# Table of Contents

**State/Territory Name: MA**

**State Plan Amendment (SPA) #: 25-0035**

This file contains the following documents in the order listed:

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

**Financial Management Group**

08/27/2026

Ryan Schwarz, Assistant Secretary
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place
Room 1109
Boston, MA 02108

RE: Massachusetts 25-0035

Dear Assistant Secretary Schwarz:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Massachusetts state plan amendment (SPA) to Attachment 4.19-A(1) MA 25-0035, which was submitted to CMS on December 30, 2025. This plan amendment updates rate year 2026 reimbursement methods and standards for acute inpatient hospital services.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), and 1923 of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of October 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or via email at Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

**Financial Management Group**

08/27/2026

Ryan Schwarz, Assistant Secretary
Commonwealth of Massachusetts
Executive Office of Health and Human Services
One Ashburton Place
Room 1109
Boston, MA 02108

RE: Massachusetts 25-0035

Dear Assistant Secretary Schwarz:

The Centers for Medicare & Medicaid Services (CMS) is providing this letter as a companion to the approval of SPA MA-25-0035, which updates reimbursement for acute inpatient hospital services, effective October 1, 2025.

It appears that some of the previously approved payment methodologies that pay out of state providers differently (noted in "same page" review) may be problematic in light of the D.C. Circuit opinion in *Asante v. Kennedy*, No. 23-5055 (D.C. Cir. 2025), *petition for cert. filed* (U.S. Sept. 17, 2025) (No. 25-361). By approving the corresponding SPA, CMS is expressly not approving any payment methodologies that would violate *Asante*. At this time, CMS will not take enforcement action against the state over such payment methodologies provided that the state does not implement such methodologies in a manner that conflicts with *Asante*. CMS is currently exploring options for how to proceed with this issue, which may include rulemaking.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or via email at Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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: 25-0035

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10 /01 /2025

5. FEDERAL STATUTE/REGULATION CITATION
42 USC 1396a(a)(13); 42 CFR Part 447; 42 CFR 440.10

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 26 $ -(169,567,000)
b. FFY 27 $

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
1-65 & Exhibit 1 pp. 1-3
Attachment 4.19-A(1) pp. ~~1-6 & Exhibit 1 pp. 1-3~~

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
1-79 & Exhibit 1 pp. 1-3
Attachment 4.19-A(1) pp. ~~1-76 & Exhibit 1 pp. 1-3~~

9. SUBJECT OF AMENDMENT

An amendment to the payment methodologies for acute inpatient hospitals

*10.* 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Mike Levine

13. TITLE
Undersecretary for MassHealth

14. DATE SUBMITTED
12/30/2025

15. RETURN TO

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 10th Floor
Boston, MA 02108

***FOR CMS USE ONLY***

16. DATE RECEIVED
December 30, 2025

17. DATE APPROVED
08/27/2026

***PLAN APPROVED - ONE COPY ATTACHED***

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Pen and ink changes in blocks 7 & 8 per state



***Instructions on Back***

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 RY26.

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:

   - RY26 admissions at in-state Acute Hospitals beginning on or after October 1, 2025 through September 30, 2026, and

   - inpatient payments made to in-state Acute Hospitals on an administrative day, psychiatric or rehabilitation per diem basis for RY26 dates of service on or after October 1, 2025 through September 30, 2026.

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 RY26 on or after October 1, 2025 through September 30, 2026**.**

3. The supplemental payment methodologies specified in **Section III.J** are effective in RY26 beginning October 1, 2025 through September 30, 2026.

4. The Clinical Quality Incentives payment methodologies, specified in **Section III.L** are effective in RY26 beginning October 1, 2025 through September 30, 2026.

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. Components of the out-of-state payment methods that are based on the in-state methods will simultaneously adjust effective with the RY26 (as defined in **Section II**) to reflect updates implemented effective with the RY26 to the in-state method, as applicable.

   Except if **subsection 6(e)** 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; provided that the out-of-state APAD is not paid for inpatient services that are paid on a per diem basis under **subsections 6(b) or (c)** and that payment for certain APAD carve-out services (as described in **subsection 6(d)**, below) is governed by **subsection 6(d)**, and not this **subsection 6(a)**. 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. An out-of-state acute hospital's charges for any APAD carve-out services (as described in **subsection 6(d),** below) will not be included in this calculation.
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:

(i) Out-of-state acute hospitals are paid the out-of-state transfer per diem for inpatient services as calculated and capped as set forth in **subsection 6(b)(ii)** ("Out-of-State Transfer Per Diem") in the following circumstances.

a. If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid the Out-of-State Transfer Per Diem for the period during which the Member was an inpatient at the transferring hospital.
b. MassHealth will pay the Out-of-State Transfer Per Diem in such other additional circumstances as MassHealth determines in-state acute hospitals would be paid the in-state Transfer Per Diem, as applicable.

(ii) The out-of-state transfer per diem equals the sum of the hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period during which the transfer per diem is payable, as calculated by EOHHS, divided by the mean in-state acute hospital all payer length of stay for the applicable APR-DRG that is assigned. Total out-of-state transfer per diem payments for a given hospital stay are capped at the sum of the hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment that would have otherwise applied for the transfer per diem period.

(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 most recently in effect for in-state acute hospitals ("Out-of-State Psychiatric Per Diem"), and no other payment methods apply.

(d) Payment for APAD Carve-Outs.

(i) Long-Acting Reversible Contraception (LARC) devices: Out-of-state acute hospitals will be paid for LARC Devices (as defined in **Section II)** in accordance with Section 8.d. of Attachment 4.19-B of the State Plan if the LARC procedure occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay for clinically appropriate members. No other payment methods apply to such devices.

(ii) APAD Carve-Out Drugs: Out-of-state acute hospitals will be paid for APAD Carve-Out Drugs (as defined in **Section II**) in accordance with the payment method applicable to such drugs as in effect for in-state acute hospitals on the date of service.

(iii) Behavioral Health Crisis Evaluation Services: Acute hospitals will be paid for behavioral health crisis evaluation services (as defined in **Section II**) in accordance with Section III.E-4 of Attachment 4.19-B of the State Plan, if the service occurs during an inpatient hospital stay rather than as an outpatient service in an emergency department.

(iv) Behavioral Health Crisis Management Services: Acute hospitals will be paid for behavioral health crisis management services (as defined in **Section II**) in accordance with Section III.E-5 of Attachment 4.19-B of the State Plan, if the service occurs during an inpatient hospital stay rather than as an outpatient service in an emergency department.

(v) Recovery Support Navigator services: Acute hospitals will be paid for recovery support navigator services and recovery support navigator services for pregnant and postpartum members (as defined in **Section II**) in accordance with Section III.E-6 of Attachment 4.19-B of the State Plan, if the service occurs during an inpatient hospital stay rather than as an outpatient service in an emergency department.

(e) 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.

(f) 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 100 MassHealth discharges during the most recent federal fiscal year for which complete data is available.

(g) 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. Hospitals are not entitled to any payment from EOHHS, and may not claim such reimbursement for any services provided to Members enrolled with an MCO that are MCO-covered services or are otherwise reimbursable 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. **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**).

5. **Behavioral Health Diversionary Services**

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

6. **Injectable Materials or Biologicals Provided by the Massachusetts Department of Public Health at No Charge**

   EOHHS will not pay for the cost of injectable materials or biologicals that provider received from the Massachusetts Department of Public Health free of charge.

## II. Definitions

The definitions set forth, below, apply during **RY26** (as defined below).

| Defined Term | Definition Applicable During RY26 |
|---|---|
| **RY25** | October 1, 2024 through September 30, 2025. |
| **RY26** | October 1, 2025 through September 30, 2026. |
| **Accountable Care Organization (ACO)** | An entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, where in the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans (ACPPs), and Primary Care ACOs. |
| **Accountable Care Partnership Plan (ACPP)** | A type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), and which is organized primarily for the purpose of providing health care services. |
| **Actual Acquisition Cost** | For purposes of **Section III.I.2**, the Hospital's "actual acquisition cost" of the Drug is the Hospital's invoice price for the Drug, net of all on- or off- invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member while the Member was admitted in the Hospital, including any efficacy-, outcome-, or performance-based guarantee (or similar arrangements), whether received pre- or post-payment. |
| **Acute Hospital** | See Hospital. |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| **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. The APAD is also not payment for LARC Devices, APAD Carve-Out Drugs, Behavioral Health Crisis Evaluations, Behavioral Health Crisis Management Services, or Recovery Support Navigator services, which may be paid separately as described in **Section III.I**. Calculation of the APAD is discussed in **Section III.B** (utilizing RY24 methodology). |
| **Administrative Day (AD)** | A day of inpatient hospitalization on which a Member's care needs can be provided in a setting other than an Acute Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. |
| **Administrative Psychiatric Day** | An Administrative Day on which a Member's clinical presentation would typically call for discharge to a lower level of care (e.g., an appropriate community-based location) but an appropriate placement has not yet been secured, the clinical barriers to discharge have been sufficiently addressed and the discharge plan is ready to be executed when an appropriate discharge placement has been secured, and the patient does not require a high degree of clinical resources daily. Administrative Psychiatric Day does not include a day on which a Member is receiving active stabilization efforts or requires inpatient hospital care to prevent further regression of the Member's condition. |
| **All Patient Refined–Diagnostic Related Group (APR-DRG** or **DRG)** | The All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper, version 40, unless otherwise specified. |
| **APAD Base Year** | The hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY21, using FY21 Massachusetts Hospital cost reports as screened and updated as of March 14, 2023. |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| **APAD Carve-Out Drugs** | Drugs that are carved out of the APAD payment and separately paid pursuant to **Section III.I.2.** APAD Carve-Out Drugs are identified on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List, available at https://mhdl.pharmacy.services.conduent.com/MHDL/, as in effect on the applicable date of service. |
| **Average (or Mean) Length of Stay** | The sum of non-psychiatric acute 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, arrange for and coordinate 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 Crisis** | A situation in which an individual demonstrates signs or symptoms of a mental health disorder, substance use disorder, co-occurring mental health and substance use disorder, or co-occurring behavioral health and medical condition that led to significant impairment in the individual's functioning and/or to behavior that puts the individual at risk of harming themselves, harming others, or being unable to appropriately care for themselves. |
| **Behavioral Health Crisis Management Services** | A set of services provided by qualified clinical professionals to members experiencing a Behavioral Health Crisis in an acute inpatient setting and in need of ongoing supports on days subsequent to receiving the initial Behavioral Health Crisis Evaluation. The crisis management services include ongoing crisis interventions, ongoing determination and coordination of appropriate disposition, and ongoing required reporting and community collaboration activities. |
| **Behavioral Health Crisis Evaluation** | An evaluation provided by qualified clinical professionals to members experiencing a behavioral health crisis in an acute inpatient setting during the first calendar day of their readiness to receive such an evaluation. The evaluation includes the initial comprehensive assessment of risk, diagnosis, and treatment needs, the initial clinical crisis interventions, the initial |

| Defined Term | Definition Applicable During RY26 |
|---|---|
| | determination and coordination of appropriate disposition, and required reporting and community collaboration activities. |
| **Behavioral Health Diversionary Services** | Mental health and substance use disorder services provided outside of the RFA and Contract as clinically appropriate alternatives to Behavioral Health Inpatient Services, to support an Enrollee returning to the community following a 24-hour acute placement, or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services: those services which are provided in a 24-hour facility, and those services which are provided in a non-24-hour setting or facility. |
| **Behavioral Health Services (or Behavioral Health)** | Services provided to Members who are being treated for psychiatric disorders or substance use disorders. |
| **Behavioral Health Treatment and Referral Platform (BHTRP)** | Technology to support automation of the ED Behavioral Health referral screening, evaluation and referral process, enables the electronic transmission of standardized admissions information, and creates a real-time, transparent view of patients seeking behavioral health treatment for participant organizations. |
| **Calendar Year (CY)** | The time period of 12 months beginning on January 1 of any given year and ending on December 31 of the same year. |
| **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. |

