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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 15-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

July 29, 2016

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

Dear Secretary Sudders:

We are pleased to enclose a copy of approved Massachusetts State Plan Amendment (SPA) No. 15-013, which was submitted to my office on December 31, 2015. This SPA was submitted to revise your approved Title XIX State plan to update the Rate Year 2016 payment methodology for acute hospital outpatient services. This SPA has been approved effective October 1, 2015.

Enclosed are copies of the following approved State plan pages.

- Attachment 4.19-B(1), pages 1-19; and
- Attachment 4.19-B(1), Exhibit 1, pages 1-2.

If you have any questions regarding this matter you may contact Julie McCarthy at (617) 565-1244 or by e-mail at Julie.McCarthy@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Daniel Cohen, State Plan Coordinator

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS 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: 015-013	2. STATE MA
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
O: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE October 1, 2015	

. 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)*

. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 USC 1396a(a)(13); 42 CFR Part 447; 42CFR 440.20	a. FFY16 ~~$ 21,169,000~~ – $30,550,740 b. FFY17 ~~$ 9,476,000~~ – $30,550,740
. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B (1), pages 1 - 19 Exhibit 1, pages 1 – 2	Attachment 4.19-B (1), pages 1 - 18 Exhibit 1, pages 1 – 2

). SUBJECT OF AMENDMENT:

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

1. 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)

2. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	16. RETURN TO: Daniel Cohen Interim State Plan Coordinator Executive Office of Health and Human Services Office of Medicaid One Ashburton Place, 11th Floor Boston, MA 02108
3. TYPED NAME: Marylou Sudders	
4. TITLE: Secretary	
5. DATE SUBMITTED: December 31, 2015	

FOR REGIONAL OFFICE USE ONLY

7. DATE RECEIVED: 12/31/2015	18. DATE APPROVED: 07/29/2016
PLAN APPROVED – ONE COPY ATTACHED	
9. EFFECTIVE DATE OF APPROVED MATERIAL: 10/01/2015	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
1. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Boston, MA

3. REMARKS:

RM CMS-179 (07-92)

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

I. Introduction

A. Overview

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

1. Except as provided in subsection 2, below, for dates of service in RY16 (October 1, 2015 through September 30, 2016), in-state Hospitals will be paid in accordance with this Attachment for Outpatient Services provided at Hospital Outpatient Departments, and at those Hospital-Licensed Health Centers (HLHCs) and other Satellite Clinics that are provider-based in accordance with 42 CFR 413.65.

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 dates of service in RY16 beginning October 1, 2015 through September 30, 2016.

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

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

5. Out-of-state acute outpatient hospitals are paid for acute outpatient hospital services as follows:

   a. Except as provided in **subsection 5.b.**, below, all out-of-state acute outpatient hospitals are paid a payment per episode of care equal to the median Payment Amount Per Episode (PAPE) in effect for in-state acute hospitals for PAPE-covered services based on Episode volume, and in accordance with the applicable MassHealth fee schedule for services for which in-state acute hospitals are not paid a PAPE.

   b. If an inpatient service payable by MassHealth is not available in-state, payment for the related acute hospital outpatient services will be made at 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. This provision does not apply to "High MassHealth Volume Hospitals", which are defined as any out-of-state acute hospital that, during the most recent federal fiscal year for which complete data is available, had at least 150 MassHealth discharges.

   c. The payment methods in this **Section I.A.5** 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 Outpatient 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. Hospitals are not entitled to, and may not claim for, any payment from EOHHS for any services that are MCO-covered services or are otherwise payable by 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. Ambulatory Services Not Governed by this Attachment

The following services provided by Hospitals to MassHealth Members on an outpatient basis are not paid pursuant to this Attachment: audiology dispensing, vision care dispensing, ambulance services, psychiatric day treatment, dental, early intervention, home health, adult day health and adult foster care, and outpatient covered drugs processed through the MassHealth Pharmacy On-Line Processing System (POPS).

II. Definitions

Acute Hospital – See Hospital.

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 — the description and categorization of a hospital's patient population including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

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

Emergency Department – A Hospital's emergency room or level I trauma center which is located at the same site as the Hospital's inpatient facility.

