Table of Contents

State/Territory Name: MA

State Plan Amendment (SPA) #: 13-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

OCT 21 2014

John Polanowicz, Secretary
Executive Office of Health and Human Services
State of Massachusetts
One Ashburton Place, Room 1109
Boston, MA 02108

RE: Massachusetts 13-002

Dear Mr. Polanowicz:

We have reviewed the proposed amendment to Attachments 4.19-A (1), of your Medicaid State plan submitted under transmittal number (TN) 13-002. This amendment provides for several updates to the rate year 2013 reimbursement methodology for acute inpatient hospital services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447. We are pleased to inform you that Medicaid State plan amendment 13-002 is approved effective January 1, 2013. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 013-002	2. STATE MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 01/01/13	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 USC 1396a(a)(13); 42 USC 1315; 42CFR Part 447; 42CFR 440.10	**a. FFY13 $ (7,170,000)** **b. FFY14 $ 2,300,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A (1), pages 1-41 **Exhibit 1** **Exhibit 2** **Exhibit 3**	**Attachment 4.19-A (1), pages 1-39** **Exhibit 1** **Exhibit 2** **Exhibit 3**

10. SUBJECT OF AMENDMENT:

Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED: **Not required under 42 CFR 430.12(b)(2)(ii)**

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **John Polanowicz**	**Michael P. Coleman** **State Plan Coordinator** **Executive Office of Health and Human Services** **Office of Medicaid** **One Ashburton Place, 11th Floor** **Boston, MA 02108**
14. TITLE: **Secretary**	
15. DATE SUBMITTED: **03/28/13**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: OCT 21 2014
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Kristin FAN	22. TITLE: Deputy Director, FMG

23. REMARKS:

FORM CMS-179 (07-92)

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services
Portion of Rate Year 2013 from January 1, 2013 to September 30, 2013

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute inpatient hospital services for the portion of RY13 from January 1, 2013 through September 30, 2013. (See TN-012-013 for the RY13 period from October 1, 2012 through December 31, 2012).

1. Except as provided in subsections 2 through 4, below, the payment methodologies specified in this Attachment 4.19-A(1) apply to:

   - RY13 admissions at in-state Acute Hospitals beginning on or after January 1, 2013 through September 30, 2013, and

   - inpatient payments made to in-state Acute Hospitals on a per diem basis for RY13 dates of service on or after January 1, 2013 through September 30, 2013.

2. In-state Critical Access Hospitals will be paid in accordance with the methods set forth in **Exhibit 1**, which is attached hereto and incorporated by reference into this Attachment, for inpatient admissions occurring in RY13 on or after November 1, 2012 through April 30, 2013. (See TN-012-013 for the RY13 period November 1, 2012 through December 31, 2012.) For inpatient admissions occurring on or after May 1, 2013 during RY13, payment to in-state Critical Access Hospitals is specified in this **Attachment 4.19-A(1),** and **Exhibit 1** does not apply.

3. For inpatient admissions occurring in RY13 on or after January 1, 2013 through September 30, 2013, the following two newly-enrolled in-state Hospitals will be paid in accordance with the methods set forth in **Exhibit 2**, which is attached hereto and incorporated by reference into this Attachment: (i) The Shriners' Hospital for Children (Boston, MA) and (ii) The Shriners' Hospital for Children (Springfield, MA) (the "Shriners Hospitals).

4. Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units will be paid as set forth in **Exhibit 3**, which is attached hereto and incorporated by reference into this Attachment, for discharges occurring in RY13 on or after January 1, 2013 through September 30, 2013.

5. The supplemental payments specified in **Sections III.I.2 through III.I.4**, apply to dates of service from October 1, 2012 through September 30, 2013. The other Acute Hospital payment methods that apply during this time period are the methods under the remainder of Attachment 4.19-A(1) in effect for the portion of Rate Year 2013 beginning October 1, 2012 through December 31, 2012 (TN-012-013), and for the portion of Rate Year 2013 beginning January 1, 2013 through September 30, 2013 (TN-013-002).

6. The Pay-for-Performance payment methodology specified in **Section III.J** is effective in RY13 beginning January 1, 2013 through September 30, 2013.

7. In-state Acute Hospitals are defined in **Section II**.

8. Payment for out-of-state acute inpatient hospital services is as follows. Effective for admissions on or after May 25, 2012, MassHealth will pay out-of-state acute inpatient hospitals a per discharge amount equal to the median inpatient MassHealth Standard Payment Amount per discharge (SPAD) in effect for in-state acute hospitals on the date of admission. In addition, for members under age 21, for each acute inpatient day following the first 20 days of an admission, MassHealth will pay out-of-state acute hospitals the median outlier per diem payment in effect for in-state acute hospitals on the date of service.

B. Non-Covered Services

The payment methods specified in this Attachment do not apply to the following Inpatient Hospital Services:

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

MassHealth contracts with a Behavioral Health (BH) Contractor to provide Behavioral Health Services to Members enrolled with the BH Contractor. Hospitals are not entitled to, and may not claim for, any fee-for-service payment from EOHHS for any services that are BH Contractor-covered services or are otherwise payable by the BH Contractor.

2. MCO Services

MassHealth contracts with Managed Care Organizations (MCOs) to provide medical services, including Behavioral Health Services, to Members enrolled with the MCO.

3. Air Ambulance Services

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

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

This Attachment shall not govern payment to Acute Hospitals for services provided to Members in separately licensed units within an Acute Hospital or in Non-Acute Units other than Rehabilitation Units (see **Section III.H below**).

II. Definitions

Acute Hospital – see Hospital.

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.

Average Length of Stay – the sum of non-psychiatric inpatient days (including Outlier Days) for relevant discharges, divided by the number of discharges. Average Length of Stay is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.

Behavioral Health (BH) Contractor – The entity with which EOHHS contracts to provide Behavioral Health Services to enrolled Members on a capitated basis, and which meets the definition of prepaid inpatient health plan at 42 C.F.R. § 438.2.

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

Casemix Index – a measure of a Hospital's relative casemix. The Casemix Index is calculated by dividing a Hospital's APR-DRG Version 26 Casemix Weight (using Massachusetts weights) by the Hospital's discharges, not including discharges from Excluded Units. Casemix Index is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.

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

Contract – See RFA and Contract.

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

DMH-Licensed Bed – a bed in a Hospital that is located in a unit licensed by the Massachusetts Department of Mental Health (DMH).

Division of Health Care Finance and Policy (DHCFP) – a division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services, or beginning as of November 5, 2012, successor agency. For purposes of rate setting, the successor agency is EOHHS. For purposes of cost reporting and Hospital Discharge Data, the successor agency is the Center for Health Information and Analysis established under M.G.L. c. 12C.

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

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

Fiscal Year (FY) – the time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. FY13 begins on October 1, 2012, and ends on September 30, 2013.

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

Gross Patient Service Revenue – The total dollar amount of a Hospital's charges for services rendered in a Fiscal Year.

Hospital – Any health care facility which:

a. operates under a hospital license issued by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111 § 51;

b. is Medicare certified and participates in the Medicare program; and

c. has more than fifty percent (50%) of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds, as determined by DPH and currently utilizes more than fifty percent (50%) of its beds exclusively as such, as determined by EOHHS.

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

Hospital Discharge Data (HDD) – Merged Casemix/Billing Tapes as accepted into DHCFP's database.

Inflation Factor for Administrative Days – an inflation factor that is a blend of the Centers 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: 1.775% reflects the price changes between RY12 and RY13.[1]

Inpatient Services (also Inpatient Hospital Services) – Medical services, including Behavioral Health Services, provided to a Member admitted to a Hospital.

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 at 42 CFR § 438.2.

[1] Applied in RY13, starting January 1, 2013.

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Massachusetts-specific Wage Area Index – Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage. Massachusetts Hospitals' wages and hours were determined based on CMS's FY_2013_Proposed_Rule_Wage_Index_PUFs file, downloaded July 9, 2012. Wage areas were assigned according to the same CMS file unless redesignated in a written decision from CMS to the Hospital provided to EOHHS by June 11, 2012. For the calculation of the Springfield area index, Baystate Medical Center's wages and hours were included.

