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State/Territory Name: MA

State Plan Amendment (SPA) #: 23-0036

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

September 25, 2023

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

RE: State Plan Amendment (SPA) TN 23-0036

Dear Assistant Secretary Levine:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 23-0036. Effective May 1, 2023, this amendment revises rate year 2023 reimbursement for acute inpatient hospital services to include additional supplemental payments to qualifying providers with established criteria**.** The amendment also includes technical changes and updates to the Pay for Performance program and the Clinical Quality Incentive program to improve clarity.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. This letter is to inform you that Massachusetts 23-0036 is approved effective May 1, 2023. The CMS-179 and approved plan pages are enclosed.

If you have any questions, please contact Novena James-Hailey at (617) 565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director

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: 23-0036

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
05/01/2023

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 23 $ 15,866,000
b. FFY 24 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-A(1) pp. 1-76 and Exhibit 1 pp. 1-3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A(1) pp. 1-71 and Exhibit 1 pp. 1-3

9. SUBJECT OF AMENDMENT

An amendment regarding methods of payment 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:
  Not required under 42 CFR 430.12(b)(2)(i)

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Mike Levine

13. TITLE
Assistant Secretary for MassHealth

14. DATE SUBMITTED
06/30/23

15. RETURN TO

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

FOR CMS USE ONLY

16. DATE RECEIVED
June 30, 2023

17. DATE APPROVED
September 25, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 1, 2023

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

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 RY23.

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:

   - RY23 admissions at in-state Acute Hospitals beginning on or after October 1, 2022 through September 30, 2023, and

   - inpatient payments made to in-state Acute Hospitals on an administrative day, psychiatric or rehabilitation per diem basis for RY23 dates of service on or after October 1, 2022 through September 30, 2023.

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 RY23 on or after October 1, 2022 through September 30, 2023**.**

3. The supplemental payment methodologies specified in **Section III.J** are effective in RY23 beginning October 1, 2022 through September 30, 2023.

4. The Pay-for-Performance payment methodologies specified in **Section III.K** are effective in RY23 beginning October 1, 2022 through September 30, 2023.

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 RY23 (as defined in **Section II**) to reflect updates implemented effective with the RY23 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.

(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 in the **RY23** column, below, apply during **RY23** (as defined below).

Defined Term	Definition Applicable During RY23
RY22	October 1, 2021 through September 30, 2022.
RY23	October 1, 2022 through September 30, 2023.
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), Primary Care ACOs, and MCO-Administered ACOs.
Accountable Care Partnership Plan (ACPP)	A type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), and which is organized primarily for the purpose of providing health care services.
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.

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 RY23
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 or for APAD Carve-Out Drugs, which may be paid separately as described in **Section III.I**. Calculation of the APAD is discussed in **Section III.B** (utilizing RY23 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.
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 38, unless otherwise specified.
APAD Base Year	The hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY19, using FY17 Massachusetts Hospital cost reports as screened and updated as of July 24, 2018.
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.
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

Defined Term	Definition Applicable During RY23
	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 Evaluation	An evaluation provided by qualified clinical professionals to members experiencing a behavioral health crisis in an acute inpatient setting. The evaluation includes the initial assessment of risk, diagnosis, and treatment needs, as well as the initial clinical stabilization interventions, and the determination and coordination of appropriate disposition.
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.
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

Defined Term	Definition Applicable During RY23
	the Hospital's MassHealth or all-payer discharges. The weight for each APR-DRG is based on Massachusetts data.
Center for Health Information and Analysis (CHIA)	The Center for Health Information and Analysis established under M.G.L. c. 12C.
Community-based Physician	Any physician or physician group practice, excluding interns, residents, fellows, and house officers, who is not a Hospital-Based Physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths.
Contract	See RFA and Contract.
Critical Access Hospital (CAH)	An acute hospital that, prior to October 1, 2022, 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 FY19 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 RY23), and the Fixed Outlier Threshold.

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Defined Term	Definition Applicable During RY23
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.
Excluded Units	Non-Acute Units as defined in this section; any unit which has a separate license from the Hospital; psychiatric and substance use disorder units; and non-distinct observation units.
Executive Office of Health and Human Services (EOHHS)	The single state agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.
Fiscal Year (FY)	The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. This period coincides with the federal fiscal year (FFY). FY23 begins on October 1, 2022 and ends on September 30, 2023.
Fixed Outlier Threshold	For RY23, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $39,925.00.
Freestanding Pediatric Acute Hospital	A Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.
Gross Patient Service Revenue	The total dollar amount of a Hospital's charges for services rendered in a Fiscal Year.

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Defined Term	Definition Applicable During RY23
High Medicaid Volume Freestanding Pediatric Acute Hospital	A Freestanding Pediatric Acute Hospital with more than 1,000 Medicaid discharges in FY12 for which a SPAD was paid, as determined by paid claims in MMIS as of May 11, 2013, and for which MassHealth was the primary payer.
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: a. operates under a hospital license issued by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111 § 51; b. is Medicare certified and participates in the Medicare program; and c. has more than fifty percent (50%) of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds, as determined by DPH and currently utilizes more than fifty percent (50%) of its beds exclusively as such, as determined by EOHHS.
Hospital-Based Physician	Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Inpatient Services to Members at a site for which the Hospital is otherwise eligible to receive payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.
Hospital Discharge Data (HDD)	Hospital discharge filings for FY19 provided and verified by each hospital, submitted to CHIA, and screened and updated by CHIA. HDD is used for

Defined Term	Definition Applicable During RY23
	determining casemix as part of the APAD rate development for purposes of **Section III.B**, as applicable to RY23
Inflation Factors for Capital Costs	For price changes between RY04 and RY18 and between RY19 and RY23, 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 RY23 are as follows: • 0.7% reflects the price changes between RY04 and RY05 • 0.7% reflects the price changes between RY05 and RY06 • 0.8% reflects the price changes between RY06 and RY07 • 0.9% reflects the price changes between RY07 and RY08 • 0.7% reflects the price changes between RY08 and RY09 • 1.4% reflects the price changes between RY09 and RY10 • 1.5% reflects the price changes between RY10 and RY11 • 1.5% reflects the price changes between RY11 and RY12 • 1.2% reflects the price changes between RY12 and RY13 • 1.4% reflects the price changes between RY13 and RY14 • 1.5% reflects the price changes between RY14 and RY15 • 1.3% reflects the price changes between RY15 and RY16 • 0.9% reflects the price changes between RY16 and RY17 • 1.3% reflects the price changes between RY17 and RY18 • 2.1108% reflects the price changes between RY18 and RY19 • 1.5% reflects the price changes between RY19 and RY20 • 1.5% reflects the price changes between RY20 and RY21 • 1.0% reflects the price changes between RY21 and RY22 • 1.7% reflects the price changes between RY22 and RY23
Inflation Factors for Operating Costs	For price changes between RY04 and RY07, and between RY09 (starting with admissions beginning December 7, 2008) and RY23, 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

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Defined Term	Definition Applicable During RY23
	is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY23 are as follows: • 1.186% reflects price changes between RY04 and RY05 • 1.846% reflects price changes between RY05 and RY06 • 1.637% reflects price changes between RY06 and RY07 • 3.300% reflects price changes between RY07 and RY08 • 3.000% reflects price changes between RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008 • 1.424% reflects price changes between RY08 and RY09 for admissions beginning from December 7, 2008 through September 30, 2009 • 0.719% reflects the price changes between RY09 and RY10* • 1.820% reflects the price changes between RY10 and RY11 • 1.665% reflects the price changes between RY11 and RY12 • 1.775% reflects the price changes between RY12 and RY13 • 1.405% reflects the price changes between RY13 and RY14 • 1.611% reflects the price changes between RY14 and RY15 • 1.573% reflects the price changes between RY15 and RY16 • 1.937% reflects the price changes between RY16 and RY17 • 2.26% reflects the price changes between RY17 and RY18. • 2.183% reflects the price changes between RY18 and RY19. • 2.236% reflects the price changes between RY19 and RY20 • 1.854 % reflects the price changes between RY20 and RY21 • 1.433% reflects the price changes between RY21 and RY22 • 2.451% reflects the price changes between RY22 and RY23 ** 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 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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Defined Term	Definition Applicable During RY23
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 RY23 Period methodology). For RY23 Period, the Marginal Cost Factor is 60%.