Enhanced Ambulatory Patient Group (EAPG) — a group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation's EAPG Grouper v. 3.5.

Episode — all Outpatient Services, except those described in **Sections I.B and III.C through E**, delivered to a MassHealth Member where the services were delivered on a single calendar day.

Episode-Specific Cost —The product of the Hospital's MassHealth allowed outpatient charges for a specific PAPE Base Year Episode as determined by EOHHS based on PAPE paid claims residing in MMIS for which MassHealth is primary payer, and the Hospital's outpatient cost-to-charge ratio as calculated by EOHHS using the Hospital's FY14 -403 cost report.

Episode Outlier Threshold – the sum of the Hospital's Outlier Base Value, as determined by EOHHS, and the Fixed Outpatient Outlier Threshold.

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

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

Fixed Outpatient Outlier Threshold – For FY16, the Fixed Outpatient Outlier Threshold is $4,500.

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 Outpatient Hospital Services to Members at a site for which the Hospital is otherwise eligible for 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-Licensed Health Center (HLHC) — A Satellite Clinic that (1) meets MassHealth requirements for payment as a HLHC as provided at 130 CMR 410.413; and (2) is approved by and enrolled with MassHealth as a HLHC.

Inflation Factors for Operating Costs — For price changes between RY08 and RY09 for the period October 1, 2008 through December 6, 2008, the CMS market basket. For price changes between RY08 and RY16 for the period beginning December 7, 2008, 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. The Inflation Factors for Operating Costs between RY08 and RY16 are as follows:

3.000% reflects price changes between RY08 and RY09 for the period October 1, 2008 through December 6, 2008

1.424% reflects price changes between RY08 and RY09 for the period December 7, 2008 through September 30, 2009

0.719% reflects the price changes between RY09 and RY10

1.820% reflects the price changes between RY10 and RY11

1.665% reflects the price changes between RY11 and RY12

1.775% reflects the price changes between RY12 and RY13.

1.405% reflects the price changes between RY13 and RY14.

1.611% reflects the price changes between RY14 and RY15.

1.573% reflects the price changes between RY15 and RY16.

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 Add-On, the percentage of payment made for the difference between the Episode-Specific Cost and the Episode Outlier Threshold. For RY16, the Marginal Cost Factor is 80%.

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

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

Observation Services — Outpatient Hospital Services provided anywhere in an Acute Hospital to evaluate a Member's condition and determine the need for admission to an Acute Hospital. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outlier Add-On – A fixed Hospital-specific add-on amount, calculated in accordance with **Section III.B.1.d**, that is a component of a Hospital's "preliminary RY16 PAPE" (see **Section III.B.1**).

Outlier Base Value – The product of the "preliminary outpatient statewide standard" (see **Section III.B.1.b)** and the Hospital-Specific Outpatient Casemix Index (see **Section III.B.1.a).**

Outpatient Department (also referred to as **Hospital Outpatient Department**) — A department or unit located at the same site as the Hospital's inpatient facility, or a School-Based Health Center that operates under the Hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, primary care clinics, specialty clinics and Emergency Departments.

Outpatient Services (also **Outpatient Hospital Services**) — Preventive, diagnostic, therapeutic or palliative services provided to a Member on an outpatient basis, by or under the direction of a physician or dentist, in a Hospital Outpatient Department, Hospital-Licensed Health Center or other Satellite Clinic. Such services include, but are not limited to, emergency services, primary care services, Observation Services, ancillary services, day surgery services, and recovery room services. Payment rules regarding Outpatient Services are found in 130 CMR Parts 410 and 450, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions and the RFA.

Payment Amount Per Episode (PAPE) — a Hospital-specific payment for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode. (See **Section III.B**).

PAPE Base Payment – The product of the Hospital-Specific Outpatient Casemix Index (see **Section III.B.1.a**) and the PAPE Outpatient Statewide Standard (see **Section III.B.1.b**). The PAPE Base Payment is added to the Hospital's Outlier Add-On to determine the Hospital's "preliminary RY16 PAPE" (see **Section III.B.1 and III.B.1.d**).

PAPE Base Year — the PAPE Base Year is FY14.