State Plan Under Title XIX of the Social Security Act
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| Defined Term | Definition Applicable During RY26 |
|---|---|
| **Certified Event Notification Service (ENS) Vendor** | An ENS vendor that is certified by EOHHS in compliance with EOHHS regulations. |
| **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, prior to October 1, 2025, 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 FY22 Massachusetts Hospital Cost Report. For applicable discharges, a Hospital's charges corresponding to LARC Devices or APAD Carve-Out Drugs are excluded in calculating the Discharge-Specific Case Cost. |
| **Discharge-Specific Outlier Threshold** | The sum of the APAD for a specific discharge (utilizing the methodology applicable to RY26), and the Fixed Outlier Threshold. |
| **Drugs** | Drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified form and strength. Each dosage form and strength is a separate Drug. |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| **Electronic Health Record (EHR)** | A digital version of a patient's medical history. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users, often including a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and/or laboratory and test results. |
| **Excluded Units** | Non-Acute Units as defined in this section; any unit which has a separate license from the Hospital; psychiatric and substance use disorder units; and non-distinct observation units. |
| **Executive Office of Health and Human Services (EOHHS)** | The single state agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers. |
| **Expedited Psychiatric Inpatient Admission (EPIA)** | The escalation protocol for securing appropriate placement for individuals awaiting psychiatric placement longer than 24 hours. |
| **Fiscal Year (FY)** | The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. This period coincides with the federal fiscal year (FFY). FY26 begins on October 1, 2025 and ends on September 30, 2026. |
| **Fixed Outlier Threshold** | For RY26, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $42,430.00. |
| **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 (GPSR)** | The total dollar amount of a Hospital's charges for services rendered in a Fiscal Year. |

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

| Defined Term | Definition Applicable During RY26 |
|---|---|
| **High Medicaid Volume Freestanding Pediatric Acute Hospital** | The Freestanding Pediatric Acute Hospital with the largest volume of inpatient discharges in FY19, as determined by Massachusetts cost report data. |
| **High Medicaid Volume Safety Net Hospital** | An Acute Hospital which had a ratio of Medicaid inpatient days to total inpatient days that was greater than 45% in FY14 based on the Hospital's FY14 403 cost report. |
| **Hospital** | Any health care facility which:<br><br>a. operates under a hospital license issued by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111 § 51;<br><br>b. is Medicare certified and participates in the Medicare program; and<br><br>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 for FY21 provided and verified by each hospital, submitted to CHIA, and screened and updated by CHIA. HDD is used for determining casemix as part of the APAD rate development for purposes of **Section III.B**, as applicable to RY26 |

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

| Defined Term | Definition Applicable During RY26 |
|---|---|
| **Inflation Factors for Capital Costs** | For price changes between RY04 and RY18 and between RY19 and RY24, the inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index. For price changes between RY18 and RY19, the inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare and are based on the CMS Capital Input Price Index, plus a RY19 capital enhancement factor of 0.9%. The Inflation Factors for Capital Costs between RY04 and RY24 are as follows:<br>• 0.7% reflects the price changes between RY04 and RY05<br>• 0.7% reflects the price changes between RY05 and RY06<br>• 0.8% reflects the price changes between RY06 and RY07<br>• 0.9% reflects the price changes between RY07 and RY08<br>• 0.7% reflects the price changes between RY08 and RY09<br>• 1.4% reflects the price changes between RY09 and RY10<br>• 1.5% reflects the price changes between RY10 and RY11<br>• 1.5% reflects the price changes between RY11 and RY12<br>• 1.2% reflects the price changes between RY12 and RY13<br>• 1.4% reflects the price changes between RY13 and RY14<br>• 1.5% reflects the price changes between RY14 and RY15<br>• 1.3% reflects the price changes between RY15 and RY16<br>• 0.9% reflects the price changes between RY16 and RY17<br>• 1.3% reflects the price changes between RY17 and RY18<br>• 2.1108% reflects the price changes between RY18 and RY19<br>• 1.5% reflects the price changes between RY19 and RY20<br>• 1.5% reflects the price changes between RY20 and RY21<br>• 1.0% reflects the price changes between RY21 and RY22<br>• 1.7% reflects the price changes between RY22 and RY23<br>• 3.5% reflects the price changes between RY23 and RY24 |
| **Inflation Factors for Operating Costs** | For price changes between RY04 and RY07, and between RY09 (starting with admissions beginning December 7, 2008) and RY24, the inflation factor for operating costs is a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY09 (for admissions through December 6, 2008), the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY24 are as follows:<br><br>• 1.186% reflects price changes between RY04 and RY05<br>• 1.846% reflects price changes between RY05 and RY06 |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| | • 1.637% reflects price changes between RY06 and RY07<br>• 3.300% reflects price changes between RY07 and RY08<br>• 3.000% reflects price changes between RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008<br>• 1.424% reflects price changes between RY08 and RY09 for admissions beginning from December 7, 2008 through September 30, 2009<br>• 0.719% reflects the price changes between RY09 and RY10*<br>• 1.820% reflects the price changes between RY10 and RY11<br>• 1.665% reflects the price changes between RY11 and RY12<br>• 1.775% reflects the price changes between RY12 and RY13<br>• 1.405% reflects the price changes between RY13 and RY14<br>• 1.611% reflects the price changes between RY14 and RY15<br>• 1.573% reflects the price changes between RY15 and RY16<br>• 1.937% reflects the price changes between RY16 and RY17<br>• 2.26% reflects the price changes between RY17 and RY18.<br>• 2.183% reflects the price changes between RY18 and RY19.<br>• 2.236% reflects the price changes between RY19 and RY20<br>• 1.854 % reflects the price changes between RY20 and RY21<br>• 1.433% reflects the price changes between RY21 and RY22<br>• 2.451% reflects the price changes between RY22 and RY23<br>• 2.599% reflects the price changes between RY23 and RY24<br><br>** 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. |
| **Long-Acting Injectable (LAI) Antipsychotics** | Antipsychotic medications that are administered through intramuscular injection and provide medication coverage for a period of weeks to months. LAI Antipsychotics does not refer to the administration of the medications. The MassHealth-designated LAI Antipsychotics are identified on the *Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units* document maintained on the MassHealth Drug List. |
| **Long-Acting Reversible Contraception (LARC) device (LARC Device)** | Long-acting reversible contraception (LARC) device refers to intrauterine devices and contraceptive implants. LARC Device does not refer to the procedure, itself. |

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|---|---|
| | |
| **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. For clarity purposes, MCO also includes Accountable Care Partnership Plans (ACPPs). |
| **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 (utilizing the RY25 Period methodology). For RY26 Period, the Marginal Cost Factor is 60%. |
| **Mass HIway** | A secure statewide network that facilitates the transmission of healthcare data and health information among providers, hospitals, and other healthcare entities as allowed by applicable state and federal laws. |
| **Massachusetts-specific Wage Area Index for RY26** | Each wage area's wage index is the average hourly wage divided by the statewide average hourly wage. For RY26, Massachusetts Hospitals' wages and hours were determined based on CMS's FY 2026-April-29-2025-Wage-Index-PUF zip file, downloaded May 5, 2025, from the CMS web site at www.cms.hhs.gov. Each Hospital was assigned to a wage area according to CMS's FY 2025 IPPS Final Rule Impact File from the CMS web site at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2025-ipps-final-rule-home-page (FY 2025 IPPS Final Rule Impact File), except that:<br>• Baystate Franklin Medical Center is assigned to the Amherst Town – Northampton wage area and their wages and hours included in the Amherst Town – Northampton area;<br>• The following hospitals were redesignated, for the purpose of wage areas, as follows:<br>o Baystate Medical Center from Springfield to Worcester;<br>o Anna Jaques Hospital, Beverly Hospital, Cambridge Health Alliance, Emerson Hospital, Holy Family Hospital, Lahey Hospital, Lawrence General Hospital, Lowell General Hospital, Marlborough Hospital, Melrose Wakefield Healthcare, MetroWest Medical Center, Mount Auburn Hospital, Newton-Wellesley Hospital, North Shore Medical Center and |

| Defined Term | Definition Applicable During RY26 |
|---|---|
| | Winchester Hospital from Cambridge-Newton-Framingham to Boston;<br>o Harrington Hospital, HealthAlliance-Clinton Hospital, Heywood Hospital, Milford Medical Center and UMass Memorial Medical Center from Worcester to Boston;<br>o Southcoast Hospitals Group and Sturdy Memorial Hospital from Providence-Warwick to Boston;<br>o St. Anne's Hospital from Providence-Warwick to Worcester; and<br>• PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined by EOHHS from the hospital's license (PPS-exempt hospitals are not included in the FY2024 Impact File).<br>The area's wage index for RY26 is the Massachusetts-specific wage area index for each Hospital assigned to the area, except for any Hospital that was redesignated to a different wage area in a written decision from CMS to the Hospital provided to EOHHS by April 8, 2025. For any such redesignated Hospital, its Massachusetts-specific wage area index for RY26 was calculated based on the wages and hours, determined from the CMS File, of (i) the redesignated hospital, (ii) all other hospitals redesignated to that same area, and (iii) all hospitals assigned to that area, combined. |
| **MassHealth (also Medicaid)** | The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions. |
| **MassHealth DRG Weight** | The MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI), applicable to RY26. |
| **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. |

