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State/Territory Name: MA

State Plan Amendment (SPA) #: 15-0012

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

AUG 04 2016

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

RE: Massachusetts 15-0012

Dear Ms. Sudders:

We have reviewed the proposed amendment to Attachments 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 15-0012. This amendment provides for several updates to the rate year (RY) 2016 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 15-0012 is approved effective October 1, 2015. 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,

[redacted]

Kristin Fan
Director

EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS 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: 015-012	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 October 1, 2015	

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); 42CFR Part 447; 42CFR 440.10	a. ~~FFY16 (17,067,000)~~ ($20,621,280) b. ~~FFY17 11,286,000~~ ($20,621,280)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A (1), pages 1-49 Exhibit 1, page 1 - 3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-A (1), pages 1-51 Exhibit 1, pages 1 - 3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)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: Marylou Sudders	Daniel Cohen Interim 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: December 31, 2015	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: AUG 04 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT 01 2015	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute inpatient hospital services for RY16.

1. Except as provided in subsection 2, and in subsection 6, below, the payment methodologies specified in this Attachment 4.19-A(1) apply to:

   - RY16 admissions at in-state Acute Hospitals beginning on or after October 1, 2015 through September 30, 2016, and

   - inpatient payments made to in-state Acute Hospitals on an administrative day, psychiatric or rehabilitation per diem basis for RY16 dates of service on or after October 1, 2015 through September 30, 2016.

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 RY16 on or after October 1, 2015 through September 30, 2016.

3. The supplemental payments specified in **Sections III.I.1 through III.I.6** apply to dates of service from October 1, 2015 through September 30, 2016.

4. The Pay-for-Performance payment methodology specified in **Section III.J** is effective in RY16 beginning October 1, 2015 through September 30, 2016.

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

6. This **Section I.A.6** describes the payment methods to out-of-state acute hospitals for inpatient hospital services.

   Except if **subsection 6(d)** applies, below, payment for out-of-state acute inpatient hospital services is as follows:

   (a) Payment Amount Per Discharge.

   (i) Out-of-State APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge ("Out-of-State APAD") for inpatient services. The discharge-specific Out-of-State APAD is equal to the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals, multiplied by the MassHealth DRG Weight assigned to the discharge using information on the claim.
   (ii) Out-of-State Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, the out-of-state acute hospital is also paid an outlier

payment for that discharge ("Out-of-State Outlier Payment"). The Out-of-State Outlier Payment is equal to the Marginal Cost Factor in effect for in-state acute hospitals multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The "calculated cost of the discharge" equals the out-of-state acute hospital's allowed charges for the discharge, multiplied by the applicable inpatient cost-to-charge ratio. For High MassHealth Volume Hospitals, the inpatient cost-to-charge ratio is hospital-specific. For all other out-of-state acute hospitals, the median in-state acute hospital inpatient cost-to-charge ratio in effect, based on MassHealth discharge volume, is used.
b. The "discharge-specific outlier threshold" equals the sum of the hospital's Out-of-State APAD corresponding to the discharge, and the Fixed Outlier Threshold in effect for in-state acute hospitals.

(b) Out-of-State Transfer Per Diem: If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid for inpatient services provided to that member at a transfer per diem rate ("Out-of-State Transfer Per Diem"), and no other payment methods will apply.

a. The Out-of-State Transfer Per Diem equals the sum of the transferring hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital, divided by the mean in-state acute hospital all payer length of stay for the applicable APR-DRG that is assigned.
b. Payments made on an Out-of-State Transfer Per Diem basis are capped at the transferring hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital.

(c) Out-of-State Psychiatric Per Diem: If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, the out-of-state acute hospital will be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem in effect for in-state acute hospitals, and no other payment methods apply.

(d) For medical services payable by MassHealth that are not available in-state, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid the rate of payment established for the medical service under the other state's Medicaid program (or equivalent) or such other rate as MassHealth determines necessary to ensure member access to services.

(e) For purposes of this **Section I.A.6**, a "High MassHealth Volume Hospital" is any out-of-state acute hospital provider that had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available.

(f) The payment methods in this **Section I.A.6** are the same for private and governmental providers.

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 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.