Massachusetts-specific Wage Area Index	Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage. Massachusetts Hospitals' wages and hours were determined based on CMS's FY 2023-April-29-2022-Wage-Index-PUF zip file, downloaded June 6, 2022 from the CMS web site at www.cms.hhs.gov (the "CMS File"). Each Hospital was assigned to a wage area according to CMS's FY 2022 IPPS FR and CN Impact File from the CMS web site at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page (FY2022 Impact File), except that:
	• Brigham and Women's Hospital and Massachusetts General Hospital were assigned to the Boston wage area and their wages and hours included in the Boston area;
	• The following hospitals were redesignated as follows:
	  ○ Baystate Medical Center and Cooley Dickinson Hospital from Springfield to Worcester,
	  ○ Beverly Hospital, Emerson Hospital, Lahey Hospital, Lowell General Hospital, Metrowest Medical Center, Mount Auburn Hospital, Newton-Wellesley Hospital, and North Shore Medical Center from Cambridge-Newton-Framingham to Boston,
	  ○ St. Vincent Hospital and Umass Memorial Medical Center from Worcester to Boston, and
	  ○ Southcoast Hospitals Group from Providence-Warwick to Boston; and
	• PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined by EOHHS from the hospital's license (PPS-exempt hospitals are not included in the FY2022 Impact File).

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Defined Term	Definition Applicable During RY23
	The area's wage index 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 March 28, 2022. For any such redesignated Hospital, its Massachusetts-specific wage area index was calculated based on the wages and hours, determined from the CMS File, of (i) the redesignated hospital, (ii) all other hospitals redesignated to that same area, and (iii) all hospitals assigned to that area, combined.
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 RY23.
Medicaid Management Information System (MMIS)	The state-operated system of data processes, certified by CMS that meets federal guidelines in Part 11 of the State Medicaid Manual.
Member	A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.
Non-Acute Unit	A chronic care, Rehabilitation, or skilled nursing facility unit within a Hospital.
Outlier Payment	A hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section III.C**, utilizing the methodology applicable to RY23 .

<table>
<tr><th>Defined Term</th><th>Definition Applicable During
RY23</th></tr>
<tr><td>Primary Care ACO</td><td>A type of ACO with which the MassHealth agency contracts under its ACO program.</td></tr>
<tr><td>Primary Care Clinician Plan (PCC Plan)</td><td>A comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive primary care, Behavioral Health, and other medical services</td></tr>
<tr><td>Rate Year (RY)</td><td>Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table:

<table>
<tr><th>Rate Year*</th><th>Dates</th></tr>
<tr><td>RY04</td><td>10/1/2003 – 9/30/2004</td></tr>
<tr><td>RY05</td><td>10/1/2004 – 9/30/2005</td></tr>
<tr><td>RY06</td><td>10/1/2005 – 9/30/2006</td></tr>
<tr><td>RY07</td><td>10/1/2006 – 10/31/2007</td></tr>
<tr><td>RY08</td><td>11/1/2007 – 9/30/2008</td></tr>
<tr><td>RY09</td><td>10/1/2008 – 10/31/2009</td></tr>
<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 - 9/30/2022</td></tr>
</table>

*In future rate years, Hosp ta s w be pa d n n accordance w th th s Attachment (unt amended).</td></tr>
<tr><td>Rehabilitation Services</td><td>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</td></tr>
</table>

Defined Term	Definition Applicable During RY23
	expectation of significant improvement that will be of practical value to the Member measured against his/her condition at the start of the rehabilitation program.
Rehabilitation Unit	A distinct unit of rehabilitation beds licensed by the Department of Public Health (DPH) as rehabilitation beds, in a licensed Acute Hospital that provides comprehensive Rehabilitation Services to Members with appropriate medical needs.
RFA and Contract	The Request for Applications and the agreement executed between each selected Hospital and EOHHS that incorporates all of the provisions of the RFA.
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.
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. SFY23 begins on July 1, 2022, and ends on June 30, 2023.
Standard Payment Amount Per Discharge (SPAD)	A payment methodology that was utilized in prior Rate Years. The SPAD was a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which was the complete fee-for-service payment for an acute episode of illness, excluding additional fee-for-service payment for services as described in prior acute inpatient hospital SPAs, including TN-013-020. Calculation of the SPAD was discussed in **Section III.B** of TN-013-020. This payment methodology was replaced by the APAD payment methodology in RY15.

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Defined Term	Definition Applicable During RY23
Total Case Payment	The sum, as determined by EOHHS, of the APAD and, if applicable, any Outlier Payment (applying RY23 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 RY23 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 and APAD Carve-Out Drugs, respectively, as described in **subsection I.1** and **I.2**, 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 and APAD Carve-Out Drugs. 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. The RY23column applies to admissions occurring in RY23, and incorporates applicable definitions in **Section II** that apply to RY23.

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RY23
(for admissions occurring in RY23)

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 payment for LARC Devices or APAD Carve-Out Drugs, if applicable, 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; (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 FY19.

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RY23
(for admissions occurring in RY23)

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 $11,566.32.

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RY23
(for admissions occurring in RY23)

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 August 11, 2021. Specific costs and discharges are included and excluded as follows:

Average Cost per Discharge: treatment of costs and discharges	
Inc uded	Exc uded
Tota non-exc uded costs of prov d ng Inpat ent Serv ces	Costs and d scharges from Exc uded Un ts.
Rout ne outpat ent costs assoc ated w th adm ss ons from the Emergency Department	Profess ona serv ces
Rout ne and anc ary outpat ent costs resu t ng from adm ss ons from Observat on status	Cap ta costs and d rect med ca educat on costs.
Cost centers dent f ed as the superv s on component of phys c an compensat on and other d rect phys c an costs	Costs assoc ated w th postpartum LARC Dev ces
A other non-exc uded med ca and non-med ca pat ent care-re ated staff expenses	Costs assoc ated w th behav ora hea th cr s s eva uat ons
Ma pract ce costs and organ acqu s t on costs	

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

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RY23
(for admissions occurring in RY23)

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 FY20 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $12,528.00.

c. Outlier Adjustment Factor and Inflation 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 RY19 and RY23, 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 statew de cap ta cost per d scharge (**subsection a**),	a. the APAD Base Year a -payer cap ta cost per d scharge b. adjusted by the APAD Base Year a payer casem x ndex c. capped at the cap ta eff c ency standard d. mu t p ed by the FY21 Hosp ta -spec f c MassHea th d scharges e. summed and d v ded by the tota FY21 statew de MassHea th d scharges	$743.89
trended to the current rate year us ng the Inf at on Factors for Cap ta Costs and mu t p ed by 101.0% (**subsection b**)		$799.07

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RY23 (for admissions occurring in RY23)
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 FY21 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 FY21 MassHealth discharges.
b. Inflation Factors for Capital Costs The Inflation Factors for Capital Costs reflecting price changes between RY19 and RY23 are applied to trend the APAD Base Year statewide capital cost per discharge forward to the current Rate Year, and then multiplied by 101.75%.

RY23
(for admissions occurring in RY23)

4. MassHealth DRG Weights

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 RY23.

5. [Reserved]

6. Calculation of the APAD

Each APAD is determined by the following steps: (1) multiplying the labor portion of the Statewide Operating Standard per Discharge by the Hospital's Massachusetts-specific Wage Area Index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to 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. For purposes of step (1) in this **subsection 6**, above, the Hospital's Massachusetts-specific Wage Area Index which is multiplied by the labor portion of the Statewide Operating Standard per Discharge, is determined as specified in the definition of "Massachusetts-specific Wage Area Index" in **Section II** as applicable to RY23.

For qualifying discharges from Freestanding Pediatric Acute Hospitals and the Hospital with a Pediatric Specialty Unit 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 57% for purposes of step (4), above, in this **subsection 6**, in the calculation of the APAD. A qualifying discharge for this purpose is one that (i) meets this minimum MassHealth DRG Weight requirement, and (ii) in the case of the Hospital with a Pediatric Specialty Unit, is for a Member who is under the age of 21 at the time of admission.

The following is an illustrative example of the calculation of the Total Case Payment for a standard APAD claim that does not also qualify for an Outlier Payment under **Section III.C**, below. The example assumes RY23 applies.

