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State Territory Name: MASSACHUSETTS

State Plan Amendment (SPA) #: 23-0054

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

December 8, 2023

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

RE: **Massachusetts State Plan Amendment (SPA) Transmittal Number 23-0054**

Dear Assistant Secretary Levine:

We have reviewed the proposed State Plan Amendment (SPA) to Attachment 4.19-B of Massachusetts's state plan, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 29, 2023. This plan amendment updates the methods and standards used to determine the rates of payment for Acute Outpatient Hospital services.

Based upon the information provided by the State, we have approved the amendment with an effective date of July 21, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Debi Benson at 1-312-886-0360 or Deborah.Benson@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

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: 23-0054

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
07/21/2023

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

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 25,348,000
b. FFY 24 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B(1) pp. 1-44 & Exhibit 1 pp. 1-3
45

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B(1) pp. 1-44 & Exhibit 1 pp. 1-3
45

9. SUBJECT OF AMENDMENT

An amendment to the payment methodologies for acute outpatient 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
09/29/2023

15. RETURN TO

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 3rd Floor
Boston, MA 02108

FOR CMS USE ONLY

16. DATE RECEIVED
SEPTEMBER 29, 2023

17. DATE APPROVED
December 8, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
JULY 21, 2023

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
TODD MCMILLION

21. TITLE OF APPROVING OFFICIAL
DIRECTOR, DIVISION OF REIMBURSEMENT REVIEW

22. REMARKS

STATE AUTHORIZED PEN AND INK CHANGE 12/6/23

Instructions on Back

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

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute outpatient hospital services for RY23.

1. Except as provided in subsection 2, below, for dates of service in RY23 (October 1, 2022 through September 30, 2023), in-state Hospitals will be paid in accordance with this Attachment for Outpatient Services provided at Hospital Outpatient Departments, and at those Hospital-Licensed Health Centers (HLHCs) and other Satellite Clinics that are provider-based in accordance with 42 CFR 413.65.

2. In-state Critical Access Hospitals will be paid in accordance with the methods set forth in **Exhibit 1**, which is attached hereto and incorporated by reference into this Attachment, for dates of service in RY23 beginning October 1, 2022 through September 30, 2023.

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

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

5. This **Section I.A.5** describes the payment methods to out-of-state acute outpatient hospitals for acute outpatient hospital services.

a. Except as provided in **subsections 5.c** and **5.d**, below, all out-of-state acute outpatient hospitals are paid utilizing an adjudicated payment per episode of care (APEC) payment methodology ("Out-of-State APEC") as described in **subsection 5.b,** below, for APEC-covered services, and in accordance with the applicable MassHealth fee schedule for services for which in-state acute hospitals are not paid the APEC. "APEC-covered services" are outpatient services for which in-state acute hospitals are paid the APEC.

b. The Out-of-State APEC for each payable episode will equal the sum of (i) the episode-specific total EAPG payment and (ii) the APEC outlier component (if applicable), as further described in **subsections 5.b.(1) and (2)**, below.

(1) The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC Outpatient Statewide Standard in effect for in-state acute hospitals, and the claim detail line's Adjusted EAPG Weight. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line's MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight for this purpose.

(2) The "APEC outlier component" is equal to the Marginal Cost Factor in effect for in-state acute hospitals multiplied by the difference between the episode-specific case

cost and the episode-specific outlier threshold. If the episode-specific case cost is less than the episode-specific outlier threshold, the APEC outlier component is $0.

(i) The "episode-specific case cost" is determined by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the applicable outpatient cost-to-charge ratio. For High MassHealth Volume Hospitals (as defined in **subsection 5.d**, below), the outpatient cost-to-charge ratio is hospital-specific. For all other out-of-state acute hospitals, the median in-state acute outpatient hospital cost-to-charge ratio in effect based on MassHealth episode volume is used.

(ii) The "episode-specific outlier threshold" is equal to the sum of the episode-specific total EAPG payment corresponding to the episode, and the Fixed Outpatient Outlier Threshold in effect for in-state acute hospitals.

(iii) An APEC outlier component is not payable if the episode-specific total EAPG payment is $0.

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

d. If an inpatient service payable by MassHealth is not available in-state, payment for the related acute hospital outpatient services will be made at the rate of payment established for the medical service under the other state's Medicaid program (or equivalent), or such other rate as MassHealth determines necessary to ensure member access to services. This provision does not apply to "High MassHealth Volume Hospitals", which are defined as any out-of-state acute hospital that, during the most recent federal fiscal year for which complete data is available, had at least 100 MassHealth discharges.

e. The payment methods in this **Section I.A.5** are the same for private and governmental providers.

B. Non-Covered Services

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

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

MassHealth contracts with a Behavioral Health (BH) Contractor to provide Behavioral Health Services to Members enrolled with the BH Contractor.

Hospitals are not entitled to, and may not claim for, any payment from EOHHS for any services that are BH Contractor-covered services or are otherwise payable by the BH Contractor.

2. MCO Services

MassHealth contracts with Managed Care Organizations (MCOs) to provide medical services, including Behavioral Health Services, to Members enrolled with the MCO. Hospitals are not entitled to 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. Ambulatory Services Not Governed by this Attachment

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

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 a Hospital received from the Massachusetts Department of Public Health free of charge.

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

II. Definitions

The definitions set forth in the **RY22** column, below, apply during **RY22** (as defined below). The definitions set forth in the **RY23** column, below, apply during **RY23** (as defined below), unless (i) that column specifies that there is no change to the definition, or (ii) for purposes of the APEC payment methodology set forth in **Section III.B**, the Episode's first date of service for Emergency Department, Observation, or Remote Patient Monitoring Services that extend past midnight occurred in RY22, in which case, the definitions set forth in the **RY23** column continue to apply.

Defined Term	Definition Applicable During RY23
RY22	November 1, 2021 through September 30, 2022.
RY23	October 1, 2022 through September 30, 2023.
3M EAPG Grouper	The 3M Corporation's EAPG Grouper version 3.16, configured for the MassHealth APEC payment method.
Accountable Care Organization (ACO)	An entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein 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.
Acute Hospital	See Hospital.

