to the procurement document as such, references to RFA shall constitute references to the Contract (or Agreement).

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

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

Critical Access Hospital (CAH)—An Acute Hospital that, prior to October 1, 2026, 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 FY24 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.

Electronic Health Record (EHR)—A digital version of a patient's medical history. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users, often including a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and/or laboratory and test results.

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.

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 Solventum EAPG Grouper Version 3.18.

Episode—All MassHealth-covered Outpatient Services, except those described in Section 4.C and Sections 5.C.3 through 5.C.18, 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 FY22 outpatient cost-to-charge ratio, as calculated by EOHHS using the Hospital's FY22 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)**.

Event Notification Service (ENS)—A specialized form of Health Information Exchange (HIE) alerts for existing care providers that occurs after admissions, discharges, and transfers (ADT) to and from Emergency Departments (EDs), hospitals and post-acute care facilities. ADT alerts can include some clinical data through a Certified ENS Vendor.

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.

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.

Expedited Psychiatric Inpatient Admission (EPIA)—The escalation protocol for securing appropriate placement for individuals awaiting psychiatric placement longer than 24 hours.

Fiscal Year (FY)—The time period of 12 months beginning October 1 of any calendar year and ending 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 $42,430.

Fixed Outpatient Outlier Threshold—The Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $4,460.

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.

Health Information Exchange (HIE)—A secure connection which allows health care professionals and patients to appropriately access and share a patient's medical information. The Mass HIway is a secure Health Information Exchange (HIE) for all healthcare systems in Massachusetts.

High Medicaid Volume Freestanding Pediatric Acute Hospital—The freestanding pediatric acute hospital with the largest volume of inpatient discharges in fiscal year 2019, as determined by EOHHS using Massachusetts hospital cost report data.

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 the 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 the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.

Hospital Discharge Data (HDD)—Hospital discharge filings for FY21 provided and verified by each hospital, submitted to CHIA and screened and updated by CHIA as of April 7, 2023. HDD is used for determining casemix as part of the APAD rate development, as set forth in Section 5.B.1.

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 RY24, 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 RY24 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
- 3.5% reflects the price changes between RY23 and RY24

Inflation Factors for Operating Costs—For price changes between RY04 and RY07, and between RY08 and RY24, 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 RY24 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
- 2.599% reflects the price changes between RY23 and RY24

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 the RFA.

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

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

Long-Acting Injectable (LAI) Antipsychotics—Antipsychotic medications that are administered through intramuscular injection and provide medication coverage for a period of weeks to months. LAI Antipsychotics does not refer to the administration of the medications. The EOHHS-designated LAI Antipsychotics are identified on the *Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units* document maintained on the MassHealth Drug List (MHDL). The MassHealth Drug List is published at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.

Long-Acting Reversible Contraception (LARC) Device—Specifically, 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 the RFA, except for Sections 4.A.2, 4.B.4, and 5.D.1. 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— 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 RY27 MassHealth EAPG Weights for the APEC methodology). The Solventum 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."

Mass HIway—A secure statewide network that facilitates the transmission of healthcare data and health information among providers, hospitals, and other healthcare entities as allowed by applicable state and federal laws.

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.

Medication for the Treatment of Opioid Use Disorder (OUD)—Use of a medication approved by the FDA for the treatment of an opioid use disorder.

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 to evaluate a Member's condition and determine the need for admission to an Acute Hospital, 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 the 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 aged 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, 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 the RFA.

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)—This refers to the pay-for-performance program formerly set forth in **Section 7** of the RFA.

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.

Qualified Behavioral Health Professional—A qualified behavioral health professional shall include a (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in the field of psychiatry (vii) advanced practice registered nurse who practices in the field of psychiatry, including but not limited to a licensed nurse practitioner or licensed psychiatric clinical nurse specialist; or (viii) healthcare provider qualified within the scope of the individual's license to conduct an evaluation of a mental health condition, including an intern, resident or fellow pursuant to the policies and practices of the hospital and medical staff.

Quality and Performance Initiatives—Data-driven systemic efforts anchored on measurement-driven activities, including the Clinical Quality Initiative (CQI) described in **Section 7B** and Health Quality and Equity Incentive Program (HQEIP) described in **Section 8.A**, to improve performance of health-delivery systems that result in positive outcomes, including quality and equity improvements.

Query and Retrieve—A method utilized in the Health Information Exchange (HIE) to allow providers to search for and retrieve patient information that was made accessible by other care providers, public agencies, and other sources.

Rate Year (RY)—Generally, the period beginning October 1 and ending the following September 30. RY27 will begin October 1, 2026, and end September 30, 2027.

Recovery Support Navigator—A paraprofessional or peer specialist who receives specialized training in the essentials of substance use disorder (SUD) or other addictive disorders and evidence-based techniques, such as motivational interviewing, and who supports members in accessing and navigating the SUD treatment system through activities that can include care coordination, case management, and motivational support.

Recovery Support Navigator for Pregnant and Postpartum Members—A specialized recovery support navigator who receives specialized training to provide recovery support navigator services to individuals who are pregnant or have been pregnant in the last 12 months.

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—The use of medical devices which transmit digital personal health information in a synchronous or asynchronous manner from an at-risk patient to a treating provider at a distant location. Information is generated with the expectation of responsive management for the patient and the monitored condition. Eligibility criteria and appropriate coding methods are defined by MassHealth Transmittal Letter PHY-170 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's 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.

Solventum EAPG Grouper – the Solventum's EAPG Grouper Version 3.18, configured for the MassHealth APEC payment method.

Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders—An intensive level of specialized inpatient psychiatric care for youth with severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions. In addition to all the clinical service components required within Psychiatric Inpatient Hospitals, pursuant to this Contract, Specialty Inpatient Psychiatric Services for Children/Adolescents with Neurodevelopmental Disorders must be supported by specially trained staff. Additionally, specialized components of services include specialized treatment milieu, clinical expertise, clinical interventions, and evidence-based practices and procedures.

Specialty Inpatient Psychiatric Service for Eating Disorders—An intensive level of specialized inpatient care for adults and youth with eating disorder diagnoses who require acute psychiatric and medical stabilization. In addition to all clinical service components required within Hospitals, Specialty Inpatient Psychiatric Services for Eating Disorders must be supported by specially trained staff. Additionally, specialized components of services include specialized treatment milieu, clinical expertise, clinical interventions, and evidence-based practices and procedures for supporting the unique needs of individuals with severe eating disorders.

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; or an Acute Hospital that is not a Freestanding Pediatric Acute Hospital and is designated by the Department of Public Health (DPH) as providing Level II Pediatric Trauma care in Region I as of October 1, 2024, as determined by EOHHS.

Statewide Event Notification Service (ENS) Framework—An interoperable ENS network consisting of Certified ENS Vendors who have interconnected their ENS systems to serve all care providers in Massachusetts.

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

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

Total Case Payment—The sum, as determined by EOHHS, of the 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 the RFA if they

1. operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH);

2. are Medicare-certified and participate in the Medicare program;

3. have more than 50% of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by DPH; and

4. currently utilize more than 50% of their beds exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by EOHHS.

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

B. The Hospital shall apply on behalf of all Inpatient Departments, Outpatient Departments, Emergency Departments and Satellite Clinics.

C. The Hospital is not permitted to apply on behalf of, or claim payment for services provided by, any other related clinics, Provider groups, or other entities, except as otherwise provided in **Sections 5.B.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 the 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 the RFA and accompanying Contract for all covered Inpatient, Outpatient, and Emergency Services provided to MassHealth Members except for the following.

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

EOHHS's 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 the 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.) 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. Reserved

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

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 the RFA, which provide, through contract or regulation, alternative reimbursement methodologies for Hospital services or certain Hospital services. In such cases, payment for such services is made pursuant to the contract or regulations governing the special program initiative, and not through the RFA and resulting Contract.

2. Demonstration Projects

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

3. MassHealth Drug List

To help ensure consistency in medication regimens and services, prescribers need to conform to the MassHealth Drug List (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 the 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, 2026, all Hospitals that are parties to a Hospital Contract under the 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

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 subregulatory 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 (PCACO), the Hospital must notify the Member's PCC Plan or PCACO, as applicable, or the Member's 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 also 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 subregulatory 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 PCACO, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's PCC Plan or PCACO, as applicable, or the Member's 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 subregulatory guidance.

(2) For all Members receiving Inpatient Services, the Hospital shall communicate with, as applicable, the Member's primary care provider, health plan, PCC Plan or PCACO (as applicable), and CP(s) to ensure that, consistent with all applicable federal and state laws, regulations, and subregulatory 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, including a designated key contact for parties to liaise with 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 subregulatory 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 birthing parent 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 parent in the selection of a pediatrician by, at a minimum, providing the parent with

i. a paper copy of and/or web access to the MassHealth Enrollment Guide and MassHealthChoices.com; and
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.

