DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations (CMSO)

Dr. Judy Ann Bigby, Secretary
Executive Office of Health and Human Services
State of Massachusetts
One Ashburton Place
Boston, MA 02108

AUG 13 2009

RE: Massachusetts 08-015

Dear Dr. Bigby:

We have reviewed the proposed amendment to Attachment 4.19-A (1) of your Medicaid State plan submitted under transmittal number (TN) 08-015. This amendment updates the acute inpatient hospital payment methods for hospital rate year (RY) 2009.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 08-015 is approved effective October 1, 2008. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **08-015**	2. STATE **MA**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **10/01/08**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 USC 1396a(a)(13); 42 USC 1315; 42CFR Part 447; 42CFR 440.10	**a. FFY09 $ (52,670,000)** **b. FFY10 $ 4,720,000**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A (1), pages 1- 30 **Exhibits to Attachment 4.19-A (1), numbers 1-6**	**Attachment 4.19-A (1), pages 1- 29** **Exhibits to Attachment 4.19-A (1), numbers 1-7**

10. SUBJECT OF AMENDMENT:

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

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED:
Not required under 42 CMR 430.12(b)(2)(ii)

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **JudyAnn Bigby, M.D.**	**Michael P. Coleman** **State Plan Coordinator** **Executive Office of Health and Human Services** **Office of Medicaid** **One Ashburton Place, 11th Floor** **Boston, MA 02108**
14. TITLE: **Secretary**	
15. DATE SUBMITTED: **12/31/08**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 8-13-09
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2008	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: William Lasowski	22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM CMS-179 (07-92)

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

Exhibits to Attachment 4.19-A (1)

Exhibit 1: 130 CMR 450.233

Exhibit 2: 130 CMR 415.415 and 415.416

Exhibit 3: Appendix F to the Inpatient Hospital Manual

Exhibit 4: Chapter 147 of the Acts and Resolves of 1995

Exhibit 5: 130 CMR 435.408, 435.410, and 435.411

Exhibit 6: 114.6 CMR 14.00

Exhibit 7: MA-TN-07-014 excerpt

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

I. Overview

On August 19, 2009 , the Executive Office of Health and Human Services (EOHHS) issued the Rate Year 2009 Acute Hospital Request for Applications (RFA) to solicit applications from eligible, in-state Acute Hospitals that seek to participate as MassHealth providers of Acute Hospital services. In-state Acute Hospitals that: (1) operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH); (2) are Medicare certified and participate in the Medicare program; (3) have more than fifty percent (50%) of their 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 beds (Level III), as determined by DPH; and (4) currently utilize more than fifty percent (50%) of their beds as such, as determined by EOHHS, are eligible to apply for a contract pursuant to the RFA. Reimbursement of out-of-state inpatient Hospital services is governed by 130 CMR 450.233 (**Exhibit 1**).

The RFA is effective October 1, 2008.

II. Definitions

Administrative Day (AD) – A day of inpatient hospitalization on which a Member's care needs can be provided in a setting other than an Acute Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416 attached as **Exhibit 2**

Behavioral Health (BH) Contractor – The entity with which EOHHS contracts to provide Behavioral Health Services to enrolled members.

Behavioral Health Services – services provided to Members who are being treated for psychiatric disorders or substance-related disorders.

Community-Based Physician – Any physician, or physician group practice, excluding interns, residents, fellows and house officers, who is not a Hospital-Based Physician. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths.

Contract (Hospital Contract or Agreement) – The agreement executed between each selected Hospital and EOHHS, which incorporates all of the provisions of the RFA.

Contractor – Each Hospital that is selected by EOHHS after submitting a satisfactory application in response to the RFA and that enters into a contract with EOHHS to meet the purposes specified in the RFA.

Department of Mental Health (DMH) – An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

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

Division of Health Care Finance and Policy (DHCFP) – a division of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

Essential MassHealth Hospital – A Hospital that meets the qualifications set forth in **Section IV.C.4.**

Excluded Units – Non-Acute Units as defined in this section; any unit which has a separate license from the Hospital; Psychiatric and Substance Abuse units; and Non-distinct Observation Units.

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

Fiscal Year (FY) – the time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. FY09 begins on October 1, 2008, and ends on September 30, 2009.

Gross Patient Service Revenue – The total dollar amount of a Hospital's charges for services rendered in a fiscal year.

Hospital (also referred to as **Acute Hospital)** – Any Hospital licensed under M.G.L. c. 111, § 51, and which meets the eligibility criteria set forth in **Section I**.

Hospital-Based Physician – Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Inpatient Services to Members at a site for which the Hospital is otherwise eligible to receive reimbursement under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives and physician assistants are not Hospital-Based Physicians.

Hospital Discharge Data (HDD) – For RY09, Merged Casemix/Billing Tapes as accepted into DHCFP's database as of May 16, 2008, for the period October 1, 2006 through September 30, 2007

Inflation Factors for Administrative Days – a blend of the Centers 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 Factor for Administrative Days is as follows:

2.244% reflects the price changes between state fiscal year 2008 and RY09

Inflation Factors for Capital Costs – the factors used by CMS to update capital payments made by Medicare. The Inflation Factors for Capital Costs between RY04 and RY09 are as follows:

0.7% reflects the price changes between RY04 and RY05
0.7% reflects the price changes between RY05 and RY06
0.8% reflects the price changes between RY06 and RY07
0.9% reflects the price changes between RY07 and RY08
0.7 % reflects the price changes between RY08 and RY09

Inflation Factors for Operating Costs —for price changes between RY04 and RY07, and between RY08 and RY09 for admissions beginning December 7, 2008, a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY08, and between RY08 and RY09 for admissions beginning October 1, 2008 through admissions beginning December 6, 2008, the inflation factor for operating costs is the CMS market basket The Inflation Factors for Operating Costs between RY04 and RY09 are as follows:

1.186% reflects price changes between RY04 and RY05
1.846% reflects price changes between RY05 and RY06
1.637% reflects price changes between RY06 and RY07
3.300% reflects price changes between RY07 and RY08
3.000% reflects price changes between RY08 and the period of RY09 from October 1, 2008 through December 6, 2008
1.424% reflects price changes between RY08 and the period of RY09 beginning December 7, 2008.

Inpatient Admission – The admission of a Member to an Acute Hospital for the purposes of receiving Inpatient Services in that Hospital.

Inpatient Services (also Inpatient Hospital Services or Hospital Services) – Medical services, including Behavioral Health Services, provided to a Member admitted to an Acute Hospital. Payment rules regarding Inpatient Services are found in 130 CMR Parts 415 and 450, the regulations referenced therein, Appendix F to the MassHealth Acute Inpatient Hospital Manual, MassHealth billing instructions, and the RFA. See **Exhibits 2** and **3**.

Managed Care Organization (MCO) – Any entity with which EOHHS contracts to provide primary care and certain other medical services, including Behavioral Health Services, to members on a capitated basis, and which meets the definition of an MCO at 42 CFR § 438.2.

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

MassHealth Average Length of Stay (ALOS) – the sum of non-psychiatric inpatient days from October 1, 2006through September 30, 2007, reported by each Hospital to DHCFP, including Outlier Days, divided by the sum of SPAD and transfer admissions, using the casemix data accepted into DHCFP's database as of May 16, 2008.

Medicaid Management Information System (MMIS) – the state-operated system of automated and manual processes, certified by CMS, that meets the federal guidelines in Part 11 of the State Medicaid Manual, used to process Medicaid claims from providers of medical care and services furnished to Members and to retrieve and produce service utilization and management information for program administration and audit purposes.

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

Non-Acute Unit – A Chronic Care, Rehabilitation or Skilled Nursing Facility within a Hospital.

Outlier Day – Each day beyond twenty acute days during a single admission, for which a Member remains hospitalized at an acute status, other than in a DMH-licensed bed.

Pass-Through Costs – Organ acquisition, malpractice, and direct medical education costs that are paid on a cost-reimbursement basis and are added to the Hospital-specific standard payment amount per discharge.

Pay-for-Performance (P4P) – MassHealth's method for quality scoring and converting quality scores to rate payments contingent upon Hospital adherence to quality standards and achievement of performance thresholds and benchmarks.

Pediatric Specialty Hospital – An Acute Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Pediatric Specialty Unit – A designated pediatric unit in an Acute Hospital in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20, unless located in a facility already designated as a Specialty Hospital.

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 certain other medical services.

Psychiatric Per Diem – a statewide per diem payment for psychiatric services provided to Members in DMH-Licensed beds who are not enrolled with the BH Contractor or an MCO.

Psychiatric Per Diem Base Year – the base year for the psychiatric per diem is RY04, using RY04 DHCFP Cost Reports as screened and updated as of March 10, 2006.

Public Service Hospital – Any public Acute Hospital or any Acute Hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 (see attached **Exhibit 4**) which has a private sector payer mix that constitutes less than thirty-five percent (35%) of its Gross Patient Service Revenue (GPSR) and where uncompensated care comprises more than ten percent (10%) of its GPSR.

Rate Year (RY) – Generally, the period beginning October 1 and ending September 30. RY09 begins on October 1, 2008 and ends on September 30, 2009.