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Defined Term	Definition Applicable During RY23
Actual Acquisition Cost	For purposes of **Section III.E-1**, 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 during an Acute Outpatient Hospital visit, including any efficacy-, outcome-, or performance-based guarantee (or similar arrangements), whether received pre- or post-payment.
Adjudicated Payment per Episode of Care (APEC)	A Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in **Sections I.B, III.C through III.E, III.E-1, III.E-2, and III.E-3**. The APEC is calculated as set forth in **Section III.B**, utilizing the methodology applicable to RY23.
Adjusted EAPG Weight	The EAPG weight that is multiplied by the Hospital's Wage Adjusted APEC Outpatient Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating the Episode-Specific Total EAPG Payment, utilizing the methodology applicable to RY23. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight, including as follows: • **consolidation** is the collapsing of multiple identical or related significant procedure EAPGs into a single EAPG for payment purposes, with the additional procedures weighted at zero percent; • **packaging** applies to ancillary service EAPGs present with a significant procedure EAPG or medical visit EAPG, with the ancillary service EAPGs weighted at zero percent; • **discounting** applies to multiple unrelated significant procedures, repeat ancillary procedures, terminated procedures, and bilateral procedures. All discounting rates are 50%, with the exception of terminated

Defined Term	Definition Applicable During RY23
	procedures (75% of full weight) and the third and subsequent ancillary procedures (25% of full weight).
Adult Mobile Crisis Intervention (AMCI)	A community-based behavioral health service available 24/7/365 and providing short-term mobile, on-site, face-to-face crisis assessment, intervention, and stabilization to individuals 21 years of age and older experiencing a behavioral health crisis. Services may be provided in community-based settings outside the CBHC, at the CBHC, or in emergency department sites of services when necessary. Services may also be provided via telehealth. The purpose is to identify, assess, treat, and stabilize the situation and reduce the immediate risk of danger to the individual or others consistent with the individual's risk management/safety plan, if any.
APEC Base Year	The APEC Base Year is FY19.
APEC Carve-Out Drugs	Drugs that are carved out of the APEC payment and separately paid pursuant to **Section III.E-1**. APEC Carve-Out Drugs are identified on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List.
APEC-Covered Services	MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, except those services described in **Sections I.B, III.C through III.E, III.E-1, III.E-2, and III.E-3.**
APEC Outlier Component	A Hospital-specific, Episode-specific component of the APEC which is calculated by EOHHS as described in **Section III.B.2.b**, utilizing the methodology applicable to RY23, and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.
APEC Outpatient Statewide Standard	

Defined Term	Definition Applicable During RY23
	The APEC outpatient statewide standard determined by EOHHS as described in **Section III.B.2.a(1)(a)** and applicable to RY23
Baseline ED Psychiatric Services	a. Family support and education. b. Screening for substance use disorder (i.e., Screening, Brief Intervention, and Referral to Treatment), including medication-assisted treatment initiation when appropriate. c. Referring members to community-based providers for ongoing care after discharge, as necessary. d. Observation for those with suicidal ideation and/or homicidal ideation.
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.
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.
Behavioral Health Diversionary Services	Mental health and substance use disorder services provided outside of the RFA 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

Defined Term	Definition Applicable During RY23
	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.
Casemix	The description and categorization of a hospital's patient population including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.
Community-Based Acute Treatment (CBAT)	24-hour-per-day, seven-day-per-week, staff-secure treatment settings for children/adolescents up to the age of 18 with serious behavioral health disorders that provide short-term crisis stabilization, therapeutic intervention, and specialized programming.
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.
Community Behavioral Health Center (CBHC)	An entity that serves as a hub of coordinated and integrated behavioral health disorder treatment for individuals of all ages, including routine and urgent behavioral health outpatient services, mobile crisis services for adults and youth, and community crisis stabilization services for adults and youth.
Community Crisis Stabilization (CCS)	A community-based program that serves as a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides short-term staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and

Defined Term	Definition Applicable During RY23
	treatment also include the capacity to provide induction onto and bridging for medication for the treatment of opioid use disorders (MOUD) and withdrawal management for opioid use disorders (OUD) as clinically indicated.
Contract	See RFA and Contract.
Critical Access Hospital	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.
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.
ED-Presenting Psychiatric Member	A Member who presents to a Hospital's ED for clinical evaluation and treatment.
Emergency Department	A Hospital's emergency room or level I trauma center which is located at the same site as the Hospital's inpatient facility or at a separate site included in the Hospital's DPH license.
Emergency Department Behavioral Health Crisis Evaluations	An evaluation provided in an Emergency Department by qualified clinical professionals to members experiencing a behavioral health crisis. 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.
Emergency Services Program (ESP) Services	Medically necessary services provided through designated ESP providers, and which are available seven (7) days per week, twenty-four (24) hours per day to provide treatment of any individual who is experiencing a mental health or substance use disorder crisis, or both. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization. ESP

Defined Term	Definition Applicable During RY23
	Services include Mobile Crisis Intervention for members under the age of 21.
Enhanced Ambulatory Patient Group (EAPG)	A group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M EAPG Grouper.
Enhanced ED Psychiatric Services	Mental health or substance use disorder services provided to ED-Presenting Psychiatric Members in need of Inpatient Behavioral Health (BH) Services (including CBAT and CCS services), who needs to remain in the Hospital's ED or one of the Hospital's non-psychiatric beds for at least 24 hours while awaiting transfer to an Inpatient Facility (whether located in that Hospital, another acute hospital, a psychiatric inpatient hospital, a CBAT unit, or CCS unit).
Episode	All MassHealth-covered Outpatient Services, except those set forth in Sections I.B, III.C through III.E, III.E-1, III.E-2, and III.E-3, delivered to a MassHealth Member on a single calendar day, or if the services extend past midnight in the case of Emergency Department, Observation, or Remote Patient Monitoring Services, on consecutive days. Additionally, in limited circumstances, APEC-Covered Services delivered to a MassHealth Member during a second distinct and independent visit on the same calendar day may be considered a separate Episode for payment purposes if the services are for unrelated purposes and conditions as determined by EOHHS.
Episode's Total Allowed Charges	The sum of the MassHealth allowed charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.
Episode-Specific Case Cost	The product of the Episode's Total Allowed Charges, and the Hospital's FY19 outpatient cost-to-charge ratio as calculated by EOHHS using the Hospital's FY19 Massachusetts Hospital cost report.