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|---|---|
| | |
| **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,** utilizing the methodology applicable to RY26. |
| **Primary Care ACO** | A type of ACO with which the MassHealth agency contracts under its ACO program. |
| **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 |
| **Qualified Behavioral Health Professional** | A qualified behavioral health professional shall include a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in the field of psychiatry (vii) advanced practice registered nurse who practices in the field of psychiatry, including but not limited to a licensed nurse practitioner or licensed psychiatric clinical nurse specialist; or (viii) healthcare provider qualified within the scope of the individual's license to conduct an evaluation of a mental health condition, including an intern, resident or fellow pursuant to the policies and practices of the hospital and medical staff. |
| **Query and Retrieve** | A method utilized in the Health Information Exchange (HIE) to allow providers to search for and retrieve patient information that was made accessible by other care providers, public agencies, and other sources. |
| **Rate Year (RY)** | Generally, 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 |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| | <table><tr><td>RY10</td><td>11/1/2009 – 11/30/2010</td></tr><tr><td>RY11</td><td>12/01/2010–09/30/2011</td></tr><tr><td>RY12</td><td>10/01/2011 –9/30/2012</td></tr><tr><td>RY13</td><td>10/01/2012 –09/30/2013</td></tr><tr><td>RY14</td><td>10/1/2013 – 09/30/2014</td></tr><tr><td>RY15</td><td>10/1/2014 – 9/30/2015</td></tr><tr><td>RY16</td><td>10/1/2015 – 9/30/2016</td></tr><tr><td>RY17</td><td>10/1/2016 – 9/30/2017</td></tr><tr><td>RY18</td><td>10/1/2017 – 9/30/2018</td></tr><tr><td>RY19</td><td>10/1/2018 – 9/30/2019</td></tr><tr><td>RY20</td><td>10/1/2019 – 9/30/2020</td></tr><tr><td>RY21</td><td>10/1/2020 – 9/30/2021</td></tr><tr><td>RY22</td><td>10/1/2021-9/30/2022</td></tr><tr><td>RY23</td><td>10/1/2022 - 9/30/2023</td></tr><tr><td>RY24</td><td>10/1/2023 – 9/30/2024</td></tr><tr><td>RY25</td><td>10/1/2024 – 9/30/2025</td></tr><tr><td>RY26</td><td>10/1/2025 – 9/30/2026</td></tr></table> *In future rate years, Hospitals will be paid in 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. |
| **Recovery Support Navigator** | A paraprofessional or peer specialist who receives specialized training in the essentials of substance use disorder (SUD) or other addictive disorders and evidence-based techniques such as motivational interviewing, and who supports members in accessing and navigating the SUD treatment system through activities that can include care coordination, case management, and motivational support. |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| | |
| **Recovery Support Navigator for Pregnant and Postpartum Members** | A specialized recovery support navigator who receives specialized training to provide recovery support navigator services to individuals who are pregnant or have been pregnant in the last 12 months. |
| **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. |
| **Specialized Pediatric Service Hospital** | A High Medicaid Volume Freestanding Pediatric Acute Hospital or an Acute Hospital, other than a Freestanding Pediatric Acute Hospital, that maintains a DPH licensed pediatric unit and has a burn unit verified by the American Burn Association as of August 31, 2019, as determined by EOHHS, or a Hospital that is not a Freestanding Pediatric Acute Hospital and that is designated by the Massachusetts Department of Public Health as providing level II pediatric trauma care in Massachusetts Emergency Medical Service (EMS) Region I as of October 1, 2024. |
| **Specialty Inpatient Psychiatric Service for Children with Neurodevelopmental Disorders** | An intensive level of specialized inpatient psychiatric care for youth with severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions. In addition to all the clinical service components required within Psychiatric Inpatient Hospitals, pursuant to this Contract, Specialty Inpatient Psychiatric Services for Children/Adolescents with Neurodevelopmental Disorders must be supported by specially-trained staff. Additionally, specialized components of services include specialized treatment milieu, clinical expertise, clinical interventions, and evidence-based practices and procedures. |
| **Specialty Inpatient Psychiatric Service for Eating Disorders** | An intensive level of specialized inpatient care for adults and youth with eating disorder diagnoses who require acute psychiatric and medical stabilization. In addition to all clinical service components required within Hospitals, Specialty Inpatient Psychiatric Services for Eating Disorders must be supported by specially-trained staff. Additionally, specialized components of services include specialized treatment milieu, clinical expertise, clinical interventions, and evidence-based practices and procedures for supporting the unique needs of individuals with severe eating disorders. |

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| Defined Term | Definition Applicable During RY26 |
|---|---|
| **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. SFY26 begins on July 1, 2025, and ends on June 30, 2026. |
| **Statewide Event Notification System (ENS) Framework** | An interoperable ENS network consisting of Certified ENS Vendors who have interconnected their ENS systems to serve all care providers in Massachusetts. |
| **Total Case Payment** | The sum, as determined by EOHHS, of the APAD and, if applicable, any Outlier Payment (applying RY26 methodology(ies)). |
| **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** (applying RY26 Period methodology(ies)). |
| **Transferring Hospital** | An Acute Hospital that is being paid on a Transfer Per Diem basis, pursuant to **Section III.D**. |
| **Wholesale Acquisition Cost (WAC)** | The wholesale acquisition cost (WAC) of the Drug as published by First Data Bank or other national price compendium designated by EOHHS. |

## III. Payment for Inpatient Services

### A. Overview

1. Except as otherwise provided in **subsections C through I** 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.

   Payment separate from the APAD may also be made to Hospitals for LARC Devices, APAD Carve-Out Drugs, Behavioral Health Crisis Evaluations, Behavioral Health Crisis Management Services, and Recovery Support Navigator services, as described in **subsection I.1 through I.5**, respectively.

2. **Subsections C through I** describe non-APAD fee-for-service payments, including, as applicable, Outlier Payments, and payment for Behavioral Health Services, transfer patients, Hospital-Based Physician services, Administrative Days, Rehabilitation Unit services in Acute Hospitals, LARC Devices, APAD Carve-Out Drugs, Behavioral Health Crisis Evaluations, Behavioral Health Crisis Management Services, and Recovery Support Navigator services. Payment for other unique circumstances is described in **subsection J**, and **Exhibit 1**. Pay-for-Performance payments are described in **subsection K.**

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)

The APAD methodology is set forth in **Section III.B** below and applies to admissions occurring in RY26. It incorporates applicable definitions in **Section II** that apply to RY26.

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**RY26**
**(for admissions occurring in RY26)**

**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 (exclusive of any separate applicable payment for carved out services, as described in **Section III.I)**.

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 for RY26 (2) the Statewide Capital Standard per Discharge; and (3) the discharge-specific MassHealth DRG Weight. Each of these components, and the calculation of the APAD, is described more fully below.

The APAD Base Year is FY21.

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**RY26**
**(for admissions occurring in RY26)**

**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 91.85%; 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 $11,423.66.

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**RY26**
**(for admissions occurring in RY26)**

**a. APAD Base Year Standardized Cost per Discharge**

The APAD Base Year standardized cost per discharge is based on the average all-payer 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 and discharges are determined using the Hospital's APAD Base Year Massachusetts Hospital cost report as screened and updated as of March 14, 2023. 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 | Capital costs and direct medical education costs. |
| Cost centers identified as the supervision component of physician compensation and other direct physician costs | Costs associated with postpartum LARC Devices |
| All other non-excluded medical and non-medical patient care-related staff expenses | Costs associated with behavioral health crisis Evaluations |
| Malpractice costs and organ acquisition costs | Costs associated with behavioral health crisis management services |
| | Costs associated with recovery supports navigator services |

The APAD Base Year average cost per discharge for each Hospital is then adjusted by the Hospital's Massachusetts-specific Wage Area Index for RY26 and by the APAD Base Year all-payer Casemix Index. This adjusted value is the APAD Base Year standardized cost per discharge.

**RY26**
**(for admissions occurring in RY26)**

**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 60th percentile of the cumulative frequency of FY22 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $15,211.43.

**c. Outlier Adjustment Factor and Infation Factors for Operating Costs**

The weighted average of the APAD Base Year standardized cost per discharge, as limited by the efficiency standard, is multiplied by the outlier adjustment factor referenced above, and by the Inflation Factors for Operating Costs reflecting price changes between RY21 and RY24. The product is then divided by a conversion factor of 1.1722, to result in the Statewide Operating Standard per Discharge.

**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<br>b. adjusted by the APAD Base Year all payer casemix index<br>c. capped at the capital efficiency standard<br>d. multiplied by the FY21 Hospital-specific MassHealth discharges<br>e. summed and divided by the total FY21 statewide MassHealth discharges | $873.67 |
| trended to the current rate year using the Inflation Factors for Capital Costs and divided by 1.1722 (**subsection b**) | | $792.37 |

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**RY26**
**(for admissions occurring in RY26)**

**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 the Buildings and Fixtures and Movable Equipment categories reported on the APAD Base Year Massachusetts Hospital cost report. Total capital costs for Buildings and Fixtures are allocated to inpatient services through the square-footage-based allocation formula, and total capital costs for Movable Equipment are allocated to inpatient services through the dollar-value-based allocation formula, of the APAD Base Year Massachusetts Hospital 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 Massachusetts Hospital cost reports 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 60th percentile of the cumulative frequency of FY22 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 FY22 MassHealth discharges.

**b. Inflation Factors for Capital Costs**

The Inflation Factors for Capital Costs reflecting price changes between RY21 and RY24 are applied to trend the APAD Base Year statewide capital cost per discharge forward to the current Rate Year, and then divided by 1.1722.

| RY26<br>(for admissions occurring<br>in RY26) |
|---|
| **4. MassHealth DRG Weights**<br><br>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 applicable to RY26. |
| **5. [Reserved]** |
| **6. Calculation of the APAD**<br><br>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 for RY26, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to result in the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "**APAD Base Payment**"), and (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight. |

| RY26<br>(for admissions occurring<br>in RY26) |
|---|
| For purposes of step (4) in this **subsection 6**, for qualifying discharges, the APAD Base Payment will be adjusted as follows:<br><br>a. For Freestanding Pediatric Acute Hospitals for which the MassHealth DRG Weight assigned to the discharge is 3.0 or greater, the APAD Base Payment will be adjusted to include an additional 67%;<br><br>b. For Hospitals that (i) are not Freestanding Pediatric Acute Hospitals, and (ii) maintain between 1 and 15 pediatric beds, the APAD Base Payment will be adjusted to include an additional 25% for discharges of patients who are under 21 years of age;<br><br>c. For Hospitals that (i) are not Freestanding Pediatric Acute Hospitals, and (ii) do not maintain between 1 and 15 pediatric beds, the APAD Base Payment will be adjusted to include an additional 6% for discharges of patients who are under 21 years of age.<br><br>A qualifying discharge for the purpose of this **subsection 6** is one that meets the minimum MassHealth DRG Weight requirement. |

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. The example assumes RY26 applies.