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.

Medicaid Management Information System (MMIS) – the state-operated system of data processes, certified by CMS that meets federal guidelines in Part 11 of the State Medicaid Manual.

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

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

Outlier Day – Each day beyond twenty acute days during a single admission for which a Member remains hospitalized at an acute status, other than in a DMH-licensed bed or an Excluded Unit. See **Section III.E**.

Pass-Through Costs – Organ acquisition and malpractice costs described in **Section III.B.3**.

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.

Pediatric Standard Payment Amount Per Discharge – a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of a pediatric inpatient hospitalization in a Pediatric Specialty Unit, which is complete fee-for-service payment for an acute episode of illness, excluding additional fee-for-service payment for services described in **Sections III.C through H**.

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.

Rate Year (RY) – Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table:

Rate Year	Dates
RY04	10/1/2003 – 9/30/2004
RY05	10/1/2004 – 9/30/2005
RY06	10/1/2005 – 9/30/2006
RY07	10/1/2006 – 10/31/2007
RY08	11/1/2007 – 9/30/2008
RY09	10/1/2008 – 10/31/2009
RY10	11/1/2009 – 11/30/2010
RY11	12/01/2010 – 09/30/2011
RY12	10/01/2011 -9/30/2012
RY13*	10/01/2012 – 09/30/2013

*In future rate years, Hospitals will be paid in accordance with this Attachment (until amended).

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 licensed by the Department of Public Health (DPH) as rehabilitation beds, in a licensed Acute Hospital that provides comprehensive Rehabilitation Services to Members with appropriate medical needs.

RFA and Contract – The Request for Applications and the agreement executed between each selected Hospital and EOHHS that incorporates all of the provisions of the RFA.

State Fiscal Year (SFY) – the time period of 12 months beginning on July 1 of any calendar year and ending on June 30 of the immediately following calendar year. SFY13 begins on July 1, 2012, and ends on June 30, 2013.

Standard Payment Amount Per Discharge (SPAD) – a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is a complete fee-for-service payment for an acute episode of illness, excluding additional fee-for-service payment for services described in **Sections III.C through H**. Calculation of the SPAD is discussed in **Section III.B**.

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III. Payment for Inpatient Services

A. Overview

1. Except as otherwise provided in **subsections C through H** below, fee-for-service payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be a Hospital-specific Standard Payment Amount per Discharge (SPAD) (see **subsection B** below).

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

3. Maternity cases in which delivery occurs will be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn.

4. **Subsections C through H** describe non-SPAD fee-for-service payments for psychiatric services, transfer patients, Outlier Days, Hospital-Based Physician services, Administrative Days, and Rehabilitation Unit services in Acute Hospitals. Payment for other unique circumstances is described in **subsection I**, and **Exhibits 1 through 3**. Pay-for-Performance payments are described in **subsection J.**

5. 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.

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

1. Overview

The Standard Payment Amount per Discharge for each Hospital is the sum of the Base SPAD, the Pass-through Amount per Discharge, and the Capital Payment Amount per Discharge, adjusted by the SPAD Adjustments for qualifying Hospitals. Each of these components is noted in the table below, and described in greater detail in the following sections.

The SPAD Base Year is RY05.

Component	Description / sub-components	Amount
Base SPAD (**subsection 2**)	a. statewide average payment amount per discharge (except for Critical Access Hospitals – see subsection 2.a.ii below).	$8,252.93 (statewide)
	b. adjusted by Hospital-specific MassHealth casemix and wage area	Hospital-specific
Pass-through Amount per Discharge (**subsection 3**)	a per-discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs	Hospital-specific
Capital Payment Amount per Discharge (**subsection 4**)	a. statewide weighted average capital cost per discharge,	$458.03 (statewide)
	b. adjusted by Hospital-specific MassHealth casemix	Hospital-specific
SPAD Adjustments (**subsection 5**)	a percentage increase or decrease in the SPAD for qualifying Hospitals	Hospital-specific percentage (does not apply to per diem rates, except for purposes of capping the transfer per diem rate at the Hospital-specific SPAD)

2. Base SPAD

The base standard payment amount per discharge (Base SPAD) is Hospital-specific, calculated by multiplying the statewide average payment amount per discharge by the Hospital's MassHealth Casemix Index and adjusted by the Hospital's Massachusetts-specific Wage Area Index. For Critical Access Hospitals, the statewide average payment amount per discharge component in the Base SPAD calculation is replaced by the formula set forth in subsection 2.a.ii, below.

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a. The Statewide Average Payment Amount Per Discharge

i. The statewide average payment amount per discharge is determined by multiplying

- the weighted average of the SPAD Base Year standardized cost per discharge, where any Hospital's standardized cost per discharge that exceeds the efficiency standard is limited by the efficiency standard; by
- an outlier adjustment factor of 93.0% and by
- the Inflation Factors for Operating Costs to trend SPAD Base Year costs forward to the current Rate Year.

These elements are described in greater detail below. The statewide average payment amount per discharge is $8,252.93.

ii. For Critical Access Hospitals, rather than using the statewide average payment amount per discharge formula (subsection 2.a.i., above) in the calculation of the Base SPAD, the following calculation is used in its place. Multiply:

- the Critical Access Hospital's SPAD Base Year standardized cost per discharge, calculated using 101% of the hospital's SPAD Base Year costs; by
- the inflation Factors for Operating Costs to trend SPAD Base Year costs forward to the current Rate Year.

These elements are described in greater detail below.

iii. SPAD Base Year Standardized Cost per Discharge

The SPAD Base Year standardized cost per discharge is the average payment amount per discharge for each Hospital, adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the Hospital-specific SPAD Base Year all-payer casemix index.

The average payment amount per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. SPAD Base Year costs are determined using the SPAD Base Year 403 cost report as screened and updated as of June 2, 2008. SPAD Base Year discharges are determined using SPAD Base Year Hospital Discharge Data (HDD). Specific costs and discharges are included and excluded as follows:

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Average Payment Amount per Discharge: treatment of costs and discharges	
Included	Excluded
Total non-excluded costs of providing Inpatient Services Routine outpatient costs associated with admissions from the Emergency Department Routine and ancillary outpatient costs resulting from admissions from Observation status Cost centers identified as the supervision component of physician compensation and other direct physician costs All other non-excluded medical and non-medical patient care-related staff expenses	Costs and discharges from Excluded Units. Professional services Malpractice costs, organ acquisition costs, capital costs and direct medical education costs.

The SPAD Base Year average payment amount per discharge for each Hospital is then adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the SPAD Base Year all-payer Casemix Index. This adjusted value is the SPAD Base Year standardized cost per discharge.

iv. Efficiency Standard

All Hospitals are ranked with respect to their SPAD Base Year standardized costs per discharge, and the efficiency standard is set at the 75th percentile of the cumulative frequency of discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $8,901.19.

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v. Inflation Factors for Operating Costs

The inflation factors for operating costs are applied to trend SPAD Base Year costs forward to the current Rate Year.

Inflation Factors for Operating Costs		
Reflecting price changes between...	**Source**	**Inflation Factor for Operating Costs**
RY04 and RY05*	A blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy.	1.186%
RY05 and RY06		1.846 %
RY06 and RY07		1.637%
RY07 and RY08	CMS market basket	3.300%
RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008		3.000%
RY08 and RY09 for admissions beginning from December 7, 2008 through September 30, 2009	A blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy.	1.424%
RY09 and RY10**		0.719%
RY10 and RY11		1.820%
RY11 and RY12		1.665%
RY12 and RY13***		1.775%

** The Inflation Factor for Operating Costs reflecting price changes between RY04 and RY05 is not used to calculate the statewide average payment amount per discharge, but is used to calculate the psychiatric per diem (see **Section III.C** below).*

*** The Inflation Factor for Operating Costs reflecting price changes between RY09 and RY10 was calculated based on the RY09 rate in effect for admissions beginning from December 7, 2008 through September 30, 2009.*

**** The Inflation Factor for Operating Costs reflecting price changes between RY12 and RY13 was applied starting January 1, 2013.*

b. Hospital-specific Adjustments

For calculating the SPAD, each Hospital's Casemix Index is calculated using FY11 MassHealth SPAD, transfer, and Outlier claims in MMIS where MassHealth is the primary payer to ensure that only MassHealth discharges are included.

