

Notice of Proposed Agency Action

SUBJECT: MassHealth: Payment for In-State Acute Hospital Services and Out-of-State Acute Hospital Services, effective November 1, 2019

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 2020 (RY20), which begins November 1, 2019, and ends October 31, 2020 (see Attachment A to Part I).

Part II of this notice describes and summarizes proposed changes in MassHealth payment for services provided by in-state acute hospitals, effective for RY20, which begins November 1, 2019, and ends October 31, 2020. A complete description of the RY20 MassHealth in-state acute hospital inpatient and outpatient payment methods is attached to Part II (see also Attachment B for RY20 in-state acute hospital rates and rate components). For further information regarding RY20 acute hospital payment methods and rates, or to provide written comments, you may contact Steven Sauter at the Executive Office of Health and Human Services, MassHealth Office of Providers and Pharmacy Programs, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or by email at steven.sauter@state.ma.us. EOHHS specifically invites comments regarding the impact of the proposed changes on member access to care.

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

1. Out-of-State Acute Inpatient Hospital Services

In RY20, the MassHealth out-of-state acute inpatient hospital payment methodologies are generally unchanged from RY19. However, as a result of changes to the in-state acute inpatient hospital rates and rate components described in Part II.1 of this notice, the corresponding out-of-state acute inpatient hospital rates and rate components will also be changing effective with RY20 (see Attachment A to Part I of this notice).

Out-of-State Acute Inpatient Hospital Payment Methods

Except as provided in Section 3 of Part I, the out-of-state acute inpatient hospital payment methods applicable to RY20 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) Weight¹ assigned to the discharge by MassHealth using information contained on a properly submitted inpatient hospital claim.

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

- **Out-of-State Outlier Payment.** For qualifying discharges, out-of-state acute hospitals will also continue to be paid an outlier payment in addition to the Out-of-State APAD if the calculated cost of the discharge, as determined by MassHealth, exceeds the discharge-specific outlier threshold (“Out-of-State Outlier Payment”). The Out-of-State Outlier Payment will equal the marginal cost factor in effect for in-state acute hospitals, multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold, as determined by MassHealth. The “calculated cost of the discharge” equals the out-of-state acute hospital’s allowed charges for the discharge,² as determined by MassHealth, multiplied by the applicable inpatient cost-to-charge ratio. For High MassHealth Volume Hospitals,³ the cost-to-charge ratio is hospital-specific; for all other out-of-state acute hospitals, the median in-state acute hospital inpatient cost-to-charge ratio in effect, based on MassHealth discharge volume, is used. The “discharge-specific outlier threshold” equals the sum of the hospital’s Out-of-State APAD for the discharge, and the inpatient fixed outlier threshold in effect for in-state acute hospitals.
- **Out-of-State Transfer per Diem.** For MassHealth members transferred to another acute hospital, the transferring out-of-state acute hospital will continue to be paid at a transfer per diem rate (“Out-of-State Transfer Per Diem”), and no other payment methods will apply. The Out-of-State Transfer Per Diem will equal the sum of the transferring hospital’s Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by MassHealth, divided by the mean in-state acute hospital all payer length of stay for the particular APR-DRG assigned, as determined by MassHealth. Payments made on an Out-of-State Transfer Per Diem basis are capped. The Out-of-State Transfer Per Diem (similarly capped) will also be paid in certain other circumstances to generally align with the in-state method.
- **Out-of-State Psychiatric per Diem.** If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, the out-of-state acute hospital will continue to be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem most recently in effect for in-state acute hospitals on the date of service, and no other payment methods apply.
- **APAD Carve-Outs.** The Out-of-State APAD does not provide payment for LARC Devices or APAD Carve-Out Drugs. Instead payment is as described next.
 - ***Long-Acting Reversible Contraception (LARC) devices (LARC Devices).*** Out-of-state acute inpatient hospitals will continue to be paid separately for a LARC Device if the LARC procedure occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay, and all other MassHealth acute inpatient hospital requirements are met. Payment will be in accordance with the fee schedule rates for such devices set forth in EOHHS regulations at 101 CMR 317.00 (Medicine). LARC Devices are defined specifically as intrauterine devices and contraceptive implants; they do not refer to the procedure itself.

² A hospital’s charges for a LARC Device and for APAD Carve-Out Drugs will be excluded.

³ In RY20, as in RY19, an out-of-state “High MassHealth Volume Hospital” is an out-of-state hospital that had at least 100 MassHealth discharges during the most recent federal fiscal year for which complete data is available, as determined by MassHealth at least 90 days prior to the start of the federal fiscal year. As in RY19, in RY20 the two High MassHealth Volume Hospitals will be Rhode Island Hospital and Women & Infants Hospital (RI).

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

2. Out-of-State Acute Outpatient Hospital Services

In RY20, the MassHealth out-of-state acute outpatient hospital payment methodologies are generally unchanged from RY19. However, as a result of changes to the in-state acute outpatient hospital adjudicated payment per episode of care (APEC) rate components as described in Part II.2 of this notice, the Out-of-State APEC rate components will also be changing effective with RY20 (see Attachment A to Part I of this notice).

Out-of-State Acute Outpatient Hospital Payment Methods

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

- **Out-of-State APEC.** The Out-of-State APEC is an episode-specific all-inclusive facility payment for all APEC-covered services provided in the episode. The Out-of-State APEC for each payable episode will equal the sum of the episode-specific total Enhanced Ambulatory Patient Group (EAPG) payment and the APEC outlier component (if applicable).
 - The “episode-specific total EAPG payment” is equal to the sum of all of the episode’s claim detail line EAPG⁵ payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC outpatient statewide standard in effect for in-state acute hospitals on the date of service, and the claim detail line’s adjusted EAPG weight. The 3M EAPG grouper’s discounting, consolidation and packaging logic is applied to each of the episode’s claim detail line MassHealth EAPG weights to produce the claim detail line’s adjusted EAPG weight for this calculation. The “MassHealth EAPG weight” is the MassHealth relative weight developed by MassHealth for each unique EAPG.
 - The “APEC outlier component” equals the marginal cost factor in effect for in-state acute hospitals on the date of service, multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold. The “episode-specific case cost” is determined by MassHealth by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the applicable outpatient cost-to-charge ratio. For High MassHealth Volume Hospitals,⁶ the cost-to-charge ratio is hospital-specific; for all other out-of-

⁴ The MassHealth-designated APAD Carve-Out Drugs are identified on the “MassHealth Acute Hospital Carve-Out Drugs List” page of the MassHealth Drug List, and may be updated from time to time. The MDHL is posted at <https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do>.

⁵ EAPG refers to Enhanced Ambulatory Patient Group. EAPGs are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient hospital claim by the 3M EAPG grouper and refer to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix.

⁶ See footnote 3 and accompanying text.

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

- **APEC Carve-Out Drugs.** Out-of-state acute outpatient hospitals will be paid separately from the APEC for APEC Carve-Out Drugs⁷ 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 Hospital⁸ will be paid the rate of payment established for the medical service under the other state’s Medicaid program, as determined by MassHealth, or such other rate as MassHealth determines necessary to ensure member access to services. For an inpatient service MassHealth determines is not available in-state, payment to the out-of-state acute hospital under this method will also include acute hospital outpatient services MassHealth determines are directly related to the service not available in-state.

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

⁸ See footnote 3 and accompanying text.

ATTACHMENT A

Out-of-State Acute Hospital Rates

I. INPATIENT — Effective 11/1/19

Here are the out-of-state acute inpatient hospital rates/rate components for the Out-of-State APAD, Outlier Payment and Transfer Per Diem rates, as well as the Psychiatric Per Diem rate, effective for RY20. See Part I.1 for descriptions of the calculations of the out-of-state acute hospital inpatient payment methods. Payment for LARC Devices will be in accordance with the fee schedule rates for such devices at 101 CMR 317.00 (Medicine), and payment for APAD Carve-Out Drugs will be in accordance with the in-state acute hospital payment method for such drugs. Components of Out-of-State APAD, Outlier Payment, & Transfer Per Diem Rates (applicable to admissions in Rate Year 2020)									Other (for dates of service in RY20)
	1. In-state Statewide Operating Standard Per Discharge	2. In-state Statewide Capital Standard Per Discharge	Sum of Columns 1 and 2	MassHealth DRG Weight	In-State Marginal Cost Factor	Cost-to- Charge Ratio	In-State Fixed Outlier Threshold	Mean In- State All- Payer Length of Stay	Out-of- State Psych Per Diem
High MassHealth Volume Hospitals:									
<i>Rhode Island Hospital</i>	\$ 11,391.79	\$773.16	\$12,164.95	See Chart C*	60%	36.20%	\$38,000.00	See Chart C*	\$941.10
<i>Women & Infants Hospital (RI)</i>	\$11,391.79	\$773.16	\$12,164.95	See Chart C*	60%	42.49%	\$38,000.00	See Chart C*	\$941.10
All Other Out-of-State Acute Hospitals:**	\$11,391.79	\$773.16	\$12,164.95	See Chart C*	60%	47.74%	\$38,000.00	See Chart C*	\$941.10

***See Chart C for the RY20 MassHealth DRG Weights and Mean All-Payer Lengths of Stay.**

Click here: [Chart C- Acute Hospital RY20 MassHealth DRG Weights and Mean All Payer Lengths of Stay](#)

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

Out-of-State Acute Hospital Rates (continued)

II. **OUTPATIENT APEC – Effective 11/1/19**

Out-of-State Acute Hospitals will be paid an Out-of-State APEC for APEC-covered outpatient services, which is an episode-specific payment method. APEC rate components are as follows for the dates of service in RY20. (See description of this payment method in Part I.2 earlier in this document.) Payment for APEC Carve-Out Drugs will be in accordance with the in-state acute hospital payment method for such drugs. Components of Out-of-State APEC Rates (applicable to dates of service in RY20)					
	In-state APEC Outpatient Statewide Standard	MassHealth EAPG Weight	In-State Marginal Cost Factor	Cost-to- Charge Ratio	In-State Fixed Outpatient Outlier Threshold
High MassHealth Volume Hospitals:					
<i>Rhode Island Hospital</i>	\$638.56	See Chart D*	60%	27.78%	\$3,800.00
<i>Women & Infants Hospital (RI)</i>	\$638.56	See Chart D*	60%	37.57%	\$3,800.00
All Other Out-of- State Acute Hospitals**	\$638.56	See Chart D*	60%	35.97%	\$3,800.00

***See Chart D for the RY20 MassHealth EAPG Weights.**

Click here: [Chart D-Acute Hospital RY20 MassHealth EAPG Weights](#)

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

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

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

1. In-State Acute Inpatient Hospital Inpatient Services

A. Summary of Proposed RY20 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. For RY20, MassHealth is continuing its 30-day readmission policy, with some modifications (see Part II, Section 5).

The APAD Base Year is federal fiscal year (FY) 2017. The components of the APAD applicable to admissions in RY20 are described here.

- The statewide operating standard per discharge is derived from the statewide average hospital all payer cost per discharge using APAD Base Year data, standardized for casemix differences and area wage variation. An efficiency standard is determined by capping hospital costs, weighted by FY17 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 FY18 MassHealth discharges, at the 60% level of costs. Each hospital's capital cost per discharge was then held to the lower of its capital cost per discharge or the casemix-adjusted efficiency standard, and a statewide weighted average capital cost per discharge is calculated, and adjusted for inflation to the current year to produce the statewide capital standard per discharge.

- The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness, using the 3M Corporation’s APR-DRG grouper version 36 and Massachusetts weights.
- For discharges assigned a MassHealth DRG Weight of 3.5 or greater from either (i) the Hospital with a Pediatric Specialty Unit⁹ for members under the age of 21 at the time of admission, or (ii) Freestanding Pediatric Acute Hospitals,¹⁰ the APAD Base Payment will be adjusted to include an additional 57%.

Outlier Payment

For qualifying discharges that correspond to admissions occurring in RY20, 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 FY18 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 \$38,000. 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 (Medicine).

⁹ “Pediatric Specialty Unit” is as defined in the RY20 MassHealth Acute Hospital Request for Applications (RFA).

¹⁰ “Freestanding Pediatric Acute Hospitals” is as defined in the RY20 RFA.

APAD Carve-Out Drugs

Acute inpatient hospitals will be paid separately from the APAD for APAD Carve-Out Drugs¹¹ 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 lowest of (1) the Hospital's actual acquisition cost of the drug,¹² (2) the drug's wholesale acquisition cost (WAC), and (3) if available, the Medicare Part B rate for the drug, each as determined by EOHHS.

Critical Access Hospitals

Final payment to Critical Access Hospitals (CAHs) for FY20 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 RY20 have been updated utilizing more recent data (based on FY18 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.

RY20 In-State Acute Inpatient Hospital Rates and Rate Components

The in-state acute inpatient hospital rates and rate components applicable to RY20 are set forth in Attachment B.

B. Summary of Proposed Changes

RY20 payment methods for in-state acute inpatient hospital services include changes from the RY19 payment methods, including the following.

(1) In calculating the APAD:

- The APAD Base Year remains FY17.
- 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 set at the 60% level of costs.
- In calculating the statewide operating standard and the hospital's wage adjusted operating standard per discharge, the labor factor was updated consistent with CMS updates, and the method used to calculate the hospital's Massachusetts-specific wage area index remains the same, except for Southcoast Hospitals Group, which is redesignated to the Boston area.
- The outlier adjustment factor applied for the statewide operating standard per discharge was 92.7%.
- For price changes between RY19 and RY20, an inflation update of 2.236% was applied to the statewide operating standard and 1.5% to the statewide capital standard per discharge.

¹¹ The list of MassHealth designated "APAD Carve-Out Drugs" are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" of the MassHealth Drug List (MHDL), and may be updated from time to time. The MHDL is posted at <https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do>.

¹² References to "drugs" in this notice refers to drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

- For discharges assigned a MassHealth DRG Weight of 3.5 or greater from either (i) a Freestanding Pediatric Acute Hospital or (ii) a Hospital with a Pediatric Specialty Unit (for members under the age of 21 at the date of admission), the APAD Base Payment will be adjusted to include an additional 57% (an increase from 45% in RY19).
- (2) To calculate the Outlier Payment (if any), the fixed outlier threshold was changed to \$38,000, the marginal cost factor to 60%, and each Hospital's inpatient cost-to-charge ratio was calculated based on the hospital's FY18 Massachusetts Hospital cost report.
- (3) EOHHS utilized FY16 base median nursing facility rates and updated for inflation to RY20 when calculating the administrative day (AD) per diem rate for RY20.
- (4) For critical access hospitals paid at 101% of allowable costs utilizing Medicare's cost-based reimbursement methodology, interim APAD rates for admissions in RY20 were derived utilizing cost data from the hospital's FY18 CMS 2552-10 cost report. Final payment for the FY20 period will be made as described in Part II, Section 1.A.

2. In-State Acute Hospital Outpatient Services

A. Summary of Proposed RY20 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 RY20, 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.¹³ 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 RY20 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 FY14.

¹³ 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.

The “Episode-Specific Total EAPG Payment” is equal to the sum of all of the episode’s claim detail line EAPG¹⁴ 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.¹⁵
 - In determining the APEC Outpatient Statewide Standard, an average outpatient cost per episode is calculated for each hospital, utilizing the hospital’s FY14 outpatient cost-to-charge ratio from its 403 cost report, and allowed charges and episodes from FY14 PAPE 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 FY14 outpatient casemix index to produce the hospital’s standardized cost per episode. An efficiency standard was applied by capping standardized hospital costs, weighted by total statewide FY18 episodes, at the 60% level of costs. The weighted mean of the hospitals’ capped costs per episode is adjusted by an outlier adjustment factor and inflation is applied, which result is then divided by a conversion factor to result in the APEC Outpatient Statewide Standard.
 - Except for certain hospitals identified later in this document, for each hospital, the APEC Outpatient Statewide Standard is then adjusted for that hospital’s Massachusetts-specific wage area index to produce the hospital’s Wage Adjusted APEC Outpatient Standard. In calculating the APEC for a hospital that is (1) a PPS-exempt cancer hospital under 42 CFR 412.23(f) or (2) a Group 1 safety net hospital in Appendix N to the MassHealth 1115 waiver, EOHHS applied different Wage Adjusted APEC Outpatient Standards.
- EAPGs are assigned to the Episode’s APEC-covered services based on information within a properly submitted outpatient Hospital claim, utilizing the 3M EAPG grouper version 3.14. EAPGs are assigned at the claim detail line level. The MassHealth EAPG weight is the MassHealth relative weight developed by MassHealth for each unique EAPG. The 3M EAPG grouper’s discounting, consolidation and packaging logic is applied to each of the Episode’s claim detail line MassHealth EAPG weights to produce the claim detail line’s Adjusted EAPG Weight.

The APEC Outlier Component (if applicable) is equal to the product of the marginal cost factor of 60%, and the amount by which the episode-specific case cost exceeds the episode-specific outlier threshold, as calculated by EOHHS. The episode-specific case cost is the product of 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 FY18 outpatient cost-to-charge ratio (based on the hospital’s FY18 Massachusetts Hospital cost report). The episode-specific outlier threshold is the sum of (1) the Episode-Specific Total EAPG Payment and (2) the RY20 fixed outpatient outlier threshold of \$3,600. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is \$0.

¹⁴ EAPG stands for Enhanced Ambulatory Patient Group, and refers to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix. EAPGs are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient hospital claim by the 3M EAPG grouper version 3.14 (configured for the MassHealth APEC methodology).

¹⁵ The hospital’s Massachusetts-specific wage area index used in the APEC calculation is determined the same way as it is determined for the inpatient APAD calculation.

APEC-Carve-Out Drugs

Acute outpatient hospitals will be paid separate from the APEC for APEC Carve-Out Drugs¹⁶ 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 lowest of (1) the Hospital's actual acquisition cost of the drug, (2) the drug's wholesale acquisition cost (WAC), and (3) if available, the Medicare Part B rate for the drug, each as determined by EOHHS.

Critical Access Hospitals

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

RY20 In-State Acute Outpatient Hospital APEC Rate Components

The in-state acute outpatient hospital APEC rate components applicable to RY20 are set forth in Attachment B.

B. Summary of Proposed Changes

RY20 payment methods for in-state acute outpatient hospital services include changes from the RY19 payment methods, including the following.

(1) In calculating the APEC:

- The 3M EAPG Grouper was changed to version 3.14, and updated MassHealth EAPG Weights developed.
- For the Episode-Specific Total EAPG Payment, the individual claim detail line EAPG payment amounts will be determined by multiplying the hospital's Wage Adjusted APEC Outpatient Standard (which is the APEC Outpatient Statewide Standard, adjusted by the hospital's Massachusetts-specific wage area index) by the claim detail line's Adjusted EAPG Weight.
- In determining the APEC Outpatient Statewide Standard:
 - To produce each hospital's standardized costs per episode, an adjustment for each hospital's Massachusetts-specific wage area index was also applied, and the hospital's APEC Base Year outpatient casemix index was calculated utilizing the updated grouper and weights, as adjusted by EOHHS.
 - FY18 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 95%.
 - An inflation update of 2.246% was applied to reflect price changes between RY19 and RY20;
 - The conversion factor applied was 1.11.

¹⁶ The list of MassHealth designated "APEC Carve-Out Drugs" are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" of the MassHealth Drug List (MHDL), and may be updated from time to time. The MHDL is posted at <https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do>.

- For the APEC Outlier Component calculation, the fixed outpatient outlier threshold was set at \$3,800, the marginal cost factor at 60%, and the Hospital's outpatient cost-to-charge ratio was calculated based on the Hospital's FY18 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 RY20 were derived utilizing cost data from the hospital's FY18 CMS 2552-10 cost report. Final payment for the FY20 period will be made as set forth in Section II.1.A.

3. In-State Acute Hospital Supplemental Payments

In addition to the payments specified earlier, EOHHS makes state plan supplemental payments to qualifying in-state acute hospitals. The FY20 state plan supplemental payment methods for in-state acute hospitals that qualify as Essential MassHealth Hospitals, Acute Hospitals with High Medicaid Discharges, the High Medicaid Volume Freestanding Pediatric Acute Hospital, and the High Medicaid Volume Safety Net Hospital, are substantially similar to the FY19 supplemental payment methods, except utilizing more recent data, and provided that the maximum state plan supplemental payment amounts to certain Essential MassHealth Hospitals have been updated to reflect increased estimated payments, and the maximum payment amount to the High Medicaid Volume Safety Net Hospital has been increased.¹⁷ The aggregate supplemental payment amount for High Public Payer Hospitals has remained unchanged from FY19, although the methodology for that payment has been revised to give added weight to Accountable Care Partnership Plan (ACPP) volume and Primary Care Accountable Care Organization (ACO) volume and to utilize more recent data. EOHHS has also added three new supplemental payments for FY20.

- A \$5.5 million total aggregate payment for hospitals that qualify as Specialized Pediatric Service Hospitals, allocated based on each qualifying hospital's volume of pediatric discharges of members enrolled in an ACPP or Primary Care ACO.
- A \$9 million total aggregate High Public Payer Behavioral Health Service payment for High Public Payer hospitals that provided Inpatient Behavioral Health Services to Members in FY18. The total amount is allocated based on (1) each hospital's inpatient behavioral health days, weighted toward pediatric and adolescent days, and (2) the relative acuity of the members receiving Inpatient Behavioral Health Services from each hospital in FY18, determined using the APAD payment methodology to develop a proxy payment amount.
- A \$2 million total aggregate High Medicaid Volume Safety Net Hospital Licensed Health Center (HLHC) payment for the benefit of any HLHC (1) that is operated by a High Medicaid Volume Safety Net Hospital and (2) whose MassHealth annual outpatient volume exceeds 75,000 episodes.

4. In-State Pay for Performance (P4P)

¹⁷ A qualifying High Medicaid Volume Safety Net Hospital is an acute hospital with a ratio of Medicaid inpatient days to total inpatient days that was greater than 45% based on the Hospital's FY14 403 cost report, and that enters into a separate payment agreement with EOHHS.

The RY20 RFA Pay-for-Performance (P4P) Program is generally unchanged from RY19, including the maximum allocation (\$25M) and the slate of measures. Updates include the following.

- Within the Safety Outcomes quality measure category, the Healthcare Associated Infections measures will be weighted in the aggregate more heavily in comparison to the Patient Safety and Adverse Events Composite measure.
- The CCM-2 Care Coordination Measure will require the presence of eight elements (instead of six in the RY19 RFA).
- Dates of service for data periods have been updated.
- Case minimums have been established for clinical process measures and for the Health Disparities composite measure.