| | | | |
|---|---|---|---|
| **DRG Model Example - Massachusetts Hospitals** | | | |
| (Values are for demonstrative purposes only) | | | |
| | | | |
| **Table 1: Standard APAD claim** | | | |
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital, Boston AWI** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | 2 | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Statewide Operating Standard per Discharge | $11,423.66 | RY26 RFA |
| 2 | Hospital's Massachusetts-specific wage area index | 1.05330 | Varies by hospital |
| 3 | Labor Factor | 0.67615 | RY26 RFA |
| 4 | Hospital's Wage Adjusted Operating Standard per Discharge | $11,835.35 | (Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3)) |
| 5 | Statewide Capital Standard per Discharge | $792.37 | RY26 RFA |
| 6 | APAD Base Payment | $12,627.72 | Line 4 + Line 5 |
| 7 | MassHealth DRG Weight | 0.3827 | Appendix C, Chart C |
| **8** | **Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)** | **$4,832.63** | Line 6 * Line 7 |

## C. Outlier Payment

The Outlier Payment methodology is set forth in this **Section III.C**; provided that, (i) it applies to admissions occurring in RY26 and incorporates applicable definitions from **Section II** that apply to RY26; and (ii) all references in this **Section III.C** to the APAD method (or any component of the APAD) shall refer to the APAD (or APAD component) as calculated utilizing the methodology that applies to RY26 method for admissions in RY26.

| **RY26 (for admissions occurring in the RY26)** |
|---|
| 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:<br><br>1. the amount of the APAD for the discharge exceeds $0.<br><br>2. the Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge;<br><br>3. the patient is not in a DMH-licensed bed for any part of the discharge; and<br><br>4. the patient is not a patient in an Excluded Unit within the Hospital.<br><br>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. |

The following is an illustrative example of the calculation of the Total Case Payment for a claim that also involves an Outlier Payment. The example assumes the RY26 applies.

| Table 2: Claim with Outlier Payment | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | APAD (must be >$0) | $4,832.63 | Table 1, Line 8 |
| 2 | Allowed Charges | $80,000.00 | Determined from claim |
| 3 | Hospital's Inpatient Cost-to-Charge Ratio | 72% | FY22 Massachusetts Hospital Cost Report |
| 4 | Discharge-Specific Case Cost | $57,600.00 | Line 2 * Line 3 |
| 5 | Fixed Outlier Threshold | $42,430.00 | RY26 RFA |
| 6 | Discharge-Specific Outlier Threshold | $47,262.63 | Line 1 + Line 5 |
| 7 | Does Discharge-Specific Case Cost exceed Discharge-Specific Outlier Threshold? | TRUE | Is Line 4 > Line 6? If TRUE, then Outlier Payment is due |
| 8 | Marginal Cost Factor | 60% | RY26 RFA |
| 9 | Outlier Payment | $6,202.42 | (Line 4 - Line 6) * Line 8 |
| **10** | **Total Case Payment = APAD plus Outlier Payment** | **$11,035.05** | Line 1 + Line 9 |

## D. Transfer Per Diem Payments

The Transfer Per Diem payment methodology is set forth in this **Section III.D**; provided that, (i) for admissions in RY26, applicable definitions from **Section II** that apply to RY26 are incorporated; and (ii) all references in this **Section III.D** to the APAD and Outlier Payment methodologies in **Sections III.B** and **III.C** shall refer to the methodology that applies to the specific admission RY26 method for admissions in RY26.

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 will equal the following for admissions in RY26.

| RY26 Period (for admissions occurring in RY26) |
|---|
| 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 applicable to RY26. 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**, and assume that RY26 applies.

| **Table 3: Claim with Transfer (APAD only)** | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | APAD (Total Case Payment Amount) | $4,832.63 | Table 1, line 8 |
| 2 | Patient length of stay (# of days) | 2.00 | Determined from claim |
| 3 | Mean all-payer length of stay for DRG 203 | 2.19 | Appendix C, Chart C |
| 4 | Transfer per diem | $2,206.68 | Line 1 / Line 3 |
| 5 | Transfer per diem x Patient length of stay (# of days) | $4,413.36 | Line 4 * Line 2 |
| 6 | Total Transfer Payment Cap | $4,832.63 | Line 1 |
| **7** | **Total Transfer Case Payment** | **$4,413.36** | **Lower of Line 5 or Line 6** |

| Table 4: Claim with Transfer (APAD and Outlier) | | | |
|---|---|---|---|
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | Total Case Payment Amount (Claim with Outlier Payment) | $11,035.05 | Table 2, line 10 |
| 2 | Patient length of stay (# of days) | 2.00 | Determined from claim |
| 3 | Mean all-payer length of stay for DRG 203 | 2.19 | Appendix C, Chart C |
| 4 | Transfer per diem | $5,038.84 | Line 1 / Line 3 |
| 5 | Transfer per diem x Patient length of stay (# of days) | $10,077.67 | Line 4 * Line 2 |
| 6 | Total Transfer Payment Cap | $11,035.05 | Line 1 |
| **7** | **Total Transfer Case Payment** | **$10,077.67** | **Lower of Line 5 or Line 6** |

## 2. Transfers within a Hospital

Except as described below, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be 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 from the PCC Plan, Primary Care ACO, or Fee-for-Service to an MCO (or vice versa) during a Hospital Stay, or in the Event of Exhaustion of (or eligibility for) Other Insurance

When a patient becomes MassHealth-eligible (or loses MassHealth eligibility), after the date of admission and prior to the date of discharge, changes enrollment from the PCC Plan, a Primary Care ACO, or Fee-for-Service to an MCO (or vice versa) during the course of a Hospital stay, or exhausts other insurance benefits (or becomes eligible for other insurance benefits) after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap, or if the patient is at the Administrative Day level of care, at the applicable 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 at the Hospital, 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 and the Hospital is in the BH Contractor's network, EOHHS will pay only for the non-DMH-licensed bed portion of the stay, and 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 and the Hospital is in the BH Contractor's network, 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 Behavioral Health Services in a DMH-licensed Bed, or at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-licensed Bed.

## E. Payments for Behavioral Health Services (Psychiatric Per Diem)

### 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. 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.

d. Below is the RY26 Psychiatric Per Diem payment methodology.

**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 Standard**

In calculating the final statewide standard Psychiatric Per Diem rate applicable to dates of service in RY26, the below methodology, applies.

| RY26 (for dates of service occurring in RY26) |
|---|
| 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).<br><br>The Inflation Factors for Operating Costs (see Section II above) between RY08 and RY10, between RY12 and RY19, and between RY21 and RY22 were then applied to the rate calculated above to determine the statewide standard Psychiatric Per Diem rate applicable to dates of service in RY26.<br><br>The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs for RY26 Psychiatric Per Diem is $178.62. The statewide standard Psychiatric Per Diem rate applicable to dates of service in RY26 remains at $954.59.<br><br>Notwithstanding the statewide standard Psychiatric Per Diem rate applicable to dates of service in RY26, described in this Section III.4, the Specialty Inpatient Psychiatric Services for Children with Neurodevelopmental Disorders Per Diem is a daily rate of $1,936.21, which shall be payable instead of the RY26 standard Psychiatric Per Diem rate per member per day on which the Hospital renders Specialty Inpatient Psychiatric Services for Children with Neurodevelopmental Disorders.<br><br>Notwithstanding the statewide standard Psychiatric Per Diem rate applicable to dates of service in RY26, described in this Section III.4, the Specialty Inpatient Psychiatric Service for Eating Disorders Per Diem rate is a daily rate of $1,500, which shall be payable instead of the RY26 standard Psychiatric Per Diem rate per member per day on which the Hospital renders Specialty Inpatient Psychiatric Services for Eating Disorders. |

5. **Inpatient Behavioral Health Admission Rates Payments**

For inpatient behavioral health admissions in DMH-Licensed Beds for members who are not enrolled with the BH Contractor or an MCO, an inpatient admission rate will be paid in addition to the inpatient psychiatric per diem rate described in Section III.E.4, above. The inpatient behavioral health admission rate is determined based on criteria met upon admission, as set forth below. Each admission may meet only one category below:

| | (1) Category 1 Per Admission Inpatient Rate; OR | (2) Category 2 Per Admission Inpatient Rate; OR | (3) Category 3 Per Admission Inpatient Rate |
|---|---|---|---|

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| | | | |
|---|---|---|---|
| **(A) Weekday Admission - Patient admission occurs Monday to Friday; OR** | The Member admission does not meet eligibility criteria for either Category 2 or Category 3 Per Inpatient Admission Rates. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 14 years old to 17 years old (inclusive); or<br>2. The Member has a diagnosis of Autism Spectrum Disorder or Intellection Disability Disorder (ASD/IDD);<br>3. The Member has a diagnosis of an eating disorder; or<br>4. The Member is homeless as indicated by diagnosis code Z59.0x, or housing unstable as indicated by diagnosis code Z59.1 or Z59.819; or<br>5. The member is admitted to a hospital identified by CHIA as a teaching hospital (HFY 2023 Massachusetts Hospital Profiles- January 2025);<br>AND<br>The Member admission does not meet eligibility criteria for the Category 3 Per Inpatient Admission Rate. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 13 years old or below; or<br>2. The Member is aged 65 years old or above; or<br>3. The Member is affiliated (as indicated in MMIS) with one or more of the following Massachusetts human service agencies: DDS, DCF, DMH, or DYS. |
| **(B) Weekend Admission - Patient admission occurs Saturday or Sunday** | The Member admission does not meet eligibility criteria for either Category 2 or Category 3 Per Inpatient Admission Rates. | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 14 years old to 17 years old (inclusive); or<br>2. The Member has a diagnosis of ASD/IDD;<br>3. The Member has a diagnosis of an eating disorder; or<br>4. The Member is homeless as indicated by diagnosis code 759.0x, or housing unstable as indicated by diagnosis code Z59.1 or Z59.819; or | The Member admission meets at least one of the following criteria:<br>1. The Member is aged 13 years old or below; or<br>2. The Member is aged 65 years old or above; or<br>3. The Member is affiliated (as indicated in MMIS) with one or more of the following Massachusetts human service agencies: DDS, DCF, DMH, or DYS. |

| | | | |
|---|---|---|---|
| | | 5. The member is admitted to a hospital identified by CHIA as a teaching hospital (HFY 2023 Massachusetts Hospital Profiles- January 2025);<br>AND<br>The Member admission does not meet eligibility criteria for the Category 3 Per Inpatient Admission Rate. | |

The inpatient behavioral health admission rate for the admissions described in the chart above, to be paid in addition to the psychiatric per diem rate described in Section III.E.4, above, are as follows:

a. Category A1 rate - $350 per admission
b. Category B1 rate - $1,000 per admission
c. Category A2 rate - $1,850 per admission
d. Category B2 rate - $2,500 per admission
e. Category A3 rate - $2,975 per admission
f. Category B3 rate - $3,625 per admission

### 6. Long-Acting Injectable (LAI) Antipsychotics

In addition to the appropriate inpatient psychiatric per diem rate, hospitals will be reimbursed for LAI Antipsychotics in accordance with Section 8.d. of Attachment 4.19-B of the State Plan; provided that such LAI Antipsychotics are administered to members during an in-state hospital behavioral health inpatient admission.