Rehabilitation Unit — a distinct unit of beds licensed by the Department of Public Health (DPH) as rehabilitation beds, in a licensed Acute Hospital that provides comprehensive Rehabilitation Services to Members with appropriate medical needs.

Rehabilitation Services — services provided in an Acute Hospital that are medically necessary to be provided at a Hospital level of care, to a member with medical need for an intensive rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his/her ability to function with a reasonable expectation of significant improvement that will be of practical value to the Member measured against his/her condition at the start of the rehabilitation program.

SPAD Base Year – the Hospital-specific base year for the Standard Payment Amount Per Discharge (SPAD) for admissions beginning October 1, 2008 through admissions beginning December 6, 2008 is RY06,based on the RY06 DHCFP 403 cost report as screened and updated as of June 2, 2008. The Hospital-specific base year for the SPAD for admissions beginning December 7, 2008 is RY05, based on the RY05 DHCFP 403 cost report as screened and updated as of June 2, 2008.

State Fiscal Year (SFY) - the time period of 12 months beginning on July 1 of any calendar year and ending on June 30 of the immediately following calendar year. SFY09 begins on July 1, 2008, and ends on June 30, 2009.

Standard Payment Amount Per Discharge (SPAD) – a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is a complete fee-for-service payment for an acute episode of illness, excluding the additional payment of Outlier Days, Transfer Per Diems, Administrative Days and Physician Payments.

Transfer Patient – Any patient who meets any of the following criteria: 1) transferred between Acute Hospitals; 2) transferred between a DMH-licensed bed and a medical/surgical unit in an Acute Hospital; 3) is receiving treatment for a substance-related disorder or mental health services and whose enrollment status with the BH Contractor changes; 4) who becomes eligible for MassHealth after the date of admission and prior to the date of discharge; 5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge; 6) who transfers, after date of admission, from the PCC Plan or non-managed care to an MCO, or from an MCO to the PCC Plan or non-managed care; or 7) has a primary diagnosis of a psychiatric disorder in a non-DMH-licensed bed.

Usual and Customary Charges – Routine fees that Hospitals charge for Acute Hospital services rendered to patients regardless of payer source.

III. Non-Covered Services

EOHHS will reimburse MassHealth-participating Hospitals at the rates established in the RFA and accompanying contract for all covered Inpatient Services, provided to MassHealth Members except for the following:

A. Behavioral Health Services for Members Assigned to the BH Contractor

EOHHS's BH Contractor contracts with providers to form a network through which Behavioral Health Services are delivered to MassHealth Members enrolled with the BH Contractor. Hospitals in the BH Contractor's network are paid solely by the BH Contractor for services to Members enrolled with the BH Contractor, pursuant to contracts between the BH Contractor and each contracting Hospital.

Hospitals that are not in the BH Contractor's network (hereinafter "Non-Network Hospitals") do not qualify for MassHealth reimbursement for Members enrolled with the BH Contractor who receive services other than Emergency or post-stabilization Behavioral Health Services, except in accordance with a service-specific agreement with the BH Contractor.

Non-Network Hospitals that provide medically necessary Behavioral Health Emergency Services and Post-Stabilization Services to Members enrolled with the BH Contractor qualify for reimbursement solely by the BH Contractor.

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

B. MCO Services

Hospitals providing medical services, including behavioral health services, to MassHealth Members enrolled in MCOs will be reimbursed by the MCO for those services that are covered services provided by the MCO.

Hospitals are not entitled to any reimbursement from EOHHS, and may not claim reimbursement for any services that are MCO-covered services or are otherwise reimbursable by the MCO. Furthermore, Hospitals may not "balance bill" EOHHS for any services covered by the MCO contract with EOHHS. MCO reimbursement shall be considered payment in full for any MCO-covered services provided to MassHealth Members enrolled in an MCO.

C. Air Ambulance Services

In order to receive reimbursement for air ambulance services, providers must have a separate contract with EOHHS for such services.

D. Non-Acute, Skilled Nursing, and Other Separately Licensed Units in Acute Hospitals

Except as otherwise provided in **Section IV.B.12**, EOHHS shall not reimburse Acute Hospitals through the RFA for services provided to Members in Non-Acute Units, other than Rehabilitation Units, and any units which have a separate license, such as a skilled nursing unit, or any unit which is licensed to provide services other than Acute Hospital level services.

IV. Reimbursement System

A. Data Sources

In the development of each Hospital's standard payment amount per discharge (SPAD), EOHHS used the SPAD Base Year costs; and the RY07 Merged Casemix/Billing Tapes as accepted by DHCFP, as the primary sources of data to develop base operating costs per discharge. The wage area data was derived from the CMS Hospital Wage Index Federal Fiscal Year 2009

EOHHS used casemix information from DHCFP Hospital Discharge Data (as defined above) which was then matched with MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations. The casemix data did not include discharges from Excluded Units.

B. Methodology for Inpatient Services

1. Overview

Except as otherwise provided herein, payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be a Hospital-specific Standard Payment Amount per Discharge (SPAD), which will consist of the sum of 1) a statewide average payment amount per discharge that is adjusted for wage area differences and the Hospital-specific MassHealth casemix; 2) a per-discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs; 3) a per-discharge, Hospital-specific payment amount for certain direct medical education costs, and 4) a per-discharge payment amount for the capital cost allowance, adjusted by Hospital-specific casemix and by a capital inflation factor. Each of these elements is described in **Sections IV.B.2** through **IV.B.4**.

Payment for psychiatric services provided in DMH-Licensed Beds to MassHealth Members who are not served either through a contract between EOHHS and its BH Contractor or an MCO shall be made through an all-inclusive Statewide Standard Psychiatric Per Diem. Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD (see **Sections IV.B.6** and 7).

Payment for physician services rendered by Hospital-Based Physicians will be made as described in **Section IV.B.9**.

2. Calculation of the Standard Payment Amount Per Discharge (SPAD)

The statewide average payment amount per discharge is based on the actual statewide costs of providing Inpatient Services in the SPAD Base year cost report.

The average payment amount per discharge in each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those

costs and discharges from Excluded Units. Routine outpatient costs associated with admissions from Emergency Department and routine and ancillary outpatient costs resulting from admissions from observation status were included. The cost centers that are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Malpractice costs, organ acquisition costs, capital costs and direct medical education costs were excluded from the calculation of the statewide average payment amount per discharge.

The average payment amount per discharge for each Hospital was then divided by the Hospital's Massachusetts-specific wage area index and by the Hospital-specific FY06 all-payer casemix index using the version APR20 of the 3M grouper and Massachusetts weights. Massachusetts Hospitals wage areas were assigned according to the CMS FY_09_May_PUF_WI_OM_WEB.ZIP file , unless redesignated by the Medicare Geographical Classification Review Board (MGCRB), according to the MCGRB Case Status Listing, Run Date April 16, 2008, or in accordance with a written decision from CMS. Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, Baystate Medical Center's wages and hours were included. This step results in the calculation of the standardized costs per discharge for each Hospital.

All Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of MassHealth discharges for the Hospitals was produced from the casemix data described above. For admissions beginning October 1, 2008 through admissions beginning December 6, 2008, the efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 90 percent of the total number of statewide discharges in the HDD. The resulting efficiency standard is $10,551.23. For admissions beginning December 7, 2008, the efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75 percent of the total number of statewide discharges in the HDD. The resulting efficiency standard is $8,770.16.

The statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-five percent (95%); and by c) the Inflation Factors for Operating Costs between RY05 and RY09. The resulting RY09 statewide average payment amount per discharge for admissions beginning October 1, 2008 through admissions beginning December 6, 2008 is $8,547.94. The resulting statewide average payment amount per discharge for admissions beginning December 7, 2008 is $7,778.47.

The statewide average payment amount per discharge was then multiplied by the Hospital's MassHealth casemix index adjusted for outlier acuity (using version APR20 of the 3M Grouper and Massachusetts weights) and the Hospital's Massachusetts-specific wage area index to derive the Hospital-specific standard payment amount per discharge (SPAD). To develop the Hospital's RY09casemix index, EOHHS used casemix data from the DHCFP HDD, which was then matched with the MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations. The casemix data did not include discharges from Excluded Units. The wage area indexes were derived from the CMS Hospital Wage Index File as described above..

Costs for outpatient ancillary services for Members admitted from observation status are included in Hospital-specific SPADs.

For hospitals with designated Pediatric Specialty Units, a separate SPAD is developed for the Pediatric Specialty Unit using the methodology in Section IV.B.1-4, except that only the Pediatric Specialty Unit's case mix index and average length of stay are used in the calculation

An outlier adjustment is used for the payment of Outlier Days as described in **Section IV.B.8.**

When groupers are changed and modernized, it may be necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that EOHHS is following, and one that has been a feature of the Medicare DRG program since its inception. EOHHS reserves the right to update to a new grouper.