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

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

All Patient Refined–Diagnostic Related Group (APR-DRG or **DRG)** – the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper.

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

Average Length of Stay – the sum of non-psychiatric inpatient 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 intensity of services provided by a Hospital to a group of patients, using the APR-DRG methodology, as specified in this Attachment. A Hospital's Casemix Index is calculated by dividing a Hospital's APR-DRG cumulative MassHealth or all-payer weights (using Massachusetts weights) by the Hospital's MassHealth or all-payer discharges. The weight for each APR-DRG is based on Massachusetts data.

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

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, by October 1, 2015, was designated by CMS as a Critical Access Hospital, and that continues to maintain that status.

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

Discharge-Specific Case Cost — The product of the Hospital's MassHealth allowed charges for a specific discharge and the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY14 -403 cost report.

Discharge-Specific Outlier Threshold — The sum of the Pre-Adjusted APAD for a specific discharge and the Fixed Outlier Threshold.

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

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

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. FY16 begins on October 1, 2015 and ends on September 30, 2016.

Fixed Outlier Threshold — For RY16, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $24,000.00.

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.

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

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

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:

1.659% reflects the price changes between RY15 and RY16.

Inflation Factors for Capital Costs – the chart below specifies the inflation factors for capital costs. These inflation factors are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index.

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%
RY13 and RY14	1.4%
RY14 and RY15	1.5%
RY15 and RY16	1.3%

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Inflation Factors for Operating Costs – the chart below specifies the inflation factors for operating costs, with the corresponding applicable source.

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%
RY13 and RY14		1.405%
RY14 and RY15		1.611%
RY15 and RY16		1.573%

** 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.*

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.

Marginal Cost Factor – As used in the calculation of an Outlier Payment, the percentage of payment made for the difference between the Discharge-Specific Case Cost and the Discharge-Specific Outlier Threshold. For RY16, the Marginal Cost Factor is 80%.

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_2016_Proposed_Rule_Wage_Index_PUFs file, downloaded May 14, 2015. Wage areas were assigned according to the same CMS file unless re-designated in a written decision from CMS to the Hospital provided to EOHHS by May 8, 2015. 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.

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

Medicaid Management Information System (MMIS) – the state-operated system of 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 Payment– A hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section III.C**.

Pass-Through Costs – Organ acquisition and malpractice costs described in **Section III.B.5**.

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

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

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
RY14	10/1/2013 – 09/30/2014
RY15	10/1/2014 – 9/30/2015
RY16*	10/1/2015 – 9/30/2016

*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. SFY16 begins on July 1, 2015, and ends on June 30, 2016.

Standard Payment Amount Per Discharge (SPAD) – A payment methodology that was utilized in prior Rate Years, including RY14. The SPAD was a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which was the complete fee-for-service payment for an acute episode of illness, excluding additional fee-for-service payment for services as described in TN-013-020. Calculation of the SPAD was discussed in **Section III.B** of TN-013-020. This payment methodology was replaced by the APAD payment methodology in RY15.

Total Case Payment: The sum, as determined by EOHHS, of the Pre-Adjusted APAD and, if applicable, any Outlier Payment, adjusted for Potentially Preventable Readmissions pursuant to **Section IV**.

Total Transfer Payment Cap: The Total Case Payment amount calculated by EOHHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in **Section III.B and III.C**, respectively, for the period for which the Transferring Hospital is being paid on a Transfer per diem basis under **Section III.D.**

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

III. Payment for Inpatient Services

A. Overview

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

   For qualifying discharges, Hospitals may also be paid an Outlier Payment in addition to the APAD, under the conditions set forth in, and calculated as described in, **subsection C**, below.

2. **Subsections C through H** describe non-APAD fee-for-service payments, including, as applicable, Outlier Payments, and payment for psychiatric services, transfer patients, Hospital-Based Physician services, Administrative Days, and Rehabilitation Unit services in Acute Hospitals. Payment for other unique circumstances is described in **subsection I**, and **Exhibit 1**. Pay-for-Performance payments are described in **subsection J.**

3. 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.

B. Calculation of the Adjudicated Payment Amount Per Discharge (APAD)

1. APAD Overview

The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge.