5. In-State 30-day Readmissions Policy

In RY20, EOHHS is retaining the RY19 30-day readmissions policy regarding certain hospital readmissions that occur within 30 days of discharge from the same inpatient hospital, with updated descriptions of the criteria for determining preventability. The Transitional Period used to implement the policy in RY19 will be continued until January 1, 2020, at which time it will be replaced by the Full Implementation Period, during which MassHealth will seek recovery of payments made for preventable 30-day readmissions, identified through clinical reviews.

Justification

Except as specified earlier, the acute inpatient and outpatient hospital payment methods for RY20 are substantially similar to those for RY19. All changes to hospital payment rates and methods, including the updated rates and rate components effective with RY20, are in accordance with state and federal law and are within the range of reasonable payment levels to acute hospitals.

Estimated Fiscal Effect

EOHHS estimates that annual aggregate acute hospital state plan expenditures resulting from the FY20 (October 1, 2019 – September 30, 2020) payment methods will increase by approximately \$49.3M overall, broken down as follows: an estimated \$49.3M increase in estimated annual aggregate in-state acute inpatient and outpatient hospital state plan expenditures; and no estimated annual aggregate impact to out-of-state acute inpatient and outpatient hospital state plan expenditures. Holding utilization constant, EOHHS estimates that the fiscal impact resulting from the changes in payment methods for rates to acute inpatient and outpatient hospitals applicable to FY20 will result in an increase, in the aggregate, of 2.4% to the rates on an annualized basis, compared to estimated annualized base year rate payments.

Statutory Authority: M.G.L. c. 118E; St. 2019, c. 41; St. 2012, c. 224; 42 USC 1396a; 42 USC 1396b.

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

In-State Acute Hospitals

Section 2: Definitions

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

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. The terms of the MassHealth Acute Hospital 30-Day RP for RY20 are set forth in Section 8.1.

3M EAPG Grouper – the 3M Corporation’s EAPG Grouper Version 3.14, configured for the MassHealth APEC payment method.

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

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

Adjudicated Payment Amount Per Discharge (APAD) – a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge, which is the complete fee-for-service payment for such acute hospitalization, excluding the additional payment of any inpatient Hospital Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a per diem basis under this RFA (for example, Transfer per diem). The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in Section 5.B.8. The APAD is calculated as set forth in Section 5.B.1.

Adjudicated Payment per Episode of Care (APEC) – a Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in Section 4.C and Sections 5.C.3 through 5.C.9, as such services are excluded from the definitions of “APEC-Covered Services” and “Episode” under this RFA. The APEC is calculated as set forth in Section 5.C.1.

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

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

In-State Acute Hospitals

All Patient Refined–Diagnostic Related Group (APR-DRG or DRG) – the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper, Version 36, unless otherwise specified.

APAD Base Year – the hospital-specific base year for the APAD is FY17, using the FY17 Massachusetts Hospital cost reports as screened and updated as of July 24, 2018.

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 FY14.

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.9.

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.

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

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

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

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

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

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

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

In-State Acute Hospitals

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 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 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, and incorporates all of the provisions of this RFA. Unless the context indicates that the term “RFA” refers exclusively to the procurement document as such, references to RFA shall constitute references to the Contract (or Agreement).

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

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

Critical Access Hospital (CAH) – an Acute Hospital that, prior to October 1, 2019, 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 FY18 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.

In-State Acute Hospitals

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.

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 seven (7) days per week, twenty-four (24) hours per day to provide treatment of any individual who is experiencing a mental health or substance use disorder crisis, or both. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization. ESP Services include Mobile Crisis Intervention for members under the age of 21.

Enhanced Ambulatory Patient Group (EAPG) – a group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation's EAPG Grouper Version 3.14.

Episode – all MassHealth-covered Outpatient Services, except those described in Section 4.C and Sections 5.C.3 through 5.C.9, 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.

In-State Acute Hospitals

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 FY18 outpatient cost-to-charge ratio, as calculated by EOHHS using the Hospital's FY18 Massachusetts Hospital Cost Report.

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

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

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

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

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

Fixed Outlier Threshold (inpatient) – the Fixed Outlier Threshold for purposes of calculating any inpatient Hospital Outlier Payment is \$38,000.

Fixed Outpatient Outlier Threshold – the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is \$3,800.

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

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

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

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

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

Hospital-Based Physician – any physician or physician group practice (excluding interns, residents, fellows, and house officers) who contracts with a Hospital to provide Hospital Services to Members at a site for which the hospital is otherwise eligible for reimbursement under this RFA. For purposes of this definition and related

In-State Acute Hospitals

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 FY17 provided and verified by each hospital, submitted to CHIA and screened and updated by CHIA as of May 22, 2018. 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 Administrative Days – an inflation factor that is a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factor for Administrative Days is as follows.

- 1.937% 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

Inflation Factors for Capital Costs – for price changes between RY04 and RY18 and between RY19 and RY20, 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 RY19 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

Inflation Factors for Operating Costs – for price changes between RY04 and RY07, and between RY08 and RY20, 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

In-State Acute Hospitals

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 RY20 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

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

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

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

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

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

Managed Care Organization (MCO) – any entity with which EOHHS contracts to provide Primary Care and certain other medical services, including Behavioral Health Services, to Members on a capitated basis and which meets the definition of an MCO as set forth in 42 CFR Part 438.2. MCOs include "traditional" MCOs, Senior Care Organizations (SCOs) and Accountable Care Partnership Plans (ACPPs). In addition, MCOs include One Care plans for all purposes under this RFA, except for Sections 4.A.2, 4.B.4, 5.D.1 and Section 7.

In-State Acute Hospitals

When historical MCO data is used in a methodology, the term MCO will also include CarePlus MCOs, to the extent CarePlus MCOs existed during the period for which the MCO data is used in such methodology, as applicable.

Marginal Cost Factor – the Marginal Cost Factor is 60% (inpatient) and 60% (outpatient).

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

MassHealth DRG Weight – the MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). See Chart C in Appendix C for the MassHealth DRG Weights.

MassHealth EAPG Weight – the MassHealth relative weight developed by EOHHS for each unique EAPG (See Chart D in Appendix D for the RY20 MassHealth EAPG Weights for the APEC methodology). The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight as part of the APEC payment methodology. See also the definition of "Adjusted EAPG Weight."

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

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

Mobile Crisis Intervention (MCI) – services provided by designated ESP providers to members under age 21. MCI services include a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a behavioral health crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention 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. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours. Payment rules regarding Observation Services are found in 130 CMR 410.414, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions, and this RFA.

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

In-State Acute Hospitals

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 this RFA.

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

Participating PCP – see definition of Primary Care ACO Participating Primary Care Provider.

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

Pay-for-Performance Program for Acute Hospitals (P4P) – for RY20, this refers to the pay-for-performance program set forth in Section 7 of the RFA.

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

Pediatric Specialty Unit – a designated pediatric unit, pediatric intensive care unit, or neonatal intensive care unit in an Acute Hospital other than a Freestanding Pediatric Acute Hospital, in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20.

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.

In-State Acute Hospitals

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

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

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

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

Psychiatric Per Diem Base Year – the base year for the psychiatric per diem is FY04, using FY04 -403 cost reports as screened and updated as of March 10, 2006.

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

Rate Year (RY) – generally, the period beginning October 1 and ending the following September 30. Please note that RY20 will begin on November 1, 2019, and end on October 31, 2020.

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

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

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

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

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

Specialized Pediatric Service Hospital – a High Medicaid Volume Freestanding Pediatric Acute Hospital; an Acute Hospital with a Pediatric Specialty Unit; 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.

In-State Acute Hospitals

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

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

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; or (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.

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.

In-State Acute Hospitals

Section 3: Eligible Applicants

- A.** In-state Acute Hospitals are eligible to apply for a Contract pursuant to this RFA if they
- 1.** Operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH);
 - 2.** Are Medicare-certified and participate in the Medicare program;
 - 3.** Have more than 50% of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by DPH; and
 - 4.** Currently utilize more than 50% of their beds exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by EOHHS.
- In determining whether a Hospital satisfies the utilization requirement set forth in Section 3.A.4, EOHHS may evaluate, pursuant to an on-site audit or otherwise, a number of factors including, but not limited to, the average length of patient stay (see Section 11.B.5) at that Hospital.
- B.** The Hospital shall apply on behalf of all Inpatient Departments, Outpatient Departments, Emergency Departments and Satellite Clinics.
- C.** The Hospital is not permitted to apply on behalf of, or claim payment for services provided by, any other related clinics, Provider groups, or other entities, except as otherwise provided in Sections 5.B.5 and 5.C.
- D.** For public state-owned hospitals that contract under the RFA, EOHHS may waive these or any other requirements and may, at its discretion, agree to requirements and conditions of participation that differ from those set forth in this RFA to address specific situations. Any such requirements and conditions of participation may be documented in any resulting contract or may be specified through other such means as may be agreed to by the parties.

In-State Acute Hospitals

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

A. Non-Covered Services

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

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

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

Hospitals that are not in the BH Contractor's network (hereinafter "non-network Hospitals") do not qualify for payment from MassHealth or the BH Contractor for Members enrolled with the BH Contractor who receive BH Contractor-covered services, except in accordance with a service-specific agreement with the BH Contractor.

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

2. MCO Services

- a.** Hospitals that provide medically necessary MCO-covered services, including Emergency and Post-Stabilization Services, qualify for payment solely by the MCO for services to Members enrolled with the MCO pursuant to contracts between the MCO and each contracting Hospital.
- b.** In accordance with 42 USC 1396u-2(b)(2), 42 CFR 438.114, 42 CFR 422.113(c), and 42 CFR 422.214(b), if an MCO offers to pay a non-network Hospital a rate equal to the Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the MCO's MassHealth enrollees, that non-network Hospital must accept the MCO's rate offer as payment in full. This requirement does not prohibit an MCO from negotiating to pay any non-network Hospital at rates lower than the non-network Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for Emergency and Post-Stabilization Services.
- c.** For purposes of this Section 4.A.2.c, "MCO" refers to all MCOs as defined in Section 2, except Senior Care Organizations (SCOs), and One Care plans; and "non-Emergency services" means services that correspond to the types of Inpatient and Outpatient Services for which Hospitals are paid on a fee-for-service basis under Sections 5.B.1 through 5.B.3, 5.B.6, 5.B.7, 5.C.1 and 5.D.7 of this RFA (subject to Sections 8.2 and 8.3, as applicable), with the exception of (1) Emergency and

In-State Acute Hospitals

Post-Stabilization Services (which are governed by Section 4.A.2.b., above) and (2) Behavioral Health Services.

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

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

3. [RESERVED]

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 this RFA, EOHHS shall not reimburse Acute Hospitals through this RFA and the accompanying contract for services provided to Members in Non-Acute Units, other than Rehabilitation Units, and any units which have a separate license, such as a skilled nursing unit, or any

In-State Acute Hospitals

unit which is licensed to provide services other than Acute Hospital services as described in Section 3.A.4.

8. Behavioral Health Diversionary Services

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

B. Program Initiatives

1. Hospital Services Reimbursed through Other Contracts or Regulations

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

2. Demonstration Projects

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

3. MassHealth Drug List

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

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

4. MCO Offer of Contract

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

Effective as of November 1, 2019, all Hospitals that are parties to a Hospital Contract under this RFA must have a written contract with at least one MCO to participate as a network Hospital provider under

In-State Acute Hospitals

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 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

In-State Acute Hospitals

Member. For Members that are identified in EVS as Community Partner Assigned Members, the Hospital must notify the Member's CP(s) within one business day of the commencement of ED services for the Member. Notification may include a secure electronic notification of the visit. For the avoidance of doubt, Hospitals shall ensure that any such notification is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance. EOHHS reserves the right to specify the form and format for such notification.

2. Notification of Inpatient Admission and Discharge Planning Activities

- a.** For Members enrolled in the PCC Plan or a Primary Care ACO, the Hospital must notify the Member's PCC or Participating PCP within one business day of the Member's: (1) Inpatient Admission and (2) subsequent discharge (which includes, for purposes of this Section 4.D.2, a transfer to another Acute Inpatient Hospital or to a 24-hour facility that provides Behavioral Health Diversionary Services.) For members that are identified in EVS as Community Partner Assigned Members, the Hospital must notify the Member's CP(s) within one business day of the Member's: (1) Inpatient Admission and (2) subsequent discharge (which includes, for purposes of this Section 4.D.2, a transfer to another Acute Inpatient Hospital or to a 24-hour facility that provides Behavioral Health Diversionary Services.) Notification may include a secure electronic notification of the visit. For the avoidance of doubt, Hospitals shall ensure that any such notification is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance. EOHHS reserves the right to specify the form and format for such notification.
- b.** The Hospital, when possible, must begin formulating a discharge plan on the first day of a Member's Inpatient Admission.
- c.** In addition to satisfying all other requirements for discharge planning set forth in MassHealth regulations or other formal written statements of policy:
 - (1)** For Members enrolled in the PCC Plan or a Primary Care ACO, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's PCC or Participating PCP within two business days of the discharge. For Members identified in EVS as Community Partner Assigned Members, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's CP(s) within two business days of the discharge. The discharge summary must include a copy of the Hospital's discharge instructions that were provided to the Member, and include details on the Member's diagnosis and treatment. For the avoidance of doubt, Hospitals shall ensure that any such transmission is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance.
 - (2)** For all Members receiving Inpatient Services, the Hospital shall communicate with, as applicable, each of the Member's primary care provider, health plan, and CP(s) to ensure that, consistent with all applicable federal and state laws, regulations, and sub-regulatory guidance, all appropriate parties are included in the Member's discharge planning process. Such appropriate parties may include CPs, case managers, caregivers, and other critical supports for the Member. Examples of these activities may include setting up appropriate consent and communication protocols, and protocols to allow staff from these parties onto hospital units to participate in discharge planning and care coordination. For the avoidance of doubt, Hospitals shall ensure that any such communications comply with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance.

In-State Acute Hospitals

- (3) For Members admitted for childbirth and newborn care, the hospital's discharge planning process shall include, at a minimum, the following activities to help ensure appropriate follow-up care for the mother and newborn.
- (a) Completing and submitting MassHealth's Notification of Birth form in accordance with MassHealth's instructions on that form;
 - (b) Advising the family to select a pediatrician if one has not yet been selected and, if requested by the family, assisting the mother in the selection of a pediatrician by, at a minimum, providing the mother with
 - i. A paper copy of and/or web access to the MassHealth Enrollment Guide and MassHealthChoices.com website;
 - ii. The telephone number by which members contact MassHealth's Customer Service;
 - (c) Advising the family to schedule an appointment with the pediatrician for the initial well baby visit and aftercare services as clinically appropriate and, if requested by the family, assisting in securing such an appointment. For any appointment that is critical to the patient's health and safety, the hospital shall strongly encourage and offer to assist the member in securing an appointment; and
 - (d) Advising the mother to schedule an appointment for a postpartum visit and any aftercare services (e.g., staple removal post cesarean section) as clinically appropriate and, if requested by the mother, assisting in securing such an appointment. For any appointment that is critical to the patient's health and safety, the hospital shall strongly encourage and offer to assist the member in securing an appointment.
- 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 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.

In-State Acute Hospitals

Section 5: Reimbursement System

A. General Provisions

Acute Hospitals that participate in the MassHealth program under the terms of the Hospital Contract and its accompanying payment methodology shall accept payment at the rates established in this RFA as payment in full for services reimbursable by EOHHS that are rendered to MassHealth Members admitted as inpatients or treated as outpatients on or after November 1, 2019.

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

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

A Hospital with a DMH-licensed inpatient psychiatric unit must accept into its DMH-licensed inpatient psychiatric unit all referrals of MassHealth Members that meet the established admission criteria of the inpatient unit. Such Hospitals shall report all available DMH-Licensed Beds into the Massachusetts Behavioral Health Access website at a minimum three times per day, 7 days per week. Such updates shall occur, at a minimum, between 8am-10am, 12pm-2pm, and 6pm-8pm. EOHHS may designate an alternative frequency for such updates.

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

B. Payment for Inpatient Services

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

Except as otherwise provided in Sections 5.B.2 through 5.B.9 and in Section 5.D.7, fee-for-service payments to Hospitals for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be an Adjudicated Payment Amount Per Discharge (APAD), calculated as described more fully in Sections 5.B.1.a through 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.

In-State Acute Hospitals

Payment for Behavioral Health Services provided in DMH-Licensed Beds to MassHealth Members who are not served either through a contract between EOHHS and its BH Contractor or an MCO shall be made through an all-inclusive Psychiatric Per Diem (see Section 5.B.4).

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

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

1. Adjudicated Payment Amount per Discharge (APAD)

a. Overview

The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge (exclusive of any separate payment for LARC Devices or APAD Carve-Out Drugs, if applicable, as described in Section 5.B.8, below). The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific wage area index; (2) the Statewide Capital Standard per Discharge; and (3) the discharge-specific MassHealth DRG Weight. These components and the calculation of the APAD are described further below in Sections 5.B.1.b through 5.B.1.e. For components calculated based on data from all Hospitals, the calculation included data for all Hospitals that were operating as of August 1, 2018.

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 FY17 HDD as the primary sources of data to develop operating costs per discharge.

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

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

Wage area and casemix adjustments to calculate each hospital's standardized costs per discharge: The labor portion of the average cost per discharge for each Hospital was adjusted by the Hospital's Massachusetts-specific wage area index, and the labor and non-labor portions were then adjusted by the Hospital-specific FY17 all-payer APR-DRG Version 36 Casemix Index that was determined by using FY17 discharges, APR-DRG version 36 of the 3M grouper, and

In-State Acute Hospitals

MassHealth DRG Weights. Massachusetts Hospitals' wages and hours were determined based on CMS's FY2020-April-27-2019-Wage-Index-PUF zip file, downloaded May 1, 2019, from the CMS web site at www.cms.hhs.gov (the "CMS File"). Each Hospital was assigned to a wage area according to the same CMS File, except that Baystate Franklin Medical Center was assigned to the Springfield wage area and its wages and hours included in the Springfield area, Brigham and Women's Hospital was assigned to the Boston wage area and its wages and hours included in the Boston area, and 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 CMS 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: (1) any Hospital that was redesignated to a different wage area in a written decision from CMS to the Hospital provided to EOHHS by April 30, 2019, and (2) Southcoast Hospitals Group, which is redesignated to the Boston area. 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 FY18 MassHealth discharges for the Hospitals was produced from MMIS claims data on file as of May 31, 2019, 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 RY20 is \$13,305.69.

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 92.7%; and by (c) the Inflation Factors for Operating Costs between RY17 and RY20. The resulting Statewide Operating Standard per Discharge is \$11,391.79.

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 FY17 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 FY17 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 FY17 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 FY17 total inpatient hospital discharges net of Excluded Unit discharges.

In-State Acute Hospitals

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 FY17 All-Payer APR-DRG version 36 Casemix Index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of FY18 MassHealth discharges from MMIS claims data on file as of May 31, 2019, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges from Excluded Units were omitted. The casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 60% of the total number of discharges. The efficiency standard is \$847.39.

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 FY18 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 RY17 and RY20. The resulting Statewide Capital Standard per Discharge is \$773.16.

d. Determination of MassHealth DRG Weight

The MassHealth DRG Weight is the MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). The discharge-specific MassHealth DRG Weight is assigned to the discharge based on information contained in a properly submitted inpatient Hospital claim and determined using the 3M APR-DRG grouper version 36 and Massachusetts weights (see Chart C in Appendix C for the MassHealth DRG Weights that apply to RY20).

e. Calculation of the APAD

Each APAD is determined by the following steps: (1) multiplying the labor portion of the Statewide Operating Standard per Discharge by the Hospital's Massachusetts-specific wage area index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to determine the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "APAD Base Payment"), and (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight.

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

For qualifying discharges from Freestanding Pediatric Acute Hospitals and the Hospitals with a Pediatric Specialty Unit for which the MassHealth DRG Weight assigned to the discharge is 3.5 or greater, the APAD Base Payment will be adjusted to include an additional 57% for purposes of step (4), in the calculation of the APAD. A qualifying discharge for this purpose is one that (i) meets this minimum MassHealth DRG Weight requirement, and (ii) in the case of the Hospital

In-State Acute Hospitals

with a Pediatric Specialty Unit, is for a Member who is under the age of 21 at the time of admission.

The following is an illustrative example of the calculation of the Total Case Payment for a standard APAD claim that does not also qualify for an Outlier Payment under Section 5.B.2. As noted, values are for demonstration purposes only.

DRG Model Examples - Massachusetts Hospitals			
(Values are for demonstration purposes only)			
Table 1: Standard APAD claim			
(Values are for demonstration purposes only)			
Hospital:	Sample Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	Statewide Operating Standard per Discharge	\$11,391.79	RY20 RFA
2	Hospital's Massachusetts-specific wage area index	1.0642	Varies by hospital, determined annually
3	Labor Factor	0.68257	RY20 RFA
4	Hospital's Wage Adjusted Operating Standard per Discharge	\$11,890.99	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0-Line 3))
5	Statewide Capital Standard per Discharge	\$773.16	RY20 RFA
6	APAD Base Payment	\$12,664.15	Line 4 + Line 5
7	MassHealth DRG Weight	0.3547	Appendix C, Chart C
8	Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)	\$4,491.97	Line 6 * Line 7

2. Outlier Payments

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

- a. The amount of the APAD for the discharge, as calculated as set forth in Section 5.B.1 exceeds \$0;
- b. The Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge;
- c. The patient is not a patient in a DMH-Licensed Bed for any part of the discharge; and
- d. The patient is not a patient in an Excluded Unit within an Acute Hospital.

If a Hospital qualifies for an Outlier Payment, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold.

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

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

In-State Acute Hospitals

Table 2: Claim with Outlier Payment

(Values are for demonstration purposes only)

Hospital: Sample Hospital

DRG: 203, Chest Pain. Severity of Illness (SOI) = 2.