Table 1: Standard APAD claim - RY23			
(Values are for demonstrative purposes only)			
Hospital:	**Sample Hospital**		
DRG:	**203, Chest Pain**		
SOI:	**2**		
Line	**Description**	**Value**	**Calculation or Source**
1	Statewide Operating Standard per Discharge	$11,566.32	RY23 RFA
2	Hospital's Massachusetts-specific wage area index	1.0255	Varies by hospital, determined annually
3	Labor Factor	0.68257	RY23 RFA
4	Hospital's Wage Adjusted Operating Standard per Discharge	$11,767.64	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3))
5	Statewide Capital Standard per Discharge	$799.07	RY23 RFA
6	APAD Base Payment	$12,566.71	Line 4 + Line 5
7	MassHealth DRG Weight	0.3972	Appendix C, Chart C
8	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$4,991.50**	Line 6 * Line 7

C. Outlier Payment

The Outlier Payment methodology is set forth in this **Section III.C**; provided that, (i) the RY23 column applies to admissions occurring in RY23, and incorporates applicable definitions from **Section II** that apply to RY23; 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 RY23 method for admissions in RY23.

RY23 (for admissions occurring in the RY23)
A Hospital will be paid a discharge-specific Outlier Payment for a discharge in addition to the APAD (see **Section III.B**., above) if all of the following conditions are met: 1. the amount of the APAD for the discharge exceeds $0. 2. the Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge; 3. the patient is not in a DMH-licensed bed for any part of the discharge; and 4. the patient is not a patient in an Excluded Unit within the Hospital. In cases where an Outlier Payment applies, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold.

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 RY23 applies.

Table 2: Claim with Outlier Payment - RY23			
(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)	$4,991.50	Table 1, Line 8
2	Allowed Charges	$80,000.00	Determined from claim
3	Hospital's Inpatient Cost-to-Charge Ratio	72%	FY20 Massachusetts Hospital Cost Report
4	Discharge-Specific Case Cost	$57,600.00	Line 2 * Line 3
5	Fixed Outlier Threshold	$39,925.00	RY23 RFA
6	Discharge-Specific Outlier Threshold	$44,916.50	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%	RY23 RFA
9	Outlier Payment	$7,610.10	(Line 4 - Line 6) * Line 8
10	**Total Case Payment = APAD plus Outlier Payment**	**$12,601.60**	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 RY23, applicable definitions from **Section II** that apply to RY23 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 RY23 method for admissions in RY23.

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 RY23, the "RY23" column applies.

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RY23 Period (for admissions occurring in RY23)
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 RY23. 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 RY23 applies.

Table 3: Claim with Transfer (APAD only) - RY23

(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)	$4,991.50	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	2.39	Appendix C, Chart C
4	Transfer per diem	$2,088.49	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	$4,176.98	Line 4 * Line 2
6	Total Transfer Payment Cap	$4,991.50	Line 1
7	**Total Transfer Case Payment**	**$4,176.98**	**Lower of Line 5 or Line 6**

Table 4: Claim with Transfer (APAD and Outlier) - RY23			
(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)	$12,601.60	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	2.39	Appendix C, Chart C
4	Transfer per diem	$5,272.64	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	$10,545.27	Line 4 * Line 2
6	Total Transfer Payment Cap	$12,601.60	Line 1
7	**Total Transfer Case Payment**	**$10,545.27**	**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 RY23 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 RY23 , the RY23 column, below, apply.

RY22 (for dates of service occurring in RY 23)
The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see Section II above). The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see Section II above). The Inflation Factors for Operating Costs (see Section II above) between RY08 and RY10, 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 RY23. The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs for RY23 Psychiatric Per Diem is $178.62. The statewide standard Psychiatric Per Diem rate applicable to dates of service in RY 23 remains at $954.59.

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: 1. The Member is aged 14 years old to 17 years old (inclusive); or 2. The Member has a diagnosis of Autism Spectrum Disorder or Intellection Disability Disorder (ASD/IDD); 3. 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 4. The member is admitted to a hospital identified by CHIA as a teaching hospital; AND 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: 1. The Member is aged 13 years old or below; or 2. The Member is aged 65 years old or above; or 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: 1. The Member is aged 14 years old to 17 years old (inclusive); or 2. The Member has a diagnosis of ASD/IDD; 3. 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 4. The member is admitted to a hospital identified by CHIA as a teaching hospital; AND The Member admission does not meet eligibility criteria for the	The Member admission meets at least one of the following criteria: 1. The Member is aged 13 years old or below; or 2. The Member is aged 65 years old or above; or 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.

		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:

1. Category A1 rate - $350 per admission
2. Category B1 rate - $1,000 per admission
3. Category A2 rate - $1,850 per admission
4. Category B2 rate - $2,500 per admission
5. Category A3 rate - $2,975 per admission
6. Category C3 rate - $3,625 per 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.

G. Payments for Administrative Days

The methodology in the RY23 column applies to dates of service in RY23 and incorporates applicable definitions in **Section II** that apply to RY23.

RY23 (for dates of service occurring in RY 23)
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.

RY23 (for dates of service occurring in RY 23)
2. The AD rate is a base per diem payment and an ancillary add-on. 3. The base per diem payment is $242.03, which represents the median nursing facility rate that was effective October 1, 2021 for all nursing home rate categories, as determined by EOHHS. 4. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998. 5. These ratios are 0.278 and 0.382, respectively. The resulting AD rates for RY23are $316.90 for Medicaid/Medicare Part B eligible patients and $342.68 for Medicaid-only eligible patients. 6. The Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status.

H. Rehabilitation Unit Services in Acute Hospitals

The methodology in the RY23 column applies to dates of service in RY23 and incorporates applicable definitions in **Section II** that apply to RY23.

RY23 (for dates of service occurring in RY23)
A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Rehabilitation Unit. For dates of service in RY23, the per diem rate for such Rehabilitation Services will equal the median MassHealth RY23 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.

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.

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 FY21 public payer percentage, which is the ratio of the Hospital's FY21 Gross Patient Service Revenue from government payers and free care to the Hospital's FY21 Gross Patient Service Revenue ("FY21 Public Payer Percentage"), must exceed 63% ("High Public Payer Threshold"), as determined by EOHHS based on the Hospital's FY21 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 FY23 Accountable Care Partnership Plan (ACPP) and Primary Care ACO discharge volume, 20% of the Hospital's FY23 MCO discharge volume, and 20% of the Hospital's FY23 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 FY20 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, FY3 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 FY23, respectively, and residing in the MassHealth Data Warehouse as of March 31, 2023, and for the PCC Plan and Primary Care ACO discharges, Medicaid paid claims data for FY23 residing in MMIS as of March 31, 2024 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 2023 (FFY23) 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) (TN-022-0037) 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 FFY23 outpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.F.2** of Attachment 4.19-B(1) (TN-022-0037), 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.

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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 RY23 High Public Payer Supplemental Payment pursuant to Section III.J.1; (2) operate at least one DMH-Licensed Bed throughout RY23, and (3) have provided Inpatient Behavioral Health Services to MassHealth members in FY21.

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.

$$\left[\left[\left[\frac{\text{Hospita Specific IP Pedi Ado BH Days}}{\text{Tota IP Pedi Ado BH Days for a Hospita s}} * 0.6\right] + \left[\frac{\text{Hospita Specific IP Adu t BH Days}}{\text{Tota IP Adu t BH Days for a Hospita s}} * 0.4\right]\right] * \$9{,}000{,}000\right] \quad A$$

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 FY21, using data residing in MMIS and/or the Data Warehouse as of March 31, 2022.

"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, 2022, 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,

2021 through September 30, 2022. 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. The payment will be an amount up to the variance between the Hospital's FY22 MMIS-based inpatient hospital charges and its other inpatient hospital payments made under this Attachment for the applicable federal fiscal year, not to exceed $17.45 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. Pediatric Inpatient BH Per Diem Supplemental Payment

a. Definitions

For purposes of this **Section III.J.10**, the following terms shall have the following meanings:

1. Pediatric – a Member under 18 years of age.
2. Pediatric Inpatient BH Bed-Days Baseline - the adjusted CY19 Pediatric Inpatient BH Bed-Days for a given performance period, calculated in accordance with **Section III.J.10.b.2.**

3. Pediatric Inpatient BH Bed-Days Volume - Pediatric inpatient BH bed-days utilization equal to the Hospital's Pediatric Inpatient BH Bed-Days for a particular period.