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Defined Term	Definition Applicable During RY23
Episode-Specific Outlier Threshold	The sum of the Episode-Specific Total EAPG Payment, as determined by EOHHS, and the Fixed Outpatient Outlier Threshold.
Episode-Specific Total EAPG Payment	An Episode-specific payment amount, which summed with the APEC Outlier component (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in **Section III.B.2.a**, utilizing the methodology applicable to RY23.
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 Outpatient Outlier Threshold	For RY23, the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $4,200.
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

Defined Term	Definition Applicable During RY23
	currently utilizes more than fifty percent (50%) of its beds exclusively as such, as determined by EOHHS.
Hospital-Based Physician	Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Outpatient Hospital Services to Members at a site for which the Hospital is otherwise eligible for payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.
Hospital-Licensed Health Center (HLHC)	A Satellite Clinic that (1) meets MassHealth requirements for payment as a HLHC as provided at 130 CMR 410.413; and (2) is approved by and enrolled with MassHealth as a HLHC.
Inflation Factors for Operating Costs	For price changes between RY14 and RY23, a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factors for Operating Costs between RY14 and RY23 are as follows: • 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.
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 §

Defined Term	Definition Applicable During RY23
	438.2. For clarity purposes, MCOs also include Accountable Care Partnership Plans (ACPPs).
Marginal Cost Factor	As used in the calculation of the APEC Outlier Component, the percentage of payment made for the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. For RY23, 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 FY2023-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: o Baystate Medical Center and Cooley Dickinson Hospital from Springfield to Worcester, o 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, o St, Vincent Hospital and Umass Memorial Medical Center fromWorcester to Boston, and o 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). 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

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	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 referred to as Medicaid)	The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.
MassHealth EAPG Weight	The MassHealth relative weight developed by EOHHS for each unique EAPG, as applicable to RY23.
Member	A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.
Observation Services	Outpatient Hospital Services provided anywhere in an Acute Inpatient Hospital or Hospital Outpatient Department (a) to evaluate a Member's condition and determine the need for admission to an Acute Hospital; or (b) to assess or monitor the Member on the Hospital's premises following a discharge from a COVID-19-related Acute Inpatient Hospital admission, prior to relocating the Member home or to another non-hospital setting. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.
Outpatient Department (also referred to as **Hospital Outpatient Department**)	A department or unit located at the same site as the Hospital's inpatient facility, or a School-Based Health Center that operates under the Hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, primary care clinics, specialty clinics and Emergency Departments.
Outpatient Services (also **Outpatient Hospital Services**)	Preventive, diagnostic, therapeutic or palliative services provided to a Member on an outpatient basis, by or under the direction of a physician or dentist, in a Hospital Outpatient Department, Hospital-Licensed Health Center or other Satellite Clinic. Such services include, but are not limited to, emergency services, primary care services, Observation Services, Remote

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	Patient Monitoring Services, ancillary services, day surgery services, and recovery room services. Payment rules regarding Outpatient Services are found in 130 CMR Parts 410 and 450, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions and the RFA.
PAPE Covered Services	MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics that were paid utilizing the PAPE payment methodology under prior Acute Outpatient Hospital SPAs (including SPA 016-016 for the period up through December 29, 2016).
Payment Amount Per Episode (PAPE)	An outpatient payment methodology that was utilized in prior Acute Outpatient Hospital SPAs. The PAPE was a fixed Hospital-specific all-inclusive facility payment that was made for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode (as defined in prior Acute Outpatient Hospital SPAs, including SPA 016-016 for the RY17 period up through December 29, 2016), with the exception of those services that were excluded from the PAPE payment methodology as described in those prior SPAs. The PAPE methodology was replaced by the APEC payment methodology during RY17, effective with dates of service on or after December 30, 2016.
Primary Care ACO	A type of ACO with which the MassHealth agency contracts under its ACO program.
Primary Care Clinician Plan (PCC Plan)	A comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive primary care, behavioral health, and other medical services.
Rate Year (RY)	Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table:

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Defined Term	Definition Applicable During RY23
	<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 – 09/30/2022</td></tr><tr><td>RY23</td><td>10/01/2022 – 09/20/2022</td></tr></table> *In future rate years, Hospitals will be paid in in accordance with this Attachment (until amended).
Remote Patient Monitoring	Outpatient hospital services provided to a member with confirmed or suspected COVID-19 in the member's home or residence to evaluate the member's condition and determine the need for admission to a hospital.
RFA and Contract	The Request for Applications and the agreement executed between each selected Hospital and EOHHS that incorporates all of the provisions of the RFA.
Satellite Clinic	A facility that operates under a Hospital's license, is subject to the fiscal, administrative, and clinical management of the Hospital, provides services to Members solely on an outpatient basis, is not located at the same site as the Hospital's inpatient facility, and demonstrates to EOHHS's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.
School-Based Health Center (SBHC)	A center located in a school setting which: (1) provides health services to MassHealth Members under the age of 21; (2) operates under a Hospital's license; (3) is subject to the fiscal, administrative, and clinical management

Defined Term	Definition Applicable During RY23
	of a Hospital Outpatient Department or HLHC; and (4) provides services to Members solely on an outpatient basis.
Tier 1 ED Psychiatric Provider	A Hospital attests that it has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members according to the Tier 1 requirements during the period between November 1, 2022, and April 30, 2023, or between May 1, 2023, and September 30, 2023.
Tier 2 ED Psychiatric Provider	A Hospital attests that it has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members according to the Tier 2 requirements during the period between November 1, 2022, and April 30, 2023, or between May 1, 2023, and September 30, 2023.
Usual and Customary Charges	Routine fees that Hospitals charge for Outpatient Services rendered to patients regardless of payer sources.
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.
Youth Community Crisis Stabilization (YCCS)	Staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that provides active treatment that includes restoration of functioning; strengthening the resources and capacities of the youth, family, and other natural supports; and ensuring a timely return to previous living environment to individuals up to and including 18 years of age.
Youth Mobile Crisis Intervention (YMCI)	A community-based behavioral health service available 24/7/365 providing short-term mobile, on-site, face-to-face crisis assessment, intervention, and stabilization to individuals younger than 21 years of age experiencing a behavioral health crisis. Transition-aged youth older than 17 years of age and younger than 21 years of age may be served by adult-trained clinicians with a certified peer specialists instead of a family partner based on an individual's clinical needs. Services may be provided in community-based settings outside the CBHC or at the CBHC. Services may be provided via telehealth. The purpose is to identify, assess, treat, and stabilize the situation

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Defined Term	Definition Applicable During RY23
	and reduce the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any.