## 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 4.19-B 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.

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## G. Payments for Administrative Days

The methodology below applies to dates of service in RY26 and incorporates applicable definitions in **Section II** that apply to RY26.

| RY26 (for dates of service occurring in RY26) |
|---|
| 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.<br><br>2. The AD rate is a base per diem payment and an ancillary add-on.<br><br>3. The base per diem payment is $281.78, which represents the median nursing facility rate that was effective October 1, 2023 for all nursing home rate categories, as determined by EOHHS.<br><br>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.<br><br>5. These ratios are 0.278 and 0.382, respectively.<br><br>The resulting AD rates for RY26 are $366.81 for Medicaid/Medicare Part B eligible patients and $396.66 for Medicaid-only eligible patients.<br><br>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

The methodology below applies to dates of service in RY26 and incorporates applicable definitions in **Section II** that apply to RY26.

| RY26 (for dates of service occurring in RY26) |
|---|
| A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Rehabilitation Unit.<br><br>For dates of service in RY26, the per diem rate for such Rehabilitation Services will equal the median MassHealth RY26 Rehabilitation Hospital group per diem 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. |

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## I. APAD Carve-Outs

### 1. Payment for LARC Device

A Hospital may be paid separate from the APAD for a LARC Device if the LARC procedure is performed immediately after labor and delivery during same inpatient hospital labor and delivery stay for clinically appropriate members. For qualifying discharge, Hospitals will be reimbursed for LARC Devices in accordance with Section 8.d. of Attachment 4.19-B of the State Plan.

### 2. Payment for APAD Carve-Out Drugs

Payment to Hospitals for APAD Carve-Out Drugs administered to Members during an inpatient admission will be the Hospital's Actual Acquisition Cost of the Drug.

### 3. Payment for Behavioral Health Crisis Evaluations

A Hospital will be paid separate from the APAD for Behavioral Health Crisis Evaluations rendered in a medical/surgical inpatient setting. Hospitals will be paid for such services in accordance with Section III.E-4 of Attachment 4.19-B of the State Plan.

### 4. Payment for Behavioral Health Crisis Management Services

A Hospital will be paid separate from the APAD for Behavioral Health Crisis Management Services rendered in a medical/surgical inpatient setting. Hospitals will be paid for such services in accordance with Section III.E-5 of Attachment 4.19-B of the State Plan.

### 5. Payment for Recovery Support Navigator Services

A Hospital will be paid separate from the APAD for Behavioral Health Crisis Evaluations rendered in a medical/surgical inpatient setting. Hospitals will be paid for such services in accordance with Section III.E-6 of Attachment 4.19-B of the State Plan.

## J. Payment for Unique Circumstances

### 1. High Public Payer Hospital Supplemental Payment

#### a. Eligibility

In order to qualify for the High Public Payer Hospital Supplemental Payment, a Hospital's FY24 public payer percentage, which is the ratio of the Hospital's FY24 Gross Patient Service Revenue from government payers and free care to the Hospital's FY24 Gross Patient Service Revenue ("FY24 Public Payer Percentage"), must exceed 63% ("High Public Payer Threshold"), as determined by EOHHS based on the Hospital's FY24 Massachusetts Hospital Cost Report.

#### b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to each Hospital satisfying the eligibility criteria set forth in Section **III.J.1.a** (each an "Eligible Hospital" for purposes of this **Section III.J.1**).

"MCO" for purposes of this **Section III.J.1** includes only "traditional" MCOs, and excludes ACPPs, Senior Care Organizations (SCOs), and One Care plans.

The inpatient portion of the supplemental payment amount for each Qualifying Hospital will be determined by apportioning a total of $6.5 million to such Qualifying Hospitals on a pro-rata basis, as follows:

- First, EOHHS will calculate each Eligible Hospital's Weighted Discharge Volume by summing 60% of the Hospital's FY26 Accountable Care Partnership Plan (ACPP) and Primary Care ACO discharge volume, 20% of the Hospital's FY26 MCO discharge volume, and 20% of the Hospital's FY26 PCC Plan discharge volume;

- Second, EOHHS will calculate each Eligible Hospital's Pro-Rata Discharge Volume by dividing its Weighted Discharge Volume by the sum of all Eligible Hospitals' Weighted Discharge Volumes;

- Third, EOHHS will calculate each Eligible Hospital's HPP Ratio by:

    - Subtracting the 63% High Public Payer Threshold from that Hospital's FY24 Public Payer Percentage;

    - Multiplying that difference by 12%; and

    - Adding 2% to that product;

- Fourth, EOHHS will calculate each Eligible Hospital's Inpatient HPP Distribution Percentage by multiplying its Pro-Rata Discharge Volume by its HPP Ratio;

- Fifth, EOHHS will calculate each Eligible Hospital's Inpatient HPP Payment Factor by dividing its Inpatient HPP Distribution Percentage by the sum of all Inpatient HPP Distribution Percentages for all Eligible Hospitals; and

- Sixth, EOHHS will calculate the inpatient portion of each Eligible Hospital's supplemental payment by multiplying its Inpatient HPP Payment Factor by $6.5 million.

For purposes of this calculation, FY26 ACPP, Primary Care ACO, MCO, and PCC Plan discharge volume refers to paid inpatient discharges from the Qualifying Hospital for MassHealth Members enrolled in an ACPP, a Primary Care ACO, an MCO, or the PCC Plan, as determined by EOHHS utilizing, for the ACPP and MCO discharges, ACPP and MCO encounter data submitted by each ACPP or MCO for FY26, respectively, and residing in the MassHealth Data Warehouse as of March 31, 2027, and for the PCC Plan and Primary Care ACO discharges, Medicaid paid claims data for FY26 residing in MMIS as of March 31, 2027 for which MassHealth is primary payer. Only MCO and ACPP encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section III.J.1.a**) is considered in determining the pro rata share.

**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 2024 (FFY24) inpatient payment amount will be up to $6,000 times the total number of inpatient days for admissions beginning during FFY22, not to exceed $8.0 million.

For CHA, the Federal Fiscal Year inpatient 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 $7.5 million. Notwithstanding such maximum inpatient amount, EOHHS may make inpatient payments to CHA of up to an additional 30% of the CHA Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, and satisfying all other conditions of this **Section III.J.2.b** as it applies to CHA, so long as the total inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to CHA for the Federal Fiscal Year under this paragraph and under **Section III.F.2** of Attachment 4.19-B(1) (MA-25-0036) do not, in the aggregate, exceed the CHA Total Maximum Essential Amount. The CHA Total Maximum Essential Amount is $25.0 million.

The 30% provisions referenced above in this section may be invoked if, upon reconciliation, an applicable outpatient hospital limit would be exceeded if CHA was paid its maximum FFY26 outpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.F.2** of Attachment 4.19-B(1) (MA-25-0036), or if CHA has insufficient outpatient utilization or otherwise to support the payment of such maximum outpatient payment amount.

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 Massachusetts Hospital 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. High Public Payer Behavioral Health Service Supplemental Payment**

a. **Eligibility**

In order to qualify for the High Public Payer Hospital Behavioral Health Supplemental Payment, an Acute Care Hospital must (1) qualify for a RY26 High Public Payer Supplemental Payment pursuant to Section III.J.1; (2) operate at least one DMH-

Licensed Bed throughout RY26, and (3) have provided Inpatient Behavioral Health Services to MassHealth members in FY24.

b. **Payment Methodology**

(1) Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Hospitals that meet the qualifications described in **Section III.J.5.a**, in the aggregate amount of $9.0 million, to support access to Inpatient Behavioral Health Services for MassHealth Members, with particular emphasis on supporting access to such services for child and adolescent Members, using the APAD payment methodology to develop a proxy that takes into account the various acuity levels such Members present. EOHHS will pay qualifying hospitals in accordance with the formula set forth in **Section III.J.5.b.(2),** below.

(2) Each qualifying Hospital receives an amount as calculated by the following methodology:

**Step A. Calculate Hospital Specific Payment Amount based on Share of IP BH Days, weighted toward pediatric/adolescent days.**

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

**Step B. Calculate Hospital Specific Relative Acuity Adjusted Proxy Payment Amount, determined by APAD grouper methodology.**

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

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

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

***Glossary***: As used in this **Section III.J.5**, the following terms shall have the meanings that follow:

"BH days" refers to the total number of days in which MassHealth Members (whether fee for service or enrolled in managed care or MBHP) received Inpatient Behavioral Health Services in FY24, using data residing in MMIS and/or the Data Warehouse as of March 31, 2025.

"Hospitals" refers to qualifying Hospitals that meet the requirements of **Section III.J.5.a**, above.

"Pedi Adol" is short for "pediatric and adolescent" and refers to MassHealth members under age 18.

"Adult" refers to MassHealth members age 18 and older.

"Relative Acuity Adjusted Proxy Payment" refers to a relative acuity adjusted proxy payment calculated as follows. To develop a relative acuity adjusted proxy payment, EOHHS processed all Hospital IP BH claims (whether for fee for service members or members enrolled in managed care or MBHP) residing in MMIS and/or the Data Warehouse as of March 31, 2025, using the APAD methodology (used to price medical IP claims). The APAD methodology assigns relative acuity to each discharge and then multiplies the acuity by a base rate to establish an acuity adjusted proxy payment. EOHHS will then take the ratio of each qualifying hospital's total average relative acuity adjusted proxy payment to the sum of all qualifying hospitals' acuity adjusted proxy payments to establish each hospital's pro rata share of such total payments.

"IP" refers to inpatient.

### 6. Specialized Pediatric Service Hospital Supplemental Payment

#### a. Eligibility

In order to qualify for the Specialized Pediatric Service Hospital Supplemental Payment, a Hospital must be a Specialized Pediatric Service Hospital, as defined in **Section II**. Based on these criteria, Boston Children's Hospital, and Massachusetts General Hospital are the only hospitals eligible for this payment.

#### b. Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make $5.5 million in total aggregate supplemental payments to Specialized Pediatric Service Hospitals, with payment to each hospital based on its pro rata share of all Specialized Pediatric Service Hospitals' acute inpatient discharges of Members meeting certain criteria, according to the methodology that follows.

EOHHS will first calculate each Specialized Pediatric Service Hospital's pro rata share of all Specialized Pediatric Service Hospitals' acute inpatient discharges of members under the age of 21 and enrolled in either an ACPP or a Primary Care ACO during the period from October 1,

2024 through September 30, 2025. EOHHS will then multiply that ratio by $5.5 million to determine that Specialized Pediatric Service Hospital's supplemental payment.