4. Pediatric Inpatient BH Bed-Day – a day on which a Hospital provided Inpatient Behavioral Health Services to a Pediatric Member for which payment was made by MassHealth or a Managed Care Entity, as determined by EOHHS. Pediatric Inpatient BH Bed-Days shall include each day of utilization for each Pediatric Member to whom Inpatient Behavioral Health Services were rendered.

5. Managed Care Entity (MCE) – An MCO or the BH Contractor.

6. First RY23 Performance Period – the period beginning on October 1, 2022 and ending on March 31 31, 2023.

7. Second RY23 Performance Period – the period beginning on April 1, 2023 and ending on September 30, 2023.

8. RY23 Performance Period – either the First RY23 Performance Period or the Second RY23 Performance Period.

b. Eligibility Criteria

1. A Hospital is eligible for a Pediatric Inpatient BH Per Diem Supplemental Payment or Payments if its Pediatric Inpatient BH Bed-Days Volume for an RY23 Performance Period, calculated in accordance with **Section III.J.10.b.3**, exceeds its Pediatric Inpatient BH Bed-Days Baseline for that RY22 Performance Period, calculated in accordance with **Section III.J.10.b.2**. EOHHS shall determine a Hospital's eligibility to receive payment pursuant to this **Section III.J.10.b**.

2. EOHHS shall calculate a Hospital's Pediatric Inpatient BH Bed-Days Baseline for an RY23 Performance Period as follows:

    a. If the Hospital had at least one Pediatric Inpatient BH Bed-Day during each calendar month in CY2019, EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume during Calendar Year 2019 ("CY19 Pediatric Inpatient BH Bed-Days") by summing all of the Hospital's Pediatric Inpatient BH Bed-Days during CY19, determined based on CY2019 fee-for-service MMIS paid claims and encounter data submitted to EOHHS by Managed Care Entities as of September 11, 2020.

    b. If the Hospital had zero Pediatric Inpatient BH Bed-Days during at least one calendar month in CY2019, EOHHS will calculate the Hospital's CY19 Pediatric Inpatient BH Bed-Days Volume as follows:

        i. If the Hospital had zero Pediatric Inpatient BH Bed-Days during at least one calendar month in the second half of CY19 (July to December), EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume during

Calendar Year 2019 ("CY19 Pediatric Inpatient BH Bed-Days"), by summing all of the Hospital's Pediatric Inpatient BH Bed-Days during CY19, determined based on CY2019 fee-for-service MMIS paid claims and encounter data submitted to EOHHS by Managed Care Entities as of September 11, 2020.

ii. If a Hospital not described in **section III.J.10.b.2.b.i** had zero Pediatric Inpatient BH Bed-Days during at least one calendar month in the first half of CY19 (January to June), EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume during the second half of Calendar Year 2019, by summing all of the Hospital's Pediatric Inpatient BH Bed-Days during the second half of CY19, determined based on CY2019 fee-for-service MMIS paid claims and encounter data submitted to EOHHS by Managed Care Entities as of September 11, 2020. The Hospital's CY19 Pediatric Inpatient BH Bed-Days shall equal 200% of the Hospital's Pediatric Inpatient BH Bed-Days Volume during the second half of CY19.

c. EOHHS will multiply the Hospital's CY19 Pediatric Inpatient BH Bed-Days (as calculated pursuant to **Section III.J.10.b.2.a, III.J.10.b.2.b.i,** or **III.J.10.b.2.b.ii**) by 80%, resulting in the Hospital's Pediatric Inpatient BH Bed-Days Baseline.

d. The Hospital's Pediatric Inpatient BH Bed-Days Baseline for the First RY23 Performance Period shall equal 52.5% of the amount calculated in **Section III.J.10.b.2.c**.

e. The Hospital's Pediatric Inpatient BH Bed-Days Baseline for the Second RY23 Performance Period shall equal 47.5% of the amount calculated in **Section III.J.10.b.2.c**.

3. A Hospital's Pediatric Inpatient BH Bed-Days Volume during an RY23 Performance Period shall be calculated as follows:

a. The Hospital's Pediatric Inpatient BH Bed-Days Volume for an RY23 Performance Period shall equal the sum of the Hospital's Pediatric Inpatient BH Bed-Days during that RY22 Performance Period.

b. EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume for the first RY23 Performance Period utilizing RY23 fee-for-service MMIS paid claims and managed care encounter data submitted to EOHHS by Managed Care Entities by September 30, 2023.

c. EOHHS will determine the Hospital's Pediatric Inpatient BH Bed-Days Volume for the Second RY23 Performance Period utilizing RY23 fee-for-service MMIS paid claims and managed care encounter data submitted to EOHHS by Managed Care Entities by April 30, 2024.

c. Methodology

Subject to compliance with all applicable federal rules and payment limits, for each Hospital eligible for a Pediatric Inpatient BH Per Diem Supplemental Payment for an RY23 Performance Period in accordance with **Section III.J.10.b**, the Hospital's payment shall equal $330 multiplied by the number of days by which the Hospital's Pediatric Inpatient BH Bed-Days Volume for an RY23 Performance Period, calculated in accordance with **Section III.J.10.b.3**, exceeds the Hospital's Pediatric Inpatient BH Bed-Days Baseline for that RY23 Performance Period, calculated in accordance with **Section III.J.10.b.2**.

11. Inpatient Discharge Add-on

a. The inpatient add-on pool is $305.5 million, calculated by multiplying $650 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 RY23 in-state acute care hospital inpatient discharges, as determined by EOHHS based on paid claims and encounters on file as of March 31, 2024, to calculate the final inpatient add-on amount per discharge.

2. Second, multiply the total number of RY23 inpatient discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2024, 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 RY23, 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 RY23. 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, 2021 – December 31, 2021 for the first interim payment, October 1, 2021 – March 31, 2022 for the second interim payment, January 1, 2022 – June 30, 2022 for the third interim payment and April 1, 2022 – September 30, 2022 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. Supplemental Payment for Disaster Support

a. Eligibility Criteria

In order to qualify for a Supplemental Payment for Disaster Support under this **Section III.J.12**, a hospital must meet the following criteria:

i. The hospital must have experienced a disaster event in the form of major building fire requiring evacuation of patients and staff in February 2023, and causing temporary disruption of service delivery;

ii. The hospital must be a non-profit hospital that has a public payer mix of greater than 76% and a Medicaid payer mix of greater than 28%, as determined by EOHHS based on data reported by CHIA in the April 2022 databook titled "Massachusetts Hospital Profiles, Data through Fiscal Year 2020; and

iii. The hospital must enter into a separate payment agreement with EOHHS relating to this Supplemental Payment for Disaster Support.

b. Payment methodology

The Total supplemental payment to a qualifying hospital under this Section III.F.8 shall equal $5,000,000.

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:

i. 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, or

ii. A Freestanding Pediatric Acute Hospital, as such term id defined in Section II, above.

b. Methodology

EOHHS will make the targeted hospital supplemental payments described in this **Section III.J.13** as follows:

i. For hospitals eligible for targeted hospital supplemental payments under **Section III.J.13.a.i**, EOHHS shall make a payment of $25,000,000.

ii. For hospitals eligible for a targeted hospital supplemental payments under **Section III.J.13.a.ii**, EOHHS shall pay $22,500,000 to the hospital with the largest volume of inpatient discharges in fiscal year 2019, as determined by EOHHS using Massachusetts hospital cost report data; and shall pay $2,500,000, divided pro rata by patient volume among the remaining eligible hospitals.