PAPE Covered Services – MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, except those services described in **Section I.B and III.C through E.**

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
RY 11	12/01/2010 – 09/30/2011
RY12	10/01/2011 – 9/30/2012
RY13	10/1/2012 – 9/30/2013
RY14	10/1/2013 – 9/30/2014
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).

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.

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

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

Usual and Customary Charges — Routine fees that Hospitals charge for Outpatient Services rendered to patients regardless of payer sources.

III. Payment for Outpatient Services

A. Overview

Except as otherwise provided for Outpatient Services specified in **Sections I.B and III.C through E**, and in **Exhibit 1**, Hospitals will receive a fixed Hospital-specific payment for each Episode, known as the Payment Amount Per Episode (PAPE). This payment methodology is applicable to all public and private providers.

Except as otherwise provided for medically necessary services to a MassHealth Standard or CommonHealth member under 21, hospitals will not be paid for Outpatient Hospital Services specified as non-payable in Subchapter 6 of the MassHealth Acute Outpatient Hospital Manual.

For dates of service in RY16 beginning October 1, 2015 through September 30, 2016, Critical Access Hospitals are paid in accordance with **Exhibit 1**.

B. Payment Amount per Episode (PAPE)

Each hospital's RY16 PAPE is a blended rate that equally weights (1) the Hospital's RY15 PAPE and (2) the Hospital's "preliminary RY16 PAPE" determined and calculated as described below.

1. **Hospital's preliminary RY16 PAPE** -- The Hospital's "preliminary RY16 PAPE" is the product of the Hospital-Specific Outpatient Casemix Index and the PAPE Outpatient Statewide Standard (such product is referred to as the **PAPE Base Payment**), *plus*, if applicable, a Hospital-specific Outlier Add-On. The components of this calculation are summarized in the following table, and described in more detail below.

Preliminary RY16 PAPE		
PAPE Outpatient Statewide Standard	Average PAPE Base Year cost per Episode for all Hospitals' Episodes, standardized for casemix differences, and adjusted for efficiency standard, outlier adjustment factor, and inflation ("preliminary outpatient statewide standard"), divided by a conversion factor.	$164.47
x Hospital-Specific Casemix Index	Average of the hospital's 12 monthly EAPG weights per Episode for the PAPE Base Year	Hospital-specific
= PAPE Base Payment	PAPE Outpatient Statewide Standard multiplied by the Hospital-Specific Casemix Index	Hospital-specific
+ Outlier Add-On	Sum of Hospital's Episode-specific outlier values for all of its qualifying PAPE Base Year Episodes divided by the Hospital's number of PAPE Base Year Episodes	Hospital-specific

a. Hospital-specific Outpatient Casemix Index

The Hospital-Specific Outpatient Casemix Index is equal to the average of the Hospital's twelve (12) monthly average EAPG weights per Episode for the PAPE Base Year.

For each Hospital and month of the PAPE Base Year, an average EAPG weight per Episode was determined by assigning individual EAPGs and associated weights to the Hospital's PAPE paid claims residing in MMIS for the month (using the 3M EAPG Grouper), summing the individual EAPG weights, and dividing that sum by the number of Episodes. The sum of the Hospital's monthly average EAPG weights per Episode for the PAPE Base Year, divided by 12 is the Hospital-Specific Outpatient Casemix Index for the current Rate year (RY16).

b. PAPE Outpatient Statewide Standard

The PAPE Outpatient Statewide Standard is equal to the preliminary outpatient statewide standard, adjusted by a conversion factor. The preliminary outpatient statewide standard is the average outpatient cost per Episode for all Hospitals' Episodes for the PAPE Base Year, adjusted for casemix, an efficiency standard, an outlier adjustment factor, and inflation, as further described below.

For each Hospital, an average outpatient cost per Episode for the PAPE Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all PAPE paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. The Hospital's CCR was calculated based on the Hospital's FY14 -403 cost report, and Hospital-specific Episodes and charges were based on paid claims for Episodes residing in MMIS for the PAPE Base Year, for which MassHealth was primary payer.