**7. High Medicaid Volume Safety Net Hospital Supplemental Payment**

a. **Eligibility**

In order to qualify for this payment, a Hospital must be a High Medicaid Volume Safety Net Hospital as defined in **Section II**, and must enter into a separate payment agreement with EOHHS relating to payment as a High Medicaid Volume Safety Net Hospital. Based on these criteria, Boston Medical Center is the only hospital eligible for this payment.

b. **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 High Medicaid Volume Safety Net Hospitals to account for high Medicaid volume. The payment amount will be based on Medicaid payment and charge data for the federal fiscal year. Effective October 1, 2025, the payment will be an amount up to the variance between the Hospital's FY23 MMIS-based inpatient hospital charges and its other inpatient hospital payments made under this Attachment for the applicable federal fiscal year, not to exceed $13.8 million.

**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.

**9. [Reserved]**

**10. [Reserved]**

**11. Inpatient Discharge Add-on**

**a.** The inpatient add-on pool is $225.6 million, calculated by multiplying $480 million by 47%.

**b.** To determine each in-state acute care hospital's final adjusted inpatient discharge add-on amount, EOHHS will:

1. First, divide the inpatient add-on pool by the total number of RY26 in-state acute care hospital inpatient discharges, as determined by EOHHS based on paid claims and

encounters on file as of March 31, 2027, to calculate the final inpatient add-on amount per discharge.

2. Second, multiply the total number of RY26 inpatient discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2027, by the final inpatient add-on amount per discharge, to calculate the final inpatient add-on payment amounts.

3. Third, for each hospital, subtract the total hospital-specific interim inpatient add-on payments received in RY26, calculated as described in **Section III.J.11.c.**, from hospital-specific final inpatient add-on payment amounts, calculated in this **Section III.J.11.b.2.,** and (i) if the amount is less than $0.00, make a final true-up payment equal to the difference; or (ii) if the amount is more than $0.00, complete a recoupment equal to the difference. The total final amount after true-up or recoupment, as applicable, is the final adjusted inpatient discharge add-on amount for each hospital calculated pursuant to this **Section III.J.11.b.**

**c.** EOHHS will make four interim inpatient add-on payments in RY26. For each interim inpatient add-on payment, a new inpatient add-on amount per discharge will be calculated by dividing the pool of funding available for that payment, as determined by EOHHS, by the total number of in-state acute care hospital inpatient discharges in the applicable historic period interim dataset. The historic period interim datasets are the period July 1, 2024 – December 31, 2024 for the first interim payment, October 1, 2024 – March 31, 2025 for the second interim payment, January 1, 2025 – June 30, 2025 for the third interim payment and April 1, 2025 – September 30, 2025 for the fourth interim payment. To determine interim inpatient add-on payment amounts pursuant to this **Section III.J.11.c.**, EOHHS will multiply each in-state acute care hospital inpatient discharge from the applicable historic period interim dataset by the interim payment inpatient add-on amount.

**12. [Reserved]**

**13. Targeted Hospital Supplemental Payment**

**a. Eligibility Criteria**

In order to be eligible for a targeted hospital supplemental payment described in this **Section III.J.13**, a hospital must be either:

**iii.** A non-profit teaching acute hospital that provides medical, surgical, emergency and obstetrical services and is affiliated with a Commonwealth-owned medical school, as determined by EOHHS,

**iv.** A Freestanding Pediatric Acute Hospital, as such term is defined in Section II, above,

**v.** A freestanding cancer hospital enrolled with MassHealth as an acute inpatient hospital as of October 1, 2025,

**vi.** The acute hospital that had the lowest statewide commercial relative price in fiscal year 2019, or

**vii.** The independent hospital listed as a Group 1 Safety Net Hospital in Appendix N of the Massachusetts 1115 Demonstration that had the largest percentile of operating loss in FY2022 as reported by CHIA.

**b. Methodology**

Effective for RY26, subject to compliance with all applicable federal rules and payment limits, including hospital-specific upper payment and cost limits, EOHHS will make the targeted hospital supplemental payments described in this **Section III.J.13** to account for eligible hospitals' costs associated with Medicaid fee-for-service inpatient services. These payments are necessary to ensure ongoing provision of services to Medicaid members in a manner consistent with efficiency, economy, and quality of care, as follows:

**i.** Reserved

**ii.** Reserved

**iii.** Reserved

**iv.** Reserved

**v.** Reserved

**14. Reserved**

**15. Supplemental Payment for Continuity of Access of High Public Payer Acute Hospitals**

Effective according to the dates specified in the chart below for the rate years specified in the chart and to be paid out by the dates specified in the chart, the eligible hospitals will receive a Supplemental Payment for the Continuity of Access of High Public Payer Acute Hospitals, in accordance with the following chart. The payment amounts listed in the chart are necessary to ensure the continuation of access to essential acute hospital services for Medicaid members in the communities served by each eligible hospital, consistent with efficiency, economy, and quality of care. The amount accounts for the eligible hospital's costs associated with Medicaid fee-for-service inpatient services and is in accordance with all applicable federal rules and

payments limits, including state- and hospital-specific upper payment and cost limits. Each payment in the chart shall be paid as a single lump sum and only the single hospital, each of which is a high public payer hospital with a public payer mix above 70% for the most recent fiscal year available as reported by CHIA, listed as eligible for each payment shall receive the payment.

| **Eligible Hospital** | **RY25 New Supplemental Payments Effective October 1, 2024** | **RY25 New Supplemental Payment Effective March 28, 2025, paid by December 31, 2025** | **RY25 New Supplemental Payments Effective July 7, 2025, paid by September 30, 2026** | **RY26 New Supplemental Payments Effective December 26, 2025, paid by June 30, 2027** |
|---|---|---|---|---|
| Morton Hospital | $10,000,000 | -- | $10,000,000 | $10,000,000 |
| Holy Family Hospital | $125,000,000 | $7,000,000 | N/A | N/A |
| **Total** | **$135,000,000** | **$7,000,000** | **$10,000,000** | **$10,000,000** |

**16. Reserved**

**17. Inpatient Psychiatric Supplemental Payment**

EOHHS will make a one-time Inpatient Psychiatric Supplemental Payment to eligible hospitals in RY26, as set forth below.

**a. Definitions**

For the purpose of **Section II.J.17.a through c.**, the following definitions apply:

**1.** "Claims Period" shall mean the twelve-month period of July 1, 2024 through June 30, 2025.
**2.** "Aggregate Psychiatric Admissions" shall mean the total number of paid claims for all MassHealth members for the Claims Period as of January 1, 2026 across the eligible Hospitals' inpatient psychiatric admissions, including applicable subsets of such claims, as designated in the Payment Methodology described in **Section II.J.17.c**
**3.** "Hospital-Specific Inpatient Psychiatric Admissions" shall mean the hospital's total number of paid claims for all MassHealth members for the Claims Period as of January 1, 2026 for inpatient psychiatric admissions, including applicable subsets of such claims, as designated in the Payment Methodology described in **Section II.J.17.c**.

**b. Eligibility**

To be eligible for an Inpatient Psychiatric Supplemental Payment under **Section II.J.17**, a Hospital must:

**1.** Operate at least one service location providing psychiatric inpatient services; and

**2.** Maintain at least one inpatient bed that is licensed by the Massachusetts Department of Mental Health as a psychiatric bed as of October 1, 2025.

**c. Payment Methodology**

Inpatient Psychiatric Supplemental Payments under **Section II.J.17** will equal a total aggregate amount of $30 million, apportioned to eligible hospitals as follows:

**1.** The supplemental payment for each eligible Hospital will be determined based on the Claims Period. Effective October 1, 2025 each eligible hospital will receive one supplemental payment amount reflecting three component calculations, as follows. To ensure the continuation of access to inpatient psychiatric hospital services for Medicaid members in the communities serviced by the eligible hospital, consistent with efficiency, economy, and quality of care. The amount accounts for the eligible hospitals' costs associated with Medicaid fee-for-service inpatient services and is in accordance with all applicable federal rules and payment limits, including state- and hospital-specific upper payment and cost limits. The total aggregate amount shall be paid out by September 30, 2027.

A. $12 million will be distributed proportionally to eligible Hospitals based on inpatient psychiatric admissions according to the following calculation: (Hospital-Specific Inpatient Psychiatric Admissions / Aggregate Inpatient Psychiatric Admissions) x $12,000,000.

B. $15 million will be distributed proportionally to eligible Hospitals based on inpatient psychiatric admissions with at least one secondary diagnosis on the claim related to one or more of the following: renal, endocrinology, circulatory, substance use disorder, and/or gastroenterology, according to the following calculation: (Hospital-Specific Inpatient Psychiatric Admissions with applicable secondary diagnoses / Aggregate Inpatient Psychiatric Admissions with applicable secondary diagnoses) x $15.00,000.

C. $3 million will be distributed proportionally to eligible hospitals based on inpatient psychiatric admissions following the EPIA protocol, according to the following calculation: (Hospital-Specific Inpatient Psychiatric Admissions following the EPIA protocol / Aggregate Inpatient Psychiatric Admissions following the EPIA protocol) x $3,00,000.

**2. Total Supplemental Payment Calculation**

EOHHS will combine each Hospital's resulting payment amounts from each component described in **Section II.J.17.c.1** to calculate the Hospital's total Inpatient Psychiatric Supplemental Payment amount.

**K. Reserved**

## L. Clinical Quality Incentives Program

The Clinical Quality Incentives (CQI) program provides opportunities for Hospitals to earn incentive payments for quality reporting and performance on quality measures. RY26 CQI payments are contingent upon the Hospital's performance of all applicable requirements described in this Section III.L. Payments will be determined based on overall quality score, calculated as described in Section III.L.5 based on the CQI program measures and domains described in Section III.L.2 and the performance assessment methodology (PAM) described in Section III.L.3. The overall quality score is then multiplied by the hospital's eligible incentive dollars that are available to the hospital, as described in Section III.L.5.

### 1. Clinical Quality Incentives Program Requirements Overview

To be eligible for CQI program incentive payments, Hospitals must adhere to each of the following standards:

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

b. **Measure Specifications:** Hospitals shall comply with all data collection and submission guidelines, for all applicable measures listed in **Table L-1** and **L-2**, according to the specifications as published in the applicable EOHHS Technical Specifications Manual, to ensure completeness and accuracy of data submitted;

c. **Reporting Requirements:** Hospitals shall meet data submission deadlines, performance evaluation periods, data reporting formats, portal registration requirements, and participant forms submission requirements set forth in the RY26 Hospital RFA or as otherwise specified by EOHHS; and

d. **Data Validation:** Hospitals shall meet the minimum data reliability standards and pass data validation.