III. Payment for Outpatient Services

A. Overview

Except as otherwise provided for Outpatient Services specified in **Sections I.B, III.C through III.E, III.E-1, III.E-2, III.E-3**, **III.E-4**, and in **Exhibit 1**, Hospitals will receive a Hospital-specific, Episode-specific payment for each Episode known as the Adjudicated Payment per Episode of Care (APEC), calculated as set forth in **Section III.B**, below. This payment methodology is applicable to all public and private providers.

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

For dates of service in RY23 beginning October 1, 2022 through September 30, 2023, Critical Access Hospitals are paid in accordance with **Exhibit 1**.

B. Adjudicated Payment per Episode of Care (APEC)

1. Rate Year 2023 APEC Payment Methodology

The APEC methodology is set forth in **Section III.B.2**, below. The **RY23** column applies to dates of service in RY23, and incorporates applicable definitions in **Section II** that apply to RY23. As an exception, for Episodes that extend past midnight in the case of Emergency Department, Observation, or Remote Patient Monitoring Services, the APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode..

RY23 (for dates of service in RY23)
2. Description of APEC payment method Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for each payable Episode known as the APEC. The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus (2), if applicable, an APEC Outlier Component, as further described below.
a. Episode-Specific Total EAPG Payment. For each claim detail line containing APEC-Covered Services in the Episode, the Hospital's Wage Adjusted APEC Outpatient Standard (as described below) is multiplied by the claim detail line's Adjusted EAPG Weight (as described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.

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RY23 (for dates of service in RY23)
(1) **Wage Adjusted APEC Outpatient Standard.** The Wage Adjusted APEC Outpatient Standard is the APEC Outpatient Statewide Standard, adjusted by the Hospital's Massachusetts-specific Wage Area Index, as further described below. (a) **APEC Outpatient Statewide Standard.** The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for wage area index, casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described below. For each Hospital, an average outpatient cost per Episode for the APEC Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all CY19 APEC-paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. Each Hospital's CCR was calculated by EOHHS using the Hospital's FY19 cost report. The Hospital-specific Episodes and related charges were determined by EOHHS based on paid claims for Episodes residing in MMIS as of July 21, 2021, for the APEC Base Year, for which MassHealth was primary payer. The labor portion of the average outpatient cost per Episode for each Hospital was adjusted by the Hospital's Massachusetts-specific Wage Area Index, as defined in **Section II**, and the labor and non-labor portions were then adjusted by the Hospital-Specific CY19 Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific CY19 Outpatient CMI was determined based on CY19 paid claims data residing in MMIS as of July 21, 2021, for which MassHealth was primary payer. EOHHS calculated each Hospital's CY19 Outpatient CMI by summing the Hospital's CY19 grouper-adjusted EAPG weights for each of its APEC-paid Episodes during CY19, as determined by EOHHS, and then dividing that sum by the Hospital's total number of APEC-paid Episodes in CY19, also as determined by EOHHS. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of CY19 MassHealth Episodes for the Hospitals was produced from MMIS paid claims on file as of July 21, 2021, for which MassHealth was the primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 60% of the total number of statewide Episodes in MMIS. The APEC efficiency standard applicable to RY23 is $813.85. The APEC Outpatient Statewide Standard was then determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 93%; and by (c) the Inflation Factors for Operating Costs between RY19

RY23 (for dates of service in RY23)
and RY23, and then dividing that result by a conversion factor of 1.160. The APEC Outpatient Statewide Standard applicable to RY23 is $656.84. (b) **Wage Adjusted APEC Outpatient Standard** Except as otherwise provided in this section, the Hospital's Wage Adjusted APEC Outpatient Standard is determined by (1) multiplying the labor portion of the APEC Outpatient Statewide Standard by the Hospital's Massachusetts-specific Wage Area Index (as defined in **Section II**), and (2) adding this amount to the non-labor portion of the APEC Outpatient Statewide Standard. For this purpose, the Hospital's Massachusetts-specific wage area index which was multiplied by the labor portion of the APEC Outpatient Statewide Standard was derived as specified in Section III.B.2.a.1. For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's Wage Adjusted APEC Outpatient Standard will be $836.35. For the Acute Hospitals identified as Group 1 safety net hospitals in Appendix N to the MassHealth 1115 waiver, the Wage Adjusted APEC Outpatient Standard will be as follows: • Group 1 Hospitals that are High Medicaid Volume Safety Net Hospitals (Boston Medical Center): $714.59 • Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Boston (Brockton Hospital, Carney Hospital): $743.59 • Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Springfield (Holyoke Medical Center, Mercy Hospital): $657.05 • Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Cambridge-Newton-Framingham (Lawrence General Hospital): $705.54
(2) **Claim Detail Line's "Adjusted EAPG Weight**." EAPGs are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted Hospital claim, utilizing the 3M EAPG Grouper. EAPGs are assigned at the claim detail line level. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights (as defined in **Section II**) to produce that claim detail line's Adjusted EAPG Weight.

RY23 (for dates of service in RY23)
b. APEC Outlier Component. The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then multiplied by RY23 Marginal Cost Factor. The Episode-Specific Case Cost is the product of the Episode's Total Allowed Charges and the Hospital's FY20 Outpatient CCR (which is based on the Hospital's FY20 Massachusetts Hospital cost report). The Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section III.B.2.a,** above), and RY23 Fixed Outpatient Outlier Threshold of $4,200. If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor for RY23 set at 60%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.
c. Calculation of the APEC. The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section III.B.2.a**, above) and the APEC Outlier Component (calculated as set forth in **Section III.B.2.b**., above).

See **Tables 1, 1.1 and 1.2**, below, for an illustrative example of the RY23 calculation of a Hospital's APEC for Episode claim with multiple EAPGs.