3. Calculation of the Pass-through Amount per Discharge

a. Malpractice and Organ Acquisition

The inpatient portion of malpractice and organ acquisition costs was derived from each Hospital's FY07 DHCFP 403 cost report as screened and updated by DHCFP as of July 3, 2008. This portion of the Pass-Through amount per discharge is the sum of the Hospital's per-discharge costs of malpractice and organ acquisition. For each Hospital, the amount is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days for the SPAD Base Year and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

This calculation omits such costs related to services in Excluded Units. The days used in the denominator are also net of days associated with such units.

b. Direct Medical Education

The inpatient portion of direct medical education costs was derived from each Hospital's FY07DHCFP 403 cost report submitted to DCHFP, as screened and updated as of July 3, 2008. This portion of the Pass-Through amount was calculated by dividing the Hospital's inpatient portion of direct medical education expenses by the number of total inpatient days, omitting such costs related to Excluded Units, and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

Prior to December 7, 2008, EOHHS incorporated an incentive in favor of primary care training, which was factored into the recognized direct medical education costs by weighting costs in favor of primary care resident training. For admissions beginning October 1, 2008 through admissions beginning December 6, 2008, an incentive of 52.25% of each Hospital's costs was added to its per-discharge cost of Primary Care resident training; 61.00% of each Hospital's costs was subtracted from its per-discharge costs of specialty care resident training which results in a decrease in recognized specialty care resident training costs of approximately $5.0 million.

For admissions beginning December 7, 2008, with the exception of Pediatric Specialty Hospitals, 100% of each Hospital's costs of specialty care resident training was subtracted from its recognized per-discharge costs for direct medical education.

The number of primary care, specialty care, and total residents was derived from data provided to EOHHS by the Hospitals, at EOHHS's request. For the purposes of this provision, primary care resident training is training in internal medicine for general practice, family practice, OB/GYN, or pediatrics.

4. Capital Payment Amount per Discharge

The capital payment per discharge is a standard, prospective payment for each Hospital. The capital payment is a casemix-adjusted capital cost limit, based on the SPAD Base Year costs, updated by the Inflation Factors for Capital Costs between RY05 and RY09.

For each Hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, major moveable equipment, and long- and short-term interest. Total capital costs are allocated to Inpatient Services through the square-footage-based allocation formula of the DHCFP 403 cost report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. The capital cost per discharge was calculated by dividing total net inpatient capital costs by the Hospital's total SPAD Base Year days, net of Excluded Unit days, and then multiplying by the Hospital-specific MassHealth Average Length of Stay.

The casemix-adjusted capital efficiency standard was determined by a) dividing the cost per discharge by the All-Payer APR20 Casemix Index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. For admissions beginning October 1, 2008 through admissions beginning December 6, 2008, the casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 90 percent of the total number of statewide discharges. For admissions beginning December 7, 2008, the casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 75 percent of the total number of statewide discharges.
Each Hospital's capital cost per discharge was then held to the lower of its capital cost per discharge or the casemix-adjusted efficiency standard, to arrive at a capped capital cost per discharge. Each Hospital's capped capital cost per discharge is then multiplied by the Hospital's number of MassHealth discharges. The product of the capped capital cost per discharge and the number of MassHealth discharges for each Hospital was then summed and divided by the total number of MassHealth discharges statewide, to arrive at a statewide weighted average capital cost per discharge.

The statewide weighted average capital cost per discharge was then updated by the Inflation Factors for Capital Costs. For admissions beginning October 1, 2008 through admissions beginning December 6, 2008, The statewide weighted average capital cost per discharge is $506.04.For admissions beginning December 7, 2008 the statewide weighted average capital cost per discharge is $486.43..

The Hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the Hospital's RY09 casemix index as determined in **Section IV.B.2** above.

5. Maternity and Newborn Rates

Maternity cases in which delivery occurs will be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for *all* services (except physician services) provided in connection with such a maternity stay is included in the SPAD amount.

6. Psychiatric Per Diem Payments

Services provided to MassHealth patients in DMH-Licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive psychiatric per diem, as described below. This payment mechanism does not apply to cases in which psychiatric services are provided to Members enrolled with the BH Contractor or an MCO, except as set forth in **Sections III.A** and **B**.

Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD. See

Section IV.B.7.b(4) and **(5)** for payment rules involving transfers to and from DMH-Licensed Beds and BH managed care status.

The Statewide Standard Psychiatric Per Diem Rate is derived using the sum of the following: the Acute Hospital Psychiatric Standard for Overhead Costs, the Acute Hospital Psychiatric Standard for Direct Routine Costs, the Acute Hospital Psychiatric Standard for Direct Ancillary Cost, the Acute Hospital Psychiatric Standard for Capital Costs, plus the Adjustment to the Psychiatric Per Diem Base Year Costs.

A. Data Sources

MassHealth utilizes the Psychiatric Per Diem Base Year costs, statistics and revenue.

B. Determinations of Psychiatric Per Diem Base Year Operating Standards

1. The Standard for Inpatient Psychiatric Overhead Costs is the median of the Inpatient Psychiatric Overhead Costs per Day for the array of acute hospitals providing mental health services in DMH-Licensed beds. The median is determined based upon inpatient psychiatric days. The Base Year Standard for Inpatient Psychiatric Overhead Costs is $363.28.

2. The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the Inpatient Psychiatric Direct Routine Costs Per day (minus direct routine physician costs) for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The Base Year Standard for Inpatient Psychiatric Direct Routine Costs is $325.13.

3. The Standard for Inpatient Psychiatric Direct Ancillary Costs is the median of the Inpatient Psychiatric Direct Ancillary Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. Base Year Standard for Inpatient Psychiatric Direct Ancillary Costs is $56.83.

C. Determination of Base Year Capital Standards

1. Each hospital's base year capital cost consists of the hospital's actual Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the hospital's capital expenses.

2. Each hospital's base year Psychiatric Capital Cost Per Day equals the base year psychiatric capital cost divided by the greater of: the actual base year

psychiatric days or eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.

3. The Standard for Inpatient Psychiatric Capital Costs is the median of the Inpatient Psychiatric Capital Cost Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The Base Year Standard for Inpatient Psychiatric Capital Costs is $30.73.

D. Adjustment to Base Year Costs

The Standards for Inpatient Psychiatric Overhead Costs, Inpatient Psychiatric Direct Routine Costs, and Inpatient Psychiatric Direct Ancillary Costs are updated using the Inflation Factors for Operating Costs for the Psychiatric Per Diem Base Year through RY 09, except RY07 to RY08, for which no inflation was applied. The Standard for Inpatient Psychiatric Capital Costs is updated using the Inflation Factors for Capital Costs for the Psychiatric Per Diem Base Year through RY09, except RY07 to RY08, for which no inflation was applied. The adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs to RY09 for the Psychiatric Per Diem is $60.37 for inpatient days from October 1, 2008 through December 6, 2008, and $47.57 for inpatient days from December 7, 2008 through September 30, 2009.

7. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one Acute Hospital to another will be made on a transfer per diem basis capped at the Hospital-specific SPAD for the Hospital that is transferring the patient.

In general, the Hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in **Sections IV.B.2** through **4**, if the patient is discharged from that Hospital. This includes when a patient is transferred back and is subsequently discharged from the original hospital. If the patient is transferred to another Hospital, then the transferring Hospital will be paid at the Hospital-specific transfer per diem rate, capped at the Hospital-specific per discharge amount. Additionally, "back transferring" Hospitals (Hospitals to which a patient is first admitted and then transferred back after having been transferred to another Acute Hospital) will be eligible for outlier payments as specified in **Section IV.B.8** below.

Except as otherwise provided , the RY09 payment per day for Transfer Patients shall equal the statewide average payment amount per discharge divided by the SPAD Base Year average all-payer length of stay of 4.54 days, to which is added the Hospital-specific capital, direct medical education and

Pass-Through per diem payments which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay.

b. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be reimbursed on a per diem basis capped at the Hospital-specific SPAD. This section outlines reimbursement under some specific transfer circumstances.

Hospitals receiving a transfer per diem may be eligible for outlier payments specified in **Section IV.B.8** below, subject to all of the conditions set forth therein.

(1) Transfer to/from a Non-Acute, Skilled Nursing, or other Separately Licensed Unit within the Same Hospital

If a patient is transferred from an acute bed to a bed in a Non-Acute Unit or other separately licensed unit in the same Hospital, except as otherwise specified below when the transfer is to a DMH-licensed bed, the transfer is considered a discharge. EOHHS will pay the Hospital-specific SPAD for the portion of the stay before the patient is transferred to any such unit.

(2) MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment in the PCC Plan, MCO, or Fee-for-Service during a Hospital Stay, or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible, enrolls in or disenrolls from an MCO during the course of a Hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, MassHealth-covered portion of the acute stay will be paid at the transfer per diem rate, up to the Hospital-specific SPAD, or, if the patient is at the Administrative Day level of care, at the AD per diem rate, in accordance with **Section IV.B.10**. When a patient enrolls in or disenrolls from an MCO during the Hospital stay, the non-MCO days will be paid at the transfer per diem rate up to the SPAD.

(3) Admissions Following Outpatient Surgery or Procedure

If a patient who requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure, the Hospital shall be paid at the transfer per diem rate up to the Hospital-specific SPAD.