14. Supplemental Payment to Support Acute Hospital Financial Stability and Prevent Possible Impacts to Acute Hospital Service Provision and Access

a. Eligibility criteria:

EOHHS will make supplemental payments to support acute hospital financial stability and to prevent possible impacts to acute hospital service provision and access. Hospitals eligible for the supplemental payment under this **Section III.J.14** must meet all of the following criteria:

i. The hospital must have responded to a Request for Information Request for Information Regarding Acute Hospital Financial Stability and Possible Impacts to Acute Hospital Service Provision and Access, posted on the state's procurement website;

ii. The hospital must be categorized as a high public payer Acute Hospital by the Center for Health Information and Analysis (CHIA), calculated using the FY20 Massachusetts Hospital Cost Reports, as reported in the Databook titled “Massachusetts High Public Payer Hospitals”;

iii. The hospital must have a commercial relative price of less than 0.85, as determined by EOHHS using data reported by CHIA in the Databook titled “Relative Price and Provider

Price Variation in the Massachusetts Commercial Market" published August 2020 and updated November 10, 2022; and

iv. The hospital must enter into a separate payment agreement with EOHHS relating to this supplemental payment.

b. Payment Tiers Qualification:

Hospitals qualifying for the supplemental payment described in this **Section III.J.14** will be included in one of the following tiers:

i. Tier 1: To be in Tier 1, the hospital must have a public payer mix greater than 63%, and a commercial relative price less than 0.85, and must be part of a system that includes a critical access hospital.

ii. Tier 2: To be in Tier 2, the hospital must have a public payer mix greater than 70%, and a commercial relative price less than 0.85, and not be included in Tier 1.

iii. Tier 3: To be in Tier 3, the hospital must have a public payer mix greater than 63%, and a commercial relative price less than 0.85, and not be included in Tier 1 or Tier 2.

c. Payment Methodology:

Hospital s qualifying for the supplemental payment described in this **Section III.J.14** will be paid as follows:

i. EOHHS shall determine each hospital's estimated number of annual bed days based on hospital-reported occupancy figures from August 2022 through October 2022;

ii. EOHHS shall multiply the bed days determined under **Section III.J.14.c.i** by the following amount for each Tier:

A. For Tier 1, $750 per bed day,

B. For Tier 2, $137.50 per bed day,

C. For Tier 3, $37.50 per bed day.

K. Pay-for-Performance (P4P) Payment

Pay-for-Performance (P4P) is MassHealth's method for quality scoring and converting quality scores to P4P payments contingent upon Hospital adherence to quality standards and achievement of performance thresholds and benchmarks. Except as provided in **Section III.K.1.c**, P4P incentive payments will be based on pay-for-performance (see **Sections III.K.1.c**, below).

A Hospital will qualify to earn P4P payments if it meets data accuracy and completeness requirements, including data validation requirements where applicable, and achieves performance thresholds for the P4P measures listed below. Each measure is evaluated using the methods outlined below to produce measure rates or values which result in performance scores that are converted into incentive payments.

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

The methodology in Section III.K applies to dates of service in RY23 and incorporates applicable definitions in **Section II** that apply to RY23..

1. RY23 Pay-for-Performance (P4P) Program

a. Performance Measures

Quality performance goals and measures focus on areas where improvement is likely to have most impact on the health outcomes for this Member population. The specific hospital quality measures for which the RY23 P4P incentive payments will be based are identified in the following **Table K-1**, which displays (a) each Quality Measure Category (four in total) and (b) the inpatient measure(s), identified by Measure ID# and Measure name, that correspond to each Quality Measure Category.

Table K-1 – RY23 Hospital Quality Performance Measures

Quality Measure Category	Measure ID#	Measure Name
Perinatal	MAT-4	Cesarean Birth, NTSV
Perinatal	NEWB-1	Exclusive breast milk feeding (to be discontinued as of Q1 of 2023)
Perinatal	PMSM-1	Perinatal Morbidity Structural Measure
Care Coordination	CCM-1	Reconciled medication list received by discharged patient
Care Coordination	CCM-2	Transition record with specified data elements received by discharge patient
Care Coordination	CCM-3	Timely transmission of transition record within 48 hours at discharge
Safety Outcome	PSI-90	Patient Safety and Adverse Events Composite
Safety Outcome	HAI-1	Central Line-Associated Bloodstream Infection (CLABSI)
Safety Outcome	HAI-2	Catheter-Associated Urinary Tract Infection (CAUTI)
Safety Outcome	HAI-3	Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)
Safety Outcome	HAI-4	Clostridium Difficile Infection (CDI)
Safety Outcome	HAI-5	Surgical Site Infections: Colon and abdominal hysterectomy procedures
Patient Experience and Engagement	HCAHPS	Hospital Consumer Assessment of Healthcare Provider Systems Survey Composite (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.

b. Data Requirement

i. Quality Measure Categories

The quality measure categories include 1) perinatal, consisting of two individual chart-based measures (MAT-4 and NEWB-1) and one maternal structural measure (PMSM-1); 2) care coordination quality, consisting of three individual chart-based measures (CCM-1, CCM-2, and CCM-3); Hospitals collect and report all Medicaid payer data on the chart-based measures to EOHHS.

In order to ensure the accuracy and reliability of the submitted data, all reported chart-based measures are subject to data validation requirements. The submitted electronic data must meet a minimum reliability standard. The minimum reliability standard is defined as an 80 percent match for data elements. In RY23, Hospitals are considered to have "passed" validation if the overall agreement rate of 80 percent has been met, based on data from the first three quarters of CY2022 (Q1-2022, Q2-2022, and Q3-2022) required for performance evaluation.

For the maternal structural measure, under the perinatal quality component, all Hospitals must complete the five-item survey to attest participation and implementation activity taken during CY2022. Item responses must be submitted annually using the EOHHS-approved web-based data collection tool and must meet data accuracy and completeness requirements.

ii. Safety Outcomes Measure Category

The Safety Outcomes Measure Category consists of two measures:

Measure 1: *Patient Safety and Adverse Events Composite Measure (PSI-90)* -- The PSI-90 composite measure consists of ten (10) component patient safety indicators (PSI-3, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14 and PSI-15) that represent potentially preventable complications and adverse events. This measure is claims-based and will be collected by EOHHS on all Medicaid payer data from MMIS and the MassHealth Data Warehouse. Data accuracy and completeness requirements apply.

Measure 2: Healthcare-Associated Infections (HAI) Measures -- The five HAI measures listed in **Table K-1** (HAI-1, HAI-2, HAI-3, HAI-4, and HAI-5), are reported by Hospitals to the National Healthcare Safety Network (NHSN) registry surveillance tracking system maintained by the Centers for Disease Control and Prevention (CDC). EOHHS will access the relevant information for these measures, which are based on all payer data, for each Hospital from the NHSN system for the relevant period. EOHHS will rely on data accuracy and completeness of the data as accessed from this system.

iii. Patient Experience and Engagement Measure Category

The Patient Experience and Engagement Measure Category includes theHospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure comprised of seven (7) national survey dimensions (see HCAHPS measure in **Table K-1**, above) developed by AHRQ for CMS. Survey results are collected and submitted by Hospitals to CMS. EOHHS will collect the relevant archived data results for each Hospital, which are based on all payer data, from the CMS Provider Data Catalog website. EOHHS will rely on data accuracy and completeness of the data as set forth on the CMS Provider Data Catalog website.

c. <u>Payment Methodology</u>

P4P incentive payments will be based on pay-for-performance for each **P4P Category** listed in **Table K-2** (see Section **III.K.1.c.ii.a**, below), except for the Patient Experience and Engagement Quality Measure Category, for which P4P incentive payments will be based on pay-for-reporting. The term "P4P Category" or "P4P Categories" will refer to the P4P Category(s) listed in such Table K-2.

Formula: Incentive payments for each P4P Category are calculated by multiplying:

- the Hospital's eligible Medicaid discharges for the P4P Category, by
- the P4P Category per Discharge Amount, by
- either:
    - the Total Performance Score, calculated in accordance with Section III.K.1.c.iii, for all P4P Categories except for the Patient Experience and Engagement Quality Measure Category; or
    - the Patient Experience and Engagement Measure Category Score, calculated in accordance with Section III.K.1.c.iv, for the Patient Experience and Engagement Measure Category.

Incentive payments will be made as lump sum payments to eligible Hospitals, after finalization of the performance measure data and applicable payment amounts. EOHHS expects to make incentive payments during the 4th quarter of calendar year 2023 (October through December 2023).

i. Eligible Medicaid Discharges

For purposes of this **Section III.K.1.c.i,** "FY21 MMIS Discharge Data" refers to Hospital discharge data from MMIS paid claims for FY22 PCC Plan, Primary Care ACO and Fee-for-Service discharges, only, for which MassHealth is the primary payer.