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Table 1: Example of Hospital's RY23 APEC Calculation for a Single Episode			
(Values are for demonstrative purposes only)			
Line	**Description**	**Value**	**Calculation or Source**
Calculation of Episode-Specific Total EAPG Payment			
1	Episode-Specific Total EAPG Payment	$3,389.71	Sum of episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #s 1 through 5 from Table 5.2)
Calculation of APEC Outlier Component (only calculated if Line 1 > $0)			
2	Episode's Total Allowed Charges	$15,300.00	Sum of episode's claim detail line MassHealth allowed charges (sum of Line 2 from claim detail lines #s 1 through 5 from Table 5.2)
3	Hospital's Outpatient Cost-to-Charge Ratio	60.00%	Hospital's FY20 Massachusetts Hospital Cost Report
4	Episode-Specific Case Cost	$9,180.00	Line 2 * Line 3
5	Fixed Outpatient Outlier Threshold	$4,200.00	RY23 RFA
6	Episode-Specific Outlier Threshold	$7,589.71	Line 1 + Line 5
7	Does Episode-Specific Cost exceed Episode-Specific Outlier Threshold ?	TRUE	Is line 4 > Line 6? If TRUE, then APEC Outlier component is due
8	Marginal Cost Factor	60%	RY23 RFA
9	APEC Outlier Component	$ 954.17	(Line 4 - Line 6) * Line 8
APEC for the Episode			
10	APEC	$ 4,343.88	Line 1 + Line 9

Table 1: Example of Hospital's RY22 APEC Calculation for a Single Episode - 2nd RY22 Period			
(Values are for demonstrative purposes only)			
Line	**Description**	**Value**	**Calculation or Source**
Calculation of Episode-Specific Total EAPG Payment			
1	Episode-Specific Total EAPG Payment	$3,350.31	Sum of episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #s 1 through 5 from Table 1.2)
Calculation of APEC Outlier Component (only calculated if Line 1 > $0)			
2	Episode's Total Allowed Charges	$15,300.00	Sum of episode's claim detail line MassHealth allowed charges (sum of Line 2 from claim detail lines #s 1 through 5 from Table 1.2)
3	Hospital's Outpatient Cost-to-Charge Ratio	60.00%	Hospital's FY19 Massachusetts Hospital Cost Report
4	Episode-Specific Case Cost	$9,180.00	Line 2 * Line 3
5	Fixed Outpatient Outlier Threshold	$4,100.00	Section II Definition (2nd RY22 Period)
6	Episode-Specific Outlier Threshold	$7,450.31	Line 1 + Line 5
7	Does Episode-Specific Cost exceed Episode-Specific Outlier Threshold ?	TRUE	Is line 4 > Line 6? If TRUE, then APEC Outlier component is due
8	Marginal Cost Factor	60%	Determined Annually
9	APEC Outlier Component	$ 1,037.81	(Line 4 - Line 6) * Line 8
APEC for the Episode			
10	APEC	$ 4,388.12	Line 1 + Line 9

Table 1.1: Hospital's Wage Adjusted APEC Outpatient Standard (Example)			
(Values are for demonstrative purposes only)			
Line	**Description**	**Value**	**Calculation or Source**
1	APEC Outpatient Statewide Standard	$653.84	RY23 RFA
2	Hospital's Massachusetts-specific wage area index	1.0704	Varies by hospital, determined annually
3	Labor factor	0.6000	RY23 RFA
4	Hospital's Wage Adjusted APEC Outpatient Standard	$681.46	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3))

Table 1.1: Hospital's Wage Adjusted APEC Outpatient Standard (Example)			
(Values are for demonstrative purposes only)			
Line	**Description**	**Value**	**Calculation or Source**
1	APEC Outpatient Statewide Standard	$646.24	Section III.B.2.a(1)(a) (2nd RY22 Period)
2	Hospital's Massachusetts-specific wage area index	1.0704	Varies by hospital, determined annually
3	Labor factor	0.6000	Determined annually
4	Hospital's Wage Adjusted APEC Outpatient Standard	$673.54	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0 - Line 3))

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Table 1.2: Claim Detail Line EAPG Payment Amounts (Example)			
(Values are for demonstrative purposes only)			
Claim Detail Line #1 EAPG Payment Amount Calculation			
EAPG:	**290, PET SCANS**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$681.46	Table 5.1, Line 4
2	Claim detail line allowed charges	$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	2.3680	Appendix D, Chart D
4	Claim detail line Adjusted EAPG weight	2.3680	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$1,613.69	Line 1 * Line 4
Claim Detail Line #2 EAPG Payment Amount Calculation			
EAPG:	**220, LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$681.46	Table 5.1, Line 4
2	Claim detail line allowed charges	$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.7244	Appendix D, Chart D
4	Claim detail line Adjusted EAPG weight	1.7244	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$1,175.11	Line 1 * Line 4
Claim Detail Line #3 EAPG Payment Amount Calculation			
EAPG:	**220, LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$681.46	Table 5.1, Line 4
2	Claim detail line allowed charges	$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.7244	Appendix D, Chart D
4	Claim detail line Adjusted EAPG weight	0.8622	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$587.55	Line 1 * Line 4
Claim Detail Line #4 EAPG Payment Amount Calculation			
EAPG:	**299, LEVEL I COMPUTED TOMOGRAPHY**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$681.46	Table 5.1, Line 4
2	Claim detail line allowed charges	$2,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.1170	Appendix D, Chart D
4	Claim detail line Adjusted EAPG weight	-	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	Line 1 * Line 4
Claim Detail Line #5 EAPG Payment Amount Calculation			
EAPG:	**400, LEVEL I CHEMISTRY TESTS**		
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$681.46	Table 5.1, Line 4
2	Claim detail line allowed charges	$300.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.0196	Appendix D, Chart D
4	Claim detail line Adjusted EAPG weight	0.0196	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$13.36	Line 1 * Line 4

Table 1.2: Claim Detail Line EAPG Payment Amounts (Example)			
(Values are for demonstrative purposes only)			
Claim Detail Line #1 EAPG Payment Amount Calculation			
EAPG: 290, PET SCANS			
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$673.54	Table 1.1, Line 4
2	Claim detail line allowed charges	$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	2.3680	Determined based on claim information
4	Claim detail line Adjusted EAPG weight	2.3680	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$1,594.94	Line 1 * Line 4
Claim Detail Line #2 EAPG Payment Amount Calculation			
EAPG: 220, LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP			
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$673.54	Table 1.1, Line 4
2	Claim detail line allowed charges	$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.7244	Determined based on claim information
4	Claim detail line Adjusted EAPG weight	1.7244	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$1,161.45	Line 1 * Line 4
Claim Detail Line #3 EAPG Payment Amount Calculation			
EAPG: 220, LEVEL II NERVOUS SYSTEM INJECTIONS INCLUDING CRANIAL TAP			
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$673.54	Table 1.1, Line 4
2	Claim detail line allowed charges	$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.7244	Determined based on claim information
4	Claim detail line Adjusted EAPG weight	0.8622	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$580.72	Line 1 * Line 4
Claim Detail Line #4 EAPG Payment Amount Calculation			
EAPG: 299, LEVEL I COMPUTED TOMOGRAPHY			
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$673.54	Table 1.1, Line 4
2	Claim detail line allowed charges	$2,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.1170	Determined based on claim information
4	Claim detail line Adjusted EAPG weight	-	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	Line 1 * Line 4
Claim Detail Line #5 EAPG Payment Amount Calculation			
EAPG: 400, LEVEL I CHEMISTRY TESTS			
Line	**Description**	**Value**	**Calculation or Source**
1	Hospital's Wage Adjusted APEC Outpatient Standard	$673.54	Table 1.1, Line 4
2	Claim detail line allowed charges	$300.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.0196	Determined based on claim information
4	Claim detail line Adjusted EAPG weight	0.0196	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$13.20	Line 1 * Line 4