(4) Transfer between a DMH-Licensed Bed and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a DMH-Licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, BH Network or Non-Network Hospital, or the type of service provided. See also **Section IV.B.7.b(5).**

When a Member who is not enrolled with the BH Contractor transfers between a DMH-Licensed Bed and a non-DMH-Licensed Bed in the same Hospital, during a single admission, EOHHS will pay the Hospital at the transfer per diem capped at the Hospital-specific SPAD for the non-DMH-Licensed Bed portion of the stay, and at the psychiatric per diem for the DMH-Licensed Bed portion of the stay. (See **Section IV.B.6.)**

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-Licensed Bed portion of the stay, and only if it is for medical (i.e., non-psychiatric/substance-related disorder) treatment. In that case, such payment will be at the transfer per diem rate capped at the Hospital-specific SPAD.

(5) Change of BH Managed Care Status during a Behavioral Health Hospitalization

(a) Payments to Hospitals *without* Network Provider Agreements with EOHHS' BH Contractor

When a Member is enrolled with the BH Contractor during an Emergency or Post-Stabilization behavioral health admission at a non-network Hospital, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor shall be paid by the BH Contractor.
The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-Licensed Bed, or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

(b) Payments to Hospitals that are in the BH Contractor's Provider Network

When a Member is enrolled with the BH Contractor during an emergency or non-emergency behavioral health Hospital admission, the portion of the Hospital stay during which the

Member was enrolled with the BH Contractor shall be paid by EOHHS's BH Contractor, provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures. The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem for psychiatric services in a DMH-Licensed Bed or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

8. Outlier Payments

A Hospital qualifies for an outlier per diem payment equal to 85% of the Hospital's transfer per diem, in addition to the Hospital-specific standard payment amount per discharge or transfer per diem payment if ***all*** of the following conditions are met:

a. the Medicaid non-MCO length of stay for the Hospitalization exceeds 20 cumulative *acute* days at that Hospital (not including days in a DMH-Licensed Bed or days paid by a third party);

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

c. the patient continues to need acute level care and is therefore ***not*** on Administrative Day status on any day for which an outlier payment is claimed;

d. the patient is not a patient in a DMH-Licensed Bed on any day for which an outlier payment is claimed; and

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

9. Physician Payment

For physician services provided by Hospital-based physicians to MassHealth patients, the Hospital will be reimbursed for the professional component of physician services in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 et seq. Such reimbursement shall be at the lower of (1) the fee established in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00(Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)[1] (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual charge submitted.

[1] The regulations referred to in this paragraph are voluminous, and will be provided upon request.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the direct medical education (DME) portion of the SPAD payment and, as such, are not reimbursable separately. The Hospital-based Physician may not bill for any professional component of the service that is billed by the Hospital.

Hospitals shall not be reimbursed for inpatient physician services provided by Community-Based Physicians.

10. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is $187.02, which represents the median September 2007 nursing home rate for all nursing home rate categories, as determined by DHCFP.

The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated by the Inflation Factors for Administrative Days. The resulting AD rates for RY09 are $244.37 for Medicaid/Medicare Part B eligible patients and $264.26 for Medicaid-only eligible patients.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative MassHealth non-MCO acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative MassHealth non-managed care acute days), and then for Outlier Days, as described above.

11. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for Inpatient Services furnished

to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay.
The Infant Outlier Payment is calculated using the data and methodology as follows:

(1) Data Source. The prior year's claims data residing on EOHHS's MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.

(2) Eligibility. Eligibility for the adjustment is determined as follows:

(a) Exceptionally Long Lengths of Stay: First, the statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

(b) Exceptionally High Cost. Exceptionally high cost is calculated for Hospitals providing services to infants less than one year of age as follows:

1. The average cost per Medicaid inpatient discharge for each Hospital is calculated;

2. The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated;

3. The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two, and that amount is added to the Hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.

(c) Eligibility for an Infant Outlier Payment. First, for each Hospital providing services to infants less than one year of age, the average Medicaid inpatient length of stay involving individuals less than one year of age is determined. If this Hospital-specific average Medicaid inpatient length of stay for infants less than one year of age equals or exceeds the threshold defined in **Section IV.B.11.a(2)(a)**, then the Hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants less than one year of age is calculated. If a Hospital has a Medicaid inpatient case with a cost that equals or exceeds the Hospital's own threshold

defined in Section **IV.B.11.a(2)(b)** above, then the Hospital is eligible for an infant outlier payment.

(d) Payment to Hospitals. Annually, each Hospital that qualifies for an infant outlier adjustment receives an equal portion of $50,000. For example, if two Hospitals qualify for an outlier adjustment, then each Hospital receives $25,000.

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to children greater than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay .
The Pediatric Outlier Payment is calculated using the data and methodology as follows:

(1) Data Source. The prior year's discharge data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.

(2) Eligibility. Eligibility for the adjustment is determined as follows:

(a) Exceptionally Long Lengths of Stay: First, a statewide weighted average Medicaid inpatient length of stay is calculated. This is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. Second, the statewide weighted standard deviation for Medicaid inpatient length of stay is calculated. Third, the statewide weighted standard deviation for Medicaid inpatient length of stay is multiplied by two and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

(b) Exceptionally High Cost. Exceptionally high cost is calculated for Hospitals providing services to children greater than one year of age and less than six years of age as follows:

1. The average cost per Medicaid inpatient discharge for each Hospital is calculated.

2. The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated.

3. The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two and added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.

(c) Eligibility for a Pediatric Outlier Payment. For Acute Hospitals providing services to children greater than one year of age and less than six years of age, eligibility for a pediatric outlier payment is calculated as follows:

1. The average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this Hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in **Section IV.B.11.b(2)(a)**, then the hospital is eligible for a Pediatric Outlier Payment.

2. The cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this Hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in **Section IV.B.11.b(2)(b)**, then the Hospital is eligible for a Pediatric Outlier Payment.

3. Payment to Hospitals. Annually, each Acute Hospital qualifying for a pediatric outlier adjustment will receive $1,000.

12. Rehabilitation Unit Services in Acute Hospitals

A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided at an Acute Hospital.

The per diem rate for such rehabilitation services will equal the medianMassHealth RY09 Rehabilitation Hospital rate, for Chronic Disease and Rehabilitation Hospitals. Acute Hospital Administrative Day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care, in accordance with **Section IV.B.10**.

Such units shall be subject to EOHHS's screening program for Chronic Disease and Rehabilitation Hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410-411 (attached as **Exhibit 5**).

13. Pay-for-Performance (P4P) Payment

In accordance with the Commonwealth's Health Care Reform Law (Section 25 (codified at M.G.L. c. 118E, sec. 13B) and Section 128 of Chapter 58 of the Acts of 2006 (as subsequently amended)), a portion of hospital rate increases is contingent upon meeting quality standards, achievement of performance benchmarks, and certain data validation requirements. For RY09, MassHealth has established two classes of measures:

1. Pay-for-Reporting measures, for which Hospitals will report clinical health disparities measurement data .This data will be used as baseline data for future rate years' measurement activities;

2. Pay-for-Performance measures, which measure a Hospital's relative performance in meeting specific clinical goals based on an assessment of data reported in a prior rate

year(s) and in the current rate year. RY09 Pay-for-Performance measures include clinical measures for Community Acquired Pneumonia, maternity, neonate, surgical infection prevention, and pediatric asthma, and a health disparities measure via Cultural and Linguistic Appropriate Service Standards (CLAS).

The following table provides the anticipated performance measure submission timelines as described in the contract with hospitals and in the technical specifications manual.

Anticipated Submission Due Dates	Reporting Requirements
October 3, 2008	Hospital Key Quality Contacts
November 14, 2008	Qtr 1 Data (Jan.– Mar 2008) Qtr 2 Data (Apr -June 2008) Qtr 1+2: ICD Patient Population Data
December 15, 2008	CLAS Measures *plus* CLAS Progress Report
February 13, 2009	Qtr 3 Data (Jul – Sept 2008) Qtr 3: ICD Patient Population Data
May 15, 2009	Qtr 4 Data (Oct – Dec 2008) Qtr 4: ICD Patient Population Data
August 14, 2009	Qtr 1 Data (Jan – Mar 2009) Qtr 1: ICD Patient Population Data

Also in accordance with the statutes cited above, P4P payments for a given rate year may cumulatively total no more than the legislatively established amount, pursuant to Section 128 of the Acts of 2006, as subsequently amended. In accordance with the most recent amendment, Section 79 of Chapter 182 of the Acts of 2008, P4P payments for RY09 may cumulatively total no more than $58,000,000. The following table lists the RY09 maximum amount allocated for each quality measure category.

RY09 Quality Measure Category	RY09 Maximum Amount Allocated
Community Acquired Pneumonia	$8,000,000
Maternity	$16,200,000
Neonate	$4,000,000
Surgical Care Infection Prevention	$8,000,000
Pediatric Asthma	$4,000,000
Health Disparities CLAS	$11,250,000
Health Disparities Clinical	$6,450,000
TOTAL	$57,900,000

a. **Incentive Payments**. Incentive payments for each quality measure category will be determined using the following formula:

(Quality Measure Category per discharge amount) * (Actual Eligible Medicaid discharges per Quality Measure Category) * Performance Score per Quality Measure Category

The estimated Quality Measure Category per discharge amounts will be published at the beginning of the contract year. Each P4P-participating Hospital's Eligible Medicaid Discharges per measure category will be multiplied by its performance score to produce an "adjusted" number of discharges. The actual Quality Measure Category per discharge amount will be calculated by dividing the maximum amount allocated for payment for each measure category by the Statewide total Actual Eligible Discharges per Measure Category.