Line	Description	Value	Calculation or Source
1	APAD (must be > \$0)	\$4,491.97	Table 1, Line 8, above
2	Allowed charges	\$75,000.00	Determined from claim
3	Hospital's Inpatient Cost-to-Charge Ratio	72.00%	FY18 Massachusetts Hospital Cost Report
4	Discharge-Specific Case Cost	\$54,000.00	Line 2 * Line 3
5	Fixed Outlier Threshold	\$38,000	RY20 RFA
6	Discharge-Specific Outlier Threshold	\$42,491.97	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%	RY20 RFA
9	Outlier Payment	\$6,904.82	(Line 4 - Line 6) * Line 8
10	Total Case Payment = APAD plus Outlier Payment	\$11,396.79	Line 1 + Line 9

3. Transfer Per Diem Payments

a. Transfer Between Hospitals

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

In general, the Hospital that is receiving the patient will be paid (a) on a per-discharge basis in accordance with the APAD, and, if applicable, Outlier Payment methodology(ies) specified in Section 5.B.1 and 5.B.2, if the patient is actually discharged from that Hospital; or (b) on a Transfer Per Diem basis, capped at the Hospital's Total Transfer

Payment Cap, if the Hospital transfers the patient to another Acute Hospital or back to the Acute Hospital from which it received the patient.

The **payment per day for Transfer Patients (the Transfer Per Diem)** shall equal the Transferring Hospital's Total Case Payment amount, as determined by EOHHS, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG version 36 Massachusetts-specific weight file (Chart C in 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 RY20 that are paid on a Transfer Per Diem basis.

See Table 3: Claim with Transfer (APAD only) and Table 4: Claim with Transfer (APAD and Outlier), respectively, for illustrative examples of the calculation of the Transfer Per Diem, Total Transfer Payment Cap, and corresponding Total Transfer Case Payment, that would apply to the case. These illustrative examples apply to all subsections of Section 5.B.3. As noted, values are for demonstration purposes only.

In-State Acute Hospitals

Table 3: Claim with Transfer (APAD only)

(Values are for demonstration purposes only)

Hospital: Sample Hospital

DRG: 203, Chest Pain. Severity of Illness (SOI) = 2.

Line	Description	Value	Calculation or Source
1	APAD (Total Case Payment Amount)	\$4,491.97	Table 1, line 8, above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.06	Appendix C, Chart C
4	Transfer per diem	\$2,175.82	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	\$4,351.63	Line 4 * Line 2
6	Total Transfer Payment Cap	\$4,491.97	Table 3, Line 1
7	Total Transfer Case Payment	\$4,351.63	Lower of Line 5 or Line 6

Table 4: Claim with Transfer (APAD and Outlier)

(Values are for demonstration purposes only)

Hospital: Sample Hospital

DRG: 203, Chest Pain. Severity of Illness (SOI) = 2.

Line	Description	Value	Calculation or Source
1	Total Case Payment amount (Claim with Outlier Payment)	\$11,396.79	Table 2, Line 10 above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.06	Appendix C, Chart C
4	Transfer per diem	\$5,520.36	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	\$11,040.73	Line 4 * Line 2
6	Total Transfer Payment Cap	\$11,396.79	Table 4, Line 1
7	Total Transfer Case Payment	\$11,040.73	Lower of Line 5 or Line 6

b. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be reimbursed on a Transfer Per Diem basis capped at the Hospital's Total Transfer Payment Cap. This section outlines reimbursement under some specific transfer circumstances.

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

If a patient is transferred from an acute bed to a Non-Acute bed, except for a DMH-Licensed Bed or any separately licensed unit in the same Hospital, the transfer is considered a discharge. EOHHS will pay the Hospital's discharge 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.

In-State Acute Hospitals

(3) Admissions Following Outpatient Surgery or Procedure

If a patient who requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure at the Hospital, the Hospital shall be paid at the Transfer Per Diem rate up to the Hospital's Total Transfer Payment Cap.

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

Reimbursement for a transfer between a DMH-Licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, BH network or non-network Hospital, or the type of service provided. See also Section 5.B.3.b(5).

When a Member who is not enrolled with the BH Contractor transfers between a DMH-Licensed Bed and a non-DMH-Licensed Bed in the same Hospital during a single admission, EOHHS will pay the Hospital at the Transfer Per Diem rate capped at the Hospital's Total Transfer Payment Cap for the non-DMH-Licensed Bed portion of the stay, and at the Psychiatric Per Diem rate for the DMH-Licensed Bed portion of the stay (see Section 5.B.4).

When a Member who is enrolled with the BH Contractor transfers between a DMH-Licensed Bed and a non-DMH-Licensed Bed in the same Hospital during a single admission, EOHHS will pay the Hospital for the non-DMH-Licensed Bed portion of the stay at the Transfer Per Diem rate capped at the Hospital's Total Transfer Payment Cap.

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

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

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

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the Psychiatric Per Diem rate for Behavioral Health Services in a DMH-Licensed Bed or at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-Licensed Bed.

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

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

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the Psychiatric Per Diem rate for Behavioral Health Services in a DMH-Licensed Bed; or at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-Licensed Bed.

In-State Acute Hospitals

4. Payments for Behavioral Health Services (Psychiatric Per Diem)

Services provided to MassHealth Members in DMH-Licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive Psychiatric Per Diem, as described below. This payment mechanism does not apply to cases in which 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 eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.

In-State Acute Hospitals

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

e. Adjustment to Base Year Costs:

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

The Inflation Factors for Operating Costs between RY08 and RY10 and between RY12 and RY19 were applied to the rate calculated above to determine the RY20 Statewide Standard Psychiatric Per Diem rate.

Payment for Behavioral Health Services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap. See Sections 5.B.3.b(4) and 5.B.3.b(5) for payment rules involving transfers to and from DMH-Licensed Beds and BH managed care status.

5. Physician Payment

For physician services provided by Hospital-Based Physicians to MassHealth patients, the Hospital will be reimbursed for the professional component of physician services in accordance with, and subject to, the Physician regulations at 130 CMR 433.000 *et seq.* Such reimbursement shall be at the lower of (1) the fee established in 101 CMR 317.00 (Medicine), 101 CMR 316.00 (Surgery and Anesthesia), 101 CMR 318.00 (Radiology) and 101 CMR 320.00 (Clinical Laboratory Services), or successor regulations as applicable (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual charge submitted.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are not reimbursable separately. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in Section 2. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

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

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

6. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described next. 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.

In-State Acute Hospitals

The base per diem payment is \$201.63, which represents the median nursing facility rate that was effective October 1, 2015, for all nursing home rate categories, as determined by EOHHS.

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B-eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997, to September 30, 1998. These ratios are 0.278 and 0.382, respectively.

The resulting AD rates (base and ancillary) were then updated by the Inflation Factor for Administrative Days between RY16 and RY20. The resulting AD rates are \$280.61 for Medicaid/Medicare Part B-eligible patients and \$303.45 for Medicaid-only eligible patients.

MassHealth rules and regulations do not allow a patient to be admitted at an AD status, except in limited circumstances outlined in EOHHS regulations. In most cases, therefore, Administrative Days will follow an acute stay in the Hospital. Furthermore, the Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status in a single hospitalization.

7. Rehabilitation Unit Services in Acute Hospitals

A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Acute Hospital's Rehabilitation Unit.

The Rehabilitation Unit per diem rate for such Rehabilitation Services equals the median MassHealth RY20 Rehabilitation Hospital group per diem rate under the Chronic Disease and Rehabilitation (CDR) Hospital RFA and program, as determined by EOHHS. Acute Hospital Administrative Day rates will be paid in accordance with Section 5.B.6 for all days that a patient remains in the Rehabilitation Unit while not at Hospital level of care. Such units shall be subject to EOHHS' screening program for chronic and rehabilitation hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410 – 411.

8. Payment for APAD Carve-Out Items

a. Payment for LARC Devices

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

- (1) The member requests the LARC Device while admitted as an inpatient for a labor and delivery stay and, at the time of the procedure, is a clinically appropriate candidate for immediate post-labor and delivery LARC Device insertion;
- (2) The practitioner has been properly trained for immediate post-partum LARC Device insertion, and performs the procedure immediately after labor and delivery during the same inpatient hospital stay; and
- (3) The Hospital submits a separate claim for payment in accordance with applicable MassHealth billing instructions, including any special billing instructions for Acute Inpatient Hospital claims for LARC Devices that MassHealth may publish under "Billing Tips" on the MassHealth website at <https://www.mass.gov/service-details/billing-tips>, or in other written statements of policy issued by EOHHS. See also Section 5.G.1: Submission of Claims. EOHHS may update the billing instructions, from time to time.

In-State Acute Hospitals

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 (Medicine).

b. APAD Carve-Out Drugs

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

- (a) The EOHHS-designated APAD Carve-Out Drugs are identified on the “MassHealth Acute Hospital Carve-Out Drugs List” within the MassHealth Drug List. The MassHealth Drug List is published on the MassHealth website at <https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do>. This list of APAD Carve-Out Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at the this website location.
- (b) The APAD Carve-Out Drugs listed on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization through the MassHealth Drug Utilization Review (DUR) Program. The related inpatient stay(s) are also subject to separate MassHealth preadmission screening (PAS) requirements and approval through the MassHealth Acute Hospital Utilization Review vendor. (See also Sections 4.B.3 and 6.A.)

(2) Payment for APAD Carve-Out Drugs

- (a) Payment to Hospitals for APAD Carve-Out Drugs administered to Members during an inpatient admission will be the lowest of (1) the Hospital’s “actual acquisition cost” of the Drug (as defined below), (2) the WAC of the Drug, and (3) if available, the Medicare Part B rate for the Drug, each as determined by EOHHS. For this purpose, the Hospital’s “actual acquisition cost” of the Drug is the Hospital’s invoice price for the Drug, net of all on- or – off invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member while the Member was admitted in the Hospital, including any efficacy, outcome-, or performance-based guarantees (or similar arrangements), whether received pre- or post-payment.
- (b) Payment to the Hospital for an APAD Carve-Out Drug is conditioned on and subject to all of the following:
 - i. The Hospital must have satisfied all applicable MassHealth prior authorization and other applicable prior approval requirements, and all other MassHealth conditions of payment (see also Section 6.A).
 - ii. The Hospital must provide timely reports to EOHHS on Member progress as a result of being treated with the APAD Carve-Out Drug as required in the prior authorization approval criteria and billing instructions (or other written statements of policy issued by EOHHS).
 - iii. The Hospital must claim separate payment for APAD Carve-Out Drugs in accordance with applicable MassHealth billing instructions, including, without limitation, as set forth herein, in MassHealth billing instructions for 837P via DDE claims (unless otherwise indicated), and in any special billing instructions for Acute Inpatient Hospital claims for APAD Carve-Out Drugs that may be published under “Billing Tips” on the MassHealth website at <https://www.mass.gov/service-details/billing-tips>, EOHHS may

In-State Acute Hospitals

update the billing instructions from time to time. See also Section 5.G.1: Submission of Claims.

- iv. The Hospital's claim must be accompanied by a copy of the invoice (or invoices) for the APAD Carve-Out Drug from the drug manufacturer, supplier, distributor, or other similar party or agent, as well as any other documentation that is necessary for the Hospital to evidence that the amount listed on the claim is the Hospital's actual acquisition cost for the Drug (as defined in Section 5.B.8.b.(2)(a)). Hospitals must provide EOHHS with any additional documentation deemed necessary by EOHHS to establish or verify that the amount included on the claim is the Hospital's actual acquisition cost as defined in Section 5.B.8.b.(2)(a), upon request.
- v. In the event the drug manufacturer (or other party) offers any providers an efficacy-, outcome-, or performance-based guarantee (or similar arrangement) related to the APAD Carve-Out Drug in question, the Hospital shall make every effort to enter such an arrangement with the manufacturer (or other party), at least with respect to the Hospital's treatment of MassHealth Members, and shall make every effort to negotiate terms most favorable to the Hospital and MassHealth. Subject to the requirements of 130 CMR 450.309, in the event the terms of the arrangement allow the Hospital to pay in full or in part for the Drug only if certain conditions are met (e.g., Hospital only pays for the Drug if the Member goes into remission), the Hospital shall not submit a claim to MassHealth for the Drug until the Hospital actually remits the payment it will be required to make for the Drug (and shall not submit any claim for the Drug to MassHealth in the event it is not ultimately required to pay for the Drug). Subject to the above, in the event any other performance-based guarantee (or similar arrangement) is triggered to the benefit of the Hospital with respect to the Member's treatment with the Drug after the Hospital has submitted a claim for the Drug, the Hospital shall immediately notify EOHHS in writing and shall adjust or modify its claim for the Drug to account for the benefit, or otherwise pass the benefit back to MassHealth in the manner specified by EOHHS.

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

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

9. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In-State Acute Hospitals

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

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

- (1) Data Source:** The prior year's claims data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.
- (2) Eligibility:** Eligibility for the adjustment is determined as follows:
 - (a) Exceptionally Long Lengths of Stay:** First, the statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.
 - (b) Exceptionally High Cost:** Exceptionally high cost is calculated for Hospitals providing services to infants less than one year of age as follows.
 1. The average cost per Medicaid inpatient discharge for each Hospital is calculated;
 2. The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated;
 3. The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two, and that amount is added to the Hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.
 - (c) Eligibility for an Infant Outlier Payment:** First, for each Hospital providing services to infants less than one year of age, the average Medicaid inpatient length of stay involving individuals less than one year of age is determined. If this Hospital-specific average Medicaid inpatient length of stay for infants less than one year of age equals or exceeds the threshold defined in Section 5.B.9.a(2)(a), then the Hospital is eligible for an infant outlier payment.

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

In-State Acute Hospitals

b. Pediatric Outlier Payment Adjustment

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

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

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

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

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

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

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

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

1. The average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this Hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in Section 5.B.9.b(2)(a), then the hospital is eligible for a Pediatric Outlier Payment.
2. The cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this Hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in Section 5.B.9.b(2)(b), then the Hospital is eligible for a Pediatric Outlier Payment.
3. Payment to Hospitals: Annually, each Acute Hospital qualifying for a pediatric outlier adjustment will receive \$1,000.

In-State Acute Hospitals

C. Outpatient Hospital Services

Note: Rates for all Outpatient Hospital Services (including Emergency Department services) that are covered under a contract between the Acute Hospital and EOHHS' BH Contractor, or a contract between the Acute Hospital and an MCO, as applicable, and that are provided to MassHealth Members enrolled with EOHHS' BH Contractor or with the MCO, as applicable, shall be governed by terms agreed upon between the Acute Hospital and the BH Contractor, or between the Acute Hospital and the MCO (as applicable), as set forth in Section 4.A.1, 4.A.2 or 4.A.5 (as applicable) of this RFA.

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

Except as otherwise provided for Outpatient Services specified in Section 4.C and Sections 5.C.3 through 5.C.9, 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 2020 APEC**

For dates of service in RY20, 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 August 1, 2018.

(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.

In-State Acute Hospitals

(a) Wage Adjusted APEC Outpatient Standard.

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

1. APEC Outpatient Statewide Standard

The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for wage area index, casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described next.

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 FY14 PAPE paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. Each Hospital's CCR was calculated by EOHHS using the Hospital's FY14 -403 cost report. The Hospital-specific Episodes and related charges were determined by EOHHS based on paid claims for Episodes residing in MMIS as of May 14, 2019, for the APEC Base Year, for which MassHealth was primary payer.

Wage area and casemix adjustments to calculate each hospital's standardized costs per episode: The labor portion of the average outpatient cost per Episode for each Hospital was adjusted by the Hospital's Massachusetts-specific wage area index, which was derived as specified in Section 5.B.1.b, and the labor and non-labor portions were then adjusted by the Hospital-Specific FY14 Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific FY14 Outpatient CMI was determined based on FY14 PAPE paid claims data residing in MMIS as of May 14, 2019, for which MassHealth was primary payer. For each Hospital and month of FY14, an average EAPG weight per Episode was determined by (i) assigning individual EAPGs and associated MassHealth-developed EAPG weights, as adjusted by EOHHS, to the Hospital's PAPE paid claims for the month (utilizing the 3M EAPG Grouper), (ii) summing the individual EAPG weights together, and then (iii) dividing that sum by the Hospital's number of Episodes for the month. The sum of the Hospital's twelve (12) monthly average EAPG weights per Episode for FY14 divided by 12 is the Hospital-specific FY14 Outpatient CMI.

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 FY18 MassHealth Episodes for the Hospitals was produced from MMIS paid claims on file as of May 14, 2019, for which MassHealth was the primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 60% of the total number of statewide Episodes in MMIS. The APEC efficiency standard is \$706.77.

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 95%; and by (c) the Inflation Factors for Operating Costs

In-State Acute Hospitals

between RY14 and RY20, and then dividing that result by a conversion factor of 1.108. The APEC Outpatient Statewide Standard is \$638.56.

2. Wage Adjusted APEC Outpatient Standard

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

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

For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's Wage Adjusted APEC Outpatient Standard will be \$798.16.

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

HOSPITAL	WAGE ADJUSTED APEC OUTPATIENT STANDARD
Group 1 Hospitals that are High Medicaid Volume Safety Net Hospitals	\$699.16
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Boston	\$728.16
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Springfield	\$661.57
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Cambridge-Newton-Framingham	\$681.07

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

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

(2) APEC Outlier Component

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

In-State Acute Hospitals

The Episode-Specific Case Cost is determined by multiplying the Episode's Total Allowed Charges by the Hospital's FY18 Outpatient CCR, calculated by EOHHS using the Hospital's FY18 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 \$3,800. 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)) and the APEC Outlier Component (calculated as set forth in Section 5.C.1.b.(2)).

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

Table 5 -- Example of Hospital's RY20 APEC Calculation for a Single Episode

Line	Description	Value	Calculation or Source
Calculation of Episode-Specific Total EAPG Payment			
1	Episode-Specific Total EAPG Payment	\$3,246.54	Sum of Episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #s 1 through 5 from Table 5.2)
Calculation of APEC Outlier Component (only calculated if Line 1 > \$0)			
2	Episode's Total Allowed Charges	\$15,300.00	Sum of Episode's claim detail line MassHealth allowed

In-State Acute Hospitals

Line	Description	Value	Calculation or Source
			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 FY18 Massachusetts Hospital Cost Report
4	Episode-Specific Case Cost	\$9,180.00	Line 2 * Line 3
5	Fixed Outpatient Outlier Threshold	\$3,800	RY20 RFA
6	Episode-Specific Outlier Threshold	\$7,046.54	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%	RY20 RFA
9	APEC Outlier Component	\$1,280.08	(Line 4 - Line 6) * Line 8
APEC for the Episode			
10	APEC	\$4,526.61	Line 1 + Line 9

Table 5.1 Hospital's Wage Adjusted APEC Outpatient Standard (Example)
 (Values are for demonstration purposes only)

Line	Description	Value	Calculation or Source
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In-State Acute Hospitals

1	APEC Outpatient Statewide Standard	\$638.56	RY20 RFA
2	Hospital's Massachusetts-specific wage area index	1.0642	Varies by Hospital, determined annually
3	Labor factor	0.6000	RY20 RFA
4	Hospital's Wage Adjusted APEC Outpatient Standard	\$663.16	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3))

Table 5.2 -- Claim Detail Line EAPG Payment Amounts (Example)

(Values are for demonstration purposes only)

Claim Detail Line #1 EAPG Payment Amount Calculation

290 EAPG 290 (PET SCANS)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	\$663.16	Table 5.1, Line 4
2	Claim detail line allowed charges	\$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	3.0285	Appendix D, Chart D
4	Claim detail line Adjusted EAPG Weight	3.0285	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	\$2,008.35	Line 1 * Line 4

Claim Detail Line #2 EAPG Payment Amount Calculation

220 EAPG 220 (LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	\$663.16	Table 5.1, Line 4
2	Claim detail line allowed charges	\$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	1.2447	Appendix D, Chart D
4	Claim detail line Adjusted EAPG Weight	1.2447	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	\$825.46	Line 1 * Line 4

Claim Detail Line #3 EAPG Payment Amount Calculation - DISCOUNTED

220 EAPG 220 (LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	\$663.16	Table 5.1, Line 4
2	Claim detail line allowed charges	\$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	1.2447	Appendix D, Chart D
4	Claim detail line Adjusted EAPG Weight	0.6224	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	\$412.73	Line 1 * Line 4

Claim Detail Line #4 EAPG Payment Amount Calculation - CONSOLIDATED

299 EAPG 299 (LEVEL I COMPUTED TOMOGRAPHY)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	\$663.16	Table 5.1, Line 4
2	Claim detail line allowed charges	\$2,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	0.1278	Appendix D, Chart D
4	Claim detail line Adjusted EAPG Weight	0.0000	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	\$0.00	Line 1 * Line 4

Claim Detail Line #5 EAPG Payment Amount Calculation - PACKAGED

400 EAPG 400 (LEVEL I CHEMISTRY TESTS)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	\$663.16	Table 5.1, Line 4
2	Claim detail line allowed charges	\$300.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	0.0635	Appendix D, Chart D
4	Claim detail line Adjusted EAPG Weight	0.0000	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	\$0.00	Line 1 * Line 4

c. Payment System

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

2. Emergency Department Services

In-State Acute Hospitals

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 ESP Services to all Members presenting with a mental health and/or substance use disorder crisis in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24. Furthermore, the Hospital is responsible for assisting in placement for fee-for-service Members requiring inpatient psychiatric treatment, in conjunction with the referring provider, MassHealth, and/or ESP.
- (3) The Hospital shall offer substance use evaluations, treatment, and notification in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24 in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.

b. Payment for Emergency Services

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

3. Outpatient Hospital Services Payment Limitations

a. Payment Limitations on Outpatient Hospital Services Preceding an Admission

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

b. Payment Limitations on Outpatient Hospital Services to Inpatients

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

4. Physician Payments

- a. A Hospital may only receive reimbursement for physician services provided by Hospital-Based Physicians to MassHealth Members. The Hospital must claim payment for the professional component of physician services in accordance with, and subject to: (1) the Physician regulations at 130 CMR 433.000 *et seq.*; (2) the Acute Outpatient Hospital regulations at 130 CMR 410.000 *et seq.*; and (3) other rules regarding physician payment as set forth in this RFA.
- b. Such reimbursement shall be the lower of (1) the fee established in 101 CMR 317.00 (Medicine), 101 CMR 316.00 (Surgery and Anesthesia), 101 CMR 318.00 (Radiology) and 101 CMR 320.00 (Clinical Laboratory Services), or successor regulations as applicable (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge for physician fees; or (3) the Hospital's actual charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than Hospital-Based Physicians as defined in Section 2.