(d) Advising the birthing parent 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 parent, 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 MassHealth Provider Online Service Center. 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 the RFA as payment in full for services reimbursable by EOHHS that are rendered to MassHealth Members admitted as inpatients or treated as outpatients on or after October 1, 2026.

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 least three times per day, 7 days per week. Such updates shall occur, at a minimum, between 8:00 a.m. and 10:00 a.m., 12:00 p.m. and 2:00 p.m., and 6:00 p.m. and 8:00 p.m. 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.13** and **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.

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**.

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**).

In-State Acute Hospitals

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). 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 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 January 1, 2023.

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 FY21 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 calculation of each hospital standardized cost per discharge, which is unchanged from the methodology used in the RY24 – RY26 RFAs, is calculated as follows.

The labor portion of the average cost per discharge for each Hospital was adjusted by the Hospital's RY24 Massachusetts-specific wage area index, and the labor and non-labor portions were then adjusted by the Hospital-specific FY21 all-payer APR-DRG Version 40 Casemix Index that was determined by using FY21 discharges, APR-DRG version 40 of the Solventum grouper, and MassHealth DRG Weights. Massachusetts Hospitals' wages and hours were determined based on CMS's FY 2024-April-28-2023-Wage-Index-PUF zip file, downloaded

May 18, 2023, from the CMS website, cms.hhs.gov. Each Hospital was assigned to a wage area according to CMS's FY 2023 IPPS FR and CA Impact File from the CMS web page cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page (FY2023 IPPS FR and CA Impact File), except that

- Brigham and Women's Hospital and Beth Israel Deaconess Hospital—Milton were assigned to the Boston wage area and their wages and hours included in the Boston area;
- Baystate Franklin Medical Center was assigned to the Springfield wage area and its wages and hours included in the Springfield area;
- the following hospitals were redesignated for the purpose of wage area as follows:
    - Baystate Medical Center and Cooley Dickinson Hospital from Springfield to Worcester;
    - Anna Jaques Hospital, Beverly Hospital, Cambridge Health Alliance, Emerson Hospital, Merrimack Health Methuen Hospital, Lahey Hospital, Merrimack Health General Hospital, Lowell General Hospital, Marlborough Hospital, Melrose Wakefield Healthcare, MetroWest Medical Center, Mount Auburn Hospital, Newton-Wellesley Hospital, North Shore Medical Center, and Winchester Hospital from Cambridge-Newton-Framingham to Boston;
    - Harrington Hospital, HealthAlliance-Clinton Hospital, Heywood Hospital, Milford Medical Center, St. Vincent Hospital, and UMass Memorial Medical Center, from Worcester to Boston;
    - Southcoast Hospitals Group from Providence-Warwick to Boston; and
    - Saint Anne's Hospital from Providence-Warwick to Worcester
- 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 FY2023 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, 2023. 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 FY22 MassHealth discharges for the Hospitals was produced from MMIS claims data on file as of June 12, 2023, 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 RY27 is unchanged as compared to RY24 at $15,211.43.

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 RY21 and RY24, and then by dividing the result by (d) a conversion factor of 1.1722. The resulting Statewide Operating Standard per Discharge is $11,423.66.

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 FY21 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 FY21 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 FY21 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 FY22 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 FY21 All-Payer APR-DRG Version 40 Casemix Index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of FY22 MassHealth discharges from MMIS claims data on file as of June 12, 2023, 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 applicable to RY27 is unchanged from RY24 at $1,080.10.

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 FY22 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 RY21 and RY24, and then divided by 1.1722. The resulting Statewide Capital Standard per Discharge is $792.37.

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 Solventum APR-DRG grouper version 40 and Massachusetts weights (see Chart C to Appendix C for the MassHealth DRG Weights that apply to RY27).

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, determined as described in Section 5.B.1.b,by the Hospital's RY27 Massachusetts-specific wage area index, determined as described in this Section 5.B.1.e, (2) adding this amount to the non-labor portion of said Statewide Operating Standard per Discharge, determined as described in Section 5.B.1.e, to determine the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding said Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge, determined as described in Section 5.B.1.c, to determine what 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), the Hospital's RY27 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**, is determined as follows.

Massachusetts Hospitals' wages and hours were determined based on CMS's FY27_April_PUF.20260429.S3andOccMixPUF zip file, downloaded May 18, 2026 from the CMS website, cms.hhs.gov. Each Hospital was assigned to a wage area according to CMS's FY 2026 IPPS Final Rule Impact File from the CMS web page https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page. (*FY 2026 Impact File*), except that:

- Brigham and Women's Hospital and Beth Israel Deaconess Hospital-Milton were assigned to the Boston wage area and their wages and hours included in the Boston area;
- The following hospitals were redesignated, for the purpose of wage areas, as follows:
    - Baystate Medical Center and from Springfield to Worcester;
    - Anna Jaques Hospital, Beverly Hospital, Cambridge Health Alliance, Emerson Hospital, Merrimack Health Methuen Hospital, Lahey Hospital, Merrimack Health General Hospital, Lowell General Hospital, Melrose Wakefield Healthcare, MetroWest Medical Center, Mount Auburn Hospital, Newton-Wellesley Hospital, North Shore Medical Center and Winchester Hospital from Cambridge-Newton-Framingham to Boston;
    - Harrington Hospital, HealthAlliance-Clinton Hospital, Heywood Hospital, Milford Medical Center, St. Vincent Hospital and UMass Memorial Medical Center from Worcester to Boston;
    - Southcoast Hospitals Group and Sturdy Memorial Hospital from Providence-Warwick to Boston; and
    - Saint Anne's Hospital from Providence-Warwick to Worcester

- Cooley Dickinson Hospital from Amherst Town-Northampton to Worcester

- 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 FY2026 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 30, 2026. 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.

For purposes of step (4), above, in the calculation of APAD, for qualifying discharges, the APAD Base Payment will be adjusted as follows.

(1) For 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 67%.
(2) For Massachusetts Acute Hospitals that (i) are not Freestanding Pediatric Acute Hospitals, and (ii) maintain between 1 and 15 pediatric beds as determined by EOHHS, the APAD Base Payment will be adjusted to include an additional 25% for discharges of patients who are under 21 years of age.
(3) For Massachusetts Acute Hospitals that (i) are not Freestanding Pediatric Acute Hospitals, and (ii) do not maintain between 1 and 15 pediatric beds as determined by EOHHS, the APAD Base payment will be adjusted to include an additional 6% for discharges of patients who are under 21 years of age.

Table 1, below, illustrates the calculation of the Total Case Payment for a standard APAD claim that does not qualify for an Outlier Payment under Section 5.B.2. Values are for demonstration purposes only and illustrate the calculation from statewide operating and capital standards to the final APAD payment amount. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 1: Standard APAD Claim

Line	Description	Value	Calculation or Source
1	Statewide Operating Standard per Discharge	$11,423.66	RY27 RFA
2	Hospital's Massachusetts-specific wage area index	1.03657	Varies by hospital
3	Labor Factor	0.67615	RY27 RFA
4	Hospital's Wage Adjusted Operating Standard per Discharge	$11,706.13	$(Line\ 1 \times Line\ 2 \times Line\ 3) + (Line\ 1 \times (1 - Line\ 3))$
5	Statewide Capital Standard per Discharge	$792.37	RY27 RFA

6	APAD Base Payment	$12,498.50	$Line\ 4 + Line\ 5$
7	MassHealth DRG Weight	0.3300	**Appendix C**, Chart C
8	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$4,124.51**	$Line\ 6 \times Line\ 7$

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.

Tables 2 is an illustrative example of the calculation of the Total Case Payment for claims involving an Outlier Payment. Values shown are for demonstration purposes only. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 2: Claim with Outlier Payment

Line	Description	Value	Calculation or Source
1	APAD (must be >$0)	$4,124.51	Table 1, Line 8
2	Allowed Charges	$80,000.00	Determined from claim
3	Hospital's Inpatient Cost-to-Charge Ratio	65%	FY22 Massachusetts Hospital Cost Report
4	Discharge-Specific Case Cost	$52,000	Line 2×Line 3
5	Fixed Outlier Threshold	$42,430	RY27 RFA
6	Discharge-Specific Outlier Threshold	$ 46,554.51	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%	RY27 RFA
9	Outlier Payment	$3,267.29	(Line $4 - Line\ 6) \times Line\ 8$

10	**Total Case Payment = APAD plus Outlier Payment**	**$7,391.80**	$Line\ 1 + Line\ 9$

3. Transfer Per Diem Payments

a. Transfer Between Hospitals

A Hospital that transfers a patient to another Acute Hospital will be paid on a per diem basis (the "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 **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 43 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 RY27 that are paid on a Transfer Per Diem basis.