The Actual Eligible Medicaid Discharges are the total MassHealth discharges from the FY08 HDD, validated by EOHHS for each performance measure category. For the CLAS measure, total Actual Eligible MassHealth discharges will be used.

Each hospital's adjusted number of discharges will be multiplied by the actual per-discharge amount for each measure category to determine the Hospital's P4P incentive payment for that measure category.

Payments to each hospital qualifying for a the P4P payment program for RY09 will be made as a single, cumulative payment which includes payments for all measures, before the end of RY10.

b. **Performance Score.**

1. Pay-for-Reporting Measures: Individual Hospital performance scores for clinical health disparities measures will be based on timely submission of data and data validation including data validation standards for the required race/ethnicity data elements codes and allowable values reported on all inpatient measure categories (maternity/neonate, pneumonia, surgical care infection prevention and pediatric asthma). To pass data validation, Hospitals must meet an agreement rate of 100% for the subset of three data elements of race, Hispanic indicator, and ethnicity based on a chart-audit validation process for data submitted in RY09

2. Pay-for-Performance Measures: An individual Hospital's performance scores for measures reported in RY2009, for discharges occurring between January 1, 2008 to December 31, 2008, will be assessed in comparison with all Hospitals. A Hospital's comparative performance score for each measure will be calculated based on the higher of attainment or improvement points awarded as follows:
The Cultural and Linguistic Appropriate Service Standards (CLAS) measure is determined by scoring the Cultural Competence Organizational Self-Assessment (CCOSA) completed by each hospital. Score adjustments are subject to validation.

For other Pay-for-Performance measures, individual ratios will be calculated based on technical specifications for each measure category. These specifications define the numerator and denominator for each measure, which can vary depending on the process being scored.

The ratios and the CLAS score, will be assessed in comparison with all Hospitals. A Hospital's comparative performance score for each of these quality measures will be calculated based on the higher of an attainment score and an improvement score on a scale of 1-10 as follows:

1. *Attainment Threshold Score*. Hospitals meeting or exceeding the attainment threshold are awarded points based on their relative placement above the attainment threshold. The attainment threshold is calculated as the median of all hospitals' performance scores. The benchmark is calculated as the mean of the scores for those hospitals in the top decile.

2. *Improvement Score Range*. A Hospital may earn points for improvement, if their current performance score is greater than the attainment threshold and the Hospital has demonstrated improvement over the previous RY.

3. *Total Performance Score*. The total performance score will be calculated as the ratio of the higher of the attainment points or the improvement points, divided by total eligible points.

See the above table for data submission deadlines. Validation of the Performance score measures occurs after the end of each quarter and is completed before the beginning of the following quarter.

c. **Point System**

1. Pay-for Performance Measures

If the hospital is at/or above the benchmark for the measure, it will receive 10 points. If the hospital is at/or above the attainment threshold but below the benchmark, it will receive 1 to 10 points. If the hospital has improved over the prior year, the hospital will receive points based on their relative improvement. Total performance score is the sum of points within each category divided by the potential points for that category. Final performance points will be the higher of the Attainment points or Improvement points.

2. Pay-for-Reporting Measures

Scores for the clinical health disparities measure will apply a Pass/Fail criterion to the subset of three data elements. Hospitals that do not meet the 100% agreement rate set forth above will receive a performance score of 0% and Hospitals that pass will receive a performance score of 100% on the subset of three data elements only.

14. Pay-for-Performance (P4P) Payment for RY08 Made During RY09

RY08 P4P incentive payments payable during RY09 are payable as follows:

RY08 P4P incentive payments may cumulatively total no more than the legislatively established amount of $20,000,000; pursuant to Section 128 of Chapter 58 of the Acts of 2006, as

subsequently amended. To qualify to earn incentive payments, Hospitals must meet the minimum quality performance requirement as follows:

Incentive payments for each quality measure category will be determined using the following formula:

(Quality Measure Category per discharge amount) * (Eligible Medicaid discharges) * Performance score

a. Quality Measure Category per Discharge Amount. The final per-discharge amounts will be determined based upon FY07 Hospital Discharge Data (HDD) for each measure category. To determine these amounts, EOHHS will use the following formula:

1. For each quality measure category ("category"), EOHHS has established a maximum allocated amount, noted in the table below. The sum of these allocated amounts equals the maximum legislatively specified amount.
2. For the CLAS measure, the actual eligible discharges are based on the total Medicaid discharges from the FY07 HDD.
3. For all other clinical measures, the actual eligible discharges are based on all Hospitals' eligible Medicaid discharges per measure category.
4. Each Hospital's Eligible Medicaid Discharges (item **5.b** below) will be multiplied by its performance score (item **5.c** below) to produce an "adjusted" number of discharges.
5. Each Hospital's adjusted number of discharges will be multiplied by the actual per discharge amount for each category to determine the Hospital's P4P incentive payment for that measure category.

   The following table lists the lists the amount allocated for payment for RY08 P4P payments during RY09 for each RY08 quality measure category.

Quality Measure Category	Maximum Allocated Amount
Health Disparities	$4,500,000
Community Acquired Pneumonia	$4,500,000
Obstetric & Newborn	$4,500,000
Surgical Infection Prevention	$4,500,000
Pediatric Asthma	$2,000,000
TOTAL	$20,000,000

b. Actual Eligible Medicaid Discharges. The Actual Eligible Medicaid Discharges are the total MassHealth discharges reported by all Hospitals to DHCFP in the RY07 Merged Casemix/Billing Tapes (HDD). For the CLAS measure, total Actual Eligible MassHealth discharges will be used.

c. Performance Score.

1. Pay-for-Reporting Measures: Individual Hospital performance scores for these measures will be based on timely submission of data and data validation in accordance with the deadlines and data validation requirements. Calculation of scores for these measures is contingent on meeting the minimum agreement rate of 80% based on a chart-audit validation process for the four quarters of data submitted in RY08. The score will be 0% or 100%.

2. Pay-for-Performance Measures: The Cultural and Linguistic Appropriate Service Standards (CLAS) measure is determined by scoring the Cultural Competence Organizational Self-Assessment (CCOSA) completed by each hospital. Score adjustments are subject to validation.

For other Pay-for-Performance measures, individual ratios will be calculated based on technical specifications for each measure category. These specifications define the numerator and denominator for each measure, which can vary depending on the process being scored.

The ratios and the CLAS score, will be assessed in comparison with all Hospitals. A Hospital's comparative performance score for each of these quality measures will be calculated based on the higher of an attainment score and an improvement score on a scale of 1-10 as follows:

1. *Attainment Threshold Score*. Hospitals meeting or exceeding the attainment threshold are awarded points based on their relative placement above the attainment threshold. The attainment threshold is calculated as the median of all hospitals' performance scores. The benchmark is calculated as the mean of the scores for those hospitals in the top decile.

2. *Improvement Score Range*. A Hospital may earn points for improvement, if their current performance score is greater than the attainment threshold and the Hospital has demonstrated improvement over the previous RY.

3. *Total Performance Score*. The total performance score will be calculated as the ratio of the higher of the attainment points or the improvement points, divided by total eligible points.

d. Point System

If the hospital is at/or above the benchmark for the measure, it will receive 10 points. If the hospital is at/or above the attainment threshold but below the benchmark, it will receive 1 to 10 points. If the hospital has improved over the prior year, the hospital will receive points based on their relative improvement. Total performance score is the sum of points within each category divided by the potential points for that category. Final performance points will be the higher of the Attainment points or Improvement points.

C. Reimbursement for Unique Circumstances

1. Extension of RY08 Rates

Notwithstanding any provisions of **Sections IV.A. and B**. to the contrary, in order to ensure continuity of services, for admissions beginning October 1, 2008 through admissions beginning December 6, 2008, fee-for-service payments to Pediatric Specialty Hospitals, and to Public Service Hospitals which provide more than 10% of the statewide inpatient Medicaid days shall be made in accordance with the fee for service methodologies specified in TN 07-014 (see Exhibit 7), which are incorporated by reference into this section.

2. Hospitals Eligible for Rate Buffers

Notwithstanding any provisions of **Sections IV.A. and B**. to the contrary, in order to mitigate extreme changes in reimbursement from RY08 to RY09, the following fee-for-service payment methods apply to (1) Pediatric Specialty Hospitals, and (2) Public Service Hospitals which provide more than 10% of the statewide inpatient Medicaid days.

For admissions beginning December 7, 2008, EOHHS is providing a transition buffer in the Standard Payment Amount per Discharge (SPAD) of 18.1% to Pediatric Specialty Hospitals and 6.46% to Public Service Hospitals which provide more that 10% of the statewide inpatient Medicaid days. The one-time transition buffer percentages shall not apply to per diem rates.

3. Public Service Hospitals

Subject to compliance with all applicable federal rules and payment limits, EOHHS shall make a supplemental payment to recognize the extraordinary resources required of Public Service Acute hospitals to serve MassHealth members. Boston Medical Center (BMC) and Cambridge Health Alliance (CHA) are the only hospitals eligible for this payment. This payment is based on approval by EOHHS of the hospital's accurately submitted EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report. For RY09, this payment will not exceed $ 0 for BMC, and will be $0 for Cambridge Health Alliance.