The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific Wage Area Index; (2) the Statewide Capital Standard per Discharge; (3) the discharge-specific MassHealth DRG Weight; (4) a per-discharge, Hospital-specific payment amount for expenses related to malpractice and organ acquisition costs, if applicable, equal to the Hospital's Pass-Through Amount Per Discharge; and (5) a Hospital-specific adjustment, where applicable, for Potentially Preventable Readmissions (PPR) pursuant to **Section IV**. Each of these components, and the calculation of the APAD, is described more fully below.

The APAD Base Year is FY12.

2. Statewide Operating Standard per Discharge

The Statewide Operating Standard per Discharge is determined by multiplying:

- the weighted average of the APAD 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 APAD Base Year costs forward to the current Rate Year.

These elements are described in greater detail below. The Statewide Operating Standard per Discharge is $9,391.96.

a. APAD Base Year Standardized Cost per Discharge

The APAD Base Year standardized cost per discharge is based on the average cost per discharge for each Hospital, adjusted as described below.

The average cost per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. APAD Base Year costs are determined using the APAD Base Year 403 cost report as screened and updated as of June 9, 2014. APAD Base Year discharges are determined using FY12 Hospital Discharge Data (HDD). Specific costs and discharges are included and excluded as follows:

Average Cost per Discharge: treatment of costs and discharges	
Included	Excluded
Total non-excluded costs of providing Inpatient Services	Costs and discharges from Excluded Units.
Routine outpatient costs associated with admissions from the Emergency Department	Professional services
Routine and ancillary outpatient costs resulting from admissions from Observation status	Malpractice costs, organ acquisition costs, capital costs and direct medical education costs.
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	

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

b. **Efficiency Standard**

All Hospitals are ranked with respect to their APAD Base Year standardized costs per discharge, and the efficiency standard is set at the 65th percentile of the cumulative frequency of FY14 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $10,568.45.

c. **Inflation Factors for Operating Costs**

The Inflation Factors for Operating Costs reflecting price changes between RY12 and RY16 are applied to trend APAD Base Year costs forward to the current Rate Year.

3. Statewide Capital Standard per Discharge

The Statewide Capital Standard per Discharge is calculated based on the APAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the APAD Base Year and the current Rate Year. The calculation is summarized in the following chart:

Statewide Capital Standard per Discharge		
APAD Base Year statewide capital cost per discharge (**subsection a**),	a. the APAD Base Year all-payer capital cost per discharge b. adjusted by the APAD Base Year all payer casemix index c. capped at the capital efficiency standard d. multiplied by the FY14 Hospital-specific MassHealth discharges e. summed and divided by the total FY14 statewide MassHealth discharges	$611.62
trended to the current rate year using the Inflation Factors for Capital Costs (**subsection b**),		$631.63

a. APAD Base Year statewide capital cost per discharge

The APAD 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 APAD Base Year cost reports and APAD Base Year HDD by dividing total net inpatient capital costs by the Hospital's total all-payer discharges, net of Excluded Unit discharges.

Each Hospital's capital cost per discharge is then adjusted by the APAD Base Year 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 FY14 discharges where MassHealth is the primary payer in MMIS. Each Hospital's capital cost per discharge that exceeds the capital efficiency standard is then limited by the capital efficiency standard.

The APAD 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 FY14 MassHealth discharges.

b. **Inflation Factors for Capital Costs**

The Inflation Factors for Capital Costs reflecting price changes between RY12 and RY16 are applied to trend the APAD Base Year statewide capital cost per discharge forward to the current Rate Year.

4. MassHealth DRG Weight

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

5. 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 FY14 403 cost report as screened and updated by CHIA as of August 14, 2015.

The pass-through amount per discharge is Hospital-specific and is calculated by dividing the Hospital's inpatient portion of such expenses by the number of total, all-payer days for the APAD 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.

6. Potentially Preventable Readmissions (PPR) Adjustment

The hospital-specific adjustment for PPRs, if applicable, is calculated as set forth in **Section IV**, below.