In-State Acute Hospitals

- c. Hospitals will be reimbursed for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.
- d. Physician Services provided by residents and interns are not separately reimbursable.
- e. Hospitals will not be reimbursed for physician services if those services are (1) provided by a Community-Based Physician; or (2) as further described in Section 5.C.
- f. In order to qualify for reimbursement for physician services provided during the provision of Observation Services, the reasons for the Observation Services, the start and stop time of the Observation Services, and the name of the physician ordering the Observation Services, must be documented in the Member's medical record.

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

5. Laboratory Services

a. Payment for Laboratory Services

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

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

- (1) The amount listed in the most current applicable Clinical Laboratory Services fee schedule at 101 CMR 320.00 and the Surgery & Anesthesia fee schedule at 101 CMR 316.00, or successor regulations as applicable (available at the State House Bookstore and at www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html).
- (2) The Hospital's Usual and Customary Charge; or
- (3) The amount that would be recognized under 42 U.S.C. §1395l(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.

In-State Acute Hospitals

6. Audiology Dispensing

a. Payment for Audiology Dispensing Services

Hospitals will be reimbursed for services designated as hearing and 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 (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

In-State Acute Hospitals

- (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 MassHealth website at <https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do>. The list of APEC Carve-Out Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at this website location.
- (2) The APEC Carve-Out Drugs listed on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization through the MassHealth Drug Utilization Review (DUR) Program. See also Sections 4.B.3 and 6.A.

b. Payment for APEC Carve-Out Drugs

- (1) Payment to Hospitals for APEC Carve-Out Drugs administered to Members during an acute outpatient hospital visit will be the lowest of (1) the Hospital’s “actual acquisition cost” of the Drug (as defined below), (2) the WAC of the Drug, and (3) if available, the Medicare Part B rate for the Drug, each as determined by EOHHS. For this purpose, the Hospital’s “actual acquisition cost” of the Drug is the Hospital’s invoice price for the Drug, net of all on- or –off invoice reductions, discounts, rebates, charge backs, and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member during an Acute Outpatient Hospital visit, including any efficacy-, outcome, or performance-based guarantees (or similar arrangements), whether received pre- or post-payment.
- (2) Payment to the Hospital for an APEC Carve-Out Drug is conditioned on and subject to all of the following:
 - (a) The Hospital must have satisfied all applicable MassHealth prior authorization and other applicable prior approval requirements (if any), and all other conditions of payment (see also Section 6.A).
 - (b) The Hospital must provide timely reports to EOHHS on Member progress as a result of being treated with the APEC Carve-Out Drug as required in the prior authorization approval criteria and billing instructions (or other written statements of policy issued by EOHHS).
 - (c) The Hospital must claim payment for APEC Carve-Out Drugs in accordance with applicable MassHealth billing instructions, including without limitation, as set forth herein, in MassHealth billing instructions for 837I via DDE claims (unless otherwise indicated) and in any special billing instructions for Acute Outpatient Hospital claims for APEC Carve-Out Drugs that may be published under “Billing Tips” on the MassHealth website at www.mass.gov/service-details/billing-tips. EOHHS may update the billing instructions from time to time.
 - (d) The Hospital’s claim must be accompanied by a copy of the invoice (or invoices) for the APEC Carve-Out Drug from the drug manufacturer, supplier, distributor, or other similar party or agent, as well as any other documentation that is necessary for the Hospital to evidence that the amount listed on the claim is the Hospital’s actual acquisition cost for the Drug (as defined in Section 5.C.9.b.(1)). Hospitals must provide EOHHS with any additional documentation deemed necessary by EOHHS to establish or verify that the

In-State Acute Hospitals

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 not ultimately required to pay for the Drug). Subject to the previous information, 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.

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 must have received more than 63% of its Gross Patient Service Revenue in FY18 from government payers and free care, as determined by EOHHS based on the Hospital's FY18 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

In-State Acute Hospitals

participation, EOHHS will make \$13 million in total aggregate supplemental payments to qualifying High Public Payer Hospitals, 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 qualifying Hospital will be determined by apportioning a total of \$6.5 million to qualifying Hospitals on a pro-rata basis according to each qualifying Hospital’s number of Accountable Care Partnership Plan (ACPP), Primary Care ACO, MCO, and PCC Plan inpatient discharges in FY20, with each qualifying Hospital’s FY20 ACPP and Primary Care ACO discharge volume weighted at 60%, each qualifying Hospital’s FY20 MCO discharge volume weighted at 20%, and each qualifying Hospital’s PCC Plan discharge volume weighted at 20%, as determined by EOHHS.

The outpatient portion of the supplemental payment amount for each qualifying Hospital will be determined by apportioning a total of \$6.5 million to qualifying Hospitals on a pro-rata basis according to each qualifying Hospital’s number of Accountable Care Partnership Plan (ACPP), Primary Care ACO, MCO, and PCC Plan outpatient episodes in FY20, with each qualifying Hospital’s FY20 ACPP and Primary Care ACO episode volume weighted at 60%, each qualifying Hospital’s FY20 MCO episode volume weighted at 20%, and each qualifying Hospital’s PCC Plan episode volume weighted at 20%, as determined by EOHHS.

For purposes of this calculation, “ACPP, Primary Care ACO, MCO, and PCC Plan inpatient discharges in FY20” 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 “ACPP, Primary Care ACO, MCO, and PCC Plan outpatient episodes in FY20” 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 FY20, respectively, and residing in the MassHealth Data Warehouse as of March 31, 2021, and for the PCC Plan and Primary Care ACO discharges and episodes, Medicaid paid claims data for FY20 residing in MMIS as of March 31, 2021 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.

In-State Acute Hospitals

- (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.

In-State Acute Hospitals

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.

In-State Acute Hospitals

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 RY20 High Public Payer Supplemental Payment pursuant to Section 5.D.1 of this RFA and (2) have provided Inpatient Behavioral Health Services to MassHealth members in FY18. 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.

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

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

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

In-State Acute Hospitals

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 FY18.

“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 19.

“Adult” refers to MassHealth members age 19 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 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 ACP or a Primary Care ACO during the period from October 1, 2018, through September 30, 2019. 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% 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

In-State Acute Hospitals

October 1, 2019, through September 30, 2020, as described in Section 5.D.7.c. Subject to this Section 5.D.7, all sections of this RY20 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 RY20, 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 RY20, 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 FY18 CMS-2552-10 cost report, by the Hospital's number of FY18 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY18 paid claims data residing in MMIS as of March 21, 2019, for which MassHealth is the primary payer.
2. EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY18 and RY20, 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 FY18 inpatient casemix index (CMI), as determined by EOHHS.
4. That result is the CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the APAD Base Payment, used in the APAD calculations for all other Hospitals for admissions in RY20.
5. The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the CAH-Specific Total Standard Rate per Discharge by the discharge-specific MassHealth DRG Weight from Chart C in Appendix C.

The following is an illustrative example of the calculation of the Total Case Payment for a CAH's standard APAD claim that does not also qualify for an Outlier Payment. As noted, values are for demonstration purposes only.

In-State Acute Hospitals

DRG Model Examples - Massachusetts Critical Access Hospitals			
(Values are for demonstration purposes only)			
Table 6: Critical Access Hospital Interim APAD claim			
(Values are for demonstration purposes only)			
Hospital:	Sample Critical Access Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	RY20 CAH-Specific Total Standard Rate per Discharge	\$15,712.34	RY20 RFA
2	MassHealth DRG Weight	0.3547	Appendix C, Chart C
3	Total Case Payment = Adjudicated Payment Amount per Discharge (Interim APAD)	\$5,573.17	Line 1 * Line 2

Outlier Payments and Transfer Per Diem rates for Critical Access Hospitals are calculated and paid as described in Sections 5.B.2 and Section 5.B.3, respectively, except that the APAD used for purposes of those calculations is the CAH's APAD calculated as set forth Section 5.D.7.a.

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 RY20, 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 RY20, 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 FY18 CMS-2552-10 cost report by the Hospital's number of FY18 Medicaid (MassHealth) Episodes. The Hospital's Medicaid (MassHealth) Episode volume was derived from FY18 paid claims data residing in MMIS as of March 21, 2019, 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 RY18 and RY20, 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 FY18 outpatient casemix index (CMI), as determined by EOHHS.
4. That result is the CAH-Specific Outpatient Standard Rate per Episode.
5. The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the CAH-Specific Outpatient Standard Rate per Episode in place of the Wage Adjusted APEC Outpatient Standard, and calculating a CAH APEC payment as otherwise described in Section 5.C.1.b.

c. Post-RY20 Cost Review and Settlement

Each Critical Access Hospital must timely complete all Medicaid (Title XIX) data worksheets on CMS-2552 cost reports for FY20 in accordance with the CMS Provider Reimbursement Manual -

In-State Acute Hospitals

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, 2021, 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 here.

EOHHS will perform a post-RY20 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 FY20, as such amount is determined by EOHHS (“101% of allowable costs”). EOHHS will utilize the Critical Access Hospital’s FY20 CMS-2552-10 cost reports and such other information that EOHHS determines is necessary, to perform this post RY20 review. “Aggregate interim payments” for this purpose shall include all hospital payments made under (i) the RY19 RFA corresponding to the one-month period in FY19 from October 1, 2019, through October 31, 2019, and (ii) the RY20 RFA for the remainder of FY20, as determined by EOHHS, but excluding any payments under Section 5.D.1 and Section 7 under each of the RY19 RFA and the RY20 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 RY20 review and settlement will take place within approximately twelve (12) months after the close of RY20, 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-RY20 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

In-State Acute Hospitals

Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to a qualifying High Medicaid Volume Safety Net Hospital in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as a High Medicaid Volume Safety Net Hospital shall be determined by EOHHS.

9. High Medicaid Volume Safety Net Hospital HLHC Supplemental Payment

In order to qualify for a High Medicaid Volume Safety Net Hospital HLHC supplemental payment, a Hospital must be a High Medicaid Volume Safety Net Hospital that operates an HLHC that experienced a volume of at least 75,000 outpatient episodes in fiscal year 2018, as determined by EOHHS through a review of MMIS claims (“Qualifying HLHC”). Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make \$2 million in total aggregate supplemental payments to Hospitals that qualify for this payment pursuant to the preceding paragraph, divided equally among all qualifying Hospitals, provided that each such Hospital agrees to spend such funds solely for the benefit of its Qualifying HLHC. The payment amount will be specified in an agreement between EOHHS and each qualifying Hospital.

E. Safety Net Care Acute Hospital Payments

In accordance with the terms and conditions of the Commonwealth’s 1115 waiver governing the Safety Net Care Pool (SNCP), and subject to compliance with all applicable federal requirements, the Commonwealth will make additional payments above the amounts specified in Sections 5.B, 5.C, and 5.D to Hospitals which qualify for payments under the SNCP. SNCP payments are authorized by the Centers for Medicare and Medicaid Services (CMS) on a state fiscal year basis for each applicable waiver year.

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

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

F. Federal Financial Participation (FFP)

1. FFP Denials

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

2. Exceeding Limits

a. Hospital-Specific Limits

In-State Acute Hospitals

If any payments made pursuant to this RFA exceed any applicable federal Hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and limits based on federally approved payment methods, such amounts will be deemed an overpayment and EOHHS may recoup, or offset against future payments, any such overpayments.

b. Aggregate Limits

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

G. Billing

Hospitals shall submit claims for non-professional services through an 837I and for the professional component of Hospital-Based Physician (Inpatient and Outpatient) Services through an 837P, except where otherwise indicated by MassHealth regulations, billing instructions, Provider bulletins, or other written statements of policy, and in compliance with all applicable regulations, billing instructions, Provider bulletins, and other written statements of policy, as they may be amended periodically. Until further notice, inpatient Hospital claims for LARC Devices pursuant to Section 5.B.8.a and APAD Carve-Out Drugs pursuant to Section 5.B.8.b must be separately submitted through an 837P via DDE and in compliance with applicable MassHealth regulations, billing instructions, Provider bulletins, and other written statements of policy, as they may be amended periodically.

In the event that a provider's only means of submission is paper, the provider must meet the MassHealth requirements of a paper submission waiver request.

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

Except as described in the next paragraph, EOHHS shall reimburse participating Hospitals for services provided to MassHealth Members who are at acute inpatient status prior to November 1, 2019, and who remain at acute inpatient status on or after November 1, 2019, at the Hospital's MassHealth rates and payment methods established prior to this RY20 RFA, and at the Hospital's MassHealth rates and payment methods established in this RY20 RFA for inpatient services provided to MassHealth members who are admitted on or after November 1, 2019.

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 RY20 RFA apply to dates of service prior to November 1, 2019, and the Hospital's RY20 RFA rates and payment methods apply to dates of service on or after November 1, 2019. 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 RY19, then the APEC methodology under the RY19 RFA applies to the entire Episode.

In-State Acute Hospitals

I. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital Contract in effect on that date. All provisions of the RFA requiring continuing performance shall survive the termination of such RFA.

J. Compliance with Legal Requirements

The parties agree to comply with, and are subject to, all state and federal statutes, rules, and regulations governing the MassHealth Program, and reimbursement and delivery of Acute Hospital services, including but not limited to Acute Inpatient Hospital regulations at 130 CMR 415.000 *et seq.*, Outpatient Hospital regulations at 130 CMR 410.000 *et seq.*, and Administrative and Billing regulations at 130 CMR 450.00 *et seq.*; provided, however, that in the event of any conflict between the documents that are part of the Hospital's Contract with EOHHS and any MassHealth regulation now existing or hereinafter adopted, the terms of the Contract shall prevail. All references to statutes and regulations refer to such statutes and regulations as they may be amended from time to time. In addition, the parties must comply with all applicable billing instructions and Provider bulletins, and other written statements of policy issued by EOHHS and its divisions, as they may be amended from time to time.

K. Eligibility Verification

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

L. Updating Groupers

When groupers are changed and modernized, it may be necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. EOHHS may make adjustments to assure budget neutrality for such grouper changes. EOHHS reserves the right to update to a new grouper.

M. Data Sources

If data sources specified by this RFA are not available, or if other factors do not permit precise conformity with the provisions of this RFA, EOHHS shall select such substitute data sources or other methodology(ies) that EOHHS deems appropriate in determining Hospitals' rates.

N. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital during the effective period of this RFA, EOHHS, in its sole discretion, shall determine on a case-by-case basis: (1) whether the Hospital qualifies for reimbursement under this RFA; and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of this RFA to the extent that EOHHS deems possible. EOHHS' determination shall be based on the totality of the circumstances. Any such rate may, in EOHHS' sole discretion, affect computation of any statewide

In-State Acute Hospitals

average or statewide standard and/or any cost standard or component of such standard. MassHealth provider numbers are not assignable to new entities.

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

O. Headings

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

In-State Acute Hospitals

Section 6: Payment and Reporting Provisions

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

A. Services Requiring Prior Approval

- 1. Services Requiring Practitioner Prior Approval:** EOHHS will not reimburse a Hospital for services provided when the practitioner is required to, but fails to obtain prior authorization, referrals or other approval for the service. It is the Hospital's responsibility to ensure that a practitioner providing services in the Hospital has obtained the necessary approvals.
- 2. Services Requiring Hospital Prior Approval:** Services for which MassHealth requires Hospitals to obtain prior approval or prior authorization may be set forth in MassHealth regulations, Subchapter 6 of the Acute Outpatient Hospital Provider Manual (in the case of Acute Outpatient Hospitals), the MassHealth Acute Hospital Carve-Out Drug List of the MassHealth Drug List (and any other Acute Hospital section of the MassHealth Drug List that may be developed), Provider bulletins, or other written statements of policy issued by EOHHS. EOHHS will not reimburse a Hospital for services provided when the Hospital is required to, but fails to obtain prior authorization, referrals or other required approvals for the service.
- 3. Effect of Prior Authorization:** MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, program restrictions, other MassHealth utilization management or control requirements and approvals, and all other MassHealth conditions of payment.

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

1. Except to the extent prohibited by 42 U.S.C. § 1396a(a)(25)(E) or (F), the Hospital must make diligent efforts, as defined under 130 CMR 450.316(A), to identify and obtain Insurance Payments before billing MassHealth.
2. For Inpatient Admissions, Outpatient Services, and Emergency Department Services where the Member has Third-Party Insurance coverage, EOHHS will pay the Hospital according to Third-Party Liability provisions at 130 CMR 450.316 through 450.321.

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

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

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

Executive Office of Health and Human Services
Office of Medicaid

In-State Acute Hospitals

Attn.: Claims Coordination Unit

UMass-CHCF

The Schrafft Center

529 Main Street, 3rd Floor

Charlestown, MA 02129

D. Sterilization

EOHHS will pay for an inpatient stay for a sterilization or for outpatient sterilization services only when the Hospital meets all requirements regarding Member consent and service delivery as set forth in MassHealth regulations. For any sterilization for which the Hospital does not demonstrate compliance with Member consent requirements, including submission of all required documentation according to all applicable regulations, MassHealth will deduct an amount equal to the Hospital's PAPE in effect October 1, 2016, increased by the Inflation Factors for Operating Costs between Rate Year 2017 and Rate Year 2020, from the applicable Hospital payment amount. Furthermore, the performance of a sterilization without meeting all such requirements may result in sanctions against the Hospital in accordance with 130 CMR 450.238 *et seq.* as well as the applicable provisions of this RFA.

E. Reporting Requirements

All Acute Hospitals must furnish ownership, licensure, financial, and statistical documents relating to MassHealth participation, services, and payment, as required by EOHHS and other governmental entities. This shall include, but is not limited to, state and federal cost reports, charge books, merged billing and discharge filings, audited financial statements, and provider enrollment information. In addition, Critical Access Hospitals must timely complete and furnish all Medicaid (Title XIX) data worksheets on CMS-2552-10 cost reports in accordance with the CMS Provider Reimbursement Manual - Part 2 (CMS publication 15-2) (see Section 5.D.7). If any Acute Hospital does not furnish required information within the applicable time period, or within a reasonable extension of time approved in writing by EOHHS, such Hospital may have a 5% reduction applied to its APAD and inpatient Outlier Payments beginning 45 days after the required submission date. This reduction shall accrue in a cumulative manner of 5% for each month of non-compliance.

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

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

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

In-State Acute Hospitals

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 included here.

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

Such written notification shall be sent to the following address.

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

G. MassHealth Co-payments

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

In-State Acute Hospitals

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

This section sets forth the MassHealth Pay-for-Performance (P4P) Program quality reporting requirements and payment methods for the RY20 RFA. Incentive payments described in Section 7.5 are contingent upon the Hospital's performance of all applicable requirements specified in Section 7.

7.1 Pay-for-Performance Program Requirements:

The MassHealth P4P program shall operate under the following principles:

- A.** Reward Hospitals for excelling in and improving quality of care delivered to MassHealth members, including the reduction of racial and ethnic health disparities.
- B.** Evaluate Hospital performance for RY20 incentive payments, using the quality performance measures in Section 7.3 and the performance assessment methods in Section 7.4.
- C.** Calculate incentive payments in accordance with the methods set forth in Section 7.5.
- D.** To be eligible for incentive payments, Hospitals must adhere to the following standards.

1. Data Accuracy and Completeness:

- a. Hospitals shall ensure that all submitted data is complete, as described in Section 7.3, including, but not limited to, data submitted for each required individual process measure listed in Table 7-1 and identified in Section 7.3.A.1;
- b. Comply with all data collection and submission guidelines, for all measures listed in Table 7-1, as published in the applicable EOHHS Technical Specifications Manual version listed in Table 7-6, to ensure completeness and accuracy of data submitted;
- c. Meet data submission deadlines set forth in Section 7.6.A. Failure to timely submit all data and reporting in the formats required by EOHHS may render the Hospital ineligible for some or all payments under Section 7 of this RFA;
- d. Identify and authorize individuals to conduct electronic data transactions via the EOHHS designated secure portal per Section 7.2.B and Section 7.6.B.1 on the Hospital's behalf;
- e. Identify and authorize individuals to "confer rights" to access nationally reported healthcare-associated infection data for the Hospital reflected in the National Healthcare Safety Network (NHSN) registry surveillance tracking system developed and maintained by the Centers for Disease Control and Prevention (CDC), as required by Section 7.3.A.2.b and 7.6.B.4, on the Hospital's behalf for purposes of this Section 7.

- 2. Data Validation:** Meet the minimum data reliability standards and pass data validation as defined in Section 7.4.B; and

In-State Acute Hospitals

- 3. **Performance:** Achieve quality standards and performance benchmarks, as defined in Section 7.4, on all quality measures data.
- E. All Hospitals contracting with EOHHS are required to participate in P4P quality reporting for all applicable measures. A Hospital's performance with respect to the requirements in Section 7 may affect its present and future participation in the MassHealth program and its rate of reimbursement.

7.2 Hospital Key Quality Representative Requirements

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

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

- A. Serve as the primary contact for all correspondence pertinent to the Hospital's quality performance reports, including responding to all inquiries and requests made by EOHHS, in accordance with the timeframes and format specified by EOHHS.
- B. Identify the key representative responsible for obtaining and responding to quarterly medical record request lists and for receiving annual report results pertaining to all quality measures listed in Table 7-1 of Section 7.3, via the EOHHS designated secure portal, on the Hospital's behalf;
- C. Notify EOHHS of any changes in the key quality representatives that occur during the Contract period as soon as the information becomes available, using the Hospital Quality Contacts Form;
- D. Use the EOHHS mailbox address: Masshealthhospitalquality@state.ma.us to expedite communication between EOHHS and the Hospital on Section 7 requirements and comply with the following conditions that apply to use of this e-mail address:
 - 1. Only the two key quality representatives are automatically entered into the e-mail distribution list of the EOHHS mailbox system. Requests to add other staff not listed on the Hospital Quality Contact Form to this mailbox must be requested in writing.
 - 2. Key quality representatives will receive ongoing updates from the EOHHS mailbox system on quality reporting requirements and other quality-related initiatives during the Contract period.
 - 3. Key quality representatives are responsible for disseminating updates sent from the EOHHS private mailbox system and communicating to all staff and/or third-party vendors involved in quality performance reporting.
- E. **Reporting Requirement.** Each Hospital must complete and submit program participation forms that include information on all staff involved in quality reporting using the Hospital Quality Contacts Form per instructions in Section 7.6.C by the due date(s) set forth in Section 7.6.A.