4. Essential MassHealth Hospitals

a. Qualifications

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 (4) 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.

b. Reimbursement Methodology

Subject to compliance with all applicable federal rules, and payment limits, EOHHS will make a supplemental payment to Essential MassHealth Hospitals. Cambridge Health Alliance (CHA) and the UMass Memorial Health Care, Inc. Hospitals (UMass Hospitals) are the only Hospitals eligible for this payment. This payment is based on approval by EOHHS of the hospital's accurately submitted EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report. For RY08, this payment will not exceed $ 15,480,000 for CHA and $ 86,588,126 for the UMass Hospitals.

5. **Supplemental Medicaid Rate for Pediatric Specialty Hospitals**

a. **Eligibility**

Subject to compliance with all applicable federal rules, and payment limits, EOHHS will make a supplemental payment to Pediatric Specialty Hospitals, to account for high Medicaid volume.

b. **Payment Methodology**

The payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the Hospital Rate Year. Children's Hospital is the only Hospital eligible for this payment The RY09 payment is based on Medicaid payment and cost data. The payment equals the variance between the Hospital's inpatient Medicaid payments and inpatient Medicaid costs, not to exceed $3,850,000.

6. **Acute Hospitals with High Medicaid Discharges**

a. **Eligibility**

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. To be eligible for a payment pursuant to this section, a Hospital must have 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 HCF-403 cost report by the total statewide Medicaid discharges for all Hospitals.

b. **Payment Methodology**

The payment amount is based on Medicaid payment and charge data. The payment equals the variance between the Hospital's inpatient Medicaid payment and inpatient Medicaid charges, not to exceed the Hospital's Health Safety Net Trust Fund-Funded payment amount. **(See Exhibit 6)**

D Federal Limits

If any portion of the reimbursement methodology is not approved by CMS or is in excess of applicable federal limits, EOHHS may recoup or offset against future payments, any payment made to a Hospital in excess of the approved methodology. Any such recovery shall be proportionately allocated among affected hospitals.

E Treatment of Reimbursement for Members in the Hospital on the Effective Date of the Hospital Contract

Except where payments are made on a per diem basis, EOHHS shall reimburse participating Hospitals for services provided to MassHealth Members who are at acute inpatient status prior to October 1, 2008, and who remain at acute inpatient status on or after October 1, 2008, at the Hospital's rates established by the RY08 RFA. Reimbursement to participating Hospitals for services provided to MassHealth Members who are admitted on or after October 1, 2008, shall be reimbursed at the RY09 Hospital rates.

F Future Rate Years

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

G Errors in Calculation of Pass-through Amounts, Capital Costs or Casemix

As set forth below, EOHHS will make corrections to the final Hospital-specific rate retroactive to the effective date of the Contract resulting from the RFA. Such corrections will not affect computation of the statewide average payment amount or of any of the efficiency standards applied to inpatient and outpatient costs, or to capital costs.

1. Errors in Calculation of Pass-Through or Capital Costs

If a transcription error occurred or if the incorrect line was transcribed in the calculation of the RY09 pass-through costs or capital costs, resulting in an amount not consistent with the methodology, a Hospital may request a correction within six months of the start of the Contract year, which will be subject to agreement by both parties.

2. Errors in Calculation of Casemix

. In the event of an error in the calculation of casemix resulting in an amount not consistent with the methodology, a Hospital may request a correction to its RY09 casemix within six months of the start of the Contract year, which shall be at the sole discretion of EOHHS.

3. Change in Service Affecting Casemix

In the event that a Hospital opens or closes, an Inpatient Service that the Hospital believes will have a significant effect on casemix, the Hospital must provide EOHHS with a data analysis of the casemix effect for the current Rate Year and the subsequent Rate Year if it requests a casemix adjustment. EOHHS may, in its sole discretion, consider revised data submitted by the Hospital.

H. 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 RFA, EOHHS, in its sole discretion, shall determine, on a case-by-case basis (1) whether the Hospital qualifies for reimbursement under the RFA, and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of the RFA 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.

I. Data Sources

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

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

Exhibit 1

130 CMR 450.233 of the Division of Medical Assistance Acute Inpatient Hospital Regulations

450.233: Rates of Payment to Out-of-State Providers

(A) Payment to an out-of-state institutional provider for any medical service payable under MassHealth is made by the Division at the lesser of:

(1) the rate of payment established for the medical service under the other state's Medicaid program;

(2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or

(3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider must submit to the Division a copy of the applicable rate schedule under its state's Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable under MassHealth is made in accordance with the applicable fee schedule established by DHCFP or the Division, subject to any applicable federal payment limit (see 42 CFR 447.304).

Exhibit 2

130 CMR 415.415 and 415.416 of the Division of Medical Assistance Acute Inpatient Hospital Regulations

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

(1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

(2) a hospital is making regular efforts to discharge the recipient to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 415.419 must be followed, but they do not preclude additional, effective discharge-planning activities.

(B) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A recipient is awaiting transfer to a chronic disease hospital, rehabilitation hospital, nursing facility, or any other institutional placement.

(2) A recipient is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).

(3) A recipient is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.

(4) A recipient with lead poisoning is awaiting deleading of his or her residence.

(5) A recipient is awaiting results of a report of abuse or neglect made to any public agency charged with the investigation of such reports.

(6) recipient in the custody of the Department of Social Services is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

(7) A recipient cannot be treated or maintained at home because the primary caregiver is absent due to medical or psychiatric crisis, and a substitute caregiver is not available.

(8) A recipient is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to:

(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies (respiratory, speech, physical, occupational, etc.);
(f) insertion, irrigation, and replacement of catheters; and

(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition.)

415.416: Nonreimbursable Administrative Days

Administrative days are not reimbursable when:

(A) a hospitalized recipient is awaiting an appropriate placement or services that are currently available but the hospital has not transferred or discharged the recipient because of the hospital's administrative or operational delays;

(B) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and the recipient, the recipient's family, or any person legally responsible for the recipient refuses the placement or services; or

(C) the Division or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the recipient's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the recipient.

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

Exhibit 3

Acute Inpatient Hospital Admission Guidelines From Appendix F of the Division of Medical Assistance Acute Inpatient Hospital Manual

Acute Inpatient Hospital Admission Guidelines

A. Introduction

This appendix is intended to help providers make appropriate decisions about the medical necessity of acute inpatient hospital admissions. These guidelines have been approved by physicians from several medical specialties who have active practices in Massachusetts. Providers making decisions on whether to admit a member as an inpatient should use their medical judgment and these guidelines. Services that meet medical-necessity criteria at 130 CMR 450.204 and the rules governing reimbursement of inpatient, outpatient, and observation services in 130 CMR 410.414 (see section D of this appendix) and 415.414 are reimbursable by MassHealth.

B. Definitions for Inpatient, Observation, and Outpatient Services

The reimbursability of services defined below is not determined by these definitions, but by application of the MassHealth regulations in 130 CMR 410.000, 415.000, and 450.000.

Inpatient Services - medical services provided to a member admitted to an acute inpatient hospital.

Observation Services - outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outpatient Hospital Services - medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, day-surgery services, and recovery-room services.

Outpatient Services - medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

C. Admission Guidelines

The following guidelines describe admissions that generally are not medically necessary. This is not an all-inclusive list. The MassHealth agency or its agent may also determine that other admissions not characterized in this list are medically unnecessary and nonreimbursable on an inpatient basis.

1. The admission occurs following observation services, and the admitting provider has not documented at least one of the following in the medical record at the time the decision to admit is made:
* Failure to respond to outpatient treatment and a clear deterioration of the patient's clinical status;
* a significant probability that the treatment plan will continue to need frequent clinical modifications and what specific modifications are necessary;
* instability of the patient that is a deviation from either normal clinical parameters or the patient's baseline; or
* a requirement for more intensive services than were already being delivered while the patient was on observation status, and a physician's order for each specific new service.
2. The admission occurs when the member's condition had improved significantly in response to outpatient treatment with a progression toward either normal clinical parameters or the member's baseline.
3. The admission is for further monitoring or observing for potential complications when the member undergoes a procedure that is appropriately performed in an outpatient setting according to the current standards of care, the procedure is performed without complications, and the member's clinical status is approaching either normal clinical parameters or his or her baseline.
4. The admission is primarily for providing or monitoring the services and treatment of a member with multiple or complex medical needs whose needs were adequately being met in a setting other than an

acute inpatient hospital prior to that admission.
5. The admission of a member whose baseline clinical status is outside of the normal clinical parameters and whose condition has been managed successfully on an outpatient basis, when the admission is based primarily on the member's abnormal status, unless that status has significantly deteriorated.
6. The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.
7. The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s).
8. The admission is primarily because the member requires sedation or anesthesia in order to conduct diagnostic tests that are appropriately performed in an outpatient setting according to the current standards of care, when there are no serious complications requiring inpatient services.
9. The admission of a member whose baseline condition requires the use of complex medical technology, when the admission is primarily due to the need for such technology or other maintenance services related to the pre-existing medical condition(s), unless the member's condition is significantly deteriorating.
10. The admission is primarily for a continuation of treatment or monitoring that has already been delivered effectively in the home, hospital outpatient department, or other institutional setting.
11. The admission of a member who is a patient or resident in another institutional setting, and is admitted primarily for diagnostic or treatment services that could have been provided in the member's current institutional setting or by using outpatient services.
12. The admission of a member who has simple, uncomplicated, outpatient surgery and is being admitted primarily because of the time of day or the need for postoperative observation.