The Hospital's Massachusetts-specific Wage Area Index is defined in **Section II**.

3. Pass-Through Amounts per Discharge

The pass-through amount per discharge is the sum of each Hospital's per-discharge costs of malpractice and organ acquisition.

The inpatient portion of malpractice insurance and organ acquisition costs was derived from each Hospital's FY11 403 cost report as screened and updated by DHCFP as of July 20, 2012.

The pass-through amount per discharge is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days for the SPAD Base Year and then multiplying this cost per diem by the Hospital-specific MassHealth Average Length of Stay, omitting such costs and days related to services in Excluded Units.

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4. Capital Payment Amount per Discharge

The capital payment amount per discharge is a standard, prospective payment for all Hospitals. The capital payment amount is calculated based on the SPAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the base year and the current rate year, and adjusted for Hospital-specific MassHealth casemix. The calculation is summarized in the following chart:

Capital Payment Amount per Discharge		
Base year statewide capital cost per discharge (**subsection a**),	a. the base year capital cost per discharge b. adjusted by the all payer casemix index c. capped at the capital efficiency standard d. multiplied by the Hospital-specific MassHealth discharges e. summed and divided by the total statewide MassHealth discharges	$487.74
trended to the current rate year using the Inflation Factors for Capital Costs (**subsection b**),		$458.03
adjusted by the Hospital-specific MassHealth casemix index (**subsection c**).		Hospital-specific

a. Base year statewide capital cost per discharge

The base year statewide capital cost per discharge is the discharge-weighted average over all Hospitals of the all payer casemix-adjusted capital cost per discharge capped at the capital efficiency standard.

For each Hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, major moveable equipment, and long- and short-term interest. Total capital costs are allocated to inpatient services through the square-footage-based allocation formula of the 403 cost report. Capital costs for Excluded Units are omitted to derive net inpatient capital costs. Each Hospital's capital cost per discharge is calculated using SPAD Base Year cost reports and SPAD Base Year HDD by dividing total net inpatient

capital costs by the Hospital's total days, net of Excluded Unit days, multiplied by the Hospital-specific all-payer Average Length of Stay.

Each Hospital's capital cost per discharge is then adjusted by the all-payer Casemix Index.

All Hospitals are then ranked with respect to their casemix-adjusted capital cost per discharge, and the capital efficiency standard is set at the 50th percentile of the cumulative frequency of discharges in MMIS. Each Hospital's capital cost per discharge that exceeds the capital efficiency standard is then limited by the capital efficiency standard.

The base year statewide capital cost per discharge is the statewide average of these adjusted costs per discharge, weighted based on each Hospital's number of MassHealth discharges.

b. Inflation Factors for Capital Costs

The Inflation Factors for Capital Costs are applied to trend the SPAD Base Year statewide capital cost per discharge forward to the current Rate Year. These Inflation Factors are the factors used by CMS to update payments made by Medicare.

Inflation Factors for Capital Costs	
Reflecting price changes between...	**Inflation Factor for Capital Costs**
RY04 and RY05*	0.7%
RY05 and RY06	0.7%
RY06 and RY07	0.8%
RY07 and RY08	0.9 %
RY08 and RY09	0.7%
RY09 and RY10	1.4%
RY10 and RY11	1.5%
RY11 and RY12	1.5%
RY12 and RY13**	1.2%

** The Inflation Factor for Capital Costs reflecting price changes between RY04 and RY05 is not used to calculate the Capital Payment Amount per Discharge, but is used to calculate the psychiatric per diem (see **Section III.C** below).*

*** The Inflation Factor for Capital Costs reflecting price changes between RY12 and RY13 was applied starting January 1, 2013.*

c. Hospital-specific capital payment per discharge

The Hospital-specific capital payment per discharge is determined by multiplying the trended statewide capital cost per discharge by the Hospital's MassHealth Casemix Index.

5. **SPAD Adjustments**

a. EOHHS will make an adjustment to the SPAD as calculated in **Sections III.B.2** through **III.B.4** for certain Hospitals as specified below.

- Hospitals that have greater than 63% of Gross Patient Service Revenue (GPSR) from government payers and free care will receive an increase of 5% to their SPAD (including Pediatric SPAD).

- Hospitals with a greater number of potentially preventable readmission (PPR) chains than expected, as calculated in accordance with **Section IV**, below, will receive a 2.4%, 3.4%, or 4.4% reduction to their SPAD (including Pediatric SPAD), as applicable.

b. Any Hospital eligible for both SPAD adjustments specified above will receive a single combined adjustment to its SPAD equal to 5.0% minus the applicable percentage reduction in **Section III.B.5.a** above.

c. These SPAD adjustments shall not apply to the calculation of per diem rates; provided, however, that the adjustments do apply when capping the transfer per diem rate at the Hospital-specific SPAD for purposes of **subsection D**, below.

C. Payments for Psychiatric Services

1. Overview

a. Services provided to MassHealth Members in DMH-licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid on an all-inclusive Psychiatric Per Diem basis.

b. The Statewide Standard Psychiatric Per Diem Rate is the sum of the three Psychiatric Per Diem Base Year Operating Standards (see **subsection 2**) and the Psychiatric Per Diem Base Year Capital Standard (see **subsection 3**), adjusted for the current Rate Year (see **subsection 4**).

c. Payment for psychiatric services provided in beds that are not DMH-licensed Beds shall be made on a transfer per diem basis, as described in **Section III.D** below. See **Sections III.D.2.d and e** for payment rules involving transfers to and from DMH-licensed Beds and BH managed care status.

d. The Psychiatric Per Diem Base Year is RY04. MassHealth utilizes the costs, statistics, and revenue reported in the 2004 -403 cost reports as screened and updated as of March 10, 2006.

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2. Determination of the Psychiatric Per Diem Base Year Operating Standards

a. Standard for Inpatient Psychiatric Overhead Costs

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. The base year Standard for Inpatient Psychiatric Overhead Costs is $363.28.

b. Standard for Inpatient Psychiatric Direct Routine Costs

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. The base year Standard for Inpatient Psychiatric Direct Routine Costs is $325.13.

c. Standard for Inpatient Psychiatric Direct Ancillary Costs

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. The base year Standard for Inpatient Psychiatric Direct Ancillary Costs is $56.83.

3. Determination of the Psychiatric Per Diem Base Year Capital Standard

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. The base year Standard for Inpatient Psychiatric Capital Costs is $30.73.

a. 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.

b. Each Hospital's base year capital costs consist of the Hospital's actual Psychiatric Per Diem 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.

4. Adjustment to Base Year Standards

The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see **Section III. B.2a.v above).** The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see **Section III.B.4.b above**).

The Inflation Factors for Operating Costs (see **Section III.B.2.a.v above)** between RY08 and RY10 and between RY12 and RY13 were then applied to the rate calculated above to determine the Statewide Standard Psychiatric Per Diem Rate for this portion of RY13 (January 1, 2013 through September 30, 2013).

The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs to this portion of RY13 for the Psychiatric Per Diem is $68.22. The Statewide Standard Psychiatric Per Diem Rate is $844.19.

D. Transfer Per Diem Payments

Hospitals will be paid a transfer per diem, calculated as follows, under the circumstances specified in this section.

In general, total payments made on a transfer per diem basis are capped at the Hospital-specific SPAD; the payment per day is calculated as follows:

- the statewide average payment amount per discharge adjusted by the Hospital-specific MassHealth Casemix Index and Massachusetts-specific Wage Area Index
- divided by the SPAD Base Year all-payer Average Length of Stay of 4.59 days,
- plus the Hospital-specific capital and pass-through per diem payments (which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay).