Eligible Medicaid discharges are used to determine the volume of a Hospital's discharges that are included in the RY23 Pay-for-Performance payment calculations. The volume of

eligible Medicaid discharges is determined as follows utilizing FY22 MMIS Discharge Data as the data source:

a. **Perinatal and Care Coordination Quality Measure Categories.** For the Perinatal and Care Coordination Quality Measure Categories, the eligible Medicaid discharges will be the number of Hospital discharges in the FY22 MMIS Discharge Data that meet the specific ICD requirements corresponding to the measures in that P4P Category. For certain chart-based measures (MAT-4 and NEWB-1), the ICD requirements are published in the *Joint Commission National Quality Measures* (available at https://manual.jointcommission.org/Home/WebHome). Specifications for the care coordination (CCM-1, CCM-2 and CCM-3) measures are available on the MassHealth Quality Exchange website at https://www.mass.gov/masshealth-quality-exchange-massqex.

b. **Safety Outcomes Measure**. For the Safety Outcomes Quality Measure Category, the eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY22 MMIS Discharge Data that meet the medical and surgical All Payer Refined Diagnosis Related Group (APR-DRG) codes associated with the specified AHRQ clinical measure specification manuals.

c. **Patient Experience and Engagement Measure:** For the Patient Experience and Engagement Measure (HCAHPS) Quality Measure Category, the eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY22 MMIS Discharge Data that meet the specified medical, surgical, vaginal deliveries, and cesarean All Payer Refined Diagnosis Related Group (APR-DRG) service line categories associated with the MS-DRG crosswalk specified in HCAHPS Quality Assurance Manual.

ii. P4P Category per Discharge Amount

The P4P Category per Discharge Amount for each P4P Category will be determined by dividing the **maximum allocated amount** for the P4P Category by the **statewide eligible Medicaid discharges** for that P4P Category.

a. Maximum Allocated Amount

P4P incentive payments will cumulatively total no more than the maximum amount allotted for each P4P Category in the following table:

Table K-2: P4P Categories & Maximum Allocated Amounts

P4P Category	Maximum Allocated Amount
Perinatal Quality Subcategory (MAT-4 and NEWB-1)	$ 7,500,000
Care Coordination Clinical QualitySubcategory (CCM-1, CCM-2, and CCM-3)	$ 9,000,000
Safety Outcomes Measure (PSI-90 and HAI)	$ 4,500,000
Patient Experience and Engagement Measure (HCAHPS)	$ 4,000,000
TOTAL	**$25,000,000**

b. Statewide Eligible Medicaid Discharges

The statewide eligible Medicaid discharges for each P4P Category, are the sum of all eligible Medicaid discharges (see **Section III.K.2.c.i**, above) across all Hospitals for that category.

iii. Total Performance Score

a. Perinatal Quality Measure Subcategory (MAT-4 and NEWB-1) and **Care Coordination Quality Measure Subcategory (CCM-1, CCM-2 and CCM-3)**

The Total Performance Score for the chart-based measures that, collectively, comprise the Perinatal Quality Measure Category and the Care Coordination Measure Category is a percentage of **quality points** earned out of the total possible points, as reflected in the following formula:

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

For each chart-based measure, the quality points earned are calculated using the higher of the **attainment** or the **improvement points** earned. Those quality points earned for each chart-based measure are summed to yield the total awarded quality points for each Quality Measure Category.

Quality points are earned for the chart-based measures based on each Hospital's performance during the Comparative Measurement Period relative to the attainment threshold (the median performance of all Hospitals in the Baseline Measurement Period) and the benchmark (the

mean of the top decile of all Hospitals in the Baseline Measurement Period).

The **Comparative Measurement Period** and the **Baseline Measurement Period** for the chart-based measures are as follows:

	Comparative Measurement Period	Baseline Measurement Period
Chart-based Measures	January 1, 2022 – December 31, 2022	January 1, 2021 to December 31, 2021

Performance benchmarks for the chart-based measures are calculated based on Hospital data reported to MassHealth.

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

To be included in the performance assessment for a particular chart-based measure, a Hospital's reported data for that measure must contain at least 25 cases in the denominator population. Hospitals that do not meet the case minimum for a particular chart-based measure are ineligible to receive incentive payments for that measure.

i. Attainment Points

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

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

ii. Improvement Points

The Hospital can earn points for improvement based on how much its performance score on the measure has improved from the Baseline Measurement Period as follows:

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

- if a Hospital's score for a measure is greater than its score for the Baseline Measurement Period, it will receive 0-9 points for improvement.

iii. Example

The following is an example pay-for-performance calculation for the Perinatal Quality Measure Category, provided for illustrative purposes only.

Example for P4P Category: Perinatal Quality Measure Subcategory

Statewide calculations	
Max mum a ocated amount	$7,500,000
Statew de e g b e Med ca d d scharges	32,633
P4P Category per D scharge Amount	$7,500,000/32,633 = $230
Hospital-specific calculations	
Hosp ta 's awarded qua ty po nts for the P4P Category (sum of the measure-spec f c atta nment or mprovement po nts correspond ng to the P4P Category)	32
Max mum poss b e P4P Category qua ty po nts	40
Tota Performance Score for P4P Category	(32 po nts / 40 po nts) x 100% = 80%
E g b e Med ca d d scharges	500
Hospital-specific total incentive payment for the P4P Category	**500 x $230 x 80% = $92,000**

b. Perinatal Structural Morbidity Measure

The perinatal structural measure (PMSM-1) result is calculated using the number of valid responses reported by Hospitals in the required 5-item survey, described in Section III.K.1.b.i, compared to the total number of available valid responses to such 5-item survey. The Hospitals' attestation to the perinatal quality collaborative participation is calculated using one or more valid responses reported on survey items 1 through 4. The Hospitals attestation to the implementation of in-hospital safety practices to prevent

maternal morbidity is calculated using one or more the valid responses reported on survey item 5. A valid response is the usable answer provided from those listed on each survey item that represents the practical action taken. Hospital item responses are subject to verification by EOHHS.

The perinatal structural measure (PMSM-1) performance is assessed based on meeting both participation in a perinatal quality collaborative, as well as implementation of the in-hospital practice requirement. Each Hospital's valid item responses to the 5-item survey, described in Section III.K.1.b.i, are assigned a "Yes" or a "No" code. A Hospital must have a valid response for survey items 1 and 2 to meet the participation requirement and be assigned a "Yes" code. A Hospital determined not to have a valid response for either or both survey items 1 and 2, the Hospital will not meet the participation requirement and will be assigned a "No" code. In addition, the Hospital must have one or more valid responses for item 5 to meet the in-hospital implementation practice requirement. Participation is further confirmed through valid responses to survey items 3 and 4. However, a Hospital's overall result is assigned a "Yes" code only if it obtained a "Yes" code on participation (items 1 and 2) plus implementation (item 5).

c. Safety Outcomes Measure (PSI-90 and HAI)

For the Safety Outcomes Measure, each Hospital will be evaluated using both the Hospital's PSI-90 composite value and the Hospital's standard infection ratio (SIR) output values for each of the five HAI measures, as applicable.

Component 1: The PSI-90 composite value is calculated as a weighted average of the scaled risk-adjusted and reliability adjusted rates for the ten AHRQ quality indicators, combined, for the Hospital. The relevant evaluation period is a two-part 15-month period from October 1, 2018 through December, 2019 and from January 1, 2021 through December 31, 2021. If a Hospital has fewer than 3 eligible discharges for the ten indicators combined, a PSI-90 composite value will not be calculated.

Component 2 -- For each of the five HAI measures, EOHHS will obtain the Hospital's SIR output value for each measure, as calculated by the CDC, from the NHSN system. The relevant evaluation period is the 12 month period of January 1, 2021 through December 31, 2021. The Hospital will not have a SIR output value for an HAI measure(s) if the CDC was unable to calculate a SIR output value for the Hospital for that HAI measure based on its criteria.

(A) Winsorization Method

Each Hospital's performance will be assessed in comparison to all eligible Hospital's values for the PSI-90 composite and each of the HAI measures using a Winsorization method, which transforms each Hospital's measure values into

a standardized score. The Winsorization method evaluates performance using the defined period(s) only and does not use comparison year data.

1. A Winsorized measure result is obtained by creating a continuous rank distribution of all eligible Hospitals' measure values, and truncating the outliers to determine the relative position of where each measure value falls in the distribution. This Winsorization process is performed separately for the PSI-90 composite measure and for each of SIR output value for the HAI measures.

   i. If *the Hospital's measure value* falls between the minimum and the 5th percentile, then *the Hospital's Winsorized measure result* is equal to the measure value that corresponds to the 5th percentile.

   ii. If the Hospital's measure value falls between the 95th percentile and the maximum, then *the Hospital's Winsorized measure result* is equal to the measure value that corresponds to the 95th percentile.