Each Hospital's average outpatient cost per Episode was then divided by the Hospital-Specific Outpatient Casemix Index, as calculated in **Section III.B.1.a**, to determine the

Hospital's standardized cost per Episode. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY14 MassHealth Episodes for the Hospitals was produced from paid claims in MMIS for which MassHealth was primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 65% of the total number of statewide Episodes in MMIS. The RY16 PAPE efficiency standard is $196.06.

The preliminary outpatient statewide standard was then determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 94%; and by (c) the Inflation Factors for Operating Costs between RY14 and RY16. The preliminary outpatient statewide standard, which is $173.85, divided by a conversion factor of 1.057 is the PAPE Outpatient Statewide Standard, which is $164.47.

For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's PAPE Outpatient Statewide Standard is instead $229.47. The preliminary outpatient statewide standard for this Hospital is the same as it is for all other Hospitals.

c. PAPE Base Payment

For each Hospital, the PAPE Base Payment is equal to the product of the Hospital-Specific Outpatient Casemix Index **(Section III.B.1.a.)** and the PAPE Outpatient Statewide Standard **(Section III.B.1.b)**.

d. Outlier Add-On

For Hospitals with qualifying PAPE Base Year Episodes, a fixed Hospital-specific Outlier Add-On is added to the Hospital's PAPE Base Payment to calculate the Hospital's preliminary RY16 PAPE.

The fixed Hospital-specific Outlier Add-On is equal to the sum of the Hospital's Episode-Specific Outlier Values for all of the Hospital's PAPE Base Year Episodes, divided by the Hospital's number of Episodes in the PAPE Base Year. (See **Table 1.1**, below, for an illustrative example of how a Hospital's Outlier Add-On is calculated).

Each individual Episode-Specific Outlier Value is equal to the product of the Marginal Cost Factor (80%) and the amount by which the Episode-Specific Cost exceeds the Episode Outlier Threshold. (See **Table 1.2**, below, for an illustrative example of how a single Episode-Specific Outlier Value is calculated).

The Episode-Specific Cost is the product of the Hospital's MassHealth allowed charges for the PAPE Base Year Episode (based on MMIS paid claims data) and the Hospital's FY14 outpatient CCR (based on the Hospital's FY14 403 cost report). The Episode-Specific Cost is compared to the Episode Outlier Threshold, which is the sum of the

Outlier Base Value and the RY16 Fixed Outpatient Outlier Threshold of $4,500. The Hospital's Outlier Base Value is the product of the preliminary outpatient statewide standard (**Section III.B.1.b),** and the Hospital-Specific Outpatient Casemix Index (**Section III.B.1.a**).

If the Episode-Specific Cost exceeds the Episode Outlier Threshold, then an Episode-Specific Outlier Value is computed equal to the Marginal Cost Factor for RY16 set at 80%, multiplied by the difference between the computed Episode-Specific Cost and the Episode Outlier Threshold. The Hospital's fixed Outlier Add-On is the sum of the Hospital's Episode-Specific Outlier Values for all of the Hospital's PAPE Base Year Episodes, divided by the Hospital's total number of PAPE Base Year Episodes.

The Hospital-specific preliminary RY16 PAPE equals the sum of the Hospital's PAPE Base Payment, *plus* the Hospital-Specific Outlier Add-on.

2. 50/50 Blend

Each Hospital's RY16 PAPE is computed by blending 50/50 the Hospital's RY15 PAPE that was in effect on September 30, 2015, with the Hospital's preliminary RY16 PAPE.

Table 1, below, is an illustrative example of the calculation of a Hospital's RY16 PAPE.

Table 1				
(Values are for demonstration purposes only)				
Line	**Description**		**Value**	**Notes/ Source**
1	Preliminary Outpatient Statewide Standard	$	173.85	Determined annually, based on PAPE Base Year data
2	Conversion Factor		1.057	Determined annually
3	PAPE Outpatient Statewide Standard	$	164.47	Line 1 / Line 2
4	Hospital-Specific Outpatient Casemix Index		2.0402	Varies by Hospital, based on FY14 data
5	PAPE Base Payment	$	335.56	Line 3 * Line 4
6	Outlier Add-On (Note: Value could equal $0)		$9.11	Fixed amount that varies by Hospital (see example calculation from Table 1.1, below)
7	Hospital's Preliminary RY16 PAPE	$	344.67	Line 5 + Line 6
8	Hospital's RY15 PAPE	$	318.49	Varies by Hospital
9	Blend Rate Percentage		50%	Determined annually
10	**Hospital's RY16 PAPE**	**$**	**331.58**	(Line 7 + Line 8)/ 2