C. Physician Payments

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

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

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

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

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

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

D. Outpatient Hospital Services Payment Limitations

1. Payment Limitations on Hospital Outpatient Services Preceding an Admission

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

2. Payment Limitations on Outpatient Services to Inpatients

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

E. Laboratory Services

1. Payment for Laboratory Services

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

2. Physician Services

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

E-1. Payment for APEC Carve-Out Drugs

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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)
Payment to Hospitals for APEC Carve-Out Drugs administered to Members during an outpatient hospital visit will be the Hospital's Actual Acquisition Cost of the Drug.

E-2. Emergency Department-Dispensed Nasal Naloxone Packages

1. Payment for Emergency Department-Dispensed Nasal Naloxone Packages

Hospitals will be reimbursed for the dispensing of nasal naloxone packages through their emergency departments at the rate of $125 per nasal naloxone package. A single nasal naloxone package consists of two nasal spray inhalers, with each inhaler containing 4 mg of naloxone. This payment is in addition to any payment that the Hospital may receive pursuant to Section III for services rendered to the member.

2. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the dispensing of nasal naloxone packages through their emergency departments.

E-3. Payment for Outpatient Administration of Certain Physician Administered Drugs

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)
EOHHS will pay Hospitals for the outpatient administration of certain physician administered drugs identified on the "Certain MassHealth Outpatient Physician Administered Drugs to be paid by fee schedule" section of the MassHealth Drug List (Fee Schedule Drugs) in accordance with this **Section III.E-3**. Payment to hospitals for the outpatient administration of any Fee Schedule Drug shall be the amount as listed by the quarterly Medicare Part B Drug Average Sales Price for the Fee Schedule Drug, as set forth on CMS's website at 2022 ASP Drug Pricing Files | CMS This payment is in addition to any payment that the Hospital may receive pursuant to **Section III** for services rendered to the member.

E-4. Payment for Emergency Department Behavioral Health Crisis Evaluations

The Hospital will be reimbursed for rendering Emergency Department Behavioral Health Crisis Evaluations at the rate of $695.29 for dates of service on or after January 3, 2023. This payment is in addition to any payment that the Hospital may receive pursuant to Section III for services rendered to the member.

F. 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.F.1.a** (each an "Eligible Hospital" for purposes of this **Section III.F.1**).

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

The outpatient 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 Episode Volume by summing 60% of the Hospital's FY23 ACPP and Primary Care ACO episode volume, 20% of the Hospital's FY23 MCO episode volume, and 20% of the Hospital's FY23 PCC Plan episode volume;
- Second, EOHHS will calculate each Eligible Hospital's Pro-Rata Episode Volume by dividing its Weighted Episode Volume by all Eligible Hospitals' Weighted Episode Volume;
- 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 Outpatient HPP Distribution Percentage by multiplying its Pro-Rata Episode Volume by its HPP Ratio;

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

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

For purposes of this calculation, FY23 ACPP, Primary Care ACO, MCO, and PCC Plan episode volume refers to paid outpatient episodes of care delivered by the qualifying hospital to 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 episode volume, ACPP and MCO encounter data submitted by each ACPP and MCO for FY23 and residing in the MassHealth data warehouse as of March 31, 2024, and for the PCC Plan and Primary Care ACO episode volume, Medicaid paid claims data for FY23 residing in MMIS as of March 31, 2024, for which MassHealth is primary payer. Only ACPP and MCO encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section III.F.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, 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) outpatient payment amount will be up to $1,200 times the total number of Episodes with dates of service during FFY23, not to exceed $2.0 million.

For CHA, the Federal Fiscal Year outpatient 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 $17.5 million. Notwithstanding such maximum outpatient amount, EOHHS may make outpatient 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, and satisfying all other conditions of this **Section III.F.2** 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.J.2.b** of Attachment 4.19-A(1) (TN-021-036) 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 inpatient hospital limit would be exceeded if CHA was paid its maximum FFY23 inpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-021-036), or if CHA has insufficient inpatient utilization or otherwise to support such maximum inpatient 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. 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 outpatient Medicaid payment and outpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Acute Hospital with High Medicaid Discharges payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

4. High Medicaid Volume Safety Net Hospital HLHC Supplemental Payment

In order to qualify for a High Medicaid Volume Safety Net Hospital HLHC supplemental payment, a Hospital must be a High Medicaid Volume Safety Net Hospital that operates an HLHC that experienced a volume of at least 75,000 outpatient episodes in FY18, as determined by EOHHS through a review of MMIS claims ("Qualifying HLHC"). Based on these criteria, Boston Medical Center is the only hospital eligible for this payment.

Subject to compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make $2.1 million in total aggregate supplemental payments to Hospitals that qualify for this payment pursuant to the preceding paragraph, divided equally among all qualifying Hospitals, provided that each such Hospital agrees to spend such funds solely for the benefit of its Qualifying HLHC. The payment amount will be specified in an agreement between EOHHS and each qualifying Hospital.

5. Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services

a. Definitions

For the purposes of this payment, the following defined terms have been added to the definitions chart in Section II:

- Baseline ED Psychiatric Services
- Community-Based Acute Treatment (CBAT)
- Community Crisis Stabilization (CCS)
- ED-Presenting Psychiatric Member
- Enhanced ED Psychiatric Services
- Tier 1 ED Psychiatric Provider
- Tier 2 ED Psychiatric Provider
- Youth Community Crisis Stabilization (YCCS)

b. Eligibility Criteria

A Hospital is eligible for a Supplemental Payment to Promote Hospital Capacity to Provide Enhanced ED Psychiatric Services if the Hospital:

1. For the purposes of payment under **Section III.F.5.c.1**, below, attests, in a form and format to be prescribed by EOHHS:

a. To the number of bed days within calendar year 2021 (CY21) on which an ED-Presenting Psychiatric Member remained in the Hospital's ED or one of the Hospital's non-psychiatric beds while awaiting transfer to an Inpatient BH Bed, even if such Member was ultimately discharged without being admitted to an Inpatient BH Bed, provided that, for purposes of this calculation, the Hospital shall exclude any bed-day(s) in which such Member arrived in the ED and was either discharged within 24 hours of presentation to the ED or transferred to an Inpatient BH Bed within 24 hours of presentation to the ED;

b. That the hospital has the capacity to provide Baseline Services to all ED-Presenting Psychiatric Members; and

c. That the hospital is self-designating during the period from November 1, 2022, through April 30, 2023, as either a Tier 1 Provider or a Tier 2 Provider.

   i. By self-designating as a Tier 1 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced Services to each of its of its ED-Presenting Psychiatric Members, once within 48 hours of each such Member's presentation to the hospital's ED, and then at least once every 3 days thereafter until each such Member transfers to an Inpatient BH Bed or is discharged without being admitted to an Inpatient BH Bed.

   ii. By self-designating as a Tier 2 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced Services each day to each of its ED-Presenting Psychiatric Members until each such Member transfers to an Inpatient BH Bed or is discharged without being admitted to an Inpatient BH Bed.

2. For the purposes of payment under Section III.F.5.c.2, below, attests in a form and format to be prescribed by EOHHS:

   a. To the number of bed days within calendar year 2021 (CY21) on which an ED-Presenting Psychiatric Member remained in the Hospital's ED or one of

the Hospital's non-psychiatric beds while awaiting transfer to an Inpatient BH Bed, even if such Member was ultimately discharged without being admitted to an Inpatient BH Bed, provided that, for purposes of this calculation, the Hospital shall exclude any bed-day(s) in which such Member arrived in the ED and was either discharged within 24 hours of presentation to the ED or transferred to an Inpatient BH Bed within 24 hours of presentation to the ED;

b. That the hospital has the capacity to provide Baseline Services to all ED-Presenting Psychiatric Members; and

c. That the hospital is self-designating during the period from May 1, 2023, through September 30, 2023, as either a Tier 1 Provider or a Tier 2 Provider.

i. By self-designating as a Tier 1 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced Services to each of its of its ED-Presenting Psychiatric Members, once within 48 hours of each such Member's presentation to the hospital's ED, and then at least once every 3 days thereafter until each such Member transfers to an Inpatient BH Bed or is discharged without being admitted to an Inpatient BH Bed.

ii. By self-designating as a Tier 2 Provider, the Hospital must attest that it has the capacity to provide at least one of the Enhanced Services each day to each of its ED-Presenting Psychiatric Members until each such Member transfers to an Inpatient BH Bed or is discharged without being admitted to an Inpatient BH Bed.

3. Enters into a separate payment agreement with EOHHS relating to receipt of such payment. Among other things, such Hospital must agree:

a. Regardless of its designation as either a Tier 1 Provider or a Tier 2 Provider, that it has the capacity to provide Baseline Services to all ED-Presenting Psychiatric Members.

b. If self-designating as a Tier 1 Provider for the period from November 1, 2022, through April 30, 2023, or the period from May 1, 2023, through September 30, 2023, or both such periods, that the hospital has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members at Tier 1 as levels described above. For purposes of this Section III.F.5.b.3.b, a Tier 1 Provider has the required capacity if at least 90% of ED-Presenting Psychiatric Members receive at least one Enhanced Service at the Tier 1 frequency set forth above during the period(s) in which it self-designated as a Tier 1 Provider.

c. If self-designating as a Tier 2 Provider, for the period from November 1, 2022, through April 30, 2023, or the period from May 1, 2023, through September 30, 2023, or both such periods that the hospital has the capacity to provide Enhanced Services to each of its ED-Presenting Psychiatric Members at Tier 2 as levels described above. For purposes of this Section III.F.5.b.3.c, a Tier 2 Provider has the required capacity if at least 90% of ED-Presenting Psychiatric Members receive at least one Enhanced Service at the Tier 2 frequency set forth above during the period(s) in which it self-designated as a Tier 2 Provider.

d. That any supplemental payments made pursuant to this Section III.F.5 are subject to recoupment, in whole or in part, if the Hospital fails to comply with any terms, conditions, or agreements described in this Section III.F.5.

c. Methodology

Subject to applicable federal rules and payment limits, EOHHS will make a supplemental payment to each Hospital that qualifies for payment pursuant to Section III.F.5.b, in accordance with the methodology that follows.

1. For the period from November 1, 2022, through April 30, 2023, EOHHS will:
   a. Pay each self-designating Tier 1 Provider $300 multiplied by half of the number of bed-days identified in the Hospital's attestation pursuant to Section III.F.5.b.1.a.
   b. Pay each self-designating Tier 2 Provider $500 multiplied by half of the number of bed-days identified in the Hospital's attestation pursuant to Section III.F.5.b.1.a.
2. For the period from May 1, 2023, through September 30, 2023, EOHHS will:
   a. Pay each self-designating Tier 1 Provider $300 multiplied by five-twelfths of the number of bed-days identified in the Hospital's attestation pursuant to Section III.F.5.b.2.a.
   b. Pay each self-designating Tier 2 Provider $500 multiplied by five-twelfths of the number of bed-days identified in the Hospital's attestation pursuant to Section III.F.5.b.2.a.

6. Outpatient Episode Add-on

a. The outpatient add-on pool is $344.5 million, calculated by multiplying $650 million by 53%.

b. To determine each in-state acute hospital's final adjusted outpatient episode add-on payment amount, EOHHS will:

1. First, divide the outpatient add-on pool by the total number of RY23 in-state acute care hospital outpatient episodes, as determined by EOHHS based on paid claims and encounters on file as of March 31, 2024, to calculate the final outpatient add-on payment amount per episode.

2. Second, multiply the total number of RY23 outpatient episodes 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 outpatient add-on payment amount per episode, to calculate the final outpatient add-on payment amount.

3. Third, for each hospital, subtract the total hospital-specific interim outpatient add-on payments received in RY23, as calculated as described in Section III.F.6.c, from hospital-specific final outpatient add-on payment amounts, calculated in Section III.F.6.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 outpatient episode add-on amount for each hospital, calculated pursuant to this Section III.F.6.b.

c. EOHHS will make interim outpatient episode add-on payments in RY23. For each interim outpatient episode add-on payment, a new outpatient add-on amount per episode 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 outpatient episodes in a historical period, as determined by EOHHS ("interim dataset"). To determine interim outpatient add-on payment amounts pursuant to this Section III.F.6.c, EOHHS will multiply each in-state acute care hospital outpatient episode from the interim dataset by the interim payment outpatient episode add-on amount.