7. Calculation of the APAD

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

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

Table 1: Standard APAD claim

(Values are for demonstration purposes only)

Hospital: **Sample Hospital**

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

Line	Description	Value	Calculation or Source
1	Statewide Operating Standard per Discharge	$9,391.96	Determined annually
2	Hospital wage area	1.0255	Varies by hospital, determined annually
3	Labor Factor	0.69587	Determined annually
4	Wage Adjusted Operating Standard per Discharge	$9,558.61	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0-Line 3))
5	Statewide Capital Standard per Discharge	$631.63	Determined annually
6	Sum of Wage Adj. Oper. Standard and Statewide Capital Standard per Discharge	$10,190.24	Line 4 + Line 5
7	MassHealth DRG Weight	0.3668	Determined based on claim information
8	Hospital's Pass-Through Amount per Discharge	$25.30	Varies by hospital, determined annually
9	Pre-Adjusted APAD	$3,763.08	((Line 6 * Line 7) + Line 8)
10	Potentially Preventable Readmission adjustment	-1.200%	Varies by hospital, determined annually
11	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$3,717.93**	Line 9 * (100% + Line 10)

C. Outlier Payment

A Hospital will be paid a discharge-specific Outlier Payment for a discharge in addition to the APAD (see **Section III.B.**, above) if all of the following conditions are met:

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

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

3. the patient is not a patient in a DMH-licensed bed on any part of the discharge; and

4. the patient is not a patient in an Excluded Unit within the Hospital.

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

The following is an illustrative example of the calculation of the Total Case Payment for a claim that also involves an Outlier Payment.

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

D. Transfer Per Diem Payments

Hospitals will be paid a transfer per diem under the circumstances specified in this section. In general, total payments made on a transfer per diem basis are capped at the Hospital's Total Transfer Payment Cap.

The transfer per diem rate is case-specific and is calculated as set forth in **Section III.D.1**, below.

1. Transfer between Hospitals

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

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

The transfer per diem rate equals the Transferring Hospital's Total Case Payment amount, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG Massachusetts-specific weight file. For purposes of this calculation, the Total Case Payment amount is calculated utilizing the APAD, and if applicable, Outlier Payment methodology(ies) set forth in **Section III.B.** and **III.C.**, above, for the period for which the Transferring Hospital is being paid on a transfer per diem basis pursuant to this **Section III.D**. Payment on a transfer per diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap.

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

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

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

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 on a transfer per diem basis, capped at the Hospital's Total Transfer Payment Cap. This section outlines payment under some specific transfer circumstances.

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's discharge-specific APAD for the portion of the stay that preceded the patient's discharge 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, becomes eligible for managed care and is enrolled in an MCO or becomes ineligible for managed care and disenrolled from an MCO during the course of a Hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the transfer per diem rate, capped at the Hospital's Total Transfer Payment Cap, or if the patient is at the Administrative Day level of care, at the AD per diem rate, in accordance with **Section III.G.**

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, capped at the Hospital's Total Transfer Payment Cap.

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, capped at the Hospital's Total Transfer Payment Cap for the non-DMH-licensed bed portion of the stay, and on a Psychiatric Per Diem basis (see **Section III.E**, below) 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, capped at the Hospital's Total Transfer Payment Cap.

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.E,** below) for psychiatric services in a DMH-licensed Bed, or at the transfer per diem rate, capped at the Hospital's Total Transfer Payment Cap, for substance-related disorder services and for psychiatric services in a non-DMH-licensed Bed.

E. 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**, above. 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.

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 II 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 II** above).

The Inflation Factors for Operating Costs (see **Section II above**) between RY08 and RY10 and between RY12 and RY16 were then applied to the rate calculated above to determine the Statewide Standard Psychiatric Per Diem Rate for RY16.

The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs to RY16 for the Psychiatric Per Diem is $107.55. The Statewide Standard Psychiatric Per Diem Rate is $883.52.

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. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in **Section II**.

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

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 RY15 and RY16. The resulting AD rates for RY16 are $260.09 for Medicaid/Medicare Part B eligible patients and $281.25 for Medicaid-only eligible patients.

6. The Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status.

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 RY16 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. High Public Payer Hospital Supplemental Payment

a. Eligibility

In order to qualify for this supplemental payment, a Hospital must have received greater than 63% of its Gross Patient Service Revenue (GPSR) in FY2014 from government payers and uncompensated care as determined by the Hospital's FY2014 -403 cost report.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to qualifying Hospitals.