### 2. CQI Program Measures and Domains

a. **Measure and Reporting Overview**: CQI Program measures are grouped into four core quality measure domains ("Core Quality Measure Domain(s)") and two specialty quality measure domains ("Specialty Quality Measure Domain(s)"). Hospitals are required to report data for individual quality measures that are chart-based or data entry-based. Claims-based and readmission measures will be calculated by EOHHS. Registry data (e.g., safety measures), and Patient Experience (adult only) will be obtained by EOHHS through the National Health Safety Network and CMS, respectively.

b. **Hospital Accountability:** Hospitals are accountable for performance on measures for which they are eligible, where the Hospital meets the measure specifications outlined in the EOHHS Technical Specifications Manual, available through the following link: https://www.mass.gov/info-details/masshealth-cqi-technical-specifications-manuals

c. **Core Quality Measure Domains:** All Hospitals must participate in four Core Quality Measure Domains: Care Coordination/Integration of Care; Care for Acute and Chronic Conditions; Patient Safety and Patient Experience. Pediatric measures are also included in the Core Quality Measure Domains. The specific measures for each Core Quality Measure Domain are listed in **Table L-1**, below. Hospitals are required to report pediatric measures for which they are eligible, where the Hospital meets the measure specifications outlined in the EOHHS Technical Specifications Manual.

**Table L-1: CQI Program Core and Specialty Quality Domains Measures**

| (a) Quality Domain | (b) Measure ID# | (c) Measure Steward: Measure Name | (d) Data. and Measure Type | (e) Population |
|---|---|---|---|---|
| Care Coordination / Integration | **PED-1** | **Center of Excellence for Pediatric Quality Measurement: Pediatric All-Condition Readmission Measure (CBE ID2393)** | **Claims-Based, Outcome Measure** | **All Medicaid** |
| | **CCI-2** | **NCQA FUM: Follow-up After ED Visit for Mental Illness (CBE ID 3489) (7-Day and 30-Day)** - *Treated as 1 measure which includes 2 sub-measures* | **Claims-based, Process Measures** | **All Medicaid** |
| | **CCI-3** | **NCQA FUA: Follow-up After ED Visit for Alcohol or Other Drug Abuse or Dependence (CBE ID 3488) (7-Day and 30-Day)** - *Treated as 1 measure which includes 2 sub-measures* | **Claims-based, Process Measures** | **All Medicaid** |
| | **CCI-4** | **NCQA FUH: Follow-up After Hospitalization for Mental Illness (CBE ID 0576) (7-Day and 30- Day)** - *Treated as 1 measure which includes 2 sub-measures* | **Claims-based, Process Measures** | **All Medicaid** |
| **Care for Acute and Chronic Conditions** | **SUB-2** | **TJC SUB-2: Alcohol Use – Brief Intervention Provided or Offered (CBE ID 1664)** | **Chart-Abstracted. Process Measures** | **All Medicaid** |
| | **SUB-3** | **TJC SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge (CBE ID 1663)** | **Chart-Abstracted, Process Measures** | **All Medicaid** |
| | **OP-1e** | **CMS 506v5: Safe Use of Opioids – Concurrent Prescribing (CBE ID 3316e)** | **Data Entry, Process Measure** | **All Payer** |

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| (a) Quality Domain | (b) Measure ID# | (c) Measure Steward: Measure Name | (d) Data. and Measure Type | (e) Population |
|---|---|---|---|---|
| | PED-2 | NCQA: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (CBE ID 0058) | Claims-Based, Process Measure | All Medicaid |
| Patient Safety | HAI-1 | CDC: Central Line-Associated Bloodstream Infection (CLABSI) | National Registry-Based, Outcome Measures | All-Payer |
| | HAI-2 | CDC: Catheter-Associated Urinary Tract Infection (CAUTI) | National Registry-Based, Outcome Measures | All-Payer |
| | HAI-3 | CDC: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA) | National Registry-Based, Outcome Measures | All-Payer |
| | HAI-4 | CDC: Clostridium Difficile Infection (CDI) | National Registry-Based, Outcome Measures | All-Payer |
| | HAI-5 | CDC: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI) | National Registry-Based, Outcome Measures | All-Payer |
| Patient Experience | HCAHPS | AHRQ: Hospital Consumer Assessment of Healthcare Provider Systems Survey (HCAHPS) This measure includes 7 survey dimensions: 1) nurse communication, 2) doctor communication, 3) responsiveness of Hospital staff, 4) communication about medicines, 5) discharge information, 6) overall rating and 7) three item care transition. | National Survey-Based, Outcome Measure | All-Payer |
| Perinatal Care | MAT-4 | TJC PC-02: Cesarean Birth, NTSV (CBE ID 0471) | Chart-abstracted, outcome measure | All Medicaid |
| | NEWB-3 | TJC PC-06: Unexpected Newborn Complications in Term Infants (CBE ID 0716) | Chart-abstracted, outcome measure | All Medicaid |

| (a) Quality Domain | (b) Measure ID# | (c) Measure Steward: Measure Name | (d) Data. and Measure Type | (e) Population |
|---|---|---|---|---|
| | SOC | TJC PC-07: Severe Obstetric Complications | Data entry, outcome measure | All Payor |
| Behavioral Health Care | BHC-2 | CMS IPFQR: Medication Continuation Following Inpatient Psychiatric Discharge (CBE ID 3205) | Claims-based, process measure | All Medicaid |
| | BHC-3 | CMS IPFQR: Screening for Metabolic Disorders | Data entry, process measure | All Payor |

d.

e. **Measure Calculations and Case Minimums:** Each measure will be calculated using the following methods described below. For measures to be included in EOHHS's performance assessment, Hospital's reported or available data for each measure must meet minimum case requirements. Hospitals that do not meet the case minimum for the measurement periods are not eligible for quality measure performance scoring on that measure. Minimum case requirements, measurement periods, and any applicable reporting method requirements, are specified in the CQI Technical Specifications Manual for each measure.

i. **Chart-Based Measure Rate Result:** A measure rate is calculated by dividing the numerator by the denominator, to obtain a percentage for each individual chart-based measure. All measure rate results are rounded to the nearest integer (e.g., 3.3 is rounded to 3.0; 3.5 is rounded to 4.0).

ii. **Claims-Based Measure Rate Result:** A measure rate is calculated by dividing the numerator by the denominator, to obtain a percentage for each individual claims-based measure.

iii. **Healthcare-Associated Infection Measures Results.** EOHHS will obtain each Hospital's standardized infection ratio (SIR) output value and supporting data elements for each HAI measure , as calculated by the CDC, from the CDC's NHSN registry surveillance tracking system via the MassHealth NHSN Group.

iv. **Patient Experience and Engagement Measure Result:** EOHHS will obtain the archived HCAHPS measure "top box" raw results directly from the CMS Provider Data Catalog website that are posted in rounded integer format. The "top-box" raw score for each of the 5 survey dimensions represents the percentage of a Hospital's patients who chose the most positive, or "top-box," response to a survey item. The "top box" raw result calculation includes a AHRQ patient-mix adjustment and survey-mode adjustment.

v. **Other measure results:** The OP-1e, SOC, and BHC-3 measures results will be calculated using Hospital submissions of aggregated numerator and denominator values and other related elements based on all-payer data submissions to CMS.

### 3. Performance Assessment Methodology (PAM)

Each Hospital will have the opportunity to achieve its full eligible CQI program payment for excellent quality performance, scored using attainment thresholds, performance goals, and improvement targets, as applicable by measure. The scoring processes utilize measures that roll up to a domain score (e.g., sum of the Hospital points earned for each measure/the maximum number of points in a domain) and weight domain scores to calculate a single overall quality score that includes 100% weighting of measure domains available to hospitals. If a hospital is not eligible for a measure domain, the weighting is redistributed among the measure domains for which the hospital is eligible. The overall quality score is calculated as a single ratio between 0 and 1.

a. **Measure Performance Benchmarks:** Each Hospital's performance on CQI program P4P measures will be assessed for reaching a minimum threshold benchmark to determine achievement points for meeting performance toward goal or a goal benchmark for high performance. Improvement points may also be earned, as applicable, by reaching improvement targets which may be earned whether the Hospital reaches threshold or exceeds the goal benchmarks. The improvement target represents a specified percentage point improvement for each applicable measure, where a Hospital may earn improvement points. Improvement is assessed by comparing the Hospital's performance to their baseline or the most recent year performance where a Hospital reached targeted improvement.
b. The following benchmarks are established for each measure:

   i. **Threshold:** The threshold benchmark represents the minimum level of performance that must be attained on each individual measure to earn achievement points (Between 1-9 points).
   ii. **Goal:** The goal benchmark represents a high level of performance on each individual measure where a Hospital may score a maximum number of achievement points (10 points).

**Table L-3** summarizes threshold, goal and improvement targets for RY26 CQI Program P4P measures.

**Table L-3: CQI Benchmarks for each RY2024 P4P measure**

| Row Number | Quality Domain | Measure ID | Measure Name | Performance Threshold | Performance Goal | Improvement Target |
|---|---|---|---|---|---|---|
| 1 | Reserved | | | | | |
| 2 | Care Coordination / Integration | PED-1 | Pediatric All-Condition Readmission | Better or no different than the state average (based on hospital's adjusted rate) | | 1% point decrease (based on hospital's unadjusted rate) |
| 3 | Care Coordination / Integration | CCI-2 | Follow-up After ED Visit for Mental Illness | 7 day: 40%<br>30 day: 50% | 7 day: 85%<br>30 day: 90% | 7 day: 5% points increase |