7. Clinical Quality Incentive Payment

Each Hospital will receive a Clinical Quality Incentive (CQI) program payment calculated as follows:

a. The Hospital's measures, domain scoring, overall quality scoring, maximum eligible CQI payment, and actual CQI program payment will be determined as described in Attachment 4.19-A (1) pp. 57-66, at Section III.L.1 through Section III.L.5.b.
b. The CQI program payment paid through this Section III.7.F is in proportion to the hospital's Medicaid fee-for-service outpatient utilization.

8. Targeted Hospital Supplemental Payments

a. Eligibility Criteria

In order to be eligible for a targeted hospital supplemental payment, 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 determined by EOHHS.

b. Methodology

EOHHS will make the targeted hospital supplemental payments described in this Section III.F.8 as follows:

i. For hospitals eligible for targeted hospital supplemental payments under Section III.F.8.a.i, EOHHS shall make a payment of $25,000,000.

ii. For hospitals eligible for a targeted hospital supplemental payments under Section III.F.8.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 among the remaining eligible hospitals.

9. 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 the supplemental payment described in this Section III.F.9 in accordance with the eligibility criteria described in Attachment 4.19-A (1) pp. 48-49, Section III.J.14.a.

b. Payment Tier Qualification

EOHHS will make the supplemental payment described in this Section III.F.9 in accordance with the payment tiers qualifications described in Attachment 4.19-A (1) pp. 49, Section III.J.14.b.

c. Methodology

EOHHS shall pay hospitals qualifying for the supplemental payment described in this Section III.F.9 as follows:

i. EOHHS shall follow the methodology described in Attachment 4.19-A (1) pp. 50, Section III.J.14.c.iii.A;

ii. The amount paid to each hospital shall equal the lesser amount per hospital determined according to the methodology described in Attachment 4.19-A (1) pp. 50, Section III.J.14.c.iii.A.3 multiplied by 0.5938.

IV. [Reserved]

V. Other Provisions

A. Federal Limits

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

B. Future Rate Years

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

C. 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.

D. Data Sources

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

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

VI. Other Quality and Performance Based Payment Methods

A. Provider Preventable Conditions

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

Payment Adjustment for Provider Preventable Conditions

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

Other Provider-Preventable Conditions

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

☒Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
☒Additional Other Provider-Preventable Conditions identified below:

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

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

- In addition, the following:

1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.

3. Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended.
4. Patient death or serious injury associated with patient elopement (disappearance)
5. Patient suicide, attempted suicide, or self-harm resulting in serious injury, while being cared for in a healthcare setting.
6. Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)
7. Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting.
8. Death or serious injury of a neonate associated with labor and delivery in a low risk pregnancy.
9. Unstageable pressure ulcer acquired after admission / presentation in a healthcare setting.
10. Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
11. Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
12. Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area.
13. Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a health care setting.
14. Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting.

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

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

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

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

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

When a Hospital reports a PPC, MassHealth will reduce payments to the Hospital as follows:

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

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

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

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

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

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

B. Serious Reportable Events

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

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

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

1. All services provided during the outpatient visit during which a preventable SRE occurred; and

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

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

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

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

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

A Hospital not involved in the occurrence of a preventable SRE that also does not meet the criteria in number 2 above, and that provides inpatient or outpatient services to a patient who previously incurred an SRE may bill MassHealth for all medically necessary Hospital and Hospital-Based Physician services provided to the patient following a preventable SRE.

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services
Exhibit 1: RY23 Payment Method for Critical Access Hospitals
Effective October 1, 2022 through September 30, 2023

EXHIBIT 1
RY23 Payment Method Applicable to Critical Access Hospitals
Effective October 1, 2022 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 both inpatient and outpatient services in RY23, 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**. The interim payments made for Outpatient Services to Critical Access Hospitals will be made on the same basis as payment would be made for those same Outpatient Services to all other Hospitals (e.g., per Episode for Outpatient Services paid by the APEC), and the timing of the interim payments will not differ from the timing that Outpatient Services are paid to all other Hospitals. Subject to this **Exhibit 1**, **Attachment 4.19-B(1**) otherwise applies to Critical Access Hospitals. If a Hospital loses its designation as a Critical Access Hospital, the payment methods for such hospital shall revert to the standard acute hospital rate methodologies, and payments may be adjusted accordingly. Reversion to any such rate methodologies shall not affect the payment rates to other participating acute hospitals for the applicable rate year.

(A) Payment for Outpatient Services

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

For dates of service in RY23, Critical Access Hospitals will be paid a Hospital-specific, Episode-specific Adjudicated Payment per Episode of Care (APEC) for those Outpatient Services for which all other in-state Hospitals are paid an APEC.

Notwithstanding **Section III.B** of this **Attachment 4.19-B(1)**, for dates of service in RY23, the hospital-specific, episode-specific APEC for each Critical Access Hospital was calculated as follows:

(1) EOHHS calculated a cost per Episode for outpatient services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 21 of the Hospital's FY21 CMS-2552-10 cost report, by the Hospital's number of FY21 Medicaid (MassHealth) Episodes. Episode volume was derived from FY21 paid claims data residing in MMIS for which MassHealth was primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY21 and RY23, as defined in **Section II** of **Attachment 4.19-B(1)**, to derive the Critical Access Hospital's RY23 inflation-adjusted cost per Episode.

(3) EOHHS then divided each Critical Access Hospital's RY23 inflation-adjusted cost per Episode by each Hospital's FY21 outpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the ^{t} RY23 CAH-specific Outpatient Standard Rate per Episode.

(5) The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the RY23 CAH-specific Outpatient Standard Rate per Episode for the Wage Adjusted APEC Outpatient Standard and calculating a CAH APEC payment as otherwise described in **Section III.B.2** of this Attachment 4.19-B(1), utilizing the methodology applicable to RY23.

(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 both inpatient and outpatient services for FY22, as such amount is determined by EOHHS ("101% of allowable costs"). See also Exhibit 1 to Attachment 4.19-A(1). EOHHS will utilize the Critical Access Hospital's 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 supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in **Section III.F.1 o**f **Attachment 4.19-B(1)**.

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

This post RY23 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.