Table 3 is an illustrative example of calculation of the Transfer Per Diem, Total Transfer Payment Cap, and Total Transfer Case Payment under **Section 5.B.3** for a claim with transfer, with (APAD only (i.e., without outlier). Values are for demonstration purposes only. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 3: Claim with Transfer (APAD Only)

Line	Description	Value	Calculation or Source
1	APAD (Total Case Payment Amount)	$4,124.51	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	2.19	**Appendix C**, Chart C
4	Transfer per diem	$1,883.34	$\frac{Line\ 1}{Line\ 3}$
5	Transfer per diem x Patient length of stay (# of days)	$3,766.68	$Line\ 4 \times Line\ 2$
6	Total Transfer Payment Cap	$4,124.51	Line 1
7	**Total Transfer Case Payment**	**$3,766.68**	**Lower of Line 5 or Line 6**

Table 4. Illustrates the calculation of the Transfer Per Diem, Total Transfer Payment Cap, and

Total Transfer Case Payment under **Section 5.B.3** for a claim with a transfer, using the APAD with Outlier. Values are for demonstration purposes only. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 4: Claim with Transfer (APAD and Outlier)

Line	Description	Value	Calculation or Source
1	Total Case Payment Amount (Claim with Outlier Payment)	$7,391.80	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	2.19	**Appendix C**, Chart C
4	Transfer per diem	$3,375.25	$\frac{Line\ 1}{Line\ 3}$
5	Transfer per diem x Patient length of stay (# of days)	$6,750.50	$Line\ 4 \times Line\ 2$
6	Total Transfer Payment Cap	$7,391.80	Line 1
7	**Total Transfer Case Payment**	**$6,750.50**	**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's 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.

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 RY22 were applied to the rate calculated above to determine the RY27 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.

Table 4.1: Inpatient Admission Category

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. 1. The Member is aged 14 years old to 17 years old (inclusive); or 2. The Member has a diagnosis of Autism Spectrum Disorder or Intellection Disability Disorder (ASD/IDD); or 3. The Member has a diagnosis of an eating disorder; or 4. 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 5. The member is admitted to a hospital identified by CHIA as a teaching hospital; (HFY 2024 Massachusetts Hospital Profiles-January 2026); AND 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. 1. The Member is aged 13 years old or below; or 2. The Member is aged 65 years old or above; or 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.

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
(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. 1. The Member is aged 14 years old to 17 years old (inclusive); or 2. The Member has a diagnosis of ASD/IDD; or 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 4. The Member has a diagnosis of an eating disorder; or 5. The member is admitted to a hospital identified by CHIA as a teaching hospital; (HFY 2024 Massachusetts HospitalProfiles-January 2026); AND 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. 1. The Member is aged 13 years old or below; or 2. The Member is aged 65 years old or above; or 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 B3 rate—$3,625 per admission

g. Long-Acting Injectable (LAI) Antipsychotics

(1) LAI Antipsychotics Prior Approval Requirements

Drug-specific prior authorization requirements must be met, as described on the *Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units* document, published on the MDHL.

(2) Payment for LAI Antipsychotics

a. MassHealth will only pay for LAI Antipsychotics that are administered to Members during an in-state hospital behavioral health (BH) inpatient admission, and such LAI

Antipsychotics shall be paid for in addition to the appropriate inpatient psychiatric per diem rate. Hospitals will be paid for LAI Antipsychotics at the fee schedule rates in 101 CMR 317.00: *Rates for Medicine Services*, which incorporate by reference the rates for LAI Antipsychotics listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File. For LAI Antipsychotics not listed in the fee schedule, payment is set by Individual Consideration (IC).

b. The Hospital must claim separate payment for LAI Antipsychotics in accordance with applicable MassHealth billing instructions, including, without limitation, as set forth herein, in MassHealth billing instructions and in any special billing instructions for LAI Antipsychotics administered during an in-state hospital BH inpatient admission that may be published under "Billing Tips" on the MassHealth web page mass.gov/service-details/billing-tips. EOHHS may update the billing instructions from time to time.

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), and 101 CMR 320.00 (*Rates for Clinical Laboratory Services*), or successor regulations as applicable (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual charge submitted.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are not reimbursable separately. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in Section 2. 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 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 $281.78, which represents the median nursing facility rate that was effective October 1, 2023, 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 $384.97 for Medicaid/Medicare Part B-eligible patients and $416.29 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 RY27 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's 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 web page 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

In-State Acute Hospitals

(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 web page mass.gov/druglist. 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 web page.

(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 web page mass.gov/service-details/billing-tips, EOHHS may update the billing instructions from time to time. See also **Section 5.G.**
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.

vi. 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's 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; and

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), 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’s 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.

10. Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders Per Diem

The Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders per diem rate is a daily rate of $1,936.21, payable instead of the standard Psychiatric Per Diem rate under Section 5.B.4.f.(1), and payable once per day per Member under 21 years of age with a diagnosis of ASD/ID for whom the Hospital renders one or more services meeting the definition of Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders,

in accordance with Appendix L. The Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders per diem rate is not payable on days meeting the definition of Administrative Day, and such days shall be paid at the Administrative Day rate under Section 5.B.6.

11. Behavioral Health Crisis Evaluation in Medical/Surgical Units

Hospitals providing Behavioral Health Crisis Evaluations to Members experiencing Behavioral Health Crises in medical/surgical beds, in accordance with **Appendix I**, shall be paid at the same rate established in Section 5.C.11 up to once per day per member receiving such services, in accordance with **Appendix I.**

12. Behavioral Health Crisis Management Services in Medical/Surgical Units

Hospitals providing Behavioral Health Crisis Management Services to Members experiencing behavioral health crises in medical/surgical beds, in accordance with **Appendix K**, shall be paid at the same rate established in **Section 5.C.16** up to once per day per member receiving such services, in accordance with **Appendix K.**

13. Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members in Medical/Surgical Units

Hospitals providing recovery support navigator services and recovery support navigator services for pregnant and postpartum Members to Members in medical/surgical beds, in accordance with **Appendix N**, shall be paid at the same rates established in **Section 5.C.17** up to once per day per member receiving such services, in accordance with **Appendix N**.

14. Reserved

15. Specialty Inpatient Psychiatric Service for Eating Disorder Per Diem Payments

The Specialty Inpatient Psychiatric Service for Eating Disorder per diem rate is a daily rate of $1,500, payable instead of the standard Psychiatric Per Diem rate under Section 5.B.4.f.(1), and payable once per day per Member with a diagnosis of Eating Disorder for whom the Hospital renders one or more services meeting the definition of Specialty Inpatient Psychiatric Service for Eating Disorder, in accordance with Appendix O. The Specialty Inpatient Psychiatric Service for Eating Disorder per diem rate is not payable on days meeting the definition of Administrative Day, and such days shall be paid at the Administrative Day rate under Section 5.B.6.

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's BH Contractor, or a contract between the Acute Hospital and an MCO, as applicable, and that are provided to MassHealth Members enrolled with EOHHS's 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 the RFA.

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

In-State Acute Hospitals

Except as otherwise provided for Outpatient Services specified in Section 4.C and Sections 5.C.3 through 5.C.18, 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**.

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 2027 APEC

For dates of service in RY27, 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**.

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 January 1, 2023.

(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 the RY24 Massachusetts 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 FY21 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 FY22 cost report. The Hospital-specific Episodes and related charges were determined by EOHHS based on paid claims for Episodes residing in MMIS as of May 21, 2023, 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 calculation of each hospital standardized cost per episode, which is unchanged from the methodology used in the RY24 – RY26 RFAs, is calculated as follows.

The labor portion of the average outpatient cost per Episode for each Hospital was adjusted by the Hospital's RY24 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 FY21 Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific FY21 Outpatient CMI was determined based on FY21 paid claims data residing in MMIS as of May 21, 2023, for which MassHealth was primary payer. EOHHS calculated each Hospital's FY21 Outpatient CMI by summing the Hospital's FY21 grouper-adjusted EAPG weights for each of its APEC-paid Episodes during FY21, as determined by EOHHS, and then dividing that sum by the Hospital's total number of APEC-paid Episodes in FY21, 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 FY21 MassHealth Episodes for the Hospitals was produced from MMIS paid claims on file as of May 21, 2023, 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 applicable to RY27 is unchanged as compared to RY24 at $854.95.

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 RY21 and RY24, and then dividing that result by a conversion factor of 1.2303. The APEC Outpatient Statewide Standard is $645.96. For Episodes that extend past midnight in the case of Emergency Department Services, or Observation 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, determined as described in Section 5.C.1.b(1)(a)1, by the Hospital's RY27 Massachusetts-specific wage area index,

determined as described in Section 5.B.1.e, and (2) adding this amount to the non-labor portion of the APEC Outpatient Statewide Standard, determined as described in Section 5.C.1.b.(1)(a)1.

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 $823.67. For Episodes that extend past midnight in the case of Emergency Department Services, or Observation Services, the Wage Adjusted APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode.