The payment amount to each qualifying hospital will be that amount which is equal to 9.2 percent of the Hospital's total FY15 inpatient APAD and Outlier Payments, based on Medicaid paid claims data on file as of March 31, 2016.

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, including 42 CFR 447.271, 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 $127.41 million.

For CHA, the Federal Fiscal Year payment amount will be the difference between the non-state-owned public hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $9.5 million.

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. High Medicaid Volume Freestanding Pediatric Acute Hospitals

a. **Eligibility**

Based on the definition of High Medicaid Volume Freestanding Pediatric Acute Hospital as defined in **Section II**, Boston 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 High Medicaid Volume 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. High Medicaid Volume 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, cost and charge data for the federal fiscal year. The payment equals the variance between the Hospital's inpatient Medicaid payment and inpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Interim payments to Acute Hospitals with High Medicaid Discharges will be reconciled within 12 months after final settlement of the applicable Health Safety Net year.

5. Freestanding Pediatric Acute Hospitals with High Complexity Cases

a. **Eligibility**

Based on the definition of Freestanding Pediatric Acute Hospital as defined in **Section II**, Boston Children's Hospital, and the two Shriners Hospitals (Shriners Hospital – Boston, and Shriners Hospital – Springfield) 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 Freestanding Pediatric Acute Hospitals to account for the complex pediatric cases they provide care for.

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of $11.8 million to qualifying hospitals on a pro-rata basis according to each qualifying hospital's number of inpatient discharges occurring in FY15, based on Medicaid paid claims data on file as of March 31, 2016.

6. Pediatric Specialty Units with High Complexity Cases

a. **Eligibility**

In order to qualify for this payment, a Hospital must have a Pediatric Specialty Unit as defined in **Section II**. Based on this criteria, Tufts Medical Center is the only hospital eligible for this payment.

b. **Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to qualifying Hospitals with Pediatric Specialty Units to account for the complex pediatric cases they provide care for.

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of $3 million to qualifying hospitals on a pro-rata basis according to each qualifying hospital's number of inpatient discharges occurring in FY15, based on Medicaid paid claims data on file as of March 31, 2016.

7. [Reserved]

8. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for inpatient services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay 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 will be based on 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 2015 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;
- racial and ethnic health disparities;
- care coordination;
- emergency department care; and
- tobacco treatment.

The specific clinical process measures for which RY16 P4P incentive payments will be based 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
MAT-4	Cesarean Birth, Nulliparous term singleton vertex

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)

Measure ID#	Emergency Department Measure Set
ED-1	Median time from ED arrival to ED departure for admitted ED patient
ED-2	Median time from admit decision to ED departure for admitted patients

Measure ID#	Tobacco Treatment
TOB-1	Tobacco use screening
TOB-2	Tobacco use treatment provided or offered
TOB-3	Tobacco use treatment provided or offered at discharge

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 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, health disparities, care coordination, and emergency department measure categories. Incentive payments based on the pay-for-reporting approach are available solely for the tobacco treatment measure category. While performance will also be assessed for the tobacco treatment 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 tobacco treatment measure category) and will be based on the following:

- For the individual measures (maternity, tobacco treatment, care coordination, and emergency department), the eligible Medicaid discharges will be based on FY15 MMIS paid claims for PCC Plan and Fee-for-Service discharges for which an APAD or transfer per diem was paid, and that meet specific ICD requirements for each measure category. For certain measures (MAT, ED and TOB), the ICD requirements are published in the *Specifications Manual for National Hospital Inpatient Quality Measures* (available at www.qualitynet.org), or the *Specifications Manual for the Joint Commission National Quality Measures* (available at https://manual.jointcommission.org/bin/view/Manual/WebHome). 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 the Hospital's eligible Medicaid discharges for specific individual measures (i.e., maternity and care coordination) as described above, and that meet the criteria for the composite measure calculation. HD-2 will not include the emergency department or tobacco treatment measure sets.

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
Health Disparities -Clinical	$ 2,500,000
Care Coordination	$11,000,000
Emergency Department	$ 7,000,000
Tobacco Treatment (pay-for-reporting)	$ 7,500,000
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 the relevant individual measure categories (maternity, care coordination, and emergency department).