1. Transfer between Hospitals

In general, when a patient is transferred from one Acute Hospital to another, the Hospital that is transferring the patient will be paid at the transfer per diem rate, up to the Hospital-specific SPAD.

In general, the Hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in **Section III.B above**, if the patient is discharged from that Hospital. This includes when a patient is transferred back and is subsequently discharged from the original Hospital. If the patient is transferred to another Hospital, then the transferring Hospital will be paid at the transfer per diem rate, up to the

Hospital-specific SPAD. Additionally, "back transferring" Hospitals (Hospitals to which a patient is first admitted and then transferred back after having been transferred to another Acute Hospital) will be eligible for Outlier payments as specified in **Section III.E below**.

2. 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 paid at the transfer per diem rate, up to the Hospital-specific SPAD. This section outlines payment under some specific transfer circumstances.

Hospitals receiving a transfer per diem may be eligible for Outlier payments specified in **Section III.E below**, subject to all of the conditions set forth therein.

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

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

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

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

c. Admissions Following Outpatient Surgery or Procedure

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

d. Transfer between a DMH-licensed Bed and Any Other Bed within the Same Hospital

Payment 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, whether the Hospital is part of the BH network, and the type of service provided. See also **subsection (e)** below.

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, up to the Hospital-specific SPAD for the non-DMH-licensed bed portion of the stay, and on a Psychiatric Per Diem basis (see **Section III.C above**) for the DMH-licensed bed portion of the stay.

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-licensed bed portion of the stay only if it is for medical treatment. In that case, such payment will be at the transfer per diem rate, up to the Hospital-specific SPAD.

e. Change of BH Managed Care Status during a Behavioral Health Hospitalization

When a Member is enrolled with the BH Contractor during a behavioral health admission, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor is payable by 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 on a Psychiatric Per Diem basis (see **Section III.C above**) for psychiatric services in a DMH-licensed Bed, or at the transfer per diem rate, up to the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-licensed Bed.

E. Outlier Payments

A Hospital qualifies for an Outlier per diem payment equal to 75% of the Hospital's transfer per diem in addition to the SPAD (**Section III.B above**) or transfer per diem payment (**Section III.D above**) if all of the following conditions are met:

a. the Medicaid non-MCO length of stay for the hospitalization exceeds 20 cumulative acute days at that Hospital (not including days in a DMH-licensed bed or days paid by a third party);

b. the Hospital continues to fulfill its discharge planning duties as required in MassHealth's regulations;

c. the patient continues to need acute level care and is therefore not on Administrative Day status (see **Section III.G below**) on any day for which an Outlier payment is claimed;

d. the patient is not a patient in a DMH-licensed bed on any day for which an Outlier payment is claimed;

e. the patient is not a patient in an Excluded Unit within the Hospital and;

f. the patient is under 21 years of age.

F. Physician Payment

1. For physician services provided by Hospital-Based Physicians to MassHealth patients, the Hospital will be paid for the professional component of Hospital-Based Physician services in accordance with Section 8.d. of Attachment 4.19B of the State Plan.

2. Hospitals will be paid for Hospital-Based 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.

3. Physician services provided by residents and interns are not reimbursable separately. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

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

G. Payments for Administrative Days

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

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

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

4. 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.

5. These ratios are 0.278 and 0.382, respectively.

   The resulting AD rates were then updated by the Inflation Factor for Administrative Days between RY12 and RY13. The resulting AD rates for the portion of RY13 beginning January 1, 2013 are $258.22 for Medicaid/Medicare Part B eligible patients and $279.24 for Medicaid-only eligible patients.

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

H. 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 Rehabilitation Unit.

The per diem rate for such Rehabilitation Services will equal the median MassHealth RY13 Rehabilitation Hospital rate for Chronic Disease and Rehabilitation hospitals. Acute Hospital Administrative Day rates (see **Section III.G above**) will be paid for all days that a patient remains in the Rehabilitation Unit while not at hospital level of care.

I. Payment for Unique Circumstances

1. [RESERVED]

2. Essential MassHealth Hospitals

a. Eligibility

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

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

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

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

(4) The Hospital is an acute care general Hospital located in Massachusetts which 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.

Based on these criteria, Cambridge Health Alliance (CHA) and the UMass Memorial Health Care, Inc. Hospitals (UMass Hospitals) are the only Hospitals eligible for this payment.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Essential MassHealth Hospitals. This payment is based on approval by EOHHS of the Hospital's accurately submitted and certified EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report (UCCR) for the hospital fiscal year corresponding with the payment.

For the UMass hospitals, the Federal Fiscal Year payment amount will be $6,000 times the total number of inpatient days for admissions beginning during the applicable Federal Fiscal Year, not to exceed $130,000,000.

For CHA, the Federal Fiscal Year payment amount will be the difference between the non-state-owned hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $14,000,000.

Essential MassHealth Hospital payments will be made after EOHHS' receipt of the hospital's certified UCCR, finalization of payment data and applicable payment amounts, and receipt of any necessary approvals, but no later than 1 year after receipt of the hospital's final reconciliation UCCR (which must be submitted by 45 days after the Hospital's Medicare 2552 Report for the payment year has been finalized by Medicare's Fiscal Intermediary).

3. Freestanding Pediatric Acute Hospitals

a. Eligibility

Based on the definition of Freestanding Pediatric Acute Hospitals, Children's Hospital is the only Hospital eligible for this payment.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Freestanding Pediatric Acute Hospitals to account for high Medicaid volume

The supplemental 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 Federal Fiscal Year. The Federal Fiscal Year payment is based on Medicaid payment and cost data. The payment equals the variance between the Hospital's inpatient Medicaid payments and inpatient Medicaid costs, not to exceed $3,850,000. Freestanding Pediatric Acute Hospital payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

4. Acute Hospitals with High Medicaid Discharges

a. Eligibility

In order to qualify for payment as an Acute Hospital with High Medicaid Discharges, a Hospital must be an Acute Hospital that has more than 2.7% of the statewide share of Medicaid discharges, determined by dividing each Hospital's total Medicaid discharges as reported on the Hospital's -403 cost report by the total statewide Medicaid discharges for all Hospitals.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Acute Hospitals that have higher Medicaid discharges when compared with other participating MassHealth Hospitals.

The payment amount is based on Medicaid payment and charge data for the federal fiscal year. The payment equals the variance between the Hospital's inpatient Medicaid payment and inpatient Medicaid charges, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Acute Hospital with High Medicaid Discharges payments will be made after

finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

5. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for inpatient services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay based on the prior year's claims data from the Medicaid Management Information System (MMIS).

i. Eligibility

In order to qualify for an infant outlier payment, a Hospital must provide services to infants less than one year of age, and must have one of the following during the Rate Year for individuals less than one year of age:

- An average Medicaid inpatient length of stay that equals or exceeds the statewide weighted average plus two standard deviations; or
- An average cost per inpatient Medicaid discharge that equals or exceeds the Hospital's average cost per Medicaid inpatient discharge plus two standard deviations for individuals of all ages.

ii. Payment to Hospitals

Annually, each Hospital that qualifies for an infant outlier adjustment receives an equal portion of $50,000. For example, if two Hospitals qualify for an outlier adjustment, then each Hospital receives $25,000.

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for inpatient services furnished to children greater than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay based on the prior year's discharge data from MMIS.

i. Eligibility

In order to qualify for a pediatric outlier payment, a Hospital must provide services to children greater than one year of age and less than six years of age,

and must have one of the following during the Rate Year for individuals within this age range:

- An average Medicaid inpatient length of stay that equals or exceeds the statewide weighted average plus two standard deviations; or
- An average cost per inpatient Medicaid discharge that equals or exceeds the Hospital's average cost per Medicaid inpatient discharge plus two standard deviations for individuals of all ages.

ii. Payment to Hospitals

Annually, each Acute Hospital qualifying for a pediatric outlier adjustment will receive $1,000.