The chart below lists the Wage Adjusted APEC Outpatient Standard for Acute Hospitals identified as Group 1 safety net hospitals in Appendix N to the MassHealth 1115 waiver.

Table 4.2: Group 1 Safety Net Hospital Wage Adjusted APEC Outpatient Standard

HOSPITAL	WAGE ADJUSTED APEC OUTPATIENT STANDARD
Group 1 Hospitals that are High Medicaid Volume Safety Net Hospitals	$702.77
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Boston	$731.77
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Springfield	$674.64
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Cambridge-Newton-Framingham	$715.53

For Episodes that extend past midnight in the case of Emergency Department Services, or Observation 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 Solventum 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 Solventum 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 Solventum 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 FY22 Outpatient CCR, calculated by EOHHS using the Hospital's FY22 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]**) and the Fixed Outpatient Outlier Threshold of $4,460. 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).

Tables 5 through 5.6 together provide an illustrative example of calculating an APEC for an episode claim containing multiple EAPGs. The relevant example EAPGs for Tables 5.2 through 5.6, respectively are 290 for PET Scans, 220 for Level II Nervous System Injections including Cranial Tap, 220 for Level II Nervous System Injections including Cranial Tap, 299 for Level I Computed Tomography, and 305 for Level I Surgical Pathology Tests. Values shown are for demonstration purposes only.

Table 5: Example of Hospital's RY27 APEC Calculation for a Single Episode

Line	Description	Value	Calculation or Source
1	Episode-Specific Total EAPG Payment	$2,835.53	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)
2	Episode's Total Allowed Charges	$32,300.00	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 FY22 Massachusetts Hospital Cost Report
4	Episode-Specific Case Cost	$19,380.00	$Line\ 2 \times Line\ 3$
5	Fixed Outpatient Outlier Threshold	$4,460.00	RY27 RFA
6	Episode-Specific Outlier Threshold	$7,295.53	$Line\ 1 + Line\ 5$

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%	RY27 RFA
9	**APEC Outlier Component (only calculated if Line 1>$0)**	$7,250.68	$(Line\ 4 - Line\ 6) \times Line\ 8$
10	**APEC for the Episode**	$10,086.21	$Line\ 1 + Line\ 9$

Table 5.1: Example of Hospital's Wage Adjusted APEC Outpatient Standard

Line	Description	Value	Calculation or Source
1	APEC Outpatient Statewide Standard	$645.96	RY27 RFA
2	Hospital's Massachusetts-specific wage area index	1.03657	Varies by hospital, determined annually
3	Labor factor	60%	RY27 RFA
4	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	$(Line\ 1 \times Line\ 2 \times Line\ 3) + (Line\ 1 \times (1 - Line\ 3))$

Table 5.2: Example of First Claim Detail Line EAPG Payment Amounts (EAPG of 290)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	2.2567	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	2.2567	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$1,489.72	$Line\ 1 \times Line\ 4$

Table 5.3: Example of Second Claim Detail Line EAPG Payment Amounts (EAPG of 220)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$20,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.9652	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	1.9652	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment	$1,297.29	$Line\ 1 \times Line\ 4$

	amount		

Table 5.4: Example of Third Claim Detail Line EAPG Payment Amounts (EAPG of 220)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.9652	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	-	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	$Line\ 1 \times Line\ 4$

Table 5.5: Example of Fourth Claim Detail Line EAPG Payment Amounts (EAPG of 299)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$2,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.1471	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	0.0735	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$48.52	$Line\ 1 \times Line\ 4$

Table 5.6: Example of Fifth Claim Detail Line EAPG Payment Amounts (EAPG of 305)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$300.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.0591	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	-	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	$Line\ 1 \times Line\ 4$

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) The Hospital shall offer Behavioral Health Crisis Evaluations as described 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.

(3) 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 the 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*), and 101 CMR 320.00 (*Rates for Clinical Laboratory Services*), or successor regulations as applicable (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge for physician fees; or (3) the Hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than Hospital-Based Physicians as defined in **Section 2**.

c. Hospitals will be reimbursed for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-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 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 and Anesthesia fee schedule at 101 CMR 316.00, or successor regulations as applicable (available at the State House Bookstore and at mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html).

(2) The Hospital's Usual and Customary Charge, which, for the purposes of this Section 5.C.5.a, shall not exceed the amount the hospital charges any contracted laboratory to conduct laboratory services on behalf of the Hospital; 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 web page mass.gov/druglist. 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 web page.

(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 web page 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 Crisis Evaluations in the Emergency Department

Hospitals providing Behavioral Health Crisis Evaluations in accordance with **Appendix I** to Members experiencing Behavioral Health Crises will be paid at a rate of $695.29 per day per Member receiving such services. This payment is only for the first calendar day in which a Member receives a Behavioral Health Crisis Evaluation; any subsequent days of required Behavioral Health Crisis supports in the ED may be paid under **Section 5.C.16**. Payments under this **Section 5.C.11** are 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.

12. Reserved

13. Reserved

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 web page mass.gov/druglist. 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 web page.

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 web page cms.gov/medicare/medicare-part-b-drug-average-sales-price/asp-pricing-files (2026 ASP Drug Pricing).

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) is a targeted case management (TCM) service rendered by MassHealth providers participating in CARES in accordance with 130 CMR 405.477, 130 CMR 410.482, or 130 CMR 433.485 to members under the age of 21 who satisfy the eligibility criteria set forth in such regulations. Effective for dates of service on or after July 7, 2023, Hospitals providing outpatient CARES services in accordance with 130 CMR 410.482 will be reimbursed as the rate listed in 101 CMR 317.00, et seq.

16. Behavioral Health Crisis Management Services in the Emergency Department

Hospitals providing Behavioral Health Crisis Management Services in accordance with **Appendix K** to Members experiencing Behavioral Health Crises will be paid per day per Member receiving such services, at a rate of either $325.64 for Level 1 Behavioral Health Crisis Management Services or $653.64 for Level 2 Behavioral Health Crisis Management Services, dependent on clinical presentation and intensity of services, as described in **Section III.B** of **Appendix K**. Payments under this **Section 5.C.16** are 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, provided, however, that for any date of service for which the Hospital submits a claim for a Behavioral Health Crisis Evaluation for the same Member under **Section 5.C.11**, the hospital may not bill for Behavioral Health Crisis Management Services under this **Section 5.C.16.**

17. Payment for Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members Provided in the Emergency Department and Outpatient Department

a. Hospitals providing Recovery Support Navigator Services in accordance with **Appendix N** to Members in the ED will be paid for such services at the rate established for code H2015-HF in 101 CMR 444.00 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.

b. Hospitals providing Recovery Support Navigator Services for Pregnant and Postpartum Members in accordance with **Appendix N** to Members in the ED and/or Outpatient Department may bill for such services using code H2015-HF-HD and will be paid at individual consideration for the service, in accordance with 101 CMR 444.01(4), until an appropriate rate is established for this service in regulation 101 CMR 444.04. 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.

c. Hospitals may not bill for Hospital-Based Physician services related to the provision of Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members in the Emergency Department or Outpatient Department.

18. Payment for Initiation of Medication for the Treatment of OUD in the ED

Hospitals providing Initiation of Medication for the Treatment of OUD to Members in the ED (ED MOUD), in accordance with **Appendix M**, shall be paid for such ED MOUD services at a non-facility fee rate of $52.90 and a facility fee rate of $49.41. 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.

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 FY25 public payer percentage, which is the ratio of the Hospital's FY25 Gross Patient Service Revenue from government payers and free care to the Hospital's FY25 Gross Patient Service Revenue ("FY25 Public Payer Percentage"), must exceed 63% ("High Public Payer Threshold"), as determined by EOHHS based on the Hospital's FY25 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 FY27 Accountable Care Partnership Plan (ACPP) and Primary Care ACO discharge volume, 20% of the Hospital's FY27 MCO discharge volume, and 20% of the Hospital's FY27 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 FY25 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.

- 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 FY27 ACPP and Primary Care ACO episode volume, 20% of the Hospital's FY27 MCO episode volume, and 20% of the Hospital's FY27 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 FY25 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.
- 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, FY27 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 FY27 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 FY27, respectively, and residing in the MassHealth Data Warehouse as of March 31, 2028, and for the PCC plan and Primary Care ACO discharges and episodes, Medicaid paid claims data for FY27 residing in MMIS as of March 31, 2028 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 RY27 High Public Payer Supplemental Payment pursuant to **Section 5.D.1** of the RFA, (2) operate at least one DMH-Licensed Bed throughout RY27, and (3) have provided Inpatient Behavioral Health Services to MassHealth members in FY25. 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**.

(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.

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

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 FY25, using data residing in MMIS and/or the Data Warehouse as of March 31, 2026.