In-State Acute Hospitals

7.3 Hospital Quality Performance Measures

For RY20, EOHHS has maintained the FY19 hospital quality performance measures that support MassHealth delivery system reform initiatives aimed at ensuring members receive safe and high quality care. There are five inpatient quality measure categories (referred to as “Quality Measure Category(ies)” or “Measure Category(ies)”). EOHHS has designated one or more inpatient measures that it will use to measure compliance with each Quality Measure Category. Table 7-1 displays (a) each Quality Measure Category (five in total) and (b) the inpatient measure(s), identified by Measure ID# and Measure name, that correspond to each Quality Measure Category.

Table 7-1. Hospital Quality Performance Measures

Quality Measure Category	Measure ID#	Measure Name
Perinatal	MAT-4	Cesarean Birth, NTSV
Perinatal	NEWB-1	Exclusive breast milk feeding
Care Coordination	CCM-1	Reconciled medication list received by discharged patient
Care Coordination	CCM-2	Transition record with specified data elements received by discharge patient
Care Coordination	CCM-3	Timely transmission of transition record within 48 hours at discharge
Health Disparity	HD-2	Health Disparities Composite
Safety Outcome	PSI-90	Patient Safety and Adverse Events Composite
Safety Outcome	HAI-1	Central Line-Associated Bloodstream Infection (CLABSI)
Safety Outcome	HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)
Safety Outcome	HAI-3	Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)
Safety Outcome	HAI-4	Clostridium Difficile Infection (CDI)
Safety Outcome	HAI-5	Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)
Patient Experience and Engagement	HCAHPS	Hospital Consumer Assessment of Healthcare Provider Systems Survey (HCAHPS) This measure includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition.

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

In-State Acute Hospitals

- 1. Perinatal, Care Coordination, and Health Disparity Quality Measure Categories:** The measures that comprise the Perinatal Quality Measure Category and the Care Coordination Quality Measure Category are the only individual process measures described in this Section 7. The Health Disparity Quality Measure Category consists of one composite measure. In RY20, Hospitals must collect and report on such measures for which they are eligible based on the measure population definitions and type of service lines provided, as described next.
 - a. Perinatal Quality Measure Category:** This category consists of two individual process measures -- the cesarean birth measure (MAT-4) and the exclusive breast milk feeding measure (NEWB-1). Hospitals must collect and report four quarters of CY2019 data (January 1, 2019 – December 31, 2019) and one quarter of CY2020 data (January 1, 2020 – March 31, 2020) on the MAT-4 and NEWB-1 measures listed in Table 7-1, in accordance with the data submission cycle due dates set forth in Section 7.6.A.
 - b. Quality Measure Category:** This category consists of three individual process measures -- reconciled medication list (CCM-1), transition record with specified data elements (CCM-2), and timely transition of transition record (CCM-3). Hospitals must collect and report on all four quarters of CY2019 data (January 1, 2019 – December 31, 2019) and one quarter of CY2020 data (January 1, 2020 – March 31, 2020) on the CCM-1, CCM-2 and CCM-3 measures, listed in Table 7-1, in accordance with the data submission cycle due dates set forth in Section 7.6.A.
 - c. Health Disparity Quality Measure Category:** The composite measure (HD-2) that comprises this Quality Measure Category will be comprised of aggregate data from the five individual process measures listed in Table 7-1 (MAT-4, NEWB-1, CCM-1, CCM-2 and/or CCM-3) on which the Hospital reports. Hospitals must ensure that all quality measures data that they collect include Race and Hispanic Indicator codes and allowable values, as referenced in the applicable EOHHS Technical Specifications Manual. In addition, Hospitals must ensure that the sampling of cases requested for chart validation purposes includes proper documentation to verify the Race and Hispanic Indicator codes against the quality measures data files.
- 2. Safety Outcome Measures Category.** For RY20, EOHHS has retained the inpatient safety outcome measures category. This category is comprised of the following measures.
 - a. Patient Safety and Adverse Events Composite Measure:** EOHHS has retained the Patient Safety and Adverse Events Composite (PSI-90) measure developed by the Agency for Healthcare Research and Quality (AHRQ). PSI-90 consists of ten AHRQ quality indicators (PSI-3, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14, and PSI-15) that represent potentially preventable complications and adverse events resulting from in-hospital surgical and medical procedures. This claims-based measure will be collected by EOHHS, per Section 7.3.C.2, using methods further described in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required.
 - b. Healthcare-Associated Infections Measures:** EOHHS has retained the five RY19 Healthcare-Associated Infections (HAI) measures that are reported by Hospitals to the NHSN registry

In-State Acute Hospitals

surveillance tracking system developed and maintained by the CDC. The five measures, which are also listed in Table 7-1, are: central line-associated bloodstream infection (HAI-1), catheter-associated urinary tract infection (HAI-2), methicillin-resistant staphylococcus aureus bacteremia (HAI-3), clostridium difficile infection (HAI-4), and surgical site infections for colon and abdominal hysterectomy surgeries (HAI-5). EOHHS will access the relevant data pertaining to these five national registry-based HAI measures from the CDC's NHSN registry surveillance tracking system, through the MassHealth NHSN Group that has been established by EOHHS via arrangements made with the CDC. All Hospitals must enroll in the MassHealth NHSN Group and accept the "confer rights template" for this purpose. Details on the MassHealth NHSN Group enrollment process and acceptance of the "confer rights template" for group users are further outlined in the EOHHS Technical Specifications Manual. See also Section 7.1.D.1.e and 7.6.B.4. No direct electronic data file reporting to EOHHS is required.

3. **Patient Experience and Engagement Measure Category:** In RY20, EOHHS has retained a modified Hospital Consumer Assessment of Healthcare Provider and System (HCAHPS) measure, which is comprised of survey-based dimensions developed by AHRQ for the Centers for Medicare and Medicaid Services (CMS). Survey results are collected and submitted by Hospitals to CMS, which posts them on the Hospital Compare website. For each Hospital, EOHHS will collect the archived data results from the Hospital Compare website for seven (7) survey dimensions: nurse communication, doctor communication, responsiveness of hospital staff, communication about medicines, discharge information, overall rating, and 3-item care transition. Details on each survey dimension are further outlined in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required.

B. EOHHS Technical Specifications Manual. EOHHS publishes a comprehensive manual as a supplement to this RFA, that Hospitals must adhere to for data collection and reporting, and that applies to all quality measures listed in Table 7-1. The EOHHS Technical Specifications Manual contains detailed instructions on clinical and administrative data element specifications, sampling guidelines, data abstraction tools, XML schema tools, data dictionary, portal user system requirements, and more. The EOHHS Manual is regularly updated and Hospitals are responsible for downloading and using the appropriate versions of the EOHHS Manual that apply to each quarterly reporting data period noted in Section 7.6.A. EOHHS Manual versions are posted on the Mass.Gov website at www.mass.gov/eohhs/provider/insurance/masshealth/massqex/

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

1. *Chart-Abstracted Measures Data.* The individual process measures listed in Table 7-1 and identified in Section 7.3.A.1 are chart-abstracted and must be collected and reported by Hospitals on all Medicaid payer data. The Health Disparities quality measure category will be comprised of aggregate data from the individual process measures. Detailed instructions on all Medicaid payer data reporting requirements, including all relevant Medicaid payer codes, are included in the applicable version of the EOHHS Technical Specifications Manual referred to in Table 7-6.

In-State Acute Hospitals

2. *Claims-Based Measures Data.* The data for the PSI-90 composite measure listed in Table 7-1, are claims-based and will be collected on all Medicaid payer data by EOHHS from the Medicaid Management Information System (MMIS) fee-for-service claims and from MCO encounter data in the MassHealth Data Warehouse, using the criteria and methods outlined in the EOHHS Technical Specifications Manual. EOHHS will extract all Medicaid payer data that reflect a six month run-out period after the end of the applicable performance evaluation period, per Section 7.4.G.3.
3. *National Registry-Based Measures Data.* The data for the HAI measures listed in Table 7-1, are national registry-based and are reported by Hospitals on all payer data to the CDC's NHSN registry surveillance tracking system, and the relevant data will be accessed by EOHHS via the MassHealth NHSN Group, per Section 7.3.A.2.b.
4. *National Survey-Based Measures Data.* The data for the seven survey dimensions of the HCAHPS measure listed in Table 7-1, are national survey-based and are reported by Hospitals on all payer data to CMS, and will be obtained by EOHHS from the CMS Hospital Compare website, per Section 7.3.A.3.

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

1. *Chart-Abstracted Measures Data.* Hospitals are required to submit complete data on all individual process measures listed in Table 7-1, including Race and Hispanic Indicator, in the form of electronic data files, aggregate ICD patient population data, and proper documentation for chart validation purposes for each quarterly discharge period being reported. The electronic data files must include all cases that meet the inclusion criteria for each measure's eligible patient population, and conform to the XML file layout format with all required MassHealth patient identifier data. Each Hospital must also enter the ICD patient population data that supplements the upload of electronic data files, for each reporting quarter, via the secure portal, in accordance with instructions set forth in the applicable version of EOHHS Technical Specifications Manual, by submission deadlines listed in Section 7.6.A.
2. *Claims-Based Measures Data.* The PSI-90 composite measure data extracted from Medicaid claims, per Section 7.3.C.2, are subject to meeting data accuracy and completeness requirements as further described in the EOHHS Technical Specifications Manual.
3. *National Registry-Based Measures Data.* EOHHS relies on the completeness and accuracy of the HAI data, as collected and reported by Hospitals to the CDC's NHSN registry surveillance tracking system, that is shared via the MassHealth NHSN Group, per Section 7.3.A.2, to ensure reliability and comparability of results across facilities. Hospitals must adhere to all NHSN required collection and reporting protocols for the HAI measures listed on Table 7-1. Reporting incorrect data or failing to report timely data as required by NHSN protocols will affect the Hospital's eligibility for quality scoring per Section 7.4.
4. *National Survey-Based Measures Data.* EOHHS relies on the completeness and accuracy of nationally reported HCAHPS archived data posted on the CMS Hospital Compare website, per

In-State Acute Hospitals

Section 7.3.A.3, to ensure reliability and comparability of results across facilities. Hospitals must conform to the completed survey minimum requirement protocols, submission deadlines, and applicable versions of the quality assurance guidelines posted on the Center for Medicare and Medicaid Services (CMS) sponsored website www.hcahpsonline.org/. A Hospital's failure to adhere to these CMS requirements will affect the Hospital's eligibility for quality scoring per Section 7.4.

Each Hospital is required to sign and submit the MassHealth Hospital Data Accuracy and Completeness Attestation (DACA) Form that acknowledges reporting and/or service line exemptions for all quality measures, per instructions in Section 7.6.C, by the due date set forth in Section 7.6.A.

7.4 Performance Assessment Methods

Hospital performance assessment and calculation methods that apply to all measures identified in Section 7.3 are described here.

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

- 1. Individual Process Measure Rate (for MAT-4, NEWB-1, CCM-1, CCM-2, and CCM-3):** A measure rate is calculated by dividing the numerator by the denominator, to obtain a percentage for each individual process measure. The numerators and denominators for the applicable individual process measures listed in Table 7-1 are further defined in the applicable EOHHS Technical Specifications Manual listed in Table 7-6. All measure rate results are rounded to the nearest integer (e.g., 3.3 is rounded to 3.0; 3.5 is rounded to 4.0).
- 2. Health Disparities Composite Measure Result:** The HD-2 measure is calculated by dividing the composite numerator rate by the composite denominator rate for each racial/ethnic group. For each racial/ethnic group on which the Hospital reports, the composite numerator rate is created by summing the numerators of individual process measures for the racial/ethnic group, and the composite denominator rate is created by summing the denominators of individual process measures for the racial/ethnic group. A separate reference group composite rate is calculated by combining all racial/ethnic groups from the Hospital's reported data. Each racial/ethnic group composite rate for an individual Hospital is then compared to the reference group composite rate, and a between group variance (BGV) statistic is calculated for each racial/ethnic composite group. Each of the racial/ethnic group BGV statistics are summed to yield the final disparity composite value BGV statistic. The composite measure and disparity composite value are calculated only for Hospitals that report on more than one racial/ethnic group in their electronic data files submitted for the individual process measures. The numerators and denominators for this HD-2 measure are further defined in the applicable EOHHS Technical Specifications Manual listed in Table 7-6.
- 3. PSI-90 Composite Measure Result.** The PSI-90 composite value for the PSI-90 composite measure is calculated as a weighted average of the risk-adjusted and reliability-adjusted rates for the ten indicators combined. For each of the ten AHRQ quality indicators listed in Section 7.3.A.2.a, the observed and expected rates, risk-adjusted rates, smoothed rates, and reliability weights are computed using the applicable version of AHRQ Quality Indicators Software. If the number of eligible discharges is fewer than three for the ten PSI-90 indicators combined, the PSI-

In-State Acute Hospitals

90 composite value is not calculated due to insufficient data. Details on the calculation methods and AHRQ software versions used to compute the PSI-90 composite value are further described in the applicable EOHHS Technical Specifications Manual listed in Table 7-6.

4. **Healthcare-Associated Infection Measures Results.** EOHHS will obtain each Hospital's standard infection ratio (SIR) output value for each HAI measure listed in Table 7-1, as calculated by the CDC, from the CDC's NHSN registry surveillance tracking system via the MassHealth NHSN Group per Section 7.3.A.2. EOHHS will not calculate independent SIR output values but will rely on the CDC's calculations. The SIR output value is only calculated by the CDC for an HAI when the number of predicted infections is at least 1.0, and is not computed by CDC when the predicted number of infections is less than 1.0. Details regarding the calculations of SIR output values are further described in the applicable EOHHS Technical Specifications Manual listed in Table 7-6.
5. **Patient Experience and Engagement Measure Result:** EOHHS will obtain the archived HCAHPS measure "top box" raw results directly from the Hospital Compare website. The "top-box" raw score for each of the seven survey dimensions is the unrounded percentage of a Hospital's patients who chose the most positive, or "top-box," response to a survey item. The "top box" raw result calculation includes a CMS patient-mix adjustment and survey-mode adjustment, and each result is rounded to the nearest integer (e.g., 3.3 is rounded to 3.0; 3.5 is rounded to 4.0). If a Hospital has completed fewer than 100 surveys, it is identified on the Hospital Compare website as not having sufficient data for CMS to calculate results for this measure.

B. Data Validation Requirements. All reported individual process measures are subject to data validation that requires meeting the minimum reliability standard of 80 percent for data elements. Hospitals are considered to have "passed" validation if the overall agreement rate of 80 percent has been met, based only on the first three quarters of CY2019 data (Q1-2019, Q2-2019, and Q3-2019) that the Hospital must collect and report during RY20 (see Sections 7.3.A.1 and 7.6.A). Passing data validation is required prior to computing a Hospital's performance scores on each individual process measure category pursuant to Section 7.5. The applicable EOHHS Technical Specifications Manual version, listed in Table 7-6, provides detailed information on data validation methods.

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

1. Setting Performance Thresholds

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

In-State Acute Hospitals

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

Performance thresholds for each individual process measure (i.e., MAT-4, NEWB-1, CCM-1, CCM-2, and CCM-3) are derived from hospital reported data. Attainment and benchmark performance thresholds are calculated using the previous year all Medicaid payer hospital-reported data.

- 2. **Quality Points System.** A Hospital's performance on each individual process measure reported will be calculated using a quality point system. Hospitals can earn a range of quality points (from 0-10 points) based on where the Hospital's measure rate falls, relative to the attainment, improvement and the benchmark as follows.
 - a. **Attainment Points.** A Hospital can earn points for attainment based on relative placement between the attainment and benchmark. If a Hospital's rate for the measure is:
 - i. Equal to or less than the attainment threshold, it will receive zero (0) points for attainment.
 - ii. Within the attainment range (greater than the attainment threshold but below benchmark) it will receive anywhere from 1 to 9 points for attainment.
 - iii. Equal to or greater than the benchmark, it receives 10 points for attainment.
 - b. **Improvement Points.** A Hospital can earn points for improvement based on how much the Hospital's measure rate has improved from the previous reporting year period. If a Hospital's rate for the measure is:
 - i. Equal to or less than previous year, it will receive zero (0) points for improvement.
 - ii. Within the improvement range, it will receive anywhere from 0 to 9 points for improvement.
- 3. **Quality Points Criteria.** The following criteria apply to awarding quality points for each individual process measure on which the Hospital reports:
 - a. **Data Validation Standard:** If the Hospital has failed validation in the previous reporting year, data from that period is considered invalid for use in calculating comparative year performance. Therefore, the Hospital would not be eligible for improvement points. However, the Hospital may be eligible for attainment points on each individual process measure, based on calculation of calendar year 2019 data reported on the measure in RY20, if it passed validation in RY20 and also met the criteria in Section 7.4.C.3.b.
 - b. **Awarding Points:** Attainment or improvement points are awarded only after the hospital has established an initial baseline rate for each eligible measure. The initial baseline rate serves as the starting point that will be used to compare future performance data. Attainment or improvement points are not awarded for a newly reported measure. Data for newly reported measures are used to set the all- hospital attainment and benchmark thresholds for the following year.

In-State Acute Hospitals

- c. Suboptimal Performance:** When the attainment and benchmark thresholds for all hospitals indicate suboptimal performance, then no attainment points will be assigned for any hospital (e.g., when improvement would be indicated by an increase in score, but the attainment or benchmark threshold is 0%; or when improvement would be indicated by a decrease in score, but the attainment or benchmark threshold is 100%).
 - d. Case Minimum:** To be included in EOHHS's Section 7.4.C performance assessment for a particular individual process measure, a Hospital's reported data for that measure must contain at least 25 cases in the denominator population. Hospitals that do not meet the case minimum for a particular individual process measure are ineligible to receive incentive payments for that measure.
- D. Health Disparities Composite Measure Performance Assessment.** The health disparities composite measure (HD-2) performance will be assessed using the following methodology:
- 1. Minimum:** To be included in EOHHS's Section 7.4.C performance assessment for the health disparities composite measure, a Hospital's reported data for that measure must contain at least 25 cases in the reference group. Hospitals that do not meet the case minimum for that health disparities composite measure are ineligible to receive incentive payments for that measure.
 - 2. Decile Rank Method.** Performance will be assessed using a method that determines the Hospital's rank, relative to other hospitals, based on the decile ranking system. Hospitals that meet the measure calculation criteria, per Section 7.4.A.2 are divided into ten groups (deciles) based on their disparity composite value, so that approximately the same number of hospitals fall within each decile.
 - 3. Target Attainment Threshold.** The target attainment threshold represents the minimum level of performance that must be achieved to earn incentive payments. The target attainment is defined as the boundary for a disparity composite value that falls above the 2nd decile group, as shown in Table 7-2.
 - 4. Disparity Composite Value Ranking.** All Hospital disparity composite between group variance (BGV) values, computed per Section 7.4.A.2, are rounded to six decimal places. All disparity composite BGV values are ranked from highest to lowest so that approximately the same number of hospitals fall in each decile group. Hospitals that do not meet data validation standards set forth in Section 7.4.B are excluded from decile ranking.
 - 5. Conversion Factor.** Each decile group is assigned a weighted conversion factor associated with the decile threshold, as shown in Table 7-2.

In-State Acute Hospitals

Table 7-2 Decile Group Thresholds

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

To meet the target attainment threshold, the Hospital's disparity composite BGV value must be above the upper boundary of the 2nd decile. Disparity composite BGV values that are not above the upper boundary of the 2nd decile (i.e., fall into the 1st or 2nd decile) are assigned a conversion factor of zero. All disparity composite values that fall within the same given decile group are assigned the same conversion factor.

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

1. Scoring Eligibility. The Hospital's safety outcomes measure category will be evaluated using both the Hospital's PSI-90 composite value calculated as described in Section 7.4.A.3, as well as the Hospital's SIR output values for each of the five HAI measures, calculated in accordance with section 7.4.A.4. Each Hospital must meet the criteria for having sufficient data, as defined in Section 7.4.A.3 or 7.4.A.4, as applicable, to be eligible for the Winsorized z-scoring method described next.

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

- a. A Winsorized measure result is obtained by creating a continuous rank distribution of all eligible Hospitals' raw values, defined in Section 7.4.E.1, that are truncated at the 5th and 95th percentiles to determine the relative position of where each measure value falls in the distribution. Each Hospital's Winsorized measure result is determined separately for the PSI-90 composite measure and for each of the five HAI measures, as follows.
 - i. If the Hospital's measure value falls between the minimum and the 5th percentile, then the Hospital's Winsorized measure result is equal to the measure value that corresponds to the 5th percentile.
 - ii. If the Hospital's measure value falls between the 95th percentile and the maximum, then the Hospital's Winsorized measure result is equal to the measure value that corresponds to the 95th percentile.

In-State Acute Hospitals

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

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

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

- 3. **Safety Outcomes Measure Category Performance Scoring.** The Hospital's Safety Outcome Measure Category performance will be evaluated using the z-scores assigned, per Section 7.4.E.2, and is calculated as the equally weighted average of the PSI-90 composite measure z-score and each HAI measure that has a z-score, using the methods described here.
 - a. **Equal Measure Weights Method.** The assigned weights that will apply to each safety measure z-score under the equal measure weights method are shown in Table 7-3.

In-State Acute Hospitals

Table 7-3 Safety Outcome Equal Measure Weights

Number of HAI measures with a z-score	Weight applied to PSI-90	Weight applied to each HAI measure
0 (zero)	100.0	Not applicable
1	50.0	50.0
2	33.3	33.3
3	25.0	25.0
4	20.0	20.0
5	16.7	16.7
Any number (1 through 5)	Not applicable; no PSI-90 z-score	100.0 equally divided

As shown in Table 7-3, the equal measure weights method assigns the same weight to the PSI-90 and to each of the five HAI measures for which the Hospital has a z-score. Following are examples. If the Hospital has a z-score for PSI-90 and for only one HAI measure, then the weight of 50 would be assigned to each measure z-score. If the Hospital has a z-score for PSI-90 and for three HAI measures, then the weight of 25 would be assigned to each measure z-score. If a Hospital has no PSI-90 z-score and one or more HAI measure z-scores, then the weight of 100 is equally divided among the HAI measure z-scores. If the Hospital has only one PSI-90 z-score and no HAI measure z-score, then a weight of 100 is given to the PSI-90 measure z-score. If the Hospital has no z-scores for any of the safety outcome measures listed in Table 7-1, then it will not receive a safety outcome measure overall z-score.