J. Pay-for-Performance (P4P) Payment

Pay-for-Performance (P4P) is MassHealth's method for quality scoring and converting quality scores to rate payments contingent upon Hospital adherence to quality standards and achievement of performance thresholds and benchmarks. P4P incentive payment approaches include pay-for-performance and pay-for-reporting (see **subsection 3**, below).

A Hospital will qualify to earn P4P payments if it meets data validation requirements and achieves performance thresholds for P4P measures listed below. Each measure is evaluated using the methods outlined below to produce measure rates which result in performance scores that are converted into incentive payments. A Hospital's performance scores are calculated as described in **subsection 3.c**, below.

The P4P program applies to inpatient services for MassHealth Members where Medicaid is the primary payer. In general, payment calculations are based on a combination of performance scores, which utilize all-Medicaid payer data, and the number of eligible discharges, which includes only individuals enrolled in the Primary Care Clinician (PCC) Plan and with fee-for-service coverage. The P4P payments are calculated based on 2012 data as described below.

1. Performance Measures

Quality performance goals and measures focus on areas where improvement is likely to have most impact on the health outcomes for this Member population:

- Maternity;
- respiratory care (pneumonia and pediatric asthma);
- surgical care infection prevention;

- racial and ethnic health disparities; and
- care coordination.

The specific clinical process measures are identified in the following tables, organized by Quality Measure Category:

Measure ID#	Maternity
MAT-1	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus
MAT-2a	Perioperative Antibiotics for Cesarean Section – Antibody Timing
MAT-2b	Perioperative Anitbotics for Cesarian Section – Antibiotic Selection
MAT-3	Elective Delivery Prior to 39 Completed Weeks Gestation

Measure ID#	Pediatric Asthma
CAC-1a	Children's Asthma Care - Inpatient Use of Relievers
CAC-2a	Children's Asthma Care - Inpatient Use of Corticosteroids
CAC-3	Children's Asthma Care – Home management plan of care

Measure ID#	Community Acquired Pneumonia
PN-3b	Blood culture performed in ED prior to first antibiotic received in hospital
PN-6	Appropriate antibiotic selection for CAP in immuno-competent patients

Measure ID#	Surgical Care Infection Prevention
SCIP-1a	Prophylactic antibiotic received within 1 hour prior to surgical incision
SCIP-2a	Appropriate antibiotic selection for surgical prophylaxis
SCIP-3a	Prophylactic antibiotic discontinued w/in 24 hrs after surgery end time

Measure ID#	Health Disparities
HD-2	Health Disparities – Clinical Composite Measure

Measure ID#	Care Coordination Measure Set
CCM-1	Reconciled medication list received at discharge (inpatient)
CCM-2	Transition record with specified data received at discharge (inpatient)
CCM-3	Timely transmission of transition record (inpatient)

2. Data Validation Requirements

In order to ensure the accuracy and reliability of the submitted data, all reported measures are subject to data validation requirements. The submitted electronic data must meet a minimum reliability standard. The minimum reliability standard is based on a comparison between the submitted electronic data and the selected hospital medical records for a sample of discharges. The minimum reliability standard is defined as an 80 percent match for data elements. Hospitals are considered to have "passed" validation if the overall agreement score of 80 percent has been met.

3. Payment Methodology

P4P incentive payments will be based on both pay-for-performance and pay-for-reporting. Incentive payments based on the pay-for-performance approach are available with respect to the maternity, pediatric asthma, community acquired pneumonia, surgical care infection prevention and health disparities measure categories. Incentive payments based on the pay-for-reporting approach are available solely as to the care coordination measure category. While performance will also be assessed for the care coordination measure category in order to set baseline performance thresholds for pay-for-performance purposes for future rate years, P4P incentive payments are based solely on pay-for-reporting for that category.

Incentive payments are calculated by multiplying the Hospital's eligible Medicaid discharges by the quality measure category per discharge amount and the total performance score.

Incentive payments will be made as lump sum payments to eligible hospitals, after finalization of the performance measure data and applicable payment amounts.

a. Eligible Medicaid Discharges

Eligible Medicaid discharges are a Hospital's discharges that are eligible for Pay-for-Performance payment (or pay-for-reporting payment, for the care coordination measure category), and will be based on the following:

- For the individual clinical process measures (maternity, pediatric asthma, community acquired pneumonia, and surgical care infection prevention), the eligible Medicaid discharges will be based on the FY12 MassHealth HDD that meet specific ICD requirements for each measure category. For the care coordination measure set, the eligible Medicaid discharges will be based on the sum of the FY12 HDD that meet the ICD measure population inclusion criteria. For the national measures (SCIP, CAC and PN), the ICD requirements are published in the *Specifications Manual for National Hospital Inpatient Quality Measures* (available at www.qualitynet.org). Specifications for the remaining measures are available on the MassHealth Quality Exchange website at www.mass.gov/masshealth/massqex .

- For the clinical health disparities composite measure (HD-2), the eligible Medicaid discharges will be the sum of all of the Hospital's eligible Medicaid discharges for the individual clinical process measures (maternity, pediatric asthma, community acquired pneumonia, and surgical care infection prevention) as described above. HD-2 will not include the care coordination measure set.

b. Quality Measure Category per Discharge Amount

The final per-discharge amounts will be determined by dividing the **maximum allocated amount** for each measure by the **statewide eligible Medicaid discharges** for each measure.

i. Maximum Allocated Amount

Incentive payments under the RFA will cumulatively total no more than the maximum amount allotted for each quality measure category in the following table:

Quality Measure Category	Maximum Allocated Amount
Maternity	$22,000,000
Pediatric Asthma	$ 2,000,000
Community Acquired Pneumonia	$ 5,000,000
Surgical Care Infection Prevention	$ 5,000,000
Health Disparities -Clinical	$ 4,000,000
Care Coordination (pay-for-reporting)	$12,000,000
TOTAL	$50,000,000

ii. Statewide Eligible Medicaid Discharges

The statewide eligible Medicaid discharges for each measure category are the sum of all eligible Medicaid discharges (see **subsection a** above) for Acute Hospitals.

c. Total Performance Score

i. Individual Clinical Measure Categories

The total performance score is a percentage of **quality points** earned out of the total possible points for each measure category (maternity, pediatric asthma, community acquired pneumonia, surgical care infection prevention).

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

For each individual clinical measure category, the quality points awarded are the sum of the higher of the **attainment** or the **improvement points** earned for each measure. These points are awarded for each measure category based on each Hospital's performance during the Comparative Measurement Period relative to the attainment threshold (the median performance of all Hospitals in the Baseline Measurement Period) and the benchmark (the mean of the top decile of all Hospitals in the Baseline Measurement Period).

The performance score Periods are as follows:

	Comparative Measurement Period	Baseline Measurement Period
Clinical Process Measures	CY 2012	CY 2011

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

If the Hospital failed validation for a measure in the previous reporting year, data from that period is considered invalid for use in calculating the baseline performance. Therefore, the Hospital would not be eligible for improvement points. However, it may be eligible for attainment points in the current reporting year based on calculation of the current reporting year's data for the measure if it passed validation in the current year.

(A) Attainment Points

A Hospital can earn points for attainment based on relative placement between the attainment threshold and benchmark, as follows:

- if a Hospital's score for a measure is equal to or less than the attainment threshold, it will receive zero points for attainment,
- if a Hospital's score for a measure is greater than the attainment threshold but below the benchmark, it will receive 1-9 points for attainment, and
- if a Hospital's score for a measure is greater than or equal to the benchmark, it will receive the maximum 10 points for attainment.

(B) Improvement Points

If a Hospital's score for a measure is above the attainment threshold but below the benchmark, the Hospital can earn points for improvement based on how much its performance score on the measure has improved from the Baseline Measurement Period as follows:

- if a Hospital's score for a measure is less than or equal to its score for the Baseline Measurement Period, it will receive zero (0) points for improvement.
- if a Hospital's score for a measure is greater than its score for the Baseline Measurement Period, it will receive 0-9 points for improvement.

(C) Example

The following is an example pay-for-performance calculation for the individual clinical Maternity measures, provided for illustrative purposes only.