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

"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, 2026, 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 October 1, 2025, through September 30, 2026. 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, 2026 through September 30, 2027, as described in **Section 5.D.7.c**. Subject to this **Section 5.D.7**, all sections of this RY27 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 RY27, 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 RY27, 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 FY22 CMS-2552-10 cost report, by the Hospital's number of FY22 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY22 paid claims data residing in MMIS as of May 4, 2023, for which MassHealth is the primary payer.

2. EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY22 and RY24, 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 FY22 inpatient casemix index (CMI), as determined by EOHHS.

4. EOHHS then multiplied the result by 0.964

5. 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 RY27.

6. 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**.

Table 6. Illustrates the calculation of the Total Case Payment for a CAH standard APAD claim that does not qualify for an Outlier Payment. Values shown are for demonstration purposes only. This illustrative example calculation uses a DRG of 203 (chest pain) and an SOI of 2.

Table 6: DRG Model Example - Critical Access Hospital Interim APAD Claim

Line	Description	Value	Calculation or Source
1	RY27 CAH-Specific Total Standard Rate per Discharge	$15,000.00	RY27 RFA
2	MassHealth DRG Weight	0.3300	**Appendix C**, Chart C
3	**Adjudicated Payment Amount per Discharge (Interim APAD)**	**$4,950.00**	$Line\ 1 \times Line\ 2$

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**.

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 RY27, 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 RY27, 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 FY22 CMS-2552-10 cost report by the Hospital's number of FY22 Medicaid (MassHealth) Episodes. The Hospital's Medicaid (MassHealth) Episode volume was derived from FY22 paid claims data residing in MMIS as of May 4, 2023, 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 RY22 and RY24, 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 FY22 outpatient casemix index (CMI), as determined by EOHHS.

4. EOHHS then multiplied the result by 0.964

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

6. 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-RY27 Cost Review and Settlement

Each Critical Access Hospital must timely complete all Medicaid (Title XIX) data worksheets on CMS-2552 cost reports for FY27 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, 2027, 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-RY27 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 FY27, as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY27 CMS-2552-10 cost reports and such other information that EOHHS determines is necessary, to perform this post RY27 review. "Aggregate interim payments" for this purpose shall include all hospital payments made under the RY27 RFA as determined by EOHHS, but exclude any supplemental payments under Section 5, Section 7B, or Section 8.A of the RY27 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 RY27 review and settlement will take place within approximately twelve (12) months after the close of RY27, 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-RY27 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. Reserved

10. Reserved

11. Reserved

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 is paid from two pools:

a. Pool 1 is $225.6 million, calculated by multiplying $480 million by 47%.

b. Pool 2 is $41.36 million, calculated by multiplying $88 million by 47%.

(2) To determine each in-state acute care hospital's Pool 1 adjusted inpatient discharge add-on amount, EOHHS will:

a. First, divide the inpatient add-on Pool 1 by the total number of RY27 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, 2028, to determine the Pool 1 inpatient add-on amount per discharge.

b. Second, multiply the total number of RY27 inpatient discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 1 inpatient add-on amount per discharge, to determine the hospital-specific Pool 1 inpatient add-on payment amounts.

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

a. First, divide the inpatient add-on Pool 2 amount by the total number of RY27 in-state acute care hospital inpatient fee-for-service discharges, as determined by EOHHS based on paid claims on file as of March 31, 2028, to determine the Pool 2 inpatient add-on amount per discharge.

b. Second, multiply the total number of RY27 fee-for-service discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 2 inpatient add-on amount per discharge, to determine the hospital-specific Pool 2 inpatient add-on payment amounts.

(4) To determine each in-state acute care hospital's total final hospital-specific inpatient add-on amounts, EOHHS will add the hospital-specific Pool 1 inpatient add-on payment amounts described in **Section 5.D.12.a(2)** and the hospital-specific Pool 2 inpatient add-on payment amounts described in **Section 5.D.12.a(3)**.

(5) For each hospital, subtract the total hospital-specific interim inpatient add-on payments received in RY27, calculated as described in **Section 5.D.12.a(6)**, from hospital-specific final inpatient add-on payment amounts, calculated as described in **Section 5.D.12.a(4)** 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**.

(6) EOHHS will make interim inpatient add-on payments in RY27. For each interim inpatient add-on payment, a new inpatient add-on amount per discharge will be calculated by dividing the Pool 1 and Pool 2 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(6)**, 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 is paid from two pools:

a. Pool is $254.4 million, calculated by multiplying $480 million by 53%.

b. Pool 2 is $46.64 million, calculated by multiplying $88 million by 53%.

(2) To determine each in-state acute hospital's Pool 1 adjusted outpatient episode add-on payment amount, EOHHS will:

a. First, divide the outpatient add-on Pool 1 by the total number of RY27 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, 2028, to calculate the Pool 1 outpatient add-on payment amount per episode.

b. Second, multiply the total number of RY27 outpatient episodes for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31,

2028, by the Pool 1 outpatient add-on payment amount per episode, to calculate the Pool 1 outpatient add-on payment amount.

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

a. First, divide the outpatient add-on Pool 2 amount by the total number of RY27 in-state acute care hospital outpatient fee-for-service discharges, as determined by EOHHS based on paid claims on file as of March 31, 2028, to determine the Pool 2 outpatient add-on amount per discharge.

b. Second, multiply the total number of RY27 fee-for-service discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 2 outpatient add-on amount per discharge, to determine the hospital-specific Pool 2 outpatient add-on payment amounts.

(4) To determine each in-state acute care hospital's total final hospital-specific outpatient add-on amounts, EOHHS will add the hospital-specific Pool 1 outpatient add-on payment amounts described in **Section 5.D.12.b(2)** and the hospital-specific Pool 2 outpatient add-on payment amounts described in **Section 5.D.12.b(3).**

(5) For each hospital, subtract the total hospital-specific interim outpatient add-on payments received in RY27, as calculated as described in **Section 5.D.12.b(6)**, from hospital-specific final outpatient add-on payment amounts, calculated in **Section 5.D.12.b(4)**, 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**.

(6) EOHHS will make interim outpatient episode add-on payments in RY27. 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(6)**, 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. Requirements and Payments for Telehealth

MassHealth will pay for telehealth services rendered through the hospital in accordance with MassHealth telehealth policies and billing guidance established through MassHealth provider bulletins or other MassHealth publications. This includes, but is not limited to, any limitations on facility payments to hospitals for telehealth services that may be included in MassHealth provider bulletins or other MassHealth publications.

14. Reserved

15. Reserved

16. Reserved

17. Reserved

18. Reserved

19. Reserved

20. Reserved

21. MassHealth Targeted Hospital Supplemental Payments

a. Eligibility Criteria

(1) To be eligible for a targeted hospital supplemental payment, a hospital must be

(a) Reserved
(b) Reserved
(c) Reserved
(d) Reserved
(e) Reserved

(2) In addition, to qualify for a targeted hospital supplemental payment, a Hospital meeting the eligibility criteria set forth above must

(a) enter into a separate payment agreement or agreements with EOHHS relating to receipt of such payment; and

(b) satisfy any conditions of such payment agreement(s), including by providing any attestation(s) that EOHHS may require, in a form and format to be prescribed by EOHHS.

b. Payment Methodology

(1) EOHHS will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in Section 5.D.21.a. according to the following methodology.

(a) Reserved
(b) Reserved
(c) Reserved
(d) Reserved
(e) Reserved

22. Reserved

23. Reserved

24. Reserved

25. Reserved

26. Inpatient Psychiatric Supplemental Payments

In-State Acute Hospitals

In addition to other payments set forth in Section 5.D, EOHHS will make a supplemental payment in Rate Year 2027 to eligible hospitals for a one-time Psychiatric Inpatient Supplemental Payment, as set forth in this **Section 5.D.26**.

a. Definitions

For the purposes of this Section 5.D.26, the following definitions apply.

(1) "Claims Period" shall mean the twelve-month period July 1, 2025, through June 30, 2026.

(2) "Aggregate Psychiatric Admission" shall mean the total number of paid claims for all MassHealth members for the Claims Period as of January 1, 2027, across the eligible Hospitals inpatient psychiatric admissions, including applicable subsets of such claims, as designated in the Payment Methodology described in Section 5.D.26.c.

(3) "Inpatient Psychiatric Admissions" shall mean the Hospital's total number of paid claims for all MassHealth members for the Claims Period as of January 1, 2027 for inpatient psychiatric admissions, including applicable subsets of such claims, as designated in the Payment Methodology described in Section 5.D.26.c.

b. Eligibility

To be eligible for an Inpatient Psychiatric Supplemental Payment under this **Section 5.D.26**, a Hospital must

(1) operate at least one service location providing psychiatric Inpatient Services; and

(2) maintain at least one inpatient bed that is licensed by DMH as a psychiatric bed as of October 1, 2026.

c. Payment Methodology

Inpatient Psychiatric Supplemental Payments under this **Section 5.D.26** will equal a total aggregate amount of $33 million, apportioned to eligible Hospitals as follows.