13. The admission is primarily due to the:
* amount of time a member has spent as an outpatient in a hospital or other outpatient setting;
* time of day a member recovers from outpatient surgery;
* need for education of the member, parent, or primary caretaker;
* need for diagnostic testing or obtaining consultations;

* need to obtain medical devices or equipment or arrange home care or other noninstitutional services;
* age of the member;
* convenience of the physician, hospital, member, family, or other medical provider;
* type of unit within the hospital in which the member is placed; or
* need for respite care.

D. Observation Services

[excerpted from the MassHealth outpatient hospital regulations at 130 CMR 410.414]

Reimbursable Services. The Division covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the Division.

Nonreimbursable Services.
(1) Nonreimbursable observation services include but are not limited to:
(a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and
(b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.
(2) The following services are not reimbursable as a separate service:
(a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and
(b) observation services provided concurrently with therapeutic services such as chemotherapy.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 4

Chapter 147 of the Acts and Resolves of 1995

A Portable Document Format (PDF) file of this exhibit is attached.

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

Exhibit 5

From 130 CMR 435.000: Division of Medical Assistance Regulations for Chronic Disease and Rehabilitation Hospitals

435.408: Screening Program for Chronic-Disease and Rehabilitation Hospitals

(A) Introduction. The screening program applies to all in-state and out-of-state chronic-disease and rehabilitation hospitals, except those participating in a managed-care program for all inpatients (see 130 CMR 435.402). The screening program described in 130 CMR 435.408 is intended to ensure that medical and nursing services are medically necessary. The Division pays for chronic-disease and rehabilitation hospital services only when the Division or its agent determines, pursuant to a screening, that such services are medically necessary and authorizes such services prior to admission or conversion.

(B) Screening.
(1) To initiate admission or conversion screening, the hospital must telephone the Division or its agent prior to the proposed admission or anticipated conversion and must:
(a) describe the medical condition that necessitates a chronic-disease or rehabilitation hospital admission or continued stay; and
(b) state the anticipated length of stay.
(2) The Division or its agent applies the level-of-care criteria stated in 130 CMR 435.409 or 435.410, whichever is applicable, to determine the medical necessity of the proposed admission or continued stay, as well as the anticipated length of stay.
(3) If the Division or its agent determines that the proposed admission or continued stay is not medically necessary and denies authorization for such admission or continued stay, the hospital may appeal the denial as stated in 130 CMR 435.408(C).
(4) If the Division or its agent determines that the proposed admission or continued stay is medically necessary, the admission or continued stay will be authorized with a specified, approved length of stay, and the hospital will be issued a preapproved screening number to be used when billing for the hospital stay. Approval may be given by telephone; however, authorization for payment is contingent upon receipt of written authorization from the Division or its agent. The Division will not pay the hospital for any costs incurred after the expiration of the specified, approved length-of-stay period.
(5) Prior to the expiration of the approved length of stay, the hospital or attending physician may request an extension of the length of stay if the member continues to require hospitalization beyond the approved period. The Division or its agent will perform a concurrent review when such a request is made. Such request is subject to the screening program regulations in 130 CMR 435.408.
(6) The Division or its agent will send written notification of denial or written

notification of authorization for payment and a preapproved screening number to the hospital within two working days after the completion of the screening.

(C) Review of Screening Decisions.

(1) If the Division or its agent determines that a hospital admission or continued stay is not medically necessary, the member, the referring or attending physician, or the hospital on behalf of the member, may verbally request reconsideration of the Division's determination. Requests for reconsideration must be made to the Division or its agent and will result in referral of the case to a physician consultant for decision within two working days after the date of the request.

(2) If the physician consultant determines that the hospital admission or continued stay is not medically necessary, the member, the referring or attending physician, or the hospital may request further review:

(a) by written request to the Division or its agent within seven calendar days after receipt of notice of the initial screening decision. This request must include all supporting documentation to justify the request for admission or continued stay. The Division or its agent will issue a final decision by written notice to the hospital, the member, and the referring or attending physician within two working days after the date the Division receives the request for further review; or

(b) by telephone request in order to expedite the review process. An expedited review will be conducted within one working day of receipt by the Division or its agent of the additional information requested during the telephone review. The Division or its agent will issue a final decision by telephone, followed by written notification to the hospital, the member, and the referring or attending physician.

(3) The member may appeal a decision to deny an admission or continued stay by requesting a fair hearing before the Board of Hearings in accordance with the provisions governing fair hearings (130 CMR 610.000 et seq.).

435.410: Level-of-Care Criteria for Rehabilitation Hospitals

(A) Introduction. A member is considered appropriate for rehabilitation hospital placement only when a medical need exists for an intensive rehabilitation program that includes a multidisciplinary approach to improve the member's ability to function to his or her maximum potential. Factors must be present in the member's condition that indicate the potential for functional movement or freedom from pain. A member who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient.

(B) Level-of-Care Criteria. The Medicare rehabilitation hospital level-of-care criteria and the criteria below are used by the Division or its agent to determine the medical necessity of rehabilitation hospital placement. The hospital must provide a rehabilitation program that:

(1) includes specialized skilled nursing services, physical therapy, occupational therapy, and any other services that are necessary for the rehabilitative program (such as speech therapy, prosthetic, or orthotic services);

(2) is organized and directed by a physician who is board-certified in rehabilitation medicine; and
(3) is designed to achieve specified goals within a given time frame.

(C) Team Conferences. The rehabilitation hospital must conduct team conferences for each member. The first team conference must occur within seven calendar days of the member's admission; successive team conferences must occur at least every 14 calendar days thereafter. All team members must be present during the team conferences. These conferences must assess the member's progress and rehabilitation goals, and adjust them when necessary, or terminate the rehabilitation program when the expected outcome is reached. A record must be maintained of:
(1) each team member's goals and progress notes from each conference;
(2) all decisions reached during each team conference; and
(3) the reason for any lack of progress on the part of the member in reaching specific goals.

435.411: Utilization Review

(A) The hospital must determine the medical or administrative necessity of each continued inpatient hospital stay of a member in accordance with the level-of-care criteria in 130 CMR 435.409 and 435.410. For those members requiring a less-than-hospital level of care, the hospital must determine the appropriate care in accordance with the Division's medical eligibility criteria in 130 CMR 456.000.

(B) The Division may designate an agent to determine the medical or administrative necessity of each inpatient hospital stay.

Final Adoption

EXHIBIT 6

114.6 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
MEDICAL SECURITY BUREAU

114.6 CMR14:00: HEALTH SAFETY NET PAYMENTS AND FUNDING
14.01: General Provisions
14.02: Definitions
14.03: Sources and Uses of Funds
14.04: Total Hospital Assessment Liability
14.05: Surcharge Payments
14.06: Payments to Hospitals
14.07: Payments to Community Health Centers
14.08: Reporting Requirements
14.09: Special Provisions

14.01 General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 14.00 governs payments to and from the Health Safety Net Trust Fund effective October 1, 2008, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers. 114.6 CMR 13.00 specifies the criteria for determining the services for which hospitals and community health centers may be paid from the Health Safety Net Trust Fund.

(2) Authority: 114.6 CMR 14.00 is adopted pursuant to M.G.L. c. 118G.

14.02 Definitions

Meaning of Terms: As used in 114.6 CMR 14.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 14.00 are capitalized.

340B Pharmacy. A Community Health Center eligible to purchase discounted drugs through a program established by Section 340B of United States Public Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their patients, and is registered and listed as a 340B Pharmacy within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. 340B Pharmacy services may be provided at on-site or off-site locations.

Allowable Reimbursement. Payments to Acute Hospitals and Community Health Centers for health services provided to uninsured residents of the Commonwealth as further defined in 114.6 CMR 13.00.

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring Hospitalization and meets the U.S. Centers for Medicare and Medicaid (CMS) requirements for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 USC § 1395k(a)(2)(F)(i). These services include only facility services and do not include physician fees.

Centers for Medicare and Medicaid Services (CMS). The federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Charge. The uniform price for a specific service charged by a Hospital or Community Health

Community Health Center. A health center operating in conformance with the requirements of Section 330 of United States Public Law 95-926, including all community health centers which file cost reports as requested by the Division of Health Care Finance and Policy (Division). Such health center must:

(a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
(b) meet the qualifications for certification (or provisional certification) by the Office of Medicaid and enter into a provider agreement pursuant to 130 CMR 405.000; and
(c) operate in conformance with the requirements of 42 U.S.C. § 254(c).

Disproportionate Share Hospital (DSH). A Hospital where a minimum of 63% of the Gross Patient Service Revenue is attributable to Title XVIII and Title XIX of the Social Security Act, other government payers, including Commonwealth Care, and uncompensated care, as further defined in 114.6 CMR 14.03(2)(b).