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| Row Number | Quality Domain | Measure ID | Measure Name | Performance Threshold | Performance Goal | Improvement Target |
|---|---|---|---|---|---|---|
| | | | | | | 30 day: 5% points increase |
| 4 | Care Coordination / Integration | CCI-3 | Follow-up after ED Visit for Substance Use | 7 day: 25%<br>30 day: 30% | 7 day: 45%<br>30 day: 55% | 7 day: 4% points increase<br>30 day: 5% points increase |
| 5 | Care Coordination / Integration | CCI-4 | Follow-up After Hospitalization for Mental Illness | 7 day: 20%<br>30 day: 40% | 7 day: 40%<br>30 day: 60% | 7 day: 4% points increase<br>30 day: 4% points increase |
| 6 | Care for Acute and Chronic Conditions | SUB-2 | Alcohol Use – Brief Intervention Provided or Offered | 15% | 60% | 5% points increase |
| 7 | Care for Acute and Chronic Conditions | SUB-3 | Alcohol & Other Drug Use Disorder – Treatment Provided/Offered at Discharge | 40% | 75% | 5% points increase |
| 8 | Care for Acute and Chronic Conditions | OP-1e | Safe Use of Opioids – Concurrent Prescribing | 24% | 14% | 2% points decrease |
| 9 | Care for Acute and Chronic Conditions | PED-2 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis | 85% | 97% | 2% points increase |
| 10 | Patient Safety | HAI 1-5 | CLABSI, CAUTI, MRSA, CDI, SSI | Standard Infection Ratio (SIR) value <= to 1 or no different than other hospitals (nationally)<br>*Confidence intervals will be calculated for the MassHealth aggregate SIR, through available NHSN software to identify Hospitals that may have an SIR greater than 1.0, but not significantly greater than the MassHealth aggregate SIR, thus meeting the measure threshold/goal benchmark. | | For each measure: The Standard Infection Ratio (SIR) value is < 1, **and** where confidence intervals will be calculated for the MassHealth aggregate SIR, to identify Hospitals that are better than the MassHealth aggregate, thus performing above the threshold/goal benchmark. |
| 11 | Patient Experience | HCAHPS | Hospital Consumer Assessment of Healthcare Provider System Survey | Composite score of .50 Composite Score = Average of the top box scores | Composite score of .80 Composite Score = Average of | .01 - .05 improvement in a Hospital's composite score over the prior year |

| Row Number | Quality Domain | Measure ID | Measure Name | Performance Threshold | Performance Goal | Improvement Target |
|---|---|---|---|---|---|---|
| | | | | | the top box scores | |
| 12 | Perinatal Care | MAT-4 | Cesarean Birth, Nulliparous, Singleton, Vertex | 32% | 22% | 2% points decrease |
| 13 | Perinatal Care | NEWB-3 | Unexpected Newborn Complications in Term Infants | >50 and <=70 per 1000 | <=50 per 1000 | N/A |
| 14 | Perinatal Care | SOC | Severe Obstetric Complications | Better or no different than the average state rate | | N/A |
| 15 | Behavioral Health Care | BHC-2 | Medication Continuation Following Inpatient Psychiatric Discharge | 30% | 65% | 5% points increase |
| 16 | Behavioral Health Care | BHC-3 | Screening for Metabolic Disorders | 70% | 93% | 5% points increase |

c. **Individual Quality Measure Scoring:** The method for CQI Program measure scoring depends on the measure or type of measure. Hospitals can earn a range of attainment and improvement quality points based on the Hospital's measure performance rate, relative to achieving attainment (threshold or goal) benchmarks and improvement targets.

i. **Standard Scoring:** The following quality measure scoring method applies to all measures except those governed by the scoring methods described in Section III.L.3.b.ii through Section III.L.3.b,v.
**Attainment Points:** A Hospital can earn 10 attainment points based on meeting or exceeding the goal benchmark, or a Hospital can receive a range of 1-9 points based on the Hospital's measure performance relative to the goal benchmark.
If a Hospital's rate for the measure is less than the attainment threshold, it will receive zero (0) attainment points, but is eligible for the improvement points opportunity described below for those measures with an improvement target.

1. **Improvement Points Opportunity:** A Hospital can earn 5 additional improvement points if the Hospital's measure performance rate meets or exceeds the improvement target for the measure, compared to either the baseline period for initial improvement, or the most recent performance year for which improvement points were earned (whichever is the better rate). However, Hospitals may earn 7 improvement points, rather than 5, if the Hospital's measure performance did not meet threshold, and did not receive attainment points. Once a Hospital reaches threshold performance, the Hospital may only earn 5 additional improvement points. The baseline period for improvement is the first year the measure was in reporting-only or pay-for-reporting status in the Hospital Quality CQI program;

provided however that measures that were in P4P status in RY23 will use RY2023 Hospital Quality CQI program performance as baseline..

A. If the Hospital failed validation in the previous reporting year, data from that period is considered invalid for use in calculating comparative year performance. Therefore, the Hospital would not be eligible for improvement points. However, the Hospital may be eligible for attainment points on each chart-based measure, based on calculation of calendar year 2026 data reported on the measure in RY2026, if it passed validation on these measures.
B. Partial points may not be earned if the improvement target is not met during the performance year, however a stepwise approached is used so that if a target is met (e.g., cumulatively in future performance periods), the full 5 points are earned in that future performance period.
C. If a Hospital's performance improves one year and declines the following year, improvement is based on the most recent highest performing year.

ii. **Safety, Readmission, and Severe Obstetric Complications Measure Scoring.** A Hospital can earn 10 attainment points per each safety, readmission, or severe obstetric complications measure based on meeting the threshold or goal benchmark. If a Hospital's measure performance does not meet the attainment threshold, it will receive zero (0) attainment points. For safety measures, hospitals may receive 5 additional points per measure if their performance statistically exceeds State Hospital performance.

iii. **Patient Experience Measure Scoring.** The Patient Experience (HCAHPS) involves the Hospital's measure composite scores and improvement in composite scores over the prior year or the highest of the most recent performance year, to determine an improvement score. Improvement is not awarded based on comparison to the prior year if performance had declined and is lower than in prior years.

iv. **Pay-For-Reporting (P4R) Measure Scoring.** A Hospital can earn 10 attainment points for measures that are in P4R status and meet reporting and data validation requirements.

v. **Reporting-Only Measures.** Reporting-only measures are not scored.

d. **Domain Scoring:** There are two methods for calculating domain scores:

i. **For all domains except the Patient Experience domain:** The domain score is calculated by taking the number of points associated with measures in a domain that a Hospital earned (attainment + improvement points where applicable) divided by the maximum number of attainment points that the Hospital could have earned per measure (10 points) multiplied by the number of measures the Hospital was eligible for. The domain score that is calculated represents a ratio value between 0-1 (inclusive of 0 and 1). In cases where the domain score is calculated and yields a greater than 1 score, the domain score value is capped at 1.

Domain Score Calculation: (Sum of attainment and improvement points for measures in the domain) / (10 x the number of measures a Hospital was eligible for in the domain)

ii. **Patient Experience Domain scoring**: A domain score is calculated by taking a Hospital's measure composite score and dividing it by the goal composite score. If the Hospital also improved over the prior year (or highest prior year), an improvement multiplier of 2 will be applied for improvement in the Hospitals composite score (minimum improvement in composite score of .01, maximum of .05). The domain score that is calculated represents a ratio value between 0-1 (inclusive of 0 and 1). In cases where the domain score is calculated and yields a greater than 1 score, the domain score value is capped at 1.

Domain Score Calculation: [(Hospital member experience composite measure Score)/(Goal member experience composite Score)] + (2 x score improvement the Hospital's composite score over the prior year (or highest prior year))

Composite score improvement must be at least .01 and at most .05 to receive an improvement score and will be rounded.

e. **Domain Weighting:** A Hospital's domain weights will be contingent on the Hospital's domain participation. For example, some Hospitals may be eligible to participate in the core and perinatal domains, while other Hospitals may be eligible to participate in the core and behavioral health care domains. Hospital domain weights must equal 1, and must include only the domains for which the Hospital is required to participate.

f. **Overall Quality Score:** Each hospital's overall quality score is calculated by multiplying the domain scores for each domain by the domain weights for each domain in which the hospital is eligible to participate, and then summing the resulting weighted domain scores together. Each hospital's overall quality score will be a number between 0 and 1.

Overall Quality Score Calculation: Sum of each (Domain Score X Domain Weighting) = Ratio between 0-1

**5. CQI Program Payment Methodology**

A Hospital's CQI program payment is determined based on its overall quality score and on the maximum CQI program payment that the Hospital is eligible to earn, based on its Medicaid pro-rata share of $250,000,000. Each hospital's CQI program payment is calculated as follows:

a. The maximum eligible CQI program payment for each Hospital is determined, using calendar year 2026 data, by dividing each Hospital's Hospital-reported Medicaid gross patient service revenues by all Hospital-reported Medicaid Gross Patient Service Revenues, and then multiplying the quotient by $250,000,000.

b. Each Hospital's maximum eligible CQI program payment will then be multiplied by the Hospital's overall quality score (a ratio from 0-1) assessed through the PAM to determine the Hospital's actual CQI program payment.

c. Each Hospital's actual CQI program payment paid through this Section III.L.5 is in proportion to the hospital's Medicaid fee-for-service inpatient utilization.

## IV. [Reserved]

## V. [Reserved]

## VI. 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. [Reserved]

### 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.

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

## VII. 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:

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 the inpatient admission, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

2. Psychiatric, Rehabilitation, 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.*

## VIII. Serious Reportable Events

The non-payment provisions set forth in this Section VIII 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 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.

**State Plan under Title XIX of the Social Security Act**
**State: Massachusetts**
**Methods Used to Determine Rates of Payment for Acute Inpatient Hospital Services**
**Exhibit 1: RY22 Payment Method for Critical Access Hospitals Effective**
**October 1, 2021 through September 30, 2022**

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# EXHIBIT 1
## Rate Year 2026 Payment Method Applicable to Critical Access Hospitals
## Effective October 1, 2023 through September 30, 2026

### Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY26 (October 1, 2025 through September 30, 2026).

### 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 RY26 (October 1, 2025 through September 30, 2026), 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, 2025 through September 30, 2026, 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 RY26, 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 the RY26, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY22 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 21, of the Hospital's FY22 CMS-2552-10 cost report, by the Hospital's number of FY22 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY22 paid claims data residing in MMIS as of May 4, 2023, for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY22 and RY24, resulting in the inflation-adjusted RY26 cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's RY26 inflation-adjusted cost per discharge, as determined above, by each Hospital's FY22 inpatient casemix index (CMI), as determined by EOHHS.

(4) EOHHS then multiplied the result by 0.964.

(5) That result is RY26 CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the APAD Base Payment used in the APAD calculations for all other Hospitals for admissions in RY26.

(6) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying RY26 CAH-Specific Total Standard Rate per Discharge by the applicable RY26 discharge-specific MassHealth DRG Weight.

Table 6 demonstrates the payment calculation for a Critical Access Hospital's standard APAD claim that does not also qualify for an outlier payment.

| | | | |
|---|---|---|---|
| **DRG Model Example - Massachusetts Critical Access Hospitals** | | | |
| (Values are for demonstrative purposes only) | | | |
| | | | |
| **Table 6: Critical Access Hospital Interim APAD claim** | | | |
| (Values are for demonstrative purposes only) | | | |
| **Hospital:** | **Sample Critical Access Hospital** | | |
| **DRG:** | **203, Chest Pain** | | |
| **SOI:** | **2** | | |
| | | | |
| **Line** | **Description** | **Value** | **Calculation or Source** |
| 1 | RY25 CAH-Specific Total Standard Rate per Discharge | $15,000.00 | RY26 RFA |
| 2 | MassHealth DRG Weight | 0.3827 | Appendix C, Chart C |
| **3** | **Total Case Payment = Adjudicated Payment Amount per Discharge (Interim APAD)** | **$5,740.50** | Line 1 * Line 2 |

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 of Exhibit 1**, above.

### (B) Post RY26 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2026 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 FY26 as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY26 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 RY26 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for FY26, but excluding, if applicable, any supplemental payments made

to a Critical Access Hospital based on its status as a qualifying Hospital as defined in Section III.J 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 RY26 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, 2027. Assuming this date, the settlement will be complete by September 30, 2028.