(1) The supplemental payment for each eligible Hospital will be determined based on the Claims Period. Each eligible Hospital will receive one supplemental payment amount reflecting three component calculations, as follows.

(a) Percentage of Inpatient Psychiatric Admissions by Hospital. $15 million will be distributed proportionally to eligible Hospitals based on total inpatient psychiatric admissions as follows.

$$\frac{(Hospital - Specific\ Psychiatric\ Admissions\ )}{Aggregate\ Psychiatric\ Admissions)} \times \$15{,}000{,}000$$

(b) Percentage of Claims with Certain Secondary Diagnoses. $15 million will be distributed proportionally to each eligible Group A Hospital based on inpatient psychiatric admissions with at least one secondary diagnosis on the claim related to

one or more of the following: renal, endocrinology, circulatory, substance use disorder, and/or gastroenterology, as follows.

$$\frac{(Hospital - Specific\ Psychiatric\ Admissions\ with\ applicable\ secondary\ diagnoses\ )}{(Aggregate\ Psychiatric\ Admissions\ with\ applicable\ secondary\ diagnoses)} \times \$15{,}000{,}000$$

(c) Percentage of Members Admitted following the EPIA Protocol. $3 million will be distributed proportionally to each eligible Hospital based on inpatient psychiatric admissions following the EPIA protocol as follows.

$$\frac{(Hospital - Specific\ Psychiatric\ Admissions\ following\ EPIA\ protocols}{(Aggregate\ Psychiatric\ Admissions\ following\ EPIA\ protocols)} \times \$3{,}000{,}000$$

(2) EOHHS will combine the Hospital's resulting payment amounts from each component as outlined in **Sections 5.D.26.B.1.a** through **c.** to calculate the total supplemental payment amount for each eligible Hospital.

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 the 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 the 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 the RFA exceed any applicable federal Hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and limits based on federally approved payment methods, 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 the RFA exceed applicable federal aggregate payment limits, including, but not limited to, upper payment limits provided for in federal law, regulations, and the Commonwealth's 1115 waiver, EOHHS may exercise its discretion to apportion 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, 2026, and who remain at acute inpatient status on or after October 1, 2026, at the Hospital's MassHealth rates and payment methods established prior to this RY27 RFA, and at the Hospital's MassHealth rates and payment methods established in this RY27 RFA for inpatient services provided to MassHealth members who are admitted on or after October 1, 2026.

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 RY27 RFA apply to dates of service prior to October 1, 2026, and the Hospital's RY27 RFA rates and payment methods apply to dates of service on or after October 1, 2026. 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 RY26, then the APEC methodology under the RY26 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's 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 the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, EOHHS shall select such substitute data sources or other methodology(ies) that EOHHS deems appropriate in determining Hospitals' rates.

N. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital during the effective period of the RFA, EOHHS, in its sole discretion, shall determine on a case-by-case basis: (1) whether the Hospital qualifies for reimbursement under the RFA; and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of the RFA to the extent that EOHHS deems possible. EOHHS's determination shall be based on the totality of the circumstances. Any such rate may, in EOHHS's 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 the 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 the RFA are subject to the following provisions, as well as all other rules and regulations governing service limitations, claims payment, billing and claims processing procedures, utilization control requirements and all other MassHealth conditions of payment.

A. Services Requiring 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 maximum allowable amount payable under the MassHealth agency's payment methodology, 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

Executive Office of Health and Human Services
Office of Medicaid
Attn.: Claims Coordination Unit
UMass Chan Medical School
P.O. Box 2816
Worcester, MA 01613

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 APEC in effect October 1, 2026, from the applicable Hospital payment amount. Furthermore, the performance of a sterilization without meeting all such requirements may result in sanctions against the Hospital in accordance with 130 CMR 450.238 et seq. as well as the applicable provisions of the RFA.

E. 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.

Executive Office of Health and Human Services
Office of Medicaid
Casualty Recovery Unit
P.O. Box 15205
Worcester, MA 01615-0205
Phone: (800) 754-1864

Alternatively, the written notification may be emailed to the Casualty Recovery unit at casualtyrecoveryunit@umassmed.edu.

G. Reporting on Greenhouse Gas Emissions

To identify industry-specific goals to reduce greenhouse gas emissions and advance statewide goals, MassHealth requires each Hospital to report on its greenhouse gas emissions, and verify its reporting through partnership with an approved third party, as described below.

1. By January 15, 2027, or such other later date as directed by EOHHS, each Hospital must submit to MassHealth, in the form and manner directed by MassHealth, the following information.

a. The Hospital's designated staff member responsible for greenhouse gas emissions reporting under this **Section 6.G**, including the staff member's name, title, and contact information; and

b. The third party entity the Hospital intends to work with, upon MassHealth's approval, to validate the Hospital's greenhouse gas emissions reporting under this **Section 6.G**.

2. By June 30, 2027, or such other later date as directed by EOHHS, each Hospital must submit to MassHealth, in the form and manner directed by MassHealth and for the time period to be defined by MassHealth, the following information.

a. The Hospital's total Scope 1 emissions, defined as all emissions under the direct control of the Hospital, including but not necessarily limited to on-site fuel combustion, anesthetic gas, fleet vehicle gas or diesel use;

b. The Hospital's total Scope 2 emissions, defined as the Hospital's purchased energy; and

c. An attestation that such information is true, accurate, and in accordance with the data standards identified or determined by MassHealth.

H. MassHealth Copayments

For any Hospital service for which a Member copayment is applied pursuant to 130 CMR 450.130, EOHHS shall deduct the copayment amount from the applicable Hospital payment amount specified in the RFA. Hospitals may not refuse services to any Member who is unable to pay the copayment at the time the service is provided, and must otherwise comply with all applicable state and federal requirements regarding copayments.

In-State Acute Hospitals

Section 7. Reserved

Section 7B: Clinical Quality Incentive Program

This **Section 7B**, as further detailed in **Appendix J**, sets forth the MassHealth Clinical Quality Incentive (CQI) Program, including its quality measurement and reporting requirements, performance assessment methodology, and payment methodology for RY27. The CQI Program provides opportunities for Hospitals to earn incentive payments for quality reporting and performance on quality measures.

RY27 incentive payments described in **Section 7B** are contingent upon the Hospital's performance of all applicable requirements specified in **Section 7B**, as well as all requirements in **Appendix J**.

1. Clinical Quality Incentive (CQI) Program Requirements

The MassHealth CQI Program shall operate under the following principles.

a. Incentivize Hospitals to meet, excel, or improve quality of care delivered to MassHealth members, and reward Hospitals for doing so.

b. Evaluate Hospital performance for CQI Program incentive payments using the quality performance measures in Appendix J and the performance assessment methodology (PAM) in **Section 7B.4 and Appendix J**.

c. Calculate CQI Program incentive payments in accordance with the payment methodology set forth in **Section 7B.5**.

d. To be eligible for CQI Program incentive payments, Hospitals must adhere to each of the following standards.

(1) Data requirements

(a) Data Accuracy and Completeness: Hospitals shall ensure that all submitted data is complete and accurate, as described in **Appendix J**.

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

(c) Reporting Deadlines: Hospitals shall meet data submission deadlines set forth in the applicable EOHHS Technical Specifications Manual version. Failure to timely submit all data and reporting in the formats required by EOHHS may render the Hospital ineligible for some or all CQI Program incentive payments under this **Section 7B**; and

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

(2) Data Validation: Hospitals shall meet the minimum data reliability standards and pass data validation as defined in **Section 2.C** of **Appendix J**.

(3) Performance: Hospitals shall achieve quality standards and performance benchmarks, as defined in **Appendix J**, on all quality measures data.

e. All Hospitals participating in the MassHealth program and contracting with EOHHS are required to participate in CQI Program quality reporting for all eligible or applicable measures. A Hospital's performance with respect to the requirements in this **Section 7B** and **Appendix J** may affect its present and future participation in the MassHealth program and its rate of reimbursement, including the CQI Program incentive payments.

2. Hospital Key Quality Representative Requirements

Each Hospital must identify and designate two key quality representatives, with the appropriate expertise to inform, coordinate, and communicate with EOHHS on all aspects of the CQI Program requirements and associated amendments during RY27. The two key quality representatives shall be identified and act in accordance with, but not be limited to, the following responsibilities.

a. Serve as the primary contact for all correspondence pertinent to the Hospital's quality performance reports 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.

b. Identify the key staff responsible for obtaining and responding to a quarterly medical record request list and for accessing annual report results pertaining to all necessary measures listed on **Exhibit 1** of **Appendix J**, via the EOHHS designated secure portal, on the Hospital's behalf.

c. Designate the Hospital's MassHealth Quality Exchange (MassQEX) Portal users.