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

2. A Winsor Z-score will be calculated for each Hospital for each measure; it is the difference between a Hospital's Winsorized measure result from #1 above and the mean of the Winsorized measure results across all eligible hospitals, which difference is divided by the standard deviation of the Winsorized measure results from all eligible Hospitals' data.

3. The Hospital's **Overall Safety Outcomes Measure score** is calculated as the equally weighted average of the PSI-90 composite measure z-score and each HAI measure that has a z-score, using the methods described below.

   i. Equal Measure Weights Method. The assigned weights that will apply to each safety measure z-score under the equal measure weights method are shown in the table that follows:

Safety Outcome Equal Measure Weights

Total Number of Measures with a z-score	Weight assigned to each Measure z-score
6	16.7
5	20.0
4	25.0
3	33.3
2	50.0
1	100.0

As shown in this table, the equal measure weights method assigns the same weight to each Safety Outcome Measure z-score based on the total number of Safety Outcome Measures for which the Hospital has a z-score. If the Hospital has no z-scores for any of the safety outcome measures listed in **Table K-1,** then it will not receive a safety outcome measure overall z-score.

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

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

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

(B) Setting Performance Thresholds

The Hospital's Overall Safety Outcomes Measure score will be assessed using the methods described below.

1. *Interquartile Rank Method*. Performance will be assessed using a method that determines the Hospital's rank with respect to its Overall Safety Outcomes Measure score, relative to other Hospitals, and divides the ranked results into four approximately equal quartile groups. The Hospitals' Overall Safety Outcomes Measure scores are rounded to six decimal places and ranked highest (worse) to lowest (best) in performance.

2. *Minimum Attainment Threshold*. The minimum attainment threshold represents the minimum level of performance that must be attained to earn incentive payments, except that for RY23, EOHHS removes the minimum attainment threshold for data reported for CY2020, due to the impacts of COVID-19. To meet the minimum attainment threshold, the Hospital's overall Safety Outcomes Measure Category z-score must be above the upper boundary of the 1st quartile (i.e., fall into the 2nd, 3rd, or 4th quartile).

3. *Conversion Factor.* Each quartile group is assigned a conversion factor as shown in the table below:

Quartile Group Thresholds

Quartile Group Threshold	Conversion Factor
4th Quartile (Lower z-scores)	1.0
3rd Quartile	.75
2nd Quartile (Minimum attainment threshold)	.50
1st Quartile (Higher z-scores)	.25

All Overall Safety Outcome Measure scores that fall within the same quartile group are assigned the same conversion factor.

(C) Total Performance Score for Safety Outcomes Measure (PSI-90 and HAI).

A Hospital's Total Performance Score for the Safety Outcomes Measure (PSI-90 and HAI) P4P Category is the assigned conversion factor as shown in the Quartile Group Thresholds table, above, multiplied by 100%.

iv. Patient Experience and Engagement Measure Category Score

EOHHS will obtain the Hospitals' archived HCAHPS measure "top box" results corresponding to the relevant periods directly from the CMS Provider Data Catalog website for each of the seven survey dimensions in the Patient Engagement and Experience Measure (HCAHPS) category that are posted in rounded integer format. The "top box" raw result calculation includes a CMS patient-mix adjustment and survey-mode adjustment.

Each Hospital's Patient Experience and Engagement Measure Score will be determined using the Hospital's publicly reported HCAHPS survey files for the Q1-2021, Q2-2021, Q3-2021, and Q4-2021 data periods (January 1, 2021 to December 31, 2021). A Hospital's score on the Patient Experience and Engagement Quality Measure Category will be based on whether the Hospital reported HCAHPS survey data to CMS for these combined data periods. Specifically, the Hospital will receive a Patient Experience and Engagement Quality Measure Category Score of 100% if the CMS Provider Data Catalog website posts 100 or more surveys for the Hospital for these combined data periods. The Hospital will receive a Patient Experience and Engagement Quality Measure Category Score of 0% if the CMS Provider Data Catalog website posts fewer than 100 surveys for the Hospital for these combined data periods.

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. RY23 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 RY23 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, survey-based or electronic-based. Claims-based 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 at through the following link: https://www.mass.gov/doc/ry2023-eohhs-technical-specifications-manual-for-masshealth-hospital-quality-measures-160-0/download.

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 Domain Quality Measures

(a) Core Domain Quality	(b) Measure ID#	(c) Measure Steward: Measure Name	(d) Data and Measure Type	(e) Population
Care Coordination / Integration	CCM-1	CMS: Reconciled medication list received by discharged patient	Chart-Abstracted Process Measures	All Medicaid
	CCM-2	CMS: Transition record with specified data elements received by discharge patient	Chart-Abstracted Process Measures	All Medicaid
	CCM-3	CMS: Timely transmission of transition record within 48 hours at discharge	Chart-Abstracted Process Measures	All Medicaid
	CCI-1	NCQA PCR: Plan All-Cause Readmissions Adult (7-Day and 30-Day) - *Treated as two-sub measures or 1 measure*	Claims-based Outcome Measure	All Medicaid
	PED-1	Pediatric All-Condition Readmission Measure (NQF2393)	Claims-Based Outcome Measure	All Medicaid
	CCI-2	NCQA FUM: Follow-up After ED Visit for Mental Illness (NQF 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 (NQF 3488) (7-Day and 30-Day) - *Treated as 1 measure which includes 2 sub-measures*	Claims-based Process Measures	All Medicaid

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(a) Core Domain Quality	(b) Measure ID#	(c) Measure Steward: Measure Name	(d) Data and Measure Type	(e) Population
Care for Acute and Chronic Conditions	SUB-2	TJC SUB-2: Alcohol Use – Brief Intervention Provided or Offered (NQF 1664)	Chart Abstracted Process Measures	All Medicaid
	SUB-3	TJC SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge (NQF 1663)	Chart-Abstracted Process Measures	All Medicaid
	OP-1e	CMS 506v5: Safe Use of Opioids – Concurrent Prescribing (NQF 3316e)	EHR e-measure	All Payer
	PED-2	*Pediatric measure in lieu of Sub-2* NQF 0058: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Claims-Based Measure	All Medicaid
	PED-3	*Pediatric measure in lieu of Sub-3* Bronchodilator use in the ED and in-patient settings, with reductions in chest radiography, viral testing, and antibiotic use	Claims-Based Measure	All Medicaid
Patient Safety	PSI-90	AHRQ: Patient Safety and Adverse Events Composite	Claims-Based Measure	All Medicaid
	HAI-1	CDC: Central Line-Associated Bloodstream Infection (CLABSI)	National Registry-Based Measures	All-Payer
	HAI-1	CMS: CLABSI – Pediatric ICU	National Registry-Based Measures	All-Payer
	HAI-2	CDC: Catheter-Associated Urinary Tract Infection (CAUTI)	National Registry-Based Measures	All-Payer
	HAI-3	CDC: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)	National Registry-Based Measures	All-Payer
	HAI-4	CDC: Clostridium Difficile Infection (CDI)	National Registry-Based Measures	All-Payer
	HAI-5	CDC: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)	National Registry-Based Measures	All-Payer

(a) Core Domain Quality	(b) Measure ID#	(c) Measure Steward: Measure Name	(d) Data and Measure Type	(e) Population
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 Measure	All-Payer

d. **Specialty Quality Measure Domains:** In addition to being accountable to performance for all measures in Core Quality Measure Domains, Hospitals are also accountable to all measures for which the Hospital is eligible in one or more Specialty Quality Measure Domains, including the Perinatal Domain for birthing hospitals with deliveries, and the Behavioral Health Care Domain for hospitals that have an inpatient psychiatric unit and participate in the current CMS IPFQR program. The measures for each Specialty Quality Measure Domain are listed in **Table L-2**, below. Specialty Quality Measure Domain participation and accountability will be determined by EOHHS based on type of Hospital and domain service lines provided.