Statewide calculations	
Maximum allocated amount	$22,000,000
Statewide eligible Medicaid discharges	11,178
Quality measure category per-discharge amount	$22,000,000 / 11,178 = $1,968
Hospital-specific calculations	
Hospital's awarded Maternity quality points (sum of measure-specific attainment or improvement points)	16
Maximum possible Maternity quality points	20
Performance score for maternity	(16 points / 20 points) x 100% = 80%
Eligible Medicaid discharges	500
Hospital-specific total incentive payment, maternity	**500 x $1,968 x 80% = $787,200**

ii. Clinical Health Disparities Composite Measure Category

The clinical health disparities composite measure for each hospital is comprised of aggregate data from all individual clinical measure categories (maternity, pediatric asthma, community acquired pneumonia, surgical care infection prevention) on which the hospital is eligible to report. The hospital's composite measure compares the hospital's performance among race/ethnicity groups and all groups combined, and is converted to a disparity index value. The composite

measure and disparity index value are calculated only for Hospitals that report on more than one racial group in their electronic data files.

The health disparities measure will be assessed on a target attainment level using the following methods.

(A) Setting Performance Thresholds

1. Decile Thresholds. Performance will be assessed using a method that determines the hospital's rank, relative to other hospitals, based on the decile threshold system. Hospitals that meet the measure calculation criteria are divided into ten groups or deciles based on their disparity index value, so that approximately the same number of hospitals falls into each decile group.

2. Target Attainment Threshold. The target attainment threshold represents the minimum level of performance that must be achieved to earn incentive payments. The target attainment is defined as the boundary for a disparity index value that falls above the 2nd decile group, as shown in the "Decile Performance Thresholds" table below.

(B) Assessing Performance.

The Hospital's clinical health disparity performance score will be calculated using the following methods:

1. Disparity Index Value Ranking. All Hospital disparity index values are rounded to six decimal places. All index values are then divided into ten equal groups and ranked from highest to lowest so approximately the same number of hospitals falls in each decile group.

2. Conversion Factor. Each decile group is assigned a weighted conversion factor associated with the decile threshold, as shown in the table below:

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Decile Performance Thresholds

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

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

(C) Clinical Health Disparities Composite Total Performance Score.

The total performance score for the health disparities composite measure is the assigned conversion factor as shown in the preceding table, multiplied by 100%. Performance scores are calculated only for Hospitals that meet the measure calculation criteria and validation requirements, using only the Hospital's current year reported data.

iii. Care Coordination Measure Category

The pay-for-reporting incentive payment approach applies solely to the care coordination measure category. Pay-for-reporting incentive payments will be contingent on meeting the data validation standard (.80) for the measure's required data elements. Performance scoring will apply a "Pass/Fail" criterion based solely on meeting the data validation standard (.80) requirement. Hospitals that fail validation will receive a total performance score of 0%, and Hospitals that pass validation will receive a total performance score of 100%.

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IV. Potentially Preventable Readmissions (PPRs)

Hospitals with a greater number of actual Potentially Preventable Readmission (PPR) chains than expected PPR chains, based on data specified in **Section IV.B**, below, will receive a reduction to their Standard Payment Amount per Discharge (SPAD) (including Pediatric SPAD). See also **Section III.B.5** of this Attachment. This reduction will be applied to Hospitals identified using the methodology described below.

A. Definitions

Total Admissions: The total # of Medicaid fee for service /PCC Plan admissions over the time period, excluding mental health and substance abuse diagnoses.

At-risk Admission: The # of Total Admissions considered at risk for readmission, as determined by the 3M PPR methodology.

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

Actual PPR Rate: The number of initial admissions with one or more qualifying clinically related readmission within a 30-day period divided by the total number of at-risk admissions.

B. Determination of Readmission Rates

PPRs are identified in Hospital Discharge Data (HDD) for MassHealth Primary Care Clinician and Fee-for-Service non-psychiatric discharges (payer types 103 and 104 as reported by the Hospital) by using the 3M PPR software version 28.0. The time period for identifying initial admissions was from September 1, 2009 to September 1, 2010. The time period for identifying subsequent readmissions was from September 1, 2009 to September 30, 2010.

1. Statewide Average PPR Rate

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

2. Hospital-specific Actual PPR Rate

Each Hospital's risk-adjusted actual PPR rate is derived by dividing the number of readmission chains by the total number of at-risk admissions.

3. Hospital-specific Expected PPR Rate

In order to derive the Hospital-specific expected PPR rate, the statewide average PPR rates for each APR-DRG are applied to each Hospital's casemix. The expected PPR rate therefore reflects how a given Hospital could have been expected to perform on each APR-DRG recorded in their HDD filing for the time period specified above.

4. Hospital-specific Actual-to-Expected (A:E) PPR Ratio

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

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

The numerator is the rate of initial admissions with one or more qualifying clinically related readmission within a 30-day period. The denominator is the rate of initial admissions with one or more qualifying clinically related readmission that would have been expected, given statewide average PPR rates for specific APR-DRGs, as applied to the individual Hospital's casemix.

5. Calculation of payment reduction

Hospitals with a Hospital-specific A:E ratio greater than 1 (therefore, Hospitals with more actual than expected PPR chains) receive a SPAD reduction on a three-tiered scale based on performance. Hospitals with an A:E ratio of less than 1 will not be subject to a SPAD reduction.

Hospitals with an A:E ratio of >1 will be broken down into three performance-based terciles. Hospitals in the highest performing tercile receive a 2.4% SPAD reduction, the middle tercile a 3.4% reduction, and the lowest tercile a 4.4% reduction. Only Hospitals with more than 40 initial admissions at risk for a PPR are subject to this reduction.

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V. Other Provisions

A. Federal Limits

If any portion of the reimbursement methodology is not approved by CMS or is in excess of applicable federal limits, EOHHS may recoup or offset against future payments, any payment made to a Hospital in excess of the approved methodology. Any such recovery shall be proportionately allocated among affected Hospitals.

B. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital RFA and Contract in effect on that date.

C. Errors in Calculation of Pass-through Amounts, Capital Costs or Casemix

As set forth below, EOHHS will make corrections to the final Hospital-specific rate retroactive to the effective date of the state plan. Such corrections will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

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

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the pass-through costs or capital costs, resulting in an amount not consistent with the methodology, a Hospital may request a correction, consistent with the RFA and contract, which shall be at the sole discretion of EOHHS.

2. Incorrect Determination of Casemix

In the event of an error in the calculation of casemix made by EOHHS, resulting in an amount not consistent with the methodology and where the effect of the error is a decrease in the Hospital's SPAD of 2% or more, a Hospital may request a correction, consistent with the RFA and contract, which shall be at the sole discretion of EOHHS. If the error was a Hospital reporting error where the effect of the error is a decrease in the Hospital's SPAD of 30% or more, EOHHS may, in its sole discretion, consider revised data submitted by the Hospital.

3. Change in Service Affecting Casemix

In the event that a Hospital opens or closes an Inpatient Service that the Hospital believes will have a significant effect on casemix, the Hospital must provide EOHHS with a data analysis of the casemix effect for the current Rate Year and the subsequent Rate Year if it

requests a casemix adjustment. EOHHS may, in its sole discretion, consider revised data submitted by the Hospital.

D. New Hospitals/Hospital Change of Ownership

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

E. Data Sources

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

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

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VI. Provider Preventable Conditions

Citation

Payment Adjustment for Provider Preventable Conditions

42 CFR 447,434,438 and 1902(a) (4), 1902 (a) (6) and 1903

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902 (a) (4), 1902 (a) (6) and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health-Care Acquired Conditions for non-payment under Attachment 4.19-A(1), (Acute Inpatient Hospital Services) under this State plan.

☒ Hospital Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-A(1), (Acute Inpatient Hospital Services) under this State plan.

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☒ Additional Other Provider-Preventable Conditions identified below.