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

For each relevant 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 2015	CY 2014

Performance benchmarks for the maternity and care coordination measures are calculated based on Hospital data reported to MassHealth. Performance benchmarks for the nationally-reported hospital quality measure (emergency department) is 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 year over year 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 and if the hospital has passed validation and established a baseline rate for the measure in a prior 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

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	11,349
Quality measure category per-discharge amount	$22,000,000 / 11,349 = $1,938
Hospital-specific calculations	
Hospital's awarded Maternity quality points (sum of measure-specific attainment or improvement points)	32
Maximum possible Maternity quality points	40
Performance score for maternity	(32 points / 40 points) x 100% = 80%
Eligible Medicaid discharges	500
Hospital-specific total incentive payment, maternity	**500 x $1,938 x 80% = $775,200**

ii . Clinical Health Disparities Composite Measure Category

The clinical health disparities composite measure for each hospital is comprised of aggregate data from specific individual clinical measure categories (maternity and care coordination) 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 composite value. The composite measure and disparity composite value are calculated only for Hospitals that report on more than one racial group in their electronic data files.

The 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 composite 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 composite 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 composite performance score will be calculated using the following methods:

1. Disparity Composite Value Ranking. All Hospital disparity composite values are rounded to six decimal places. All composite 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:

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	(zero)
	1st decile	(zero)

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

The pay-for-reporting incentive payment approach applies solely to the tobacco treatment 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%.

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 be subject to a percentage payment reduction per discharge calculated using the methodology described below. This reduction will be applied to Hospitals identified using the methodology described below.

A. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Determination of Readmission Rates and Volumes

PPRs are identified in adjudicated and paid inpatient Hospital claims residing in MMIS as of March 31, 2015, for which MassHealth is the primary payer, by using the 3M PPR software version 30.0. The time period for identifying Total and At-risk Admissions was from September 1, 2013 to August 31, 2014, based on date of discharge. The time period for identifying PPRs associated with these At-risk Admissions was from September 1, 2013 to September 30, 2014 based on date of admission.

1. Statewide Average PPR Rate

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

2. Hospital-specific Actual PPR Volume

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

3. Hospital-specific Expected PPR Volume

In order to derive the Hospital-specific Expected PPR Volume, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions

by APR-DRG for the time period specified above and summed across all of the Hospital's APR-DRGs.

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

4. Hospital-specific Excess PPR Volume

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

5. Hospital-specific Actual PPR Rate

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

6. Hospital-specific Expected PPR Rate

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

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

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

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

C. Calculation of PPR Percentage Payment Reduction Per Discharge

1. General Initial Calculation

Hospitals with Excess PPR Volume are subject to a PPR Percentage Payment Reduction per Discharge, applied as set forth in **Section IV.F**, below. Only Hospitals with more than 40 At-

Risk Admissions are subject to a PPR Percentage Payment Reduction per Discharge, if applicable.

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

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

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

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

2. Hospitals not Qualifying for Improvement Adjustment

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

3. Hospitals Qualifying for Improvement Adjustment

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

$$\frac{\text{Actual to Expected PPR Ratio RY16}}{\text{Actual to Expected PPR Ratio RY15}} \times \text{Hospital's Non-Improvement-Adjusted PPR Percentage Payment Reduction per Discharge} =$$

Hospital's PPR Percentage Payment Reduction per Discharge

D. Improvement Adjustment

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

Hospital's PPR Percentage Payment Reduction per Discharge =

1.17 / 1.30 x 3% = 90% x 3% = 2.7% per Discharge.

E. Maximum per-Discharge Adjustment

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

F. Application of PPR Percentage Payment Reduction per Discharge

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

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 or PPR

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

1. Errors in Calculation of Pass-Through Costs

If EOHHS makes a transcription error or if EOHHS transcribes the incorrect line in the calculation of the pass-through 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 Potentially Preventable Admissions (PPR)

In the event of an error in the calculation of a Hospital's RY16 PPR made by EOHHS, resulting in an amount not consistent with the methodology and where the effect of the error is a decrease in the Hospital's estimated total RY16 APAD and Outlier Payments of 2% or more, a Hospital may request a correction to its RY16 PPR calculations, consistent with the RFA and contract, which shall be at the sole discretion of EOHHS.