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

e. Use the EOHHS email address, MassHealthhospitalquality@mass.gov (Hospital Quality Inbox), to expedite communication between EOHHS and the Hospital on **Section 7B** requirements and comply with the following conditions that apply to use of the Hospital Quality Inbox.

(1) Only the two key quality representatives are automatically entered into the Hospital Quality Inbox distribution list. Requests to add other staff not listed on the Hospital Quality Contact Form to the Hospital Quality Inbox distribution list must be submitted via email to the Hospital Quality Inbox.

(2) Key quality representatives will receive ongoing updates from the Hospital Quality Inbox on quality reporting requirements and other quality-related initiatives during the Contract period.

(3) Key quality representatives are responsible for disseminating updates received from the Hospital Quality Inbox and communicating to all Hospital staff and/or third-party vendors involved in quality performance reporting.

f. 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 4.F** of **Appendix J**.

3. Hospital CQI Program Performance Measures

For RY27, EOHHS has adopted Hospital quality performance measures for the CQI Program that incentivize safe and high-quality care. Measures included in the CQI Program are drawn from

standard measures stewarded by nationally recognized quality measure developers. Further CQI Program Measure Detail is included in **Section 2** of **Appendix J**.

a. **CQI Program Measure Domains**

(1) CQI Program measures are grouped into four core quality measure domains (referred to as "Core Quality Measure Domain(s)") and two specialty quality measure domains (referred to as "Specialty Quality Measure Domain(s)").

(2) Measures are specified according to the standard specification, with few exceptions necessary for implementation in the context of the CQI Program. Any differences from the standard measures shall be identified and noted in the annual technical specifications and any relevant release notes, since such specifications and release notes may be amended and updated from time to time. The most current EOHHS Technical Specifications Manual is at mass.gov/masshealth-quality-exchange-massqex.

(3) Hospitals are required to report data for individual quality measures that are chart-based or data-entry based. Claims-based measures will be calculated by EOHHS. Registry data (e.g., safety measures) and Patient Experience (adult only) will be obtained by EOHHS through the National Health Safety Network and CMS, respectively.

b. ***Hospital Accountability***

Hospitals are accountable for performance on measures for which they are eligible, where the Hospital meets the measure specifications outlined in the EOHHS Technical Specifications Manual.

c. **Core Quality Measure Domains**

(1) All Hospitals must participate in four Core Quality Measure Domains: Care Coordination/Integration of Care; Care for Acute and Chronic Conditions; Patient Safety; and Patient Experience.

(2) Pediatric measures are also included in the Core Quality Measure Domains. Hospitals are required to report pediatric measures for which they are eligible, where the Hospital meets the measure specifications outlined in the EOHHS Technical Specifications Manual.

d. **Specialty Quality Measure Domains**

In addition to being accountable for performance for all measures in Core Quality Measure Domains, Hospitals may also be determined by EOHHS to be accountable for all measures for which they are eligible in one or more Specialty Quality Measure Domains. Specialty Quality Measure Domain participation and accountability will be determined by EOHHS based on type of Hospital and domain service lines provided.

e. **Other Specialty Hospital Measures**

In limited cases, a Hospital may provide primarily specialty care or limited services which limits measure eligibility and participation in the Core or Specialty Quality Measure Domains (e.g., orthopedic, enterology, cancer, or other care). In such cases, EOHHS or a Hospital providing specialty care not identified in the current domains may request further consultation to determine an option to incorporate additional measures that may be incorporated into the Core Quality Measure Domain for which they would be eligible. EOHHS shall make the final determination of this option on a case-by-case basis, and measures mutually agreed upon may be incorporated into future amendments, or Agreements.

4. Performance Assessment Methodology (PAM)

This **Section 7B.4**, in addition to **Section 3** of **Appendix J**, sets forth the Performance Assessment Methodology (PAM) for the CQI Program. EOHHS considers the following components and principles for its PAM.

a. **Standard Calculation Practices**
Standard practices will be used wherever possible to calculate measure performance calculations and to validate submitted data.

b. **Opportunity to Achieve Incentive Amount**
Each Hospital will have the opportunity to achieve its full eligible CQI Program incentive payment for excellent quality performance. This is achieved through design approaches such as

(1) establishing clear threshold and goal benchmarks for measures over a multiyear time period (e.g., five years) rather than for a single performance year only;

(2) opportunity to earn incentive for year-over-year self-improvement (e.g., gap to goal targets); and

(3) opportunity to earn CQI Program incentive payments through each measure based on attainment (e.g., meeting threshold, goal or in-between threshold and goal performance), and, as applicable, meeting targets for improvement.

c. **Simple Scoring and Payment**
Design approaches, including the following, will ensure simple scoring and payment processes.

(1) Utilizing measures that roll up to a domain score (e.g., sum of the Hospital points earned for each measure/the maximum number of points in a domain)

(2) Weighting domain scores to calculate a single overall quality score that

(a) includes 100% weighting of measure domains available to Hospitals; and

(b) does not exclude 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.

(3) Applying a single Hospital overall quality score (calculated as a ratio between 0 and 1) to the Hospital's CQI Program incentive payment (described in **Section 7B.5**).

d. **Alignment of PAM with Other EOHHS Programs**
EOHHS will align PAM components and approach with other programs where possible and as appropriate (e.g., ACOs, other Hospital programs, CMS), such as aligning practices for introducing new measures or payments.

e. **Flexibility for Extenuating Circumstances**
EOHHS will monitor the PAM and may amend the RFA to adjust the PAM to extenuating circumstances. Examples of significant extenuating circumstances that may reasonably necessitate adjustments to the PAM, through an RFA amendment, include

(1) EOHHS's determination that benchmarks are set too low or too high, through EOHHS's application of rules or safeguards to re-evaluate such benchmarks; and

(2) PHE or other unforeseen events impacting performance (e.g., COVID allowances).

5. CQI Program Incentive Payment Methodology

As set forth in this **Section 7B**, a Hospital may qualify to earn a CQI Program incentive payment, through its overall quality score calculated based on its quality measure performance.
The maximum CQI Program incentive payment that each Hospital is eligible to earn will be determined by its pro rata share of $250,000,000, across both MassHealth fee-for-service and managed care, using CY27 data, as follows.

a. The maximum eligible CQI Program incentive payment 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).

b. Each Hospital's maximum eligible CQI Program incentive payment will then be multiplied by the Hospital's overall quality score or ratio (0–1) assessed through the PAM to determine the Hospital's actual CQI Program incentive payment.

c. Each Hospital's maximum eligible CQI Program incentive payment component paid directly by MassHealth through the RFA will be in proportion to the inpatient and outpatient fee-for-service utilization.

6. CQI Reporting Requirements

Each Hospital must comply with all data reporting requirements, including, without limitation, data submission deadlines, performance evaluation periods, data reporting formats, portal registration requirements, and participant form submission requirements as set forth below, ***with additional detail found in Section 4 of Appendix J and in applicable EOHHS Technical Specifications.***

Reporting requirements include

a. reporting of chart-based measures on all relevant Medicaid payer codes;

b. timely submission of measures per performance evaluation period;

c. data accuracy and completeness requirements;

d. data reporting formats; and

e. submission of program participant reporting forms including

   (1) the MassHealth Hospital Quality Contacts Form, and

   (2) the MassHealth Hospital Data Accuracy and Completeness Attestation Form.

Forms are posted on the "MassHealth Quality Exchange" web page, mass.gov/masshealth-quality-exchange-massqex.

Section 8: Other Quality- and Performance-Based Payments

A. Hospital Quality and Equity Incentive Program (HQEIP) Requirements

1. HQEIP Program Requirements

The MassHealth HQEIP shall operate under the following principles.

a. Incentivize Hospitals to meet, excel, or improve quality and equity of care delivered to MassHealth members, and reward Hospitals for doing so, in accordance with the (i) this **Section 8.A**; (ii) "Hospital Quality and Equity Initiative Implementation Plan Performance Years 1-5" (HQEI PY1-5 IP), as amended and as approved by CMS and included as **Attachment J** to the Special Terms and Conditions of the MassHealth Medicaid Section 1115 Demonstration; and (iii) the applicable HQEIP Technical Specifications Manual and measure specifications for the performance year (PY).

(1) To be eligible for HQEIP incentive payments, Hospitals must adhere to the requirements outlined in the HQEI PY1-5 IP and the applicable HQEIP Technical Specifications Manual and measure specifications for the PY. All Hospitals participating in the MassHealth program and contracting with EOHHS are required to participate in the HQEIP, unless otherwise approved for exemption by MassHealth. A Hospital's performance with respect to the requirements in this **Section 8.A and**, the HQEI PY1-5 IP will affect its HQEIP incentive payments.