Eligible Services. Reimbursable Health Services for which Providers may submit a claim for Health Safety Net Payments in accordance with 114.6 CMR 13.00. Eligible Services include Eligible Services to Low Income Patients that meet the criteria in 114.6 CMR 13.03; Medical Hardship services that meet the criteria in 114.6 CMR 13.04; and Bad Debt that meets the criteria in 114.6 CMR 13.05.

Emergency Bad Debt. The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR 13.05.

Family Income. Gross earned and unearned income as defined in 130 CMR 506.003.

Federal Poverty Level (FPL). The Federal poverty income guidelines issued annually in the *Federal Register*.

Financial Requirements. A hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

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

Fund. The Health Safety Net Trust Fund, established by M.G.L. c. 118G §36.

Governmental Unit. The Commonwealth, any department, agency board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Patient Service Revenue (GPSR). The total dollar amount of a hospital's charges for services rendered in a Fiscal Year.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of a Hospital's or Community Health Center's Charge for services.

Health Insurance Plan. The Medicare program, the MassHealth program, Commonwealth Care, or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, as defined in M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I.

Health Safety Net Office. The Office within the Division of Health Care Finance and Policy established under M.G.L. c. 118G, § 35.

Health Services. Medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Health services shall not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood, but the administrative and processing costs association with the provision of blood and its derivatives shall be payable.

Hospital. An acute Hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Hospital Services. Services listed on an acute Hospital's license by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; and home health services, or separately licensed services, including residential treatment programs and ambulance services.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I to a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, that then forward the payment to member Hospitals or Ambulatory Surgical Centers; or a payment made to an individual to reimburse him or her for a payment made to a Hospital or Ambulatory Surgical Center.

Individual Payer. A patient or Guarantor who pays his or her own Hospital or Ambulatory Surgical Center bill and is not eligible for reimbursement from an insurer or other source.

Institutional Payer. A Surcharge Payer that is an entity other than an Individual Payer.

Low Income Patient. A patient who meets the criteria in 114.6 CMR 13.03.

MassHealth. The medical assistance program administered by the Executive Office of Health and Human Services Office of Medicaid pursuant to M.G.L. c. 118E and in accordance with Titles XIX and XXI of the Federal Social Security Act, and a Section 1115 Demonstration Waiver.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Office of Pharmacy Affairs (OPA). The Office of Pharmacy Affairs, and any successor agencies, is a division within the United States Department of Health and Human Services that monitors the registration of 340B pharmacies.

Patient. An individual who receives or has received Eligible Services at a Hospital or Community Health Center.

Payment. A check, draft or other paper instrument, an electronic fund transfer, or any order, instruction, or authorization to a financial institution to debit one account and credit another.

Pediatric Hospital. An acute Hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment System (PPS).

Private Sector Charges. Gross Patient Service Revenue attributable to all patients less Gross Patient Service Revenue attributable to Titles XVIII, XIX, and XXI, other publicly aided patients, For each Fiscal Year, a Hospital's Private Sector Charges are determined using data reported in the RSC-403 for that Fiscal Year.

Provider. A Hospital or Community Health Center that provides Eligible Services.

Publicly Aided Patient. A person who receives Hospital or Community Health Center care and services for which a Governmental Unit is liable in whole or in part under a statutory obligation.

Registered Payer List. A list of Institutional Payers as defined in 114.6 CMR 14.06(3)(b).

Shortfall Amount. In a Fiscal Year, the positive difference between the sum of Allowable Health Safety Net care costs for all Hospitals and the revenue available for distribution to Hospitals.

Sole Community Hospital. Any acute Hospital classified as a Sole Community Hospital by the U.S. Centers for Medicare and Medicaid Services' Medicare regulations, or any Hospital that demonstrates to the Health Safety Net Office's satisfaction that it is located more than 25 miles from other acute Hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

Surcharge Payer. An individual or entity that (a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and (b) meets the criteria set forth in 114.6 CMR 14.05(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to Hospitals and Ambulatory Surgical Centers determined pursuant to 114.6 CMR 14.05(2).

Term Bills. A claim for outpatient services, including, but not limited to, therapy services, that includes charges for multiple dates of service.

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A Third Party Administrator may provide client services for a self-insured plan or an insurance carrier's plan. Third Party Administrators will be deemed to use a client plan's funds to pay for health care services whether the Third Party Administrator pays providers with funds from a client plan, with funds advanced by the Third Party Administrator subject to reimbursement by the client plan, or with funds deposited with the Third Party Administrator by a client plan.

Uncompensated Care Pool. The fund established under M.G.L. c. 118G, § 18 to pay hospitals and community health centers for health services provided to low income uninsured and underinsured individuals.

Urgent Care. Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function, or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life-threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

14.03 Sources and Uses of Funds

State Plan Under Title XIX of the Social Security Act
State: Massachusetts
Institutional Reimbursement

(1) Available Revenue. Revenue available to fund Provider payments from the Health Safety Net Trust Fund consists of:

(a) revenue produced by Hospital assessments and the Surcharge on Hospital and Ambulatory Surgical Center payments;
(b) funds authorized to be transferred from the Commonwealth Care Trust Fund;
(c) amounts transferred from the Uncompensated Care Trust Fund;
(d) any interest on monies in the Health Safety Net Trust Fund; and
(e) any additional funding made available through appropriation by the general court.

(2) Payments from the Health Safety Net Trust Fund.

(a) Hospital Payments established under 114.6 CMR 14.06 may be adjusted to reflect additional funding made available during the Fiscal Year or to reflect the Shortfall Allocation in accordance with 114.6 CMR 14.03 (2). The Health Safety Net Office may reserve up to 10% of available funding to ensure that funding will be available for the entire Fiscal Year.

(b) Shortfall Allocation. The Health Safety Net Office shall, using the best data available, estimate the projected total Reimbursable Services provided by Hospitals, Community Health Centers and total Bad Debt for FY 2009. If the Office determines that, after adjusting for projected Community Health Center payments, Health Safety Net payments to Hospitals will exceed available funding, the Office shall allocate the funding in a manner that reflects each Hospital's proportional financial requirements for Health Safety Net payments through a graduated payment system. The Health Safety Net Office will allocate the shortfall to Disproportionate Share Hospitals and other Hospitals as follows:

1. Disproportionate Share Hospital. The Office will determine Disproportionate Share Hospital status using data from the FY 2007 DHCFP-403 cost report as follows.

a. Determine all Hospitals with more than 63% of GPSR attributable to Medicare, Medicaid or uncompensated care.
b. Determine each Hospital's FY 2007 uncompensated care payments by multiplying the Hospital's free care charges from the FY2007 Uncompensated Care Pool (UCP) claims data by the cost to charge ratio calculated using the FY2007 DHCFP-403 cost report.
c. Rank the Hospitals from highest to lowest based on the ratio of FY 2007 uncompensated care costs to total statewide uncompensated care costs.
d. The 16 Hospitals with the highest ratios of uncompensated care costs to total statewide uncompensated care costs are Disproportionate Share Hospitals.

2. Shortfall Allocation. The Health Safety Net Office will allocate the shortfall as follows:

a. Determine the ratio of each Hospital's total patient care costs to the sum of all Hospitals' total patient care costs;
b. Multiply this ratio by the total Shortfall Amount
c. If calculated amount is greater than a Hospital's allowable Health Safety Net payments, then the shortfall allocation will be limited to the Hospital's allowable Health Safety Net payments.
d. The Health Safety Net's gross liability to each Hospital is limited by the Hospital's allowable Health Safety Net payments less the Shortfall Allocation Amount.
e. Each Disproportionate Share Hospital will be paid the greater of:

i. 85% of its Allowable Health Safety Net payments: or
ii. the revised payment calculated according to the shortfall methodology in 114.6 CMR 14.03(2)(b)1. through 4.

14.04 Total Hospital Assessment Liability to the Health Safety Net Trust Fund

A Hospital's gross liability to the Health Safety Net Trust Fund is the product of (a) the ratio of its Private Sector Charges to all Hospitals' Private Sector Charges and (b) $180 million, the total Hospital liability to the Health Safety Net Trust Fund pursuant to M.G.L. c. 118G, §37.

14.05 Surcharge on Hospital Payments

(1) General. There is a surcharge on certain payments to Hospitals and Ambulatory Surgical Centers. The surcharge amount equals the product of (a) payments subject to surcharge as defined in 114.6 CMR 14.05(1)(b) and (b) the Surcharge Percentage as defined in 114.6 CMR 14.05(2).

(a) Surcharge Payer.

1. A Surcharge Payer is an individual or entity that makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; provided, however, that the term "surcharge payer" shall not include (1) Title XVIII and Title XIX programs and their beneficiaries or recipients; (2) other governmental programs of public assistance and their beneficiaries or recipients; and (3) the workers compensation program established pursuant to M.G.L. c.152.
2. The same entity that pays that Hospital or Ambulatory Surgical Center for services must pay the surcharge. If an entity such as a Third Party Administrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, or advances funds to pay for the services for which it is reimbursed by the client plan, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge or advance funds to pay the surcharge for which it will be reimbursed by the client plan.

(b) Payments subject to surcharge. Payments subject to surcharge include:

1. direct and Indirect Payments made by Surcharge Payers on or after January 1, 1998, regardless of the date services were provided, to: (1) Massachusetts acute hospitals for the purchase of acute Hospital Services; and (