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)

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7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low-risk delivery.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen,
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

Reduction in provider payment may be limited to the extent that the following apply: (i) the identified provider preventable conditions would otherwise result in an increase in payment; (ii) the State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

Payment Method:

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Provider preventable conditions ("PPCs") are defined as those conditions that are identified as Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs") listed above. The OPPCs include the three National Coverage Determinations (the "NCDs") and the Additional Other Provider Preventable Conditions ("Additional OPPCs") that are listed above.

When a Hospital reports a PPC that the Hospital indicates was not present on admission, MassHealth will reduce payments to the Hospital as follows:

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1. SPAD:
   a. MassHealth will not pay the SPAD if the Hospital reports that only PPC-related services were delivered during the first 20 days of the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
   b. MassHealth will pay the SPAD if the Hospital reports that non-PPC related services were also delivered during the first 20 days of the inpatient admission, 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.

2. Psychiatric, Rehabilitation, Administrative Day , Outlier or Transfer Per Diem payments:
   a. MassHealth will not pay the per diem if the Hospital reports that only PPC-related services were delivered on that day, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
   b. MassHealth will pay the per diem if the Hospital reports that non-PPC related services were also delivered on that day, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

3. Inpatient Hospital payments for Hospital-Based Physician Services: MassHealth will not pay for inpatient Hospital-based physician services reported as PPC-related services.

4. Follow-up Care in Same Hospital: If a hospital reports that it provided follow-up inpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the Hospital reports that non-PPC-related services were provided during the follow-up stay, payment will be made, but 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.

The federal non-payment provision also applies to third-party liability and crossover payments by MassHealth.

Charges for service, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the member.

In the event that individual cases are identified throughout the PPC implementation period, the Commonwealth shall adjust reimbursement according to the methodology above.

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VII. Serious Reportable Events

The non-payment provisions set forth in this Section VII apply to the following serious reportable events (SREs):

1. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person
2. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas or are contaminated by toxic substances
3. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.
4. Abduction of a patient/resident of any age.
5. Sexual abuse/assault on a patient or staff member within or on the grounds of the healthcare setting.

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital and Hospital-Based Physician services include:

1. All services provided during the inpatient admission during which a preventable SRE occurred; and

2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

    a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or

    b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.

3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

The non-payment provision also applies to third-party liability and crossover payments by MassHealth.

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, 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.

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State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services
Exhibit 1: RY13 Payment Method for Critical Access Hospitals Effective November 1, 2012 through April 30, 2013

EXHIBIT 1
Rate Year 2013 Payment Method Applicable to Critical Access Hospitals Effective November 1, 2012 through April 30, 2013

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for the RY13 period November 1, 2012 through April 30, 2013. (See TN-012-013 for the RY13 period November 1, 2012 through December 31, 2012). For inpatient admissions occurring on or after May 1, 2013 during RY13, payment to Critical Access Hospitals is specified in **Attachment 4.19-A(1)**, and **Exhibit 1** does not apply.

Section II. Payment Method - General

EOHHS will pay Critical Access Hospitals an amount equal to 101 percent of the Hospital's allowable costs as determined by EOHHS utilizing the Medicare cost-based reimbursement methodology for the hospital's state plan services for the period November 1, 2012 through April 30, 2013, as more fully described below. Interim payments will be made to Critical Access Hospitals based on the rates and methods set forth in this **Exhibit 1**, which payments are provisional in nature and subject to the completion of a cost review and settlement for the time period beginning November 1, 2012 through April 30, 2013, as described in **Section II(B)** of this **Exhibit 1**, below. Subject to this **Exhibit 1**, **Attachment 4.19-A(1)** otherwise applies to Critical Access Hospitals. If a Hospital loses its designation as a Critical Access Hospital, the payment methods for such hospital shall revert to the standard acute hospital rate methodologies, and payments may be adjusted accordingly. Reversion to any such rate methodologies shall not affect the payment rates to other participating acute hospitals for the applicable rate year.

(A) Payment for Inpatient Services

For inpatient admissions occurring on or after November 1, 2012 through April 30, 2013, Critical Access Hospitals will be paid for Inpatient Services in accordance with **Attachment 4.19-A(1)** with the following changes.

Critical Access Hospitals will be paid a hospital-specific Standard Payment Amount per Discharge (SPAD) for those Inpatient Services for which all other in-state acute hospitals are paid a SPAD. Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring on or after November 1, 2012 through April 30, 2013, the hospital-specific SPAD for each Critical Access Hospital was calculated, as follows, utilizing FY2011 cost and discharge data:

(1) EOHHS calculated a cost-to-charge ratio for inpatient services (Inpatient CCR) for each Critical Access Hospital, which was determined by dividing the amount reported on Schedule II, line 100, column 10 (PAT EXP-INC CAP SUBTOT IP) of the hospital's

FY11 -403 cost report by the amount reported on Schedule II, line 100, column 11 (GPSR SUBTOT IP) of such report.

(2) EOHHS then calculated 101% of the Critical Access Hospital's Medicaid (MassHealth) inpatient costs by multiplying the hospital's Inpatient CCR by the amount reported on Schedule VA, line 57, column 6 (MCD NON-MGD TOT IP GPSR) of the hospital's FY11 -403 cost report, and then subsequently increasing that amount by an additional 1%.

(3) EOHHS then derived the Critical Access Hospital's Medicaid cost per discharge by dividing the amount that equals 101% of the hospital's Medicaid (MassHealth) inpatient costs as determined above by the hospital's Medicaid (MassHealth) discharges. The hospital's Medicaid (MassHealth) discharges were derived from Schedule VA, line 25, column 6 of the hospital's FY11 -403 cost report.

(4) The Inflation Factors for Operating Costs between RY11 and RY12 and between RY12 and RY13 were then applied to the Critical Access Hospital's Medicaid cost per discharge, as determined above, to derive the Critical Access Hospital's SPAD that will apply for inpatient admissions on or after November 1, 2012 through April 30, 2013.

(5) The Critical Access Hospital's SPAD for this time period as calculated in **subsection (A)(4)**, above, was then adjusted by any applicable SPAD adjustment(s), as set forth in **Section III.B.5.** of **Attachment 4.19-A(1)**.

The transfer per diem rate of payment for each Critical Access Hospital for purposes of **Section III.D** of **Attachment 4.19-A(1)** applicable to inpatient admissions occurring on or after November 1, 2012 through April 30, 2013, was computed by dividing the Critical Access Hospital's SPAD, as calculated above and prior to making any SPAD adjustments under **subsection (A)(5)**, above, by the SPAD Base Year average all-payer length of stay of 4.59 days. Any applicable SPAD adjustment(s), as specified in **subsection (A)(5)**, above, applies when capping the transfer per diem rate at the hospital-specific SPAD.

The outlier per diem rate of payment for each Critical Access Hospital for purposes of **Section III.E** of **Attachment 4.19-A(1)** applicable to inpatient admissions occurring on or after November 1, 2012 through April 30, 2013, was calculated by multiplying the Critical Access Hospital's transfer per diem rate as derived above by 0.75.

(B) Post RY13 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2013 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 the hospital's state plan servicesfor the period November 1, 2012 through April 30, 2013, as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY13 CMS-2552 cost reports (including completed Medicaid (Title XIX) data worksheets) and such other information that EOHHS determines is necessary, to perform this post RY13 review.

"Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for the period November 1, 2012 through April 30, 2013.

If the Critical Access Hospital was paid less than 101% of allowable costs, EOHHS will pay the Critical Access Hospital the difference between 101% of allowable costs and the aggregate interim payments. If 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 101% of allowable costs.

This post Rate Year 2013 review and settlement will take place within twelve (12) months after EOHHS has obtained all accurate and complete data needed to perform the review and settlement calculation. EOHHS estimates that it will have accurate and complete data by September 30, 2014. Assuming this date, the settlement will be complete by September 30, 2015.