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

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

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

4. **Setting Threshold.** The Hospital's performance on the Safety Outcomes Measure Category z-score is assessed using the methods described here.
- a. **Interquartile Rank Method.** Performance is assessed using a method that determines the Hospital's rank, relative to other hospitals, and divides the ranked results into four approximately equal quartile groups. The Hospitals' Safety Outcomes Measure Category z-score values are rounded to six decimal places and ranked highest (worse) to lowest (best) in performance.
- b. **Minimum Attainment Threshold.** The Safety Outcomes Measure Category z-score threshold represents the minimum level of performance that must be attained to earn incentive payments. The minimum attainment threshold is defined as the lower boundary for the overall safety outcomes measure z-score values that fall above the 1st quartile group.

In-State Acute Hospitals

- c. **Conversion Factor.** Each quartile group is assigned a conversion factor as shown in Table 7-4.

Table 7-4 Quartile Group Thresholds

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

To meet the minimum attainment threshold, the Hospital's overall Safety Outcomes Measure Category z-score must be above the upper boundary of the 1st quartile (i.e., fall into the 2nd, 3rd, or 4th quartile). A lower z-score represents better performance and a higher z-score represents worse performance. All values that fall within the same quartile group are assigned the same conversion factor.

- F. Patient Experience and Engagement Measure Category Performance Assessment.** The Hospital's performance for the Patient Experience and Engagement Measure Category will be assessed using methods described below.

- 1. Setting Performance Thresholds:** Performance thresholds will be set, and the Hospital's performance on each of the seven HCAHPS survey dimensions will be assessed on levels of attainment, improvement and benchmark using the same methods that apply to the individual clinical process measures as described in Section 7.4.C.1.
- 2. Quality Points Systems:** The Hospital's performance on each survey dimension will be calculated using the same quality points system that applies to the individual clinical process measures as described in Section 7.4.C.2.
- 3. Awarding Quality Points:** Attainment and improvement points cannot be calculated and, if applicable, awarded to a Hospital unless it has previously established a baseline rate for each survey dimension, based on evidence from data files downloaded by EOHHS from the CMS Hospital Compare website.

Attainment and benchmark performance thresholds on the HCAHPS survey dimensions are calculated using HCAHPS state-level data obtained from the CMS Hospital Compare website corresponding to the prior year period for this measure referenced in Section 7.4.G.5.

- G. Performance Evaluation Periods.** In RY20, the following performance evaluation periods apply to each performance measure listed in Table 7-1.

- 1. Individual Process Measures (MAT-4, NEWB-1, CCM-1, CCM-2, and CCM-3):** Each individual process measure's performance will be evaluated using calendar year measures data reported for the comparison year discharge period (January 1, 2019, to December 31, 2019) and the reported data for the previous year discharge period (July 1, 2018, to December 31, 2018).

In-State Acute Hospitals

2. **Health Disparities Composite Measure:** Each Hospital's performance will be evaluated using all applicable individual process measures data reported, pursuant to Section 7.4.A.2, for the calendar year discharge period only (January 1, 2019, to December 31, 2019). The decile ranking method evaluates performance on a year-by-year basis. Each year the Hospital's performance rank will be determined using the decile ranking method described in Section 7.4.D.
3. **PSI-90 Composite Measure:** Each Hospital's PSI-90 composite measure performance will be evaluated using a 24 month (October 1, 2016, to September 30, 2018) discharge period collected from all Medicaid paid claims data, per Section 7.3.C.2, using the methods described in the EOHHS Technical Specifications Manual. The quartile ranking method described in Section 7.4.E.4 evaluates performance using the defined period only and does not use comparison year data.
4. **Healthcare-Associated Infection Measures.** Each Hospital's HAI measure performance will be evaluated using a 24 month period (January 1, 2017 – December 31, 2018) of data collected from the CDC's NHSN registry surveillance tracking system via the MassHealth NHSN Group, per Section 7.3.A.2.b, using the quartile ranking method described in Section 7.4.E.4. The 24-month data snapshot reflects the final results computed by the CDC. The quartile ranking method described in Section 7.4.E.4 evaluates performance each year using the defined data period only and does not use comparison year data.
5. **Patient Experience and Engagement Measure.** Each Hospital's HCAHPS patient survey dimensions will be evaluated using calendar year data for the comparison year discharge period (January 1, 2018, to December 31, 2018) and previous year (January 1, 2017, to December 31, 2017) collected from the CMS Hospital Compare website. These 12-month data snapshots reflect the final result data files downloaded from the CMS Hospital Compare website after the national reporting correction deadlines associated with the measurement period have passed.

For detailed information about performance measurement periods that apply to all quality measures, refer to the applicable EOHHS Technical Specifications Manual version listed in Table 7-6.

H. Performance Score Calculations. A Hospital's performance score for the performance measures listed in Table 7-1 and described in Section 7.3 will be computed using the methods described next.

1. **Individual Process Measures Performance Score.** A Hospital's performance score, for each individual process measure on which it is eligible to report, is calculated based on the quality point system methods outlined in Section 7.4.C. The following methods apply to computing the points earned for the individual process measures.
 - a. **Attainment Points.** The number of "attainment points" a Hospital receives is determined by the ratio of the difference between the Hospital's measure rate and the attainment threshold divided by the difference between the benchmark and the attainment threshold. This ratio is multiplied by 9 and increased by 0.5. The Hospital's "attainment points" will be calculated based on the following formula.

In-State Acute Hospitals

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

- b. **Improvement Points.** The number of “improvement points” a Hospital receives is determined by the ratio of the difference between the Hospital’s Current Measure Rate and the Previous Year’s Measure Rate divided by the difference between the benchmark and the Previous Year’s Measure Rate. This ratio is multiplied by 10 and decreased by 0.5. The Hospital’s “improvement points” will be calculated based on the following formula.

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

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

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

Total Awarded Points	$\times 100\% = \text{Perinatal and Care Coordination Measures Categories Total Performance Score}$
Total Possible Points	

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

(Conversion Factor) x 100% = Health Disparities Composite Measure Performance Score

3. **Safety Outcomes Measure Category Performance Score.** The performance score for the Safety Outcomes Measure Category reflects the equivalent of the assigned conversion factor, per Section 7.4.E, that is calculated based on the following formula.

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

4. **Patient Experience and Engagement Quality Measure Category Performance Score.** A Hospital’s performance score on each of the seven HCAHPS survey dimensions listed in Table 7-1 and described in Section 7.3.A.3, is calculated based on the quality point system methods

In-State Acute Hospitals

referenced in Section 7.4.F, and Section 7.4.H.1.a and 7.4.H.1.b. For these calculations, the “Previous Year” refers to the prior year period for this measure referenced in Section 7.4.G.5.

All attainment and improvement points earned on each dimension will be calculated using the formulas for calculating attainment points and improvement points that are described in Section 7.4.H.1.a and 7.4.H.1.b. All attainment and improvement points earned on each dimension will be rounded to the nearest whole number (e.g., 3.3 is rounded to 3.0 and 3.5 is rounded to 4.0). For each dimension, the quality points awarded are the higher of the attainment or the improvement points earned. The quality points awarded for the seven dimensions, as applicable, are then summed to determine the total awarded points. The total awarded quality points are divided by the total possible points, and then multiplied by 100% to obtain the total performance score for the Quality Measure Category, based on the following formula.

Total Awarded Points	× 100% = Patient Experience and Engagement Quality Measure Category Total Performance Score
Total Possible Points	

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

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

A. Incentive Payment Approach. In RY20, incentive payment approaches will be based on pay-for-performance (P4P) for all measures listed in Table 7-1.

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

- 1. Maximum Allocated Amount.** Incentive payments under this Section 7 may cumulatively total no more than the maximum amount allotted by EOHHS for each Quality Measure Category in Table 7-5.

Table 7-5. Payment Calculation Components

Quality Measure Category	Maximum Allocated Amount	Estimated Eligible Medicaid Discharges	Estimated Per Discharge Amount
Perinatal	\$ 5,500,000	25,526	\$ 215.47
Care Coordination	\$ 9,000,000	49,235	\$ 182.80
Health Disparities	\$ 1,500,000	63,330	\$ 23.69
Safety Outcome	\$ 4,500,000	22,689	\$ 198.33
Patient Experience and Engagement	\$ 4,500,000	21,919	\$ 205.30
TOTAL	\$25,000,000	--	--

In-State Acute Hospitals

- 2. Eligible Medicaid Discharges.** For purposes of Section 7.5, “MMIS Discharge Data” refers to acute inpatient hospital discharge data from MMIS paid claims for PCC Plan, Primary Care ACO, and Fee-for-Service discharges only, for which MassHealth is the primary payer, as of a date to be determined by EOHHS. The estimated eligible Medicaid discharges and estimated per-discharge amount for each Quality Measure Category, listed in Table 7-5, are calculated based on FY18 MMIS Discharge Data. The actual final eligible Medicaid discharges and final per-discharge amount for each Quality Measure Category listed in Table 7-5 will be calculated based on FY19 MMIS Discharge Data, using the methods set forth in Sections 7.5.B.2.a through 7.5.B.2.d, as applicable.
- a. Perinatal and Care Coordination Quality Measure Categories:** For the Perinatal and Care Coordination Quality Measure Categories referenced in Table 7-5, the final eligible Medicaid discharges will be determined based on the number of Hospital discharges in the FY19 MMIS Discharge Data (described in Section 7.5.B.2), as determined by EOHHS, which meet the International Classification of Diseases (ICD) population requirements referenced in the EOHHS Technical Specifications Manual corresponding to the individual process measures on which the hospital reported, pursuant to Section 7.3, and that are included in the applicable Quality Measure Category.
 - b. Health Disparities Quality Measure Category.** The final eligible Medicaid discharges for the Health Disparities Quality Measure Category referenced in Table 7-5 will be determined based on the total number of “unique discharges” in the FY19 MMIS Discharge Data for the underlying individual process measures considered as a whole, so that each unique discharge is only counted once. A unique discharge is a single paid claim for a hospital discharge that meets the ICD population requirement for one or more of the individual process measures the hospital reported on, and that meets the criteria for the HD-2 composite measure calculation per Section 7.4.A.2.
 - c. Safety Outcomes Quality Measure P4P Category.** For the Safety Outcomes) P4P Quality Measure Category referenced in Table 7-5, the final eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY19 MMIS Discharge Data, as described in Section 7.5.B.2, which meet the medical and surgical All Payer Refined Diagnosis Related Group (APR-DRG) codes associated with AHRQ clinical measure specification manuals referenced in the EOHHS Technical Specifications Manual.
 - d. Patient Experience and Engagement Quality Measure P4P Category.** For the Patient Experience and Engagement Quality Measure Category referenced in Table 7-5, the final eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY19 MMIS Discharge Data, as described in Section 7.5.B.2, which meet the medical, surgical, vaginal deliveries, and cesarean All Payer Refined Diagnosis Related Group (APR-DRG) service line codes as referenced in the EOHHS Technical Specifications Manual.
- 3. P4P Quality Measure Category per-Discharge Amount.** Table 7-5 estimates the per-discharge amount for each Quality Measure Category based on FY18 MMIS Discharge Data. The final per-

In-State Acute Hospitals

discharge amounts will be determined based upon FY19 MMIS Discharge Data for each Quality Measure Category listed in Table 7-5. To determine these amounts, EOHHS will use the following formula.

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

For each Quality Measure Category, EOHHS has established a maximum allocated amount, specified in Table 7-5. The maximum allocated amount will be divided by the statewide eligible Medicaid discharges for that Quality Measure Category across all Hospitals eligible to report on measures in that Quality Measure Category, to determine the per-discharge amount for that Quality Measure Category.

C. Incentive Payment Formulas. Payments for each Quality Measure Category listed in Table 7-5 will be calculated based on the following formulas:

- 1. Perinatal and Care Coordination Quality Measure Categories:** Separately for each of the Perinatal and Care Coordination Quality Measure Categories, EOHHS will calculate incentive payments by multiplying the Hospital's eligible Medicaid discharges for each Quality Measure Category, per Section 7.5.B.2.a, by the Quality Measure Category per-discharge amount, and by the Hospital's total performance score for the Quality Measure Category, per Section 7.4.H, using the following formula.

$$(\text{Hospital's Eligible Medicaid Discharges}) \times (\text{Quality Measure Category per-Discharge Amount}) \times (\text{Hospital's Quality Measure Category Total Performance Score}) = \text{Hospital P4P Payment for the Quality Measure Category}$$

- 2. Health Disparities Quality Measure Category:** EOHHS will calculate incentive payments will be calculated for the Health Disparities Composite (HD-2) Quality Measure Category listed in **Table 7-5**, by multiplying the Hospital's eligible Medicaid discharges, per Section 7.5.B.2.b, by the Quality Measure Category per-discharge amount, and by the Hospital's Health Disparities Composite performance score, per Section 7.4.H, using the following formula.

$$(\text{Hospital's Eligible Medicaid discharges}) \times (\text{Quality Measure Category per-Discharge Amount}) \times (\text{Hospital's Health Disparities Composite Performance Score}) = \text{Hospital P4P Payment for Health Disparities Quality Measure Category}$$

- 3. Safety Outcomes Quality Measure Category:** EOHHS will calculate incentive payments for the Safety Outcomes Quality Measure Category listed in Table 7-5 by multiplying the Hospital's eligible Medicaid discharges, per Section 7.5.B.2.c, by the Quality Measure Category per-discharge amount, and by the Hospital's Safety Outcomes Quality Measure Category performance score, per Section 7.4.H, using the following formula.

$$(\text{Hospital's Eligible Medicaid Discharges}) \times (\text{Quality Measure Category per-Discharge Amount}) \times (\text{Hospital's Safety Outcomes Quality Measure Category Performance Score}) = \text{Hospital P4P Payment for Safety Outcomes Quality Measure Category}$$

In-State Acute Hospitals

- 4. Patient Experience and Engagement Quality Measure Category:** EOHHS will calculate incentive payments for the Patient Experience and Engagement Quality Measure Category listed in Table 7-5 by multiplying the Hospital's eligible Medicaid discharges, per Section 7.5.B.2.d, by the Quality Measure Category per-discharge amount, and by the Hospital's Patient Experience and Engagement Quality Measure Category total performance score, per Section 7.4.H, using the following formula.

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

A Hospital's total incentive payment will be the sum of the P4P incentive payments for each Quality Measure Category listed in Table 7-5 for which the Hospital qualifies for payment. This aggregate sum is also referred to as the "Hospital's Final RY20 RFA Total P4P Payment Amount".

7.6 Pay-for-Performance Reporting Requirements

Each Hospital must comply with all data reporting requirements, portal registration, MassHealth NHSN group enrollment procedures, and the submission of hard-copy program participant forms as set forth below.

- A. Data Submission Timelines.** All electronic data files for the hospital quality performance individual process measures listed in Section 7.3 must be submitted in quarterly reporting cycles by the due dates noted in Table 7-6.

Table 7-6. Hospital Data Submission Timelines

Submission Due Date	Data Submission Requirement	Data Reporting Format	Reporting Instructions
October 1, 2019	<ul style="list-style-type: none"> Hospital Quality Contacts Form Hospital Data Accuracy and Completeness Attestation Form 	HospContact_2020 Form HospDACA_2020 Form	RFA Section 7.2.E RFA Section 7.3.D
November 15, 2019	<ul style="list-style-type: none"> Q2-2019 (Apr – June 2019) data Q2-2019 ICD population data Q2-2019 Medical records request 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specifications Manual (Version 12.0, 12.1)
February 14, 2020	<ul style="list-style-type: none"> Q3-2019 (July – Sept 2019) data Q3-2019 ICD population data Q3-2019 Medical records request 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specifications Manual (Version 13.0)
May 15, 2020	<ul style="list-style-type: none"> Q4-2019 (Oct – Dec 2019) data Q4-2019 ICD population data No Q4 Medical records required 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specifications Manual (Version 13.0)
August 14, 2020	<ul style="list-style-type: none"> Q1-2020 (Jan – Mar 2020) data Q1-2020 ICD population data Q1-2020 Medical records request 	Electronic Data Files; and ICD online data entry form (via MassQEX Portal)	Technical Specifications Manual (Version TBD)

- B. Data Reporting Format.** All electronic data for the individual clinical process measures must be submitted using the following formats.

In-State Acute Hospitals

- 1. MassHealth Quality Exchange (MassQEX) Portal.** EOHHS has designated the MassQEX website as the secure portal for the submission of all electronic data files required in Section 7.3 that meets HIPAA requirements to ensure data confidentiality is protected. All Hospitals must identify and authorize staff that will conduct data transactions on their behalf, plus meet portal system requirements. All users of the MassQEX portal system are required to complete the on-line registration form via the website, which requires authorization from the Hospital's Chief Executive Officer and the EOHHS vendor to establish user accounts for uploading data, per instructions set forth in the EOHHS Technical Specifications Manual as described in Section 7.3.B in this RFA. The MassQEX web portal can only be accessed by registered users through the following URL: www.mass.gov/eohhs/provider/insurance/masshealth/massqex/
 - 2. ICD On-line Data Entry Form.** All aggregate ICD patient population data must be reported via the secure web portal using the on-line data entry form. This form is only visible to registered users after they have logged into the MassQEX system. Hospitals must comply with ICD data entry for each quarterly submission cycle even when the hospital has zero cases to report during a given quarter. Only Hospitals, and not third-party data vendors, are authorized to enter ICD data. Instructions on how to access and enter the ICD data are contained in the appropriate EOHHS Technical Specifications Manual as described in Section 7.3.B.
 - 3. Third-Party Data Vendors.** Hospitals can identify third-party vendors to conduct clinical data file transactions on their behalf via the MassQEX secure portal. Third-party data vendors must follow the registration process and establish user accounts, if previously authorized by the Hospital. Hospitals are responsible for communicating directly with their data vendors on all aspects of data reporting requirements set forth in Section 7 of this RFA, including adherence to the appropriate versions of the EOHHS Technical Specifications Manual to ensure completeness and accuracy of data files submitted on the Hospital's behalf.
 - 4. MassHealth NHSN Group Enrollment.** Each Hospital must complete and accept the "confer rights template" to facilitate the exchange of the Hospital's healthcare-associated infection (HAI) measures data for performance evaluation purposes, per Section 7.4. Details on how to enroll and confer rights are further outlined in the EOHHS Technical Specifications Manual described in Section 7.3.B in this RFA.
- C. Program Participant Hard Copy Reporting Forms.** Each Hospital is required to submit the MassHealth Hospital P4P Program participation hard-copy forms per instructions set forth below:
- 1. Hospital Quality Contacts Form.** Each Hospital must complete and submit information on all staff involved in quality reporting, using the HospContact_2020 pdf fillable form pursuant to Section 7.2.E. This form is due at the beginning of the rate year (by the due date set forth in Table 7-6) and must be resubmitted when any change in key quality representatives and MassQEX portal users listed occurs.
 - 2. MassHealth Hospital Data Accuracy and Completeness Attestation Form.** Each Hospital must submit this form to acknowledge data completeness requirements pursuant to Section 7.3.D using

In-State Acute Hospitals

the HospDACA_2020 pdf fillable form. This form must be signed by the Hospital's chief executive officer (CEO) and is due at the beginning of each rate year (by the due date set forth in Table 7-6), and must be resubmitted when any change to the Hospital's CEO occurs.

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

Hospitals must mail the original signed Hospital Quality Contacts Form and the Hospital Data Accuracy and Completeness Attestation Form, with a typed cover letter using Hospital stationary that identifies content enclosed, to the following address.

Iris Garcia-Caban, PhD
Executive Office of Health and Human Services
MassHealth Acute Hospital Program Office of Providers and Pharmacy Programs
100 Hancock Street, 6th Floor
Quincy, MA 02171

Hard-copy submissions must be postmarked by close of business on the due date specified in Table 7-6.

In-State Acute Hospitals

Section 8: Other Quality- and Performance-Based Payments

The following provisions regarding the MassHealth Acute Hospital 30-day Readmissions Policy (30-Day RP), Provider Preventable Conditions (PPCs), and Serious Reportable Events (SREs), reflect and further EOHHS' commitment to value-based purchasing and to help ensure safer and cost-effective care delivery to MassHealth members by encouraging Hospitals to establish measures and actions to actively improve performance in patient care safety, reduce readmissions, and avoid preventable errors.

8.1 30-day Readmissions Policy (30-Day RP)

In RY20, MassHealth is continuing an Acute Hospital 30-day Readmissions Policy for in-state acute hospitals; the terms of which are set forth in this Section 8.1. In order to allow Hospitals further opportunity to proactively identify processes to improve performance and reduce or eliminate potentially preventable readmissions in preparation for the full implementation of the 30-day Readmissions Policy, MassHealth is continuing a transitional period, which will apply to Index Admissions with discharge dates between November 1, 2019, and December 31, 2019 ("Transitional Period"). The terms of the 30-day Readmissions Policy that shall apply during the Transitional Period are set forth in Section 8.1.B. Unless otherwise extended by EOHHS in formal written subcontractual guidance, the Transitional Period will not include Index Admissions with discharge dates on or after January 1, 2020 ("Full Implementation Start Date"). The terms of the 30-day Readmissions Policy that shall apply to Index Admissions with discharge dates on or after January 1, 2020 ("Full Implementation Period") are set forth in Section 8.1.C. The 30-day Readmissions Policy applies to all in-state participating MassHealth Acute Hospital providers, including, without limitation, Critical Access Hospitals.

A. Definitions

The following terms appearing capitalized in this Section 8.1, and throughout this RFA and its appendices, shall be defined as follows, unless the context clearly indicates otherwise.

30-Day Readmission – a Readmission that occurs within 30 days of discharge from an Index Admission.

Excluded Readmissions – readmissions that are exempt from the 30-day Readmissions Policy are as follows.

1. Planned Readmissions (e.g., staged treatment/procedures);
2. Readmissions following transfers to another Acute Hospital (e.g., Readmissions to acute inpatient hospital A after a patient was transferred to and discharged from acute inpatient hospital B);
3. Readmissions where the Member's discharge status from the Index Admission is documented as having left the hospital against medical advice (AMA);
4. Readmissions with primary diagnoses of trauma, labor and delivery, malignancy, transplant, behavioral health, substance use disorders, and for neonatal care;
5. Readmissions for Members whose hospitalization is court-ordered;
6. Readmissions for recipients of the EAEDC Program;

In-State Acute Hospitals

7. Readmissions for Members for whom MassHealth is not the primary payer of the acute inpatient hospital admission, including members covered by commercial insurance or Medicare. However, if the primary payer denies coverage for the Readmission or if the member has Medicare Part B only, the Readmission is not exempt from the 30-day Readmissions Policy.