2. Hospital Key Quality and Equity Representative Requirements

Each Hospital must identify and designate two key HQEIP representatives, with the appropriate expertise to inform, coordinate, and communicate with EOHHS on all aspects of the HQEIP requirements described in this **Section 8.A**, the HQEI PY1-5 IP. The two key HQEIP representatives shall be identified and act in accordance with, but not be limited to, the following responsibilities.

a. Serve as the primary contact for all correspondence pertinent to the Hospital's HQEIP 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.

b. Identify the key staff responsible for providing, on the Hospital's behalf, reporting results pertaining to all necessary measures identified in the HQEIP Technical Specifications Manual.

c. Use the EOHHS email address, health.equity@mass.gov (Health Equity Inbox), to expedite communication between EOHHS and the Hospital about the HQEIP and comply with the following conditions that apply to use of the Health Equity Inbox.

(a) Only the two key HQEIP representatives are automatically entered into the email distribution list of the Health Equity Inbox. Requests to add other staff to this email distribution list must be submitted via email to the Health Equity Inbox.

(b) Key HQIEP representatives will receive ongoing updates from the Health Equity Inbox on reporting requirements and other programmatic updates during the Contract period.

(c) Key HQEIP representatives are responsible for disseminating updates received from the Health Equity Inbox to relevant Hospital staff and/or third-party vendors involved in HQEIP reporting.

3. Health Quality and Equity Committee

The Hospital shall have a Health Quality and Equity Committee (HQEC) designated by, and accountable to, the Hospital and its governing board. Such HQEC may be an existing health equity committee, so long as the committee meets the criteria of this **Section 8.A.3**.

The composition of the HQEC shall, to the extent possible, include individuals that represent the diversity of the MassHealth population. The HQEC shall have representation from various stakeholders of the Hospital, including, but not limited to,

a. hospital representatives;

b. at least two MassHealth Members or family members of MassHealth Members;

c. hospital clinical staff; and

d. frontline staff (e.g., community health workers).

Responsibilities of the HQEC include, but are not limited to,

a. developing and steering implementation of the Hospital's HQEIP strategy;

b. monitoring progress towards addressing disparities;

c. developing HQEIP reporting; and

d. sharing all relevant information with the Hospital's Patient and Family Advisory Counsel (PFAC).

4. Hospital HQEIP Performance Measures

For CY25 and CY26, EOHHS has adopted HQEIP performance measures that incentivize high-quality and equitable care. HQEIP performance measures are described in the HQEI PY1-5.

5. Performance Assessment Methodology (PAM)

Applicable HQEIP measure specifications accompanying the HQEI PY1-5 IP are set forth in the Performance Assessment Methodology (PAM) Manual for HQEIP, in **Sections 5.D** of the HQEI PY1-5 IP, and the Technical Specifications Manual for the PY, as applicable.

6. HQEIP Incentive Payment Methodology

Hospitals participating in the HQEIP are eligible to receive payments pursuant to this **Section 8.A.6**, in accordance with Section 4 of the HQEI PY1-5 IP. To be eligible to participate in the HQEIP and receive HQEIP payments, a Hospital must be an Acute Hospital that is not publicly owned and is affiliated with an ACO, and must meet minimum participation requirements established in the HQEIP PY1-5.

a. Each eligible Acute Hospital will be assigned to one of three HQEIP tiers (sometimes also referred to as the "Health Equity Pools"), as follows and as described in Section 4.A of the HQEI PY1-5 IP.

(1) Tier 1: HQEIP tier 1 will consist of Hospitals identified as Group 1 Safety Net Hospitals as described in Attachment N of Massachusetts's 1115 Demonstration;

(2) Tier 2: HQEIP tier 2 will consist of Hospitals identified as Group 2 Safety Net Hospitals as described in Attachment N of Massachusetts's 1115 Demonstration; and

(3) Tier 3: HQEIP tier 3 will consist of all Hospitals eligible to participate in the HQEIP that do not fall into HQEIP tier 1 or 2.

b. Total tier funding is set forth in Table 6 of Section 4.A of the HQEI PY1-5.

c. As set forth in Section 4.A of the HQEI PY1-5 IP,

(1) For Hospitals in HQEIP tier 1, each Hospital's maximum incentive payment will be equal to $1,000,000, plus its pro rata share of remaining HQEIP tier funding, determined by dividing each Hospital's FY19 Medicaid Gross Patient Service Revenues by all FY19 Medicaid Gross Patient Service Revenues within the HQEIP tier.

(2) For Hospitals in HQEIP tiers 2 and 3, each Hospital's maximum incentive payment will be equal to its pro rata share of its respective HQIEP tier funding, determined by dividing each Hospital's FY19 Medicaid Gross Patient Service Revenues by all FY19 Medicaid Gross Patient Service Revenues within the respective HQEIP tier.

d. An individual Hospital's final incentive payment will be equal to their maximum incentive payment multiplied by their Hospital health quality and equity score, of which 25% will be determined based on performance related to Domain 1, 50% related to Domain 2, and 25% related to Domain 3, as described in Section 5.C and Section 5.D, as applicable, of the HQEI PY1-5 IP.

e. Hospitals participating in and meeting relevant requirements for the HQEIP will receive quarterly interim payments as described in Section 4.A of the HQEI PY1-5 IP. Across the interim payments for CY26 and CY27, MassHealth will withhold 25% each year, of each hospital's maximum annual payment. As appropriate, the remaining 25% will be paid out as a reconciliation payment, as described in the PY1-5.

7. HQEIP Reporting Requirements

Each Hospital must comply with all data reporting requirements, including, without limitation, data submission deadlines, performance evaluation periods, data reporting formats, portal registration requirements, and participant form submission requirements as described in the HQEI PY1-5 IP, with additional detail found in applicable Technical Specifications for MassHealth Acute Hospital Health Quality and Equity Measures.

Hospitals must adhere to each of the following data requirement standards:

a. Data Accuracy and Completeness: Hospitals shall ensure that all submitted data is complete and accurate;

b. Measure Specifications: Hospitals shall comply with all data collection and submission guidelines, for all applicable measures listed in Section 3.C. of the HQEI PY1-5 IP, to ensure completeness and accuracy of data submitted; and

c. Reporting Deadlines: Hospitals shall meet applicable data submission deadlines set forth in the Technical Specifications Manual for the PY, as applicable. Failure to timely submit all data and reporting in the formats required by EOHHS may render the Hospital ineligible for some or all HQEIP incentive payments under this Section 8.A.

8. Reserved

9. Cambridge Health Alliance Health Quality and Equity Incentive Program

Pursuant to Appendix C of the HQEI PY1-5 IP , Cambridge Health Alliance, as a publicly owned acute hospital participating in the MassHealth program, may receive payments pursuant to the Cambridge Health Alliance Health Quality and Equity Incentive Program (CHA-HQEIP), in accordance with all requirements described in Appendix C of the HQEI PY1-5 IP.

All requirements in Section 8.A.1 through Section 8.A.8 are applicable to Cambridge Health Alliance, unless the CHA-HQEIP, included as Appendix C to the HQEI PY1-5 IP, or the CHA-HQEIP technical specifications document specify otherwise.

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's commitment to value-based purchasing and to helping 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 CFR 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**. 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**, 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**.

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 CFR 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 CFR 447.26(b). OPPCs may occur in any health care setting and are divided into two subcategories.

(1) **National Coverage Determinations (NCDs)**—Mandatory OPPCs under 42 CFR 447.26(b) that 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), the term "surgical or other invasive procedure" is as defined in CMS Medicare guidance on NCDs.

(2) **Additional Other Provider Preventable Condition (Additional OPPCs)**—State-defined OPPCs that meet the requirements of 42 CFR 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 Appendix V of the 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 manuals, 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 that 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**.

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**, 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 copayments 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 the RFA or Contract to implement any such laws, the Hospital agrees that, notwithstanding any other provision in the RFA and Contract, EOHHS may terminate the Hospital's Contract immediately upon written notice in the event the Hospital fails to agree to any such amendment.

6. Reporting to the Massachusetts Department of Public Health

In addition to complying with **Sections 8.B.1** through **5**, 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 sent to MassHealth must contain a cover letter that includes the patient's MassHealth ID, the event type, and the date of the event. Copies must be sent via secure email 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**, not **Section 8.C**.

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's 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** 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 the following.

(1) All services provided during the inpatient admission or outpatient visit during which a preventable SRE occurred.

(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 copayments or deductibles, deemed non-billable to MassHealth are not billable to the member.

(4) The non-payment provision of the 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 the email below. Copies of reports sent to MassHealth must contain a cover letter that includes the patient's MassHealth ID, the event type, and the date of the event. Copies must be sent 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**, 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 email set forth in **Section 8.C.3.b**, 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.

(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) MassHealth may request additional information, such as a copy of the member's medical record for the inpatient Hospital admission or outpatient episode of care during which the SRE occurred.

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**.

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

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 that 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.