Table 1.1 -- Example Calculation for Hospital's Outlier Add-On (for Table 1, Line 6, above)				
(Values are for demonstration purposes only)				
Line	**Description**		**Value**	**Notes/ Source**
1	Sum of Hospital's Episode-Specific Outlier Values for all of the Hospital's PAPE Base Year Episodes	$	61,535.97	Varies by Hospital (see example calculation for single Episode-Specific Outlier Value in Table 1.2, below)
2	Hospital's Total # of Episodes in PAPE Base Year		6,758	MassHealth MMIS claims data for PAPE Base Year
3	Hospital's Outlier Add-On (for Table 1, Line 6, above)	$	9.11	Line 1 / Line 2

*Table 1.2 -- Example Calculation for a single Episode-Specific Outlier Value**
(Values are for demonstration purposes only)

Line	Description	Value	Notes/ Source
1	Preliminary Outpatient Statewide Standard	$ 173.85	Table 1, Line 1, above
2	Hospital-Specific Outpatient Casemix Index	$ 2.0402	Table 1, Line 4, above
3	Outlier Base Value	$ 354.69	Line 1 * Line 2
4	Allowed Charges for Episode	$ 12,000.00	Determined from PAPE Base Year claims in MMIS corresponding to the Episode
5	Hospital's Outpatient Cost-to-Charge Ratio	46.36%	Varies by Hospital (based on Hospital's FY14 403 cost report)
6	Episode-Specific Cost	$ 5,563.20	Line 4 * Line 5
7	Fixed Outpatient Outlier Threshold	$ 4,500.00	Determined annually (same for all Hospitals)
8	Episode Outlier Threshold	$ 4,854.69	Line 3 + Line 7
9	Does Episode-Specific Cost exceed Episode Outlier Threshold?	Yes	Is Line 6 > Line 8
10	Marginal Cost Factor	80%	Determined annually (same for all Hospitals)
11	Episode-Specific Outlier Value	$ 566.81	(Line 6 - Line 8) * Line 10 (Note: Value always = or > $0)

* This calculation is repeated for each of the Hospital's PAPE Base Year Episodes, and the sum of the Hospital's Episode-Specific Outlier Values for all PAPE Base Year Episodes is the value for Table 1.1, Line 1.

C. Physician Payments

1. A Hospital may receive payment for the professional component of physician services provided by Hospital-Based Physicians to MassHealth members.

2. Such payment shall be as specified in Attachment 4.19B, section 8.d. of the State Plan. Hospitals will not be paid separately for professional fees for practitioners other than Hospital-Based Physicians as defined in **Section II**.

3. Hospitals will be paid for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

4. Physician services provided by residents and interns are not payable separately.

5. Hospitals will not be paid for physician services if those services are (1) provided by a Community-Based Physician; or (2) as further described herein.

6. In order to qualify for payment for Hospital-Based Physician services provided during the provision of Observation Services, the reasons for the Observation Services, the start and stop time of the Observation Services, and the name of the physician ordering the Observation Services, must be documented in the Member's medical record.

D. Outpatient Hospital Services Payment Limitations

1. Payment Limitations on Hospital Outpatient Services Preceding an Admission

Hospitals will not be separately paid for Outpatient Hospital Services when an inpatient admission to the same Hospital, on the same date of service, occurs following the Outpatient Hospital Services.

2. Payment Limitations on Outpatient Services to Inpatients

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

E. Laboratory Services

1. Payment for Laboratory Services

a. Hospitals will be paid for laboratory services as specified in Attachment 4.19-B, section 8.b. of the State Plan.