Index Admission – any previous inpatient hospital admission that has a discharge date that is within 30 days prior to the Member’s Readmission to the Same Inpatient Hospital. An Index Admission shall not include an inpatient admission that is subsequently deemed to be an Observation Service by MassHealth or its contract reviewers.

Readmission – a Member’s return admission to the Same Inpatient Hospital for conditions categorized by MassHealth as the same, similar or related to the Index Admission. A Readmission shall not include an inpatient admission that is subsequently deemed to be an Observation Service by MassHealth or its contract reviewers.

Readmission Chain – a Readmission or a sequence of Readmissions. A Readmission Chain can extend beyond 30 days, as long as the time between a discharge and subsequent Readmission to the Same Inpatient Hospital is within a 30-day time frame.

Same Inpatient Hospital – all acute inpatient hospital sites that operate under a single acute hospital RFA and contract.

B. Transitional Period – Terms

Effective with Index Admissions with a discharge date occurring during the Transitional Period, MassHealth and Hospitals will generally follow the same steps that will apply under the 30-day Readmissions Policy once the Full Implementation Start Date is in effect for such policy, with some variations that are incorporated in order to provide Hospitals an opportunity to identify ways to improve quality and performance in member care in anticipation of the Full Implementation Period. However, so long as the Hospital adheres to the timelines and steps set forth in this Section 8.1.B during the Transitional Period, MassHealth will not seek to recoup payments associated with 30-day Readmissions that would have been recoverable had the Index Admission’s discharge occurred during the Full Implementation Period. For Index Admissions with a discharge date occurring on or after the Full Implementation Start Date, this Section 8.1.B will not apply, but the terms applicable to the Full Implementation Period set forth in Section 8.1.C shall apply.

1. General Steps for Transitional Period.

The general steps that will apply to the Transitional Period are as follows.

a. 30-Day Readmissions Subject to Clinical Review

With the exception of certain Excluded Readmissions as defined in **Section 8.1.A**, above, claims for Readmissions to an Acute Inpatient Hospital occurring within 30 days of the date of discharge from an Index Admission to the Same Inpatient Hospital for conditions categorized by MassHealth as the same, similar, or related to the Index Admission will be subject to a post-payment clinical review of the medical records. Certain Readmissions may also be identified as Excluded Readmissions, as defined in Section 8.1.A, during clinical review.

In-State Acute Hospitals

b. Collecting Medical Records.

- i. MassHealth will send a written communication to the Hospital identifying each 30-Day Readmission to be reviewed, and identifying requested medical records and supporting documentation for the Index Admission(s) and subsequent 30-Day Readmission(s) at issue for the clinical review.
- ii. Hospitals must submit the requested medical records to MassHealth so that they are received within 30 calendar days of the date appearing on the request.
- iii. If the initial 30-calendar day period referenced in Section 8.1.B.1.b.ii has not yet passed, and MassHealth concludes that the records submitted are incomplete, it will inform the Hospital in writing. The Hospital must submit the documents that were missing from the medical record or records to MassHealth so that they are received within 30 calendar days of the date appearing on MassHealth's initial notice requesting such information (i.e., the same 30-calendar day period referenced in Section 8.1.B.1.b.ii).

c. Clinical Review Process

- i. In performing a clinical review, MassHealth will first determine whether the 30-Day Readmission was "Clinically Related" to an Index Admission in a Readmission Chain, and then will determine if the 30-Day Readmission was "Potentially Preventable." using the criteria set forth in Section 8.1.C.3.a, and 8.1.C.3.b, respectively.
- ii. If MassHealth determines that the 30-Day Readmission was both "Clinically Related" to an Index Admission and "Potentially Preventable" as described in this Section 8.1.B.1.c, MassHealth will notify the Hospital in writing of the facts upon which MassHealth bases its belief. MassHealth will also identify in the notice, for informational purposes only, the amount that would have been at issue had the Index Admission's discharge occurred during the Full Implementation Period, and the reasons for such conclusion.

d. Hospital Reply

- i. A Hospital must submit a reply in writing to MassHealth in response to the notice issued in accordance with Section 8.1.B.1.c.ii, which reply must be received by MassHealth within 30 calendar days of the date on such notice. In such reply, the Hospital must indicate whether it agrees or disagrees with the results of the MassHealth clinical review.
- ii. If the Hospital disagrees with the conclusion, the Hospital's reply must specifically identify and address all allegations in the notice with which the Hospital disagrees. With the reply, the Hospital may submit additional data and argument to support its claim and must include any documentary evidence it wants MassHealth to consider.
- iii. If the Hospital agrees with the findings in MassHealth's notice issued in accordance with Section 8.1.B.1.c.ii, the Hospital must, as part of its reply, provide MassHealth with a Readmissions Reduction Plan. For this purpose a "Readmissions Reduction Plan" refers to a statement by the Hospital as to steps it has taken or will take to prevent or substantially reduce the likelihood of another Readmission of a future Index

In-State Acute Hospitals

Admission under clinical and other circumstances similar to the subject Readmission. Such statement should, at a minimum, address MassHealth's findings as categorized in the notice issued under Section 8.1.B.1.c.ii, and is subject to review and acceptance by MassHealth.

- e. **MassHealth's Determination Post-Reply.** MassHealth considers and reviews only information submitted with a timely reply. If, after reviewing a Hospital's timely reply that indicates that the Hospital disagrees with MassHealth's conclusion, MassHealth continues to determine that one or more of its original findings is valid, MassHealth will so notify the Hospital in writing and include the amount that would have been at issue under the 30-day Readmissions Policy had the Full Implementation Start Date been in effect.
- f. **Informational Purposes Only.** Subject to Section 8.1.B.2, the MassHealth findings resulting from the clinical reviews of 30-Day Readmissions associated with the Transitional Period pursuant to Section 8.1.B.1, are for informational purposes, only, in order to prepare Hospitals for the Full Implementation Start Date; therefore, the adjudicatory hearing process under 130 CMR 450.241 – 450.248 does not apply.

2. Other Terms – Transitional Period

- a. If MassHealth determines that the Hospital failed to timely submit complete medical records during the 30-calendar day period referenced in Section 8.1.B.1.b, or the Hospital failed to submit a timely reply as required under Section 8.1.B.1.d, MassHealth reserves the right to deem payments made on the 30-Day Readmission at issue an overpayment under 130 CMR 450.235 subject to recovery pursuant to 130 CMR 450.237.
- b. Sections 8.1.C.1.d, 8.1.C.4.a and 8.1.C.4.c also apply during the Transitional Period.

C. Full Implementation Period – Terms

Effective with Index Admissions with a discharge date occurring on or after the Full Implementation Start Date, the MassHealth 30-day Readmissions Policy will be in full force and effect, and Section 8.1.C.1 through 8.1.C.4 shall apply.

1. General Terms

- a. Under the 30-day Readmissions Policy, with the exception of certain Excluded Readmissions as defined in Section 8.1.A, above, claims for Readmissions to an Acute Inpatient Hospital occurring within 30 days of the date of discharge from an Index Admission to the Same Inpatient Hospital for conditions categorized by MassHealth as the same, similar, or related to the Index Admission will be subject to a post-payment clinical review of the medical records.¹⁸
- b. Payments for those 30-Day Readmissions (1) for which MassHealth determines as a result of such clinical review, are both (i) "Clinically Related" to an Index Admission within a Readmission Chain; and (ii) "Potentially Preventable"; or (2) for which MassHealth determines the Hospital failed to timely submit requested medical records and supporting documentation, or failed to provide complete medical records, in order to allow MassHealth

¹⁸ Certain Readmissions may also be identified as Excluded Readmissions, as defined in Section 8.1.A, during clinical review.

In-State Acute Hospitals

to conduct a clinical review of the 30-Day Readmission, constitute overpayments under 130 CMR 450.235 subject to recovery pursuant to 130 CMR 450.237.

- c. Subject to compliance with the overpayment provisions at 130 CMR 450.237, a Hospital will have a right to challenge a final determination of overpayment issued by MassHealth based on the 30-day Readmissions Policy, using the adjudicatory hearing process set forth in 130 CMR 450.241 through 450.248. A Hospital will have no right to an adjudicatory hearing pursuant to the process set forth in 130 CMR 450.241 through 450.248, or judicial review, if it fails to comply with all requirements of 130 CMR 450.237.
- d. The 30-day Readmissions Policy will operate concurrently with MassHealth's provider preventable condition (PPC) and serious reportable events (SRE) policies (see Sections 8.2 and 8.3, respectively). Any Index Admission or Readmission that is identified, during a clinical review, as governed by the PPC (or SRE) Policy will be directed for management via the existing MassHealth PPC (or SRE) payment provisions and billing instructions, as appropriate.

2. Collection of Medical Records for Clinical Review

MassHealth will send a written communication to the Hospital identifying each 30-Day Readmission to be reviewed, and identifying requested medical records and supporting documentation for the Index Admission(s) and subsequent 30-Day Readmission(s) at issue for the clinical review.

- a. Hospitals must submit the requested medical records to MassHealth so that they are received within 30 calendar days of the date appearing on the request. If a Hospital fails to timely submit the records, MassHealth will initiate overpayment proceedings for recovery of all payments made for the 30-Day Readmission in accordance with 130 CMR 450.237.
- b. If the initial 30-calendar day period referenced in Section 8.1.C.2.a, above, has not yet passed, and MassHealth instead concludes that the records submitted are incomplete, it will inform the Hospital in writing. The Hospital must submit the documents that were missing from the medical record or records to MassHealth so that they are received within 30 calendar days of the date appearing on MassHealth's initial notice requesting such information (i.e., the same 30-calendar day period referenced in Section 8.1.C.2.a, above). If the Hospital fails to timely submit the documents to complete the medical record, MassHealth will initiate overpayment proceedings for recovery of all payments made for the 30-Day Readmission in accordance with 130 CMR 450.237.

3. Clinical Review Process

In performing a clinical review, MassHealth will first determine whether the 30-Day Readmission was "Clinically Related" to an Index Admission in a Readmission Chain, and then will determine if the 30-Day Readmission was "Potentially Preventable." If MassHealth determines that the 30-Day Readmission was both "Clinically Related" to an Index Admission and "Potentially Preventable" as described in this Section 8.1.C.3, MassHealth will initiate overpayment proceedings for recovery of all payments made for the 30-Day Readmission in accordance with 130 CMR 450.237.

- a. In its sole discretion, MassHealth may deem a 30-Day Readmission to be Clinically Related to an Index Admission for reasons that include, but are not limited, to the following.

In-State Acute Hospitals

- i. A medical Readmission for a continuation or recurrence of the reason for the Index Admission or a closely related condition.
 - ii. A medical Readmission for an acute decompensation of a chronic problem that was not the primary reason for the Index Admission but was plausibly related to care during the Index Admission.
 - iii. A medical Readmission for an acute medical complication plausibly related to care during the Index Admission.
 - iv. An unplanned Readmission for a procedure to address a continuation or a recurrence of the problem causing the Index Admission.
 - v. An unplanned Readmission for a procedure to address a complication resulting from care during the Index Admission.
- b.** Once the initial review has determined that the 30-Day Readmission(s) and Index Admission(s) at issue are Clinically Related, further evaluation determines whether the 30-Day Readmission was Potentially Preventable. As part of this review, MassHealth will holistically evaluate and weigh various factors that, in MassHealth's sole discretion, are potentially relevant to determining whether the 30-Day Readmission was Potentially Preventable. The mere fact that a single factor weighs in favor of a finding that the readmission was Potentially Preventable does not necessarily mean that the readmission was, in fact, Potentially Preventable (although, in an appropriate case, a single factor may be so significant as to demonstrate that the readmission was Potentially Preventable). In determining whether the 30-Day Readmission was Potentially Preventable, MassHealth will review only relevant factors, as determined by MassHealth in its sole discretion. Examples of potentially relevant factors include, but are not limited to, the following:
- i. Whether services provided during the Index Admission met generally accepted medical standards, as determined by a physician determined by MassHealth to be qualified by his or her training and expertise. Generally accepted medical standards are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered.
 - ii. Whether there was a failure to recognize a clinical condition or adequately treat an active clinical condition that was either present at the time of the Index Admission or developed during the course of the Index Admission. This excludes ongoing and/or chronic conditions for which lack of immediate inpatient treatment would not reasonably be expected to cause a need for readmission. This may also exclude conservative non-treatment, including monitoring of a condition, where appropriate.
 - iii. Documentation in the hospital record that the hospital advised the patient in writing about recommended follow-up appointments to the primary care and/or other relevant clinician, and that the hospital recommended a clinically appropriate time frame for that follow-up appointment after discharge from the Index Admission. Furthermore, for any follow-up appointment that is critical to the patient's health and safety, documentation that the hospital strongly encouraged and offered to assist the member to set up the

In-State Acute Hospitals

appointment. For purposes of this section 8.1, a "follow-up appointment that is critical to the patient's health and safety" is an appointment that is intended to follow up or support the treatment plan that was established during the hospital stay.

- iv. Whether the hospital provided the patient with contact information for any providers who will or may be involved in the patient's follow-up care, including contact information for the hospital and, if known, the primary care provider. If information about the patient's primary care provider or other important provider contact information is not available and/or not known by the patient, the hospital has made reasonable efforts to obtain such information and to convey it clearly to the patient to facilitate the patient's ability to ask discharge-related questions. Determination of compliance with this criterion may utilize applicable discharge rules and regulations from accepted authorities, such as CMS, DPH, and TJC.
- v. When clinically indicated during discharge screening, the hospital determined that a home safety assessment was needed and if so, offered to coordinate a home safety assessment, with the patient's permission, with an available health care advocate/provider in the patient's area.
- vi. Whether appropriate written discharge instructions were provided and explained to the patient/caregiver prior to discharge, in language understandable by the patient and/or the patient's designee. Determination of compliance with this criterion may utilize applicable discharge rules and regulations from accepted authorities, such as CMS, DPH, and TJC.
- vii. Documentation that all required prescriptions related to the index admission and discharge plan were communicated to the patient in accordance with applicable CMS, DPH, and/or TJC standards.
- viii. Whether documentation supports that medically necessary durable medical equipment (DME): (1) had been arranged for the patient and the patient has been appropriately educated on its use, or (2) the hospital has documented a referral to an available DME provider and that any special instructions from the hospital for the DME provider have been communicated. In addition, to ensure access to DME, the hospital should inquire as necessary about health plan coverage for the specific DME and, if coverage does not exist or is limited, document efforts at advising and assisting the patient with pursuing appropriate, affordable DME.
- ix. Whether documentation supports that (1) the hospital did not overlook available signs of a patient's elevated risk for readmission due to the patient's Social Determinants of Health (SDH), and (2) where such elevated risk is present, the hospital provided the patient with contact information for available resources to potentially mitigate that risk, and encouraged the patient to work with such resources. For purposes of this readmissions policy, the Social Determinants of Health include substance use disorder (SUD), homelessness, and any other Social Determinants of Health identified in www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health (See "Understanding Social Determinants of Health".) When determining whether a readmission was Potentially Preventable, MassHealth will place additional weight on this criterion if the patient: (1) is homeless and/or (2) is at risk for SUD.

In-State Acute Hospitals

4. Additional Terms

- a. If during a clinical review, MassHealth determines that the Readmission or Index Admission under review fails to meet other MassHealth requirements, standards of care or other policies that are set forth in MassHealth regulations, the Acute Hospital RFA or other written policies of MassHealth, MassHealth reserves the right to review the claims pursuant to the provisions governing those other policies.
- b. MassHealth may utilize the withhold process set forth in 130 CMR 450.249 for amounts that are the subject of a notice of overpayment under the 30-day Readmissions Policy.
- c. In no case may a Hospital bill or rebill an inpatient claim as outpatient (or as another inpatient claim) in order to circumvent the 30-day Readmissions Policy. In an appropriate case, MassHealth may, in its sole discretion, direct a Hospital to bill or rebill an inpatient claim that may be subject to the 30-day Readmissions Policy as outpatient (or as another inpatient claim). In such cases, the Hospital shall follow MassHealth's direction.
- d. Hospitals are prohibited from charging members or seeking payment from the health safety net for services for which MassHealth has issued a final determination of overpayment under the 30-day Readmission Policy, including without limitation co-payments or deductibles.
- e. MassHealth reserves the right to conduct a review of a 30-Day Readmission on a pre-payment basis if, during a prepayment utilization review or other audit, MassHealth identifies a claim that may be non-payable under the 30-day Readmissions Policy.

8.2 Provider Preventable Conditions

A. Introduction

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

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

In-State Acute Hospitals

events” identified in Appendix U of the Hospital’s Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals shall be governed entirely by the Serious Reportable Events provisions in Section 8.3.

B. Definitions

The following definitions apply to this Section 8.2.

1. **Provider Preventable Condition (PPC)** – a condition that meets the definition of a “Health Care Acquired Condition” or an “Other Provider Preventable Condition” as defined by CMS in federal regulations at 42 C.F.R. 447.26(b).
2. **Health Care Acquired Conditions (HCACs)** – conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.
3. **Other Provider Preventable Condition (OPPC)** – a condition that meets the requirements of an “Other Provider Preventable Condition” pursuant to 42 C.F.R. 447.26(b). OPPCs may occur in any health care setting and are divided into two sub-categories.
 - a) **National Coverage Determinations (NCDs)** – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:
 - A. Wrong surgical or other invasive procedure performed on a patient;
 - B. Surgical or other invasive procedure performed on the wrong body part; and
 - C. Surgical or other invasive procedure performed on the wrong patient.For each of A. through C., above, the term “surgical or other invasive procedure” is as defined in CMS Medicare guidance on NCDs.
 - b) **Additional Other Provider Preventable Condition (Additional OPPCs)** – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as Additional OPPCs.

C. Hospital Reporting of PPCs to EOHHS

1. Appendix V of the Hospital’s Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals identifies those PPCs that apply to the Hospital for inpatient and outpatient hospital services and hospital-based physician services, respectively. EOHHS may also provide this information to Hospitals through provider bulletins, or other written statements of policy, and all such documentation, including without limitation Appendix V, may be amended from time to time.
2. Hospitals must report the occurrence of a PPC and PPC-related services through MMIS claims submissions to MassHealth. Hospital reporting of PPCs, and related claims submissions, must be conducted in accordance with applicable MassHealth regulations, provider manuals and billing instructions, including without limitation as set forth in Appendix V of the MassHealth Acute

In-State Acute Hospitals

Inpatient Hospital and Acute Outpatient Hospital provider manual, respectively. EOHHS may also provide such instructions through provider bulletins, or other written statements of policy, and all such documentation, including without limitation, Appendix V, may be amended from time to time.

3. In accordance with state and federal statutes, rules, and regulations governing the MassHealth program, including but not limited to 130 CMR 415.000 *et seq.* (Acute Inpatient Hospitals); 130 CMR 410.000 *et seq.* (Acute Outpatient Hospitals) and 130 CMR 450.000, *et seq.* (administrative and billing instructions), EOHHS may request additional information from the Hospital which EOHHS deems necessary to facilitate its review of any PPC or to carry out payment, provider enrollment, quality or other routine functions of the MassHealth program, and the Hospital must comply with the request. EOHHS may use this information, as well as the reports provided pursuant to Section 8.2.F, in reviewing any PPC, and in applying any payment adjustment as set forth in Section 8.2.D.

D. Payment Adjustments to Hospitals for Provider Preventable Conditions

1. **Inpatient Hospital Services** – For inpatient hospital services, when a Hospital reports a PPC that the Hospital indicates was not present on admission, EOHHS will reduce payments to the Hospital as follows.
 - a) **APAD, Outlier Payment and Transfer per diem payments.** For inpatient services for which the Hospital would otherwise be paid an APAD, Outlier Payment or Transfer per diem payment
 - i. MassHealth will not pay the APAD, Outlier Payment, or Transfer per diem payment if the Hospital reports that only PPC-related services were delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - ii. MassHealth will pay the APAD, Outlier Payment or Transfer per diem payment, in each case as adjusted to exclude PPC-related costs/services, if the Hospital reports that non-PPC-related services were also delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - b) **Psychiatric, Rehabilitation 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.
 - i. MassHealth will not pay the per diem if the Hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - ii. MassHealth will pay the per diem if the Hospital reports that non-PPC related services were also delivered on that day, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

In-State Acute Hospitals

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

In-State Acute Hospitals

5. In the event that individual cases are identified throughout the MassHealth PPC implementation period, EOHHS may adjust reimbursement according to the methodology described earlier.

E. Additional Requirements

The Hospital agrees to take such action as is necessary in order for EOHHS to comply with all federal and state laws, regulations, and policy guidance relating to the reporting and non-payment of provider preventable conditions, including, without limitation, Section 2702 of the ACA. In addition, should EOHHS, in its sole discretion, deem it necessary to further amend this RFA and Contract to implement any such laws, the Hospital agrees that, notwithstanding any other provision in this RFA and Contract, EOHHS may terminate the Hospital's Contract immediately upon written notice in the event the Hospital fails to agree to any such amendment.

F. Reporting to the Massachusetts Department of Public Health

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

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

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

8.3 Serious Reportable Events

A. Applicability

1. "Serious Reportable Events (SREs)" for purposes of this Section 8.3 shall mean those serious reportable events (SREs) listed in Appendix U of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals. All references to SREs in Sections 8.3.B through 8.3.D are subject to this Section 8.3.A.
From time to time, EOHHS may update the list of SREs that are subject to this Section 8.3 through issuing provider bulletins or updates to provider manuals, or through other written statements of policy.

In-State Acute Hospitals

2. For purposes of this section, “preventable” is defined as DPH has defined the term in its regulations at 105 CMR 130.332 and means events that could have been avoided by proper adherence to applicable patient safety guidelines, best practices, and hospital policies and procedures.

B. Scope of Non-Reimbursable Services

1. MassHealth’s SRE policy applies to both Hospitals and Hospital-Based Physicians.
2. Hospitals are prohibited from charging or seeking reimbursement from MassHealth or the member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, an SRE occurring on premises covered by the hospital’s license that was preventable and unambiguously the result of a system failure, as described in DPH regulations (“preventable SRE”). Non-reimbursable Hospital and Hospital-based physician services include:
 - a. All services provided during the inpatient admission or outpatient visit during which a preventable SRE occurred; and
 - b. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:
 - (1) At a facility under the same license as the hospital at which a non-billable SRE occurred; or
 - (2) On the premises of a separately licensed hospital or ambulatory surgery center with common ownership or a common corporate parent of the hospital at which a non-billable SRE occurred.
 - c. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.
 - d. The non-payment provision of this RFA also applies to third-party liability and/or crossover payments by MassHealth.
 - e. A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in Section 8.3.B.2.b, and that provides inpatient or outpatient services to a patient who previously incurred an SRE, may bill MassHealth for all medically necessary Hospital and Hospital-Based Physician services provided to the patient following a preventable SRE.