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 APAD 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)
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. APAD, Outlier Payment, and Transfer per diem payments:
   a. MassHealth will not pay the APAD, Outlier Payment, or Transfer per diem payment if the Hospital reports that only PPC-related services were delivered during the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
   b. MassHealth will pay the APAD, Outlier Payment, or Transfer per diem payment, in each case as adjusted to exclude PPC-related costs or services, if the Hospital reports that non-PPC related services were also delivered during theinpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Psychiatric, Rehabilitation, or Administrative Day 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 adjusted in the case of APAD, Outlier payment, or Transfer per diem payments to exclude the PPC-related costs or services, and MassHealth will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

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.

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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Exhibit 1: RY16 Payment Method for Critical Access Hospitals Effective
October 1, 2015 through September 30, 2016

EXHIBIT 1
Rate Year 2016 Payment Method Applicable to Critical Access Hospitals Effective October 1, 2015 through September 30, 2016

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY16 (October 1, 2015 through September 30, 2016).

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 in RY16 (October 1, 2015 through September 30, 2016), 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 October 1, 2015 through September 30, 2016, 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 in RY16, Critical Access Hospitals (CAHs) will be paid for Inpatient Services in accordance with **Attachment 4.19-A(1)** with the following changes.

Critical Access Hospitals will be paid an Adjudicated Payment Amount per Discharge (APAD) for those Inpatient Services for which all other in-state acute hospitals are paid an APAD. Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring in RY16, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY14 cost and discharge data:

(1) EOHHS calculated a cost per discharge for inpatient services for each Critical Access Hospital, which was determined by dividing the amount reported on worksheet E-3, part VII, column 1, line 40, of the Hospital's FY14 CMS-2552-10 cost report, by the Hospital's number of FY14 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY14 paid claims data residing in MMIS as of May 27, 2015 for which MassHealth is the primary payer.

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(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY14 and RY16, resulting in the RY16 cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's RY16 cost per discharge, as determined above, by each Hospital's FY14 inpatient casemix index (CMI).

(4) That result is the CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the Wage Adjusted Statewide Operating Standard per Discharge, the Statewide Capital Standard per Discharge, and the Hospital's Pass-Through Amount per Discharge, used in the APAD calculations for all other Hospitals.

(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the RY16 CAH-Specific Total Standard Rate per Discharge by the discharge-specific MassHealth DRG Weight

(6) Critical Access Hospitals will not be subject to any adjustment under **Section IV** of **Attachment 4.19-A(1)**.

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

Table 5: Critical Access Hospital Standard APAD claim

(Values are for demonstration purposes only)

Hospital: **Sample Critical Access Hospital**

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

Line	Description	Value	Calculation or Source
1	RY16 CAH-Specific Total Standard Rate per Discharge (value for demonstration purposes only)	$17,900.61	All Inclusive Rate (Operating & Capital)
2	MassHealth DRG Weight	0.3668	Determined based on claim information
3	Pre-Adjusted APAD	$6,565.94	Line 1 * Line 2
4	Potentially Preventable Readmission adjustment	0.0%	Not Applicable to CAHs
5	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$6,565.94**	Line 3 * (100% + Line 4)

Outlier Payments and transfer per diem rates for Critical Access Hospitals are calculated and paid as described in **Sections III.C and III.D of Attachment 4.19-A(1),** respectively, except that the APAD used for purposes of those calculations is the CAH's APAD as calculated as set forth in **Section II.A.(1) – (6) of Exhibit 1**, above, and that **Section IV** of **Attachment 4.19-A(1)** does not apply to CAHs.

(B) Post RY16 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2016 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 services for RY16 as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY16 CMS-2552-10 cost reports (including completed Medicaid (Title XIX) data worksheets) and such other information that EOHHS determines is necessary, to perform this post RY16 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for RY16, but excluding, if applicable, any state plan payments to a Critical Access Hospital under Section III.J of Attachment 4.19-A(1), and any supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in Section III.I.1 of Attachment 4.19-A(1).

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 2016 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, 2017. Assuming this date, the settlement will be complete by September 30, 2018.