2. Physician Services

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

F. 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 1 percent of the Hospital's total FY15 PAPE 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, 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 $1,200 times the total number of Episodes with dates of service during the applicable Federal Fiscal Year, not to exceed $58.65 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 $21 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. 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 outpatient Medicaid payment and outpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Acute Hospital with High Medicaid Discharges payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

IV. [Reserved]

V. Other Provisions

A. Federal Limits

If any portion of the payment methodology is not approved by CMS or is in excess of applicable federal limits, EOHHS may recoup any payment made to a Hospital in excess of the approved methodology. Any such recovery shall be proportionately allocated among affected hospitals. Any FFP associated with such overpayments will be returned to CMS.

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. Incorrect Determination of Casemix

In the event of an error in the calculation of casemix made by EOHHS for Outpatient Services resulting in an amount not consistent with the methodology, and where the effect of the error is a decrease in the Hospital's PAPE of 2% or more, a Hospital may request a correction, consistent with the RFA and contract, which shall be at the sole discretion of EOHHS.

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

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.

VI. Other Quality and Performance Based Payment Methods

A. Provider Preventable Conditions

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

Payment Adjustment for Provider Preventable Conditions

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.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-B (1), (Acute Outpatient Hospital Services) of this State plan, where applicable.

☒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:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:

1. Foreign object retained after surgery.
2. Air Embolism
3. Blood incompatibility
4. Stage III and IV Pressure Ulcers
5. Falls and Trauma, related to:
    - fractures
    - dislocations
    - intracranial injuries
    - crushing injuries
    - burns
    - other injuries

- In addition, the following:

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 pregnancy.
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 Other Provider-Preventable Conditions ("OPPCs") 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, MassHealth will reduce payments to the Hospital as follows:

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

2. Outpatient Hospital Payments for Hospital-Based Physician Services: MassHealth will not pay for outpatient Hospital-based physician services reported as PPC-related services.

3. Follow-Up Care in Same Hospital: If a Hospital reports that it provided follow-up outpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license., MassHealth will not pay for the reported follow-up services. If the hospital reports that non–PPC-related services were provided during the follow-up episode of care, payment will be made, but MassHealth will exclude all PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

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

Charges for services, 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.

B. Serious Reportable Events

The non-payment provisions set forth in this Section VI.B. apply to the following serious reportable events (SREs), where applicable:

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 outpatient visit during which a preventable SRE occurred; and

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

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

    b. on the premises of a separately licensed hospital 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.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services
Exhibit 1: RY16 Payment Method for Critical Access Hospitals
Effective October 1, 2015 through September 30, 2016

EXHIBIT 1
RY16 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 both inpatient and outpatient services in RY16, 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**. The interim payments made for Outpatient Services to Critical Access Hospitals will be made on the same basis as payment would be made for those same Outpatient Services to all other Hospitals (e.g., per Episode for Outpatient Services paid by the PAPE), and the timing of the interim payments will not differ from the timing that Outpatient Services are paid to all other Hospitals. Subject to this **Exhibit 1**, **Attachment 4.19-B(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 Outpatient Services

For dates of service in RY16, Critical Access Hospitals will be paid for Outpatient Services in accordance with **Attachment 4.19-B(1)** with the following changes.

Critical Access Hospitals will be paid a hospital-specific Payment Amount Per Episode (PAPE) for those Outpatient Services for which all other in-state acute hospitals are paid a PAPE. Notwithstanding **Section III.B** of **Attachment 4.19-B(1)**, for dates of service in RY16, the hospital-specific PAPE for each Critical Access Hospital was calculated as follows:

(1) EOHHS calculated a cost per Episode for outpatient services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 40 of the Hospital's FY14 CMS-2552-10 cost report, by the Hospital's number of FY14

Medicaid (MassHealth) Episodes. Episode volume was derived from FY14 paid claims data residing in MMIS for which MassHealth was primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY14 and RY16, as defined in **Section II** of **Attachment 4.19-B(1)**, to derive the Critical Access Hospital's interim RY16 PAPE.

(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 both inpatient and outpatient services for RY16, as such amount is determined by EOHHS ("101% of allowable costs"). See also Exhibit 1 to Attachment 4.19-A(1). 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 supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in **Section III.F.1** of **Attachment 4.19-B(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 the amount that equals the difference between the aggregate interim payments and 101% of allowable costs.

This post RY16 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.