Table L-2: CQI Program Specialty Domain Quality Measures

(a) Specialty Domain	(b) Measure ID#	(c) Measure Steward: Measure Name	(d) Data and Measure Type	(e) Population
Perinatal Care	MAT-4	TJC PC-02: Cesarean Birth, NTSV (NQF 0471)	Outcome Measure	All Medicaid
	NEWB-3	TJC PC-06: Unexpected Newborn Complications in Term Infants (NQF 0716)	Chart-abstracted	All Medicaid
	PMSM-1	EOHHS: Perinatal Morbidity Structural Measure (Note: PMSM-1 includes a survey question that aligns with the CMS (00418) Maternal Morbidity Structural Measure)	Survey	NA
Behavioral Health Care	BHC-1	NCQA FUH: Follow-up After Hospitalization for Mental Illness	Claims-Based	All Medicaid

(a) Specialty Domain	(b) Measure ID#	(c) Measure Steward: Measure Name	(d) Data and Measure Type	(e) Population
		(NQF 0576) (7-Day and 30-Day) – *Treated as 1 measure which includes 2 sub-measures*	**Process Measure**	
	BHC-2	**CMS IPFQR: Medication Continuation Following Inpatient Psychiatric Discharge (NQF3205)**	**Claims-Based Process Measure**	**All Medicaid**
	BHC-3	**CMS IPFQR: Screening for Metabolic Disorders (SMD)**	**Chart-Abstracted Process Measure**	**All Payer**

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 established in the RY23 RFA, are not eligible for quality measure performance scoring on that 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). Minimum case requirements include 25 cases per measure for the measurement period.

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. The data are based on claims data that EOHHS accesses directly from its MMIS system. Minimum case requirements include 30 cases per measure for the measurement period.

iii. **PSI-90 Composite Measure Result.** The PSI-#90 composite value for the PSI-#90 composite measure is calculated as a weighted average of the scaled risk-adjusted and reliability-adjusted rates for the ten indicators combined, using the applicable version of AHRQ Quality Indicators Software. The Hospital must have a minimum volume of three or more eligible discharges for at least one component indicator to calculate a PSI-#90 composite measure value. If the number of eligible discharges is fewer than three for the ten PSI-#90 indicators combined, the PSI-#90 composite value is not calculated by the AHRQ software due to insufficient data.

iv. **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. Method of reporting

and case minimums will be based on CDC methodologies further detailed in EOHHS' Technical Specifications Manual.

v. **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 seven 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. A minimum of 100 surveys is required to calculate results for this measure.

vi. **Perinatal Structural Measure Result:** The PMSM-1 measure result is calculated using the number of valid responses reported by Hospitals in a required 5-item survey compared to the total number of available valid responses to such 5-item survey. The Hospitals' attestation to the perinatal quality collaborative participation is calculated using one or more valid responses reported on survey items 1 through 4.

vii. **Other measure results:** The OP-1e – Safe Use of Opioids measure and SMD measure result 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, 1) through each measure based on attainment of threshold or goal, and 2) through year-over-year self-improvement. 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 by reaching improvement targets which may be earned whether the Hospital reaches threshold or exceeds the goal benchmarks. 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).

iii. **Improvement Target:** The improvement target represents a specified percentage point improvement for each applicable measure, and 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.

Table L-3 summarizes threshold, goal and improvement targets for RY23 CQI Program P4P measures.

Table L-3: CQI Benchmarks for each RY2023 P4P measure

Measure	Performance Threshold	Performance Goal	Improvement Targets
CCM-1	80%	97%	2 percentage points for each measure (Assessed by using a gap to goal approach (over five years) utilizing median or less than median Gap to Goal.
CCM-2	60%	90%	
CCM-3	70%	90%	
MAT-4	32%	22%	
HCAHPS	Composite score of .50 (no percentile) Composite Score = Average of the top box scores	Composite score of .80 Composite Score = Average of the top box scores	.01 - .05 improvement in a Hospital's composite score over the prior year
HAI-1 **HAI-2** **HAI-3** **HAI-4** **HAI-5**	Standard Infection Ratio (SIR) value <= to 1 *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 or the PSI-90 index is < 1, **and** where confidence intervals will be calculated for the MassHealth aggregate SIR, or PSI-90 index to identify Hospitals that are better than the MassHealth aggregate, thus performing above the threshold/goal benchmark.
PSI-#90	PSI-90 composite index value of <= 1 *Confidence intervals will be calculated for the MassHealth aggregate PSI-90 index, through available AHRQ software, to identify Hospitals that may have a composite index value greater than 1, but not significantly greater than the MassHealth aggregate PSI-90 index, thus meeting the measure threshold/goal benchmark.		

b. **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.ii through Section III.L.3.v.

1. 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. The range of points are calculated as follows:

Number of Attainment Points = 10 x (Hospital Measure Performance/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.

2. **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 initial baseline period for improvement are RY2023 performance measure rates calculated from the RY2023 Hospital Quality P4P program, described in Section III.K, above.
   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 2023 data reported on the measure in RY2023, 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 Measure Scoring.** A Hospital can earn 10 attainment points per each safety 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. This approach is used specifically for patient safety measures. Hospitals may receive 5 additional points per measure if their performance statistically exceeds State (i.e., HAI measures) 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 measures that are calculated by EOHHS (e.g., via claims data) and not currently pay-for-performance measures. Hospitals are not required to report on these measures and no points are allocated to them.

c. **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 great 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), a .02 improvement multiplier 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 great 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.

d. **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.

e. **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 RY23 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

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

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY23 (October 1, 2022 through September 30, 2023).

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 RY23 (October 1, 2022 through September 30, 2023), 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, 2022 through September 30, 2023, 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 RY23, 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 RY22, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY20 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 FY20CMS-2552-10 cost report, by the Hospital's number of FY20 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY20 paid claims data residing in MMIS as of May 24, 2021, for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY20 and RY22, resulting in the inflation-adjusted [t] RY22 cost per discharge for each Critical Access Hospital.
(3) EOHHS then divided each Critical Access Hospital'sRY22 inflation-adjusted cost per discharge, as determined above, by each Hospital's FY20 inpatient casemix index (CMI), as determined by EOHHS.
(4) That result is RY22 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 RY22.
(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying RY22 CAH-Specific Total Standard Rate per Discharge by the applicable RY22 discharge-specific MassHealth DRG Weight.

Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring in the RY23 Period, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY20 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 FY21 CMS-2552-10 cost report, by the Hospital's number of FY21 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY21 paid claims data residing in MMIS as of May 4, 2022, for which MassHealth is the primary payer.
(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY21 and RY23, resulting in the inflation-adjusted RY23 cost per discharge for each Critical Access Hospital.
(3) EOHHS then divided each Critical Access Hospital'sRY23 inflation-adjusted cost per discharge, as determined above, by each Hospital's FY21 inpatient casemix index (CMI), as determined by EOHHS.
(4) That result is the RY23 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 RY23.
(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying RY23 CAH-Specific Total Standard Rate per Discharge by the applicable RY23 discharge-specific MassHealth DRG Weight.

The following is an illustrative example of the calculation of the Total Case Payment for a CAH's standard APAD claim that does not also qualify for an Outlier Payment. This example assumes the RY23 Period applies.

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

Table 6: Critical Access Hospital Interim APAD claim - RY23			
(Values are for demonstrative purposes only)			
Hospital:	**Sample Critical Access Hospital**		
DRG:	**203, Chest Pain**		
SOI:	**2**		
Line	**Description**	**Value**	**Calculation or Source**
1	RY23 CAH-Specific Total Standard Rate per Discharge	$16,000.00	RY23 RFA
2	MassHealth DRG Weight	0.3966	Appendix C, Chart C
3	**Total Case Payment = Adjudicated Payment Amount per Discharge (Interim APA**	**$6,345.60**	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, utilizing the appropriate methodology that applies to the admission (RY22 or RY23, as applicable).

(B) Post RY23 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2023 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 FY23 as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY23 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 RY23 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for FY23, but excluding, if applicable, any state plan payments to a Critical Access Hospital under Section III.K of Attachment 4.19-A(1), and any supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in Section III.J.1 of Attachment 4.19-A(1).

If the Critical Access Hospital was paid less than 101% of allowable costs, EOHHS will pay the Critical Access Hospital the difference between 101% of allowable costs and the aggregate interim payments. If the Critical Access Hospital was paid more than 101% of allowable costs, the Critical Access Hospital shall pay to EOHHS, or EOHHS may recoup or offset against future payments, the amount that equals the difference between the aggregate interim payments and 101% of allowable costs.

This post Rate Year 2023 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, 2024. Assuming this date, the settlement will be complete by September 30, 2025.