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Exhibit 2: Payment Method for the Two Shriners Hospitals for the Portion of RY13 from January 1, 2013 through September 30, 2013

EXHIBIT 2

Payment Method Applicable to the Two Shriners Hospitals for the Portion of RY13 from January 1, 2013 through September 30, 2013

Section I. Overview

The payment methods set forth in this **Exhibit 2** apply to the following two newly-enrolled in-state acute Hospitals: (i) The Shriners' Hospital for Children (Boston, MA) and (ii) The Shriners' Hospital for Children (Springfield, MA) (the "Shriners Hospitals").

Section II. Payment Method

The payment methods set forth in this **Exhibit 2** apply to the Shriners Hospitals for inpatient admissions occurring in RY13 on or after January 1, 2013 through September 30, 2013. Subject to this **Exhibit 2, Attachment 4.19-A(1)** otherwise applies to the Shriners Hospitals.

(A) Payment for Inpatient Services

For inpatient admissions occurring in RY13 on or after January 1, 2013 through September 30, 2013, the Shriners Hospitals will be paid for Inpatient Services in accordance with **Attachment 4.19-A(1)** with the following changes.

The Shriners Hospitals will be paid a hospital-specific Standard Payment Amount per Discharge (SPAD) for those Inpatient Services for which all other in-state acute hospitals are paid a SPAD. The RY13 SPAD for this period for each Shriners Hospital was calculated using substantially the same methodology set forth in **Section III.B of Attachment 4.19A-(1)**, subject to the following:

(1) Components of the calculation that were based on data from all Hospitals did not include Shriners Hospital data.
(2) To develop the Shriners Hospital's RY13 Casemix Index, EOHHS utilized the Hospital's self-reported FY11 inpatient discharge data (using APR-DRG version 26 of the 3M Grouper and Massachusetts weights), as supplied to EOHHS by the Shriners Hospital.

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(3) The Shriners Hospital's hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the New Hospital's RY13 Casemix Index, as described in **subsection** (A)**(2)**, above.

(4) To the extent that data was unavailable or otherwise not sufficient to calculate any component of or adjustment to the hospital-specific SPAD for the Shriners Hospital, the adjustment or other component of the calculation was omitted from the hospital-specific SPAD calculation for the Shriners Hospital. Due to unavailability of data, Pass-Through Amounts per Discharge, and SPAD adjustments under **Section III.B.5** of **Attachment 4.19-A(1)** were not included in the calculation.

The transfer per diem rate of payment for each Shriners Hospital for purposes of **Section III.D** of **Attachment 4.19-A(1)** applicable to inpatient admissions occurring in RY13 on or after January 1, 2013 through September 30, 2013, was computed by dividing the Shriners Hospital's RY13 SPAD for this period as calculated above, by the SPAD Base Year average all-payer length of stay of 4.59 days.

The outlier per diem rate of payment for each Shriners Hospital for purposes of **Section III.E** of **Attachment 4.19-A(1)** applicable to inpatient admissions occurring in RY13 on or after January 1, 2013 through September 30, 2013, was calculated by multiplying the Shriners Hospital's transfer per diem rate for this period as derived above by 0.75.

(B) Other

The Shriners Hospitals will not be subject to **Sections III.B.5** or **IV.** of **Attachment 4.19-A(1)** for this period of RY13.

The Shriners Hospitals shall not be eligible for, and shall not receive, any pay-for-performance or pay-for-reporting payments under **Section III.J** of **Attachment 4.19-A(1)** for this period of RY13.

For any other rate adjustment or payment that is provided for under **Attachment 4.19-A(1)** not otherwise addressed in this **Exhibit 2**, if EOHHS does not have on record the required data as it pertains to the Shriners Hospital, the rate adjustment or payment shall not be applicable to the Shriners Hospital for this period of RY13.

EXHIBIT 3

High Casemix Payment Method Applicable to Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units for RY13 Discharges from January 1, 2013 through September 30, 2013

Section I. Overview

The payment methods set forth in this **Exhibit 3** apply to Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units for the period of RY13 from January 1, 2013 through September 30, 2013, as specified below.

Section II. Payment Method

a. RY13 SPAD and Outlier Per Diem Payments (for the period 1/1/13 through 9/30/13)

Subject to the provisions of this **Exhibit 3**, EOHHS will make SPAD and outlier per diem payments to Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units for inpatient discharges occurring in RY13 from January 1, 2013 through September 30, 2013 in accordance with the rates and methods set forth in **Sections III.A** through **III.B and III.E** of **Attachment 4.19-A(1).**

b. Payment for High Casemix Discharges

Within 12 months after EOHHS has obtained all accurate and complete data needed to perform the review and settlement calculation, EOHHS shall perform a review to calculate a payment settlement for Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units. EOHHS estimates that it will have accurate and complete data by September 30, 2014. Assuming this date, the settlement will be complete by September 30, 2015. As part of such review, EOHHS will pay Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units 85% of the Hospital's/Pediatric Specialty Unit's expenses for Inpatient Services, as determined by EOHHS, as further described below, for children discharged from such Hospitals and Pediatric Specialty Units in RY13 from January 1, 2013 through September 30, 2013, whose casemix acuity is equal to or greater than 5.0 (discharges occurring within this period of RY13 shall be referred to herein as " High Casemix Discharges"). EOHHS will identify High Casemix Discharges and calculate Freestanding Pediatric Acute Hospital and Pediatric Specialty Unit expenses and payments for such discharges as provided in this **Exhibit 3.**

(1) Stratify discharges during the RY13 period from 1/1/13 – 9/30/13 by casemix level

All RY13 discharges occurring from January 1, 2013 through September 30, 2013 will be identified, and the corresponding casemix weight will be derived from MMIS paid claims data where MassHealth is the primary payer. The High Casemix Discharges will be identified and stratified from all other discharges occurring in this period of RY13 for such Hospitals/ Pediatric Specialty Units.

(2) Calculate Settlement Rate

For the purposes of determining the settlement payment for High Casemix Discharges for Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units only, a hospital-specific inpatient settlement SPAD and outlier per diem rate will be calculated based on a hospital-specific casemix index (CMI) developed using RY13 discharges for the period January 1, 2013 through September 30, 2013, excluding those discharges with a casemix acuity equal to or greater then 5.0. This calculation will otherwise be substantially in accordance with the methodology set forth in **Attachment 4.19-A(1), Sections III.A. through III.B, and III.E.**

(3) Apply Settlement rate

For discharges from Freestanding Pediatric Acute Hospitals and Pediatric Specialty Units in RY13 from January 1, 2013 through September 30, 2013 that are not High Casemix Discharges (referred to herein as "Standard Discharges"), EOHHS will calculate a settlement value for such discharges by utilizing the settlement SPAD and outlier per diem rates for such discharges, as determined by EOHHS (referred to herein as the "settlement value").

(4) Calculate High Casemix Discharge payment

Expenses for High Casemix Discharges will be determined by EOHHS by multiplying a cost-to-charge ratio against charges reported on the claim. The numerator of the cost-to-charge ratio will be the amount reported on Schedule II, line 100, column 10 of the hospital's FY11 - 403 report which is the amount of total patient related expenses for inpatient services. The denominator will be the amount reported on Schedule II, line 100, column 11 of the Hospital's FY11 -403 report, which is the total patient related charges for inpatient services.

Payments made for High Casemix Discharges and Standard Discharges will be determined by EOHHS and shall include SPAD and outlier per diem amounts previously paid for such discharges.

(5) Calculate Final High Casemix Discharge Payment

After determining expenses and payments for the High Casemix Discharges, and the settlement value for the Standard Discharges, EOHHS will make the final payment adjustments as set forth below.

The payment amount due for High Casemix Discharges pursuant to this **Exhibit 3**, if any, will be the difference between (I) the sum of (a) 85% of the Hospital's aggregate expenses for identified High Casemix Discharges, plus (b) the aggregate settlement value of the repriced Standard Discharges, and (II) the aggregate amount of the payments that were previously made for all such discharges for the same time period. If the result of this calculation is an amount equal to or less then zero, then no payment will be due to or from the Hospital / Pediatric Specialty Unit.

For Hospitals with Pediatric Specialty Units, the payment calculated under this **Exhibit 3** shall only apply to services rendered in the Pediatric Specialty Units.