C. Required Reporting and Preventability Determination

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

In-State Acute Hospitals

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

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

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

3. No later than thirty days after the date of initial reporting of the SRE to DPH and MassHealth, if upon completing a preventability determination following the occurrence of an SRE pursuant to Section 8.3.C.1, the Hospital seeks payment for Inpatient Services or Outpatient Services to a MassHealth member, the Hospital shall submit the following required documentation to MassHealth, using the address set forth in Section 8.3.C.2, so it can review the circumstances of the SRE;
 - a. A copy of the updated SRE report issued to DPH describing the hospital's preventability determination including, at a minimum, the following:
 - (1) Narrative description of the SRE;
 - (2) Analysis and identification of the root cause of the SRE;
 - (3) Analysis of the preventability criteria required by DPH;
 - (4) Description of any corrective measures taken by the hospital following discovery of the SRE; and
 - (5) Whether the hospital intends to charge or seek reimbursement from MassHealth for services provided at the hospital as a result of the SRE;
 - b. Copies of the hospital policies and procedures related to SREs;
 - c. A copy of the member's medical record for the inpatient Hospital admission or outpatient episode of care during which the SRE occurred, if the Hospital intends to charge or seek reimbursement for services provided at the Hospital during such admission or episode of care, or for follow-up care as a result of the SRE.

D. Non-Payment for SREs

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

In-State Acute Hospitals

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

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

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

Attachment B – Public Notice

In-State Acute Inpatient Hospital Rates

RY20 – Effective 11/1/19

Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates*
(*See link at end for Chart C - DRG Weights and Mean All Payer Lengths of Stay)

In-State Provider	Statewide Operating Standard per Discharge	Hospital's Massachusetts- specific wage area index	Labor Factor	Wage Adjusted Operating Standard per Discharge	Statewide Capital Standard per Discharge	APAD Base Payment	Hospital Cost-to- Charge Ratio	Fixed Outlier Threshold	Marginal Cost Factor
Anna Jaques Hospital	\$11,391.79	0.9413	0.68257	\$10,935.36	\$773.16	\$11,708.52	73.37%	\$38,000.00	60%
Baystate Franklin Medical Center	\$11,391.79	0.8904	0.68257	\$10,539.57	\$773.16	\$11,312.73	54.73%	\$38,000.00	60%
Baystate Medical Center	\$11,391.79	0.9789	0.68257	\$11,227.72	\$773.16	\$12,000.88	47.74%	\$38,000.00	60%
Baystate Noble Hospital	\$11,391.79	0.8904	0.68257	\$10,539.57	\$773.16	\$11,312.73	51.99%	\$38,000.00	60%
Baystate Wing Hospital	\$11,391.79	0.8904	0.68257	\$10,539.57	\$773.16	\$11,312.73	46.99%	\$38,000.00	60%
Berkshire Medical Center	\$11,391.79	0.9375	0.68257	\$10,905.81	\$773.16	\$11,678.97	52.98%	\$38,000.00	60%
Beth Israel Deaconess Hospital - Milton	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	47.31%	\$38,000.00	60%
Beth Israel Deaconess Hospital - Needham	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	67.61%	\$38,000.00	60%
Beth Israel Deaconess Hospital - Plymouth	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	54.05%	\$38,000.00	60%
Beth Israel Deaconess Medical Center	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	54.71%	\$38,000.00	60%
Beverly Hospital	\$11,391.79	0.9413	0.68257	\$10,935.36	\$773.16	\$11,708.52	59.33%	\$38,000.00	60%
Boston Children's Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	51.28%	\$38,000.00	60%
Boston Medical Center	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	53.33%	\$38,000.00	60%
Brigham & Women's Faulkner Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	34.49%	\$38,000.00	60%
Brigham & Women's Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	30.04%	\$38,000.00	60%
Cambridge Health Alliance	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	74.53%	\$38,000.00	60%
Cape Cod Hospital	\$11,391.79	1.0856	0.68257	\$12,057.39	\$773.16	\$12,830.55	49.52%	\$38,000.00	60%
Carney Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	92.88%	\$38,000.00	60%
Cooley Dickinson Hospital	\$11,391.79	0.9789	0.68257	\$11,227.72	\$773.16	\$12,000.88	45.45%	\$38,000.00	60%
Dana Farber Cancer Institute	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	44.46%	\$38,000.00	60%
Emerson Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	58.45%	\$38,000.00	60%
Falmouth Hospital	\$11,391.79	1.0856	0.68257	\$12,057.39	\$773.16	\$12,830.55	53.16%	\$38,000.00	60%
Good Samaritan Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	59.49%	\$38,000.00	60%
Hallmark Health Systems	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	63.77%	\$38,000.00	60%
Harrington Memorial Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	50.46%	\$38,000.00	60%
Heywood Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	65.58%	\$38,000.00	60%
Holy Family Hospital	\$11,391.79	0.9413	0.68257	\$10,935.36	\$773.16	\$11,708.52	55.57%	\$38,000.00	60%
Holyoke Medical Center	\$11,391.79	0.8904	0.68257	\$10,539.57	\$773.16	\$11,312.73	67.82%	\$38,000.00	60%
Lahey Hospital & Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	48.44%	\$38,000.00	60%

RY20 In-State Acute Hospital Inpatient Rates

In-State Provider	Statewide Operating Standard per Discharge	Hospital's Massachusetts- specific wage area index	Labor Factor	Wage Adjusted Operating Standard per Discharge	Statewide Capital Standard per Discharge	APAD Base Payment	Hospital Cost-to- Charge Ratio	Fixed Outlier Threshold	Marginal Cost Factor
Lawrence General Hospital	\$11,391.79	0.9413	0.68257	\$10,935.36	\$773.16	\$11,708.52	56.21%	\$38,000.00	60%
Lowell General Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	46.48%	\$38,000.00	60%
Massachusetts Eye & Ear Infirmary	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	66.32%	\$38,000.00	60%
Massachusetts General Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	26.73%	\$38,000.00	60%
Mercy Hospital	\$11,391.79	0.8904	0.68257	\$10,539.57	\$773.16	\$11,312.73	58.87%	\$38,000.00	60%
MetroWest Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	50.20%	\$38,000.00	60%
Milford Regional Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	59.94%	\$38,000.00	60%
Morton Hospital and Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	54.10%	\$38,000.00	60%
Mount Auburn Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	67.08%	\$38,000.00	60%
Nantucket Cottage Hospital	\$11,391.79	1.1363	0.68257	\$12,451.62	\$773.16	\$13,224.78	104.57%	\$38,000.00	60%
Nashoba Valley Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	54.10%	\$38,000.00	60%
New England Baptist Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	64.04%	\$38,000.00	60%
Newton-Wellesley Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	43.87%	\$38,000.00	60%
North Shore Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	45.43%	\$38,000.00	60%
Norwood Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	61.55%	\$38,000.00	60%
Saint Vincent Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	36.76%	\$38,000.00	60%
Shriners Hospitals for Children - Boston	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	141.67%	\$38,000.00	60%
Shriners Hospitals for Children - Springfield	\$11,391.79	0.8904	0.68257	\$10,539.57	\$773.16	\$11,312.73	114.18%	\$38,000.00	60%
Signature Healthcare Brockton Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	42.30%	\$38,000.00	60%
South Shore Hospital	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	54.31%	\$38,000.00	60%
Southcoast Hospitals Group	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	42.59%	\$38,000.00	60%
St. Anne's Hospital	\$11,391.79	0.9251	0.68257	\$10,809.39	\$773.16	\$11,582.55	45.14%	\$38,000.00	60%
St. Elizabeth's Medical Center	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	64.74%	\$38,000.00	60%
Sturdy Memorial Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	62.11%	\$38,000.00	60%
Tufts Medical Center	\$11,391.79	1.0642	0.68257	\$11,890.99	\$773.16	\$12,664.15	34.95%	\$38,000.00	60%
UMass Memorial - HealthAlliance-Clinton Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	42.00%	\$38,000.00	60%
UMass Memorial - Marlborough Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	39.46%	\$38,000.00	60%
UMass Memorial Medical Center	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	37.43%	\$38,000.00	60%
Winchester Hospital	\$11,391.79	1.0216	0.68257	\$11,559.74	\$773.16	\$12,332.90	65.18%	\$38,000.00	60%

RY20 In-State Acute Hospital Inpatient Rates

Other Per Diem Rates

In-State Provider	Administrative Day without Medicare Part B	Administrative Day with Medicare Part B	Psychiatric per Diem	Rehabilitation Unit per Diem
Anna Jaques Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Baystate Franklin Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Baystate Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Baystate Noble Hospital	\$303.45	\$ 280.61	\$941.10	\$ 1,091.28
Baystate Wing Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Berkshire Medical Center	\$303.45	\$ 280.61	\$941.10	\$ 1,091.28
Beth Israel Deaconess Hospital - Milton	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Beth Israel Deaconess Hospital - Needham	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Beth Israel Deaconess Hospital - Plymouth	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Beth Israel Deaconess Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Beverly Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Boston Children's Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Boston Medical Center	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Brigham & Women's Faulkner Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Brigham & Women's Hospital	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Cambridge Health Alliance	\$303.45	\$ 280.61	\$941.10	Not Applicable
Cape Cod Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Carney Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Cooley Dickinson Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Dana Farber Cancer Institute	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Emerson Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Falmouth Hospital	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Good Samaritan Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Hallmark Health Systems	\$303.45	\$ 280.61	\$941.10	Not Applicable
Harrington Memorial Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Heywood Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Holy Family Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Holyoke Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Lahey Hospital & Medical Center	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Lawrence General Hospital	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Lowell General Hospital	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Massachusetts Eye & Ear Infirmary	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Massachusetts General Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Mercy Hospital	\$303.45	\$ 280.61	\$941.10	\$ 1,091.28

RY20 In-State Acute Hospital Inpatient Rates

In-State Provider	Administrative Day without Medicare Part B	Administrative Day with Medicare Part B	Psychiatric per Diem	Rehabilitation Unit per Diem
MetroWest Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Milford Regional Medical Center	\$303.45	\$ 280.61	Not Applicable	Not Applicable
Morton Hospital and Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Mount Auburn Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Nantucket Cottage Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Nashoba Valley Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
New England Baptist Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Newton-Wellesley Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
North Shore Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Norwood Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Saint Vincent Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Shriners Hospitals for Children - Boston	\$303.45	\$ 280.61	\$941.10	Not Applicable
Shriners Hospitals for Children - Springfield	\$303.45	\$ 280.61	\$941.10	Not Applicable
Signature Healthcare Brockton Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
South Shore Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Southcoast Hospitals Group	\$303.45	\$ 280.61	\$941.10	\$ 1,091.28
St. Anne's Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
St. Elizabeth's Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Sturdy Memorial Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
Tufts Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
UMass Memorial - HealthAlliance-Clinton Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
UMass Memorial - Marlborough Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable
UMass Memorial Medical Center	\$303.45	\$ 280.61	\$941.10	Not Applicable
Winchester Hospital	\$303.45	\$ 280.61	\$941.10	Not Applicable

***See Chart C** for RY20 MassHealth DRG Weights and Mean All Payer Lengths of Stay.

Click here: [Chart C- Acute Hospital RY20 MassHealth DRG Weights and Mean All Payer Lengths of Stay](#)

For Freestanding Pediatric Acute Hospitals — for discharges assigned a MassHealth DRG Weight of 3.5 or greater, the APAD Base Payment will be \$19,882.72 for Boston Children's Hospital and Shriners' Hospital for Children-Boston; and \$17,760.99 for Shriners' Hospital for Children-Springfield. For the Hospital with a Pediatric Specialty Unit (Tufts Medical Center)- - for discharges assigned a MassHealth DRG Weight of 3.5 or greater, the APAD Base Payment will be \$19,882.72 if the Member is under the age of 21 at the time of admission.

RY20 In-State Acute Hospital Inpatient Rates

Critical Access Hospitals

Components of Adjudicated Payment Amount per Discharge (APAD), Outlier Payment, & Transfer Per Diem Rates*

Critical Access Hospitals** In-State Provider	CAH-Specific Total Standard Rate per Discharge	Hospital Cost-to- Charge Ratio	Fixed Outlier Threshold	Marginal Cost Factor
Athol Memorial Hospital**	\$ 15,712.34	85.07%	\$ 38,000.00	60%
Fairview Hospital**	\$ 26,858.54	93.66%	\$ 38,000.00	60%
Martha's Vineyard Hospital**	\$ 29,417.33	87.92%	\$ 38,000.00	60%

Other Per Diem Rates

Critical Access Hospitals** In-State Provider	Administrative Day without Medicare Part B	Administrative Day with Medicare Part B	Psychiatric per Diem
Athol Memorial Hospital**	\$303.45	\$280.61	\$941.10
Fairview Hospital**	\$303.45	\$280.61	Not Applicable
Martha's Vineyard Hospital**	\$303.45	\$280.61	Not Applicable

***See Chart C** for RY20 MassHealth DRG Weights and Mean All Payer Lengths of Stay.

Click here: [Chart C- Acute Hospital RY20 MassHealth DRG Weights and Mean All Payer Lengths of Stay](#)

** For Critical Access Hospitals—subject to reconciliation

Public Notice – In-State Acute Hospitals (Outpatient)

In-State Acute Outpatient Hospital Adjudicated Payment per Episode of Care (APEC)

RY20 – Effective 11/1/19

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

(*See link at end for Chart D – RY2020 EAPGs and MassHealth EAPG Weights)

In-State Provider	APEC Outpatient Statewide Standard	Hospital's Massachusetts- specific wage area index	Labor Factor	Wage Adjusted Outpatient Standard	Hospital Cost-to- Charge Ratio	Fixed Outlier Threshold	Marginal Cost Factor
Anna Jaques Hospital	\$638.56	0.9413	0.60000	\$616.07	37.59%	\$3,800.00	60%
Baystate Franklin Medical Center	\$638.56	0.8904	0.60000	\$596.57	33.01%	\$3,800.00	60%
Baystate Medical Center	\$638.56	0.9789	0.60000	\$630.48	38.26%	\$3,800.00	60%
Baystate Noble Hospital	\$638.56	0.8904	0.60000	\$596.57	28.05%	\$3,800.00	60%
Baystate Wing Hospital	\$638.56	0.8904	0.60000	\$596.57	44.23%	\$3,800.00	60%
Berkshire Medical Center	\$638.56	0.9375	0.60000	\$614.61	38.00%	\$3,800.00	60%
Beth Israel Deaconess Hospital - Milton	\$638.56	1.0642	0.60000	\$663.16	31.80%	\$3,800.00	60%
Beth Israel Deaconess Hospital - Needham	\$638.56	1.0642	0.60000	\$663.16	38.95%	\$3,800.00	60%
Beth Israel Deaconess Hospital - Plymouth	\$638.56	1.0642	0.60000	\$663.16	33.66%	\$3,800.00	60%
Beth Israel Deaconess Medical Center	\$638.56	1.0642	0.60000	\$663.16	34.94%	\$3,800.00	60%
Beverly Hospital	\$638.56	0.9413	0.60000	\$616.07	28.93%	\$3,800.00	60%
Boston Children's Hospital	\$638.56	1.0642	0.60000	\$663.16	49.81%	\$3,800.00	60%
Boston Medical Center	\$638.56	1.0642	0.60000	\$699.16	40.64%	\$3,800.00	60%
Brigham & Women's Faulkner Hospital	\$638.56	1.0642	0.60000	\$663.16	25.37%	\$3,800.00	60%
Brigham & Women's Hospital	\$638.56	1.0642	0.60000	\$663.16	22.85%	\$3,800.00	60%
Cambridge Health Alliance	\$638.56	1.0216	0.60000	\$646.84	60.85%	\$3,800.00	60%
Cape Cod Hospital	\$638.56	1.0856	0.60000	\$671.36	32.21%	\$3,800.00	60%
Carney Hospital	\$638.56	1.0642	0.60000	\$728.16	50.00%	\$3,800.00	60%
Cooley Dickinson Hospital	\$638.56	0.9789	0.60000	\$630.48	37.01%	\$3,800.00	60%
Dana Farber Cancer Institute	\$768.56	1.0642	0.60000	\$798.16	28.08%	\$3,800.00	60%
Emerson Hospital	\$638.56	1.0216	0.60000	\$646.84	30.00%	\$3,800.00	60%
Falmouth Hospital	\$638.56	1.0856	0.60000	\$671.36	29.14%	\$3,800.00	60%
Good Samaritan Hospital	\$638.56	1.0642	0.60000	\$663.16	30.34%	\$3,800.00	60%
Hallmark Health Systems	\$638.56	1.0216	0.60000	\$646.84	32.27%	\$3,800.00	60%
Harrington Memorial Hospital	\$638.56	1.0216	0.60000	\$646.84	28.24%	\$3,800.00	60%
Heywood Hospital	\$638.56	1.0216	0.60000	\$646.84	33.48%	\$3,800.00	60%
Holy Family Hospital	\$638.56	0.9413	0.60000	\$616.07	34.09%	\$3,800.00	60%
Holyoke Medical Center	\$638.56	0.8904	0.60000	\$661.57	37.74%	\$3,800.00	60%
Lahey Hospital & Medical Center	\$638.56	1.0216	0.60000	\$646.84	38.14%	\$3,800.00	60%
Lawrence General Hospital	\$638.56	0.9413	0.60000	\$681.07	34.77%	\$3,800.00	60%
Lowell General Hospital	\$638.56	1.0216	0.60000	\$646.84	25.98%	\$3,800.00	60%
Massachusetts Eye & Ear Infirmary	\$638.56	1.0642	0.60000	\$663.16	38.92%	\$3,800.00	60%
Massachusetts General Hospital	\$638.56	1.0642	0.60000	\$663.16	26.22%	\$3,800.00	60%
Mercy Hospital	\$638.56	0.8904	0.60000	\$661.57	41.07%	\$3,800.00	60%
MetroWest Medical Center	\$638.56	1.0216	0.60000	\$646.84	22.45%	\$3,800.00	60%
Milford Regional Medical Center	\$638.56	1.0216	0.60000	\$646.84	31.08%	\$3,800.00	60%

In-State Hospitals –RY20 Outpatient APEC

In-State Provider	APEC Outpatient Statewide Standard	Hospital's Massachusetts- specific wage area index	Labor Factor	Wage Adjusted Outpatient Standard	Hospital Cost-to- Charge Ratio	Fixed Outlier Threshold	Marginal Cost Factor
Morton Hospital and Medical Center	\$638.56	1.0216	0.60000	\$646.84	48.76%	\$3,800.00	60%
Mount Auburn Hospital	\$638.56	1.0216	0.60000	\$646.84	39.91%	\$3,800.00	60%
Nantucket Cottage Hospital	\$638.56	1.1363	0.60000	\$690.78	53.51%	\$3,800.00	60%
Nashoba Valley Medical Center	\$638.56	1.0216	0.60000	\$646.84	33.88%	\$3,800.00	60%
New England Baptist Hospital	\$638.56	1.0642	0.60000	\$663.16	48.44%	\$3,800.00	60%
Newton-Wellesley Hospital	\$638.56	1.0216	0.60000	\$646.84	26.63%	\$3,800.00	60%
North Shore Medical Center	\$638.56	1.0216	0.60000	\$646.84	23.88%	\$3,800.00	60%
Norwood Hospital	\$638.56	1.0642	0.60000	\$663.16	35.97%	\$3,800.00	60%
Saint Vincent Hospital	\$638.56	1.0216	0.60000	\$646.84	18.92%	\$3,800.00	60%
Shriners Hospitals for Children - Boston	\$638.56	1.0216	0.60000	\$646.84	68.43%	\$3,800.00	60%
Shriners Hospitals for Children - Springfield	\$638.56	0.8904	0.60000	\$596.57	47.06%	\$3,800.00	60%
Signature Healthcare Brockton Hospital	\$638.56	1.0642	0.60000	\$728.16	29.94%	\$3,800.00	60%
South Shore Hospital	\$638.56	1.0642	0.60000	\$663.16	40.11%	\$3,800.00	60%
Southcoast Hospitals Group	\$638.56	1.0216	0.60000	\$646.84	30.86%	\$3,800.00	60%
St. Anne's Hospital	\$638.56	0.9251	0.60000	\$609.86	33.14%	\$3,800.00	60%
St. Elizabeth's Medical Center	\$638.56	1.0642	0.60000	\$663.16	44.56%	\$3,800.00	60%
Sturdy Memorial Hospital	\$638.56	1.0216	0.60000	\$646.84	40.71%	\$3,800.00	60%
Tufts Medical Center	\$638.56	1.0642	0.60000	\$663.16	34.46%	\$3,800.00	60%
UMass Memorial – HealthAlliance Hospital	\$638.56	1.0216	0.60000	\$646.84	25.15%	\$3,800.00	60%
UMass Memorial - Marlborough Hospital	\$638.56	1.0216	0.60000	\$646.84	24.78%	\$3,800.00	60%
UMass Memorial Medical Center	\$638.56	1.0216	0.60000	\$646.84	27.94%	\$3,800.00	60%
Winchester Hospital	\$638.56	1.0216	0.60000	\$646.84	40.71%	\$3,800.00	60%

***See Chart D** for the RY2020 EAPGs and MassHealth EAPG Weights.

Click here: [Chart D-Acute Hospital RY20 MassHealth EAPG Weights](#)

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

In-State Hospitals –RY20 Outpatient APEC

Critical Access Hospitals**				
Components of Adjudicated Payment per Episode of Care (APEC)* RY20 Outpatient				
In-State Provider	CAH-Specific Outpatient Standard Rate per Episode	Hospital Cost-to- Charge Ratio	Fixed Outpatient Outlier Threshold	Marginal Cost Factor
Athol Memorial Hospital**	\$1,277.15	28.68%	\$ 3,800.00	60%
Berkshire Fairview Hospital**	\$1,189.89	41.93%	\$ 3,800.00	60%
Martha's Vineyard Hospital**	\$1,757.94	47.76%	\$ 3,800.00	60%

***See Chart D** for the RY2020 EAPGs and MassHealth EAPG Weights.

Click here: [Chart D-Acute Hospital RY20 MassHealth EAPG Weights](#)

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

** For Critical Access Hospitals—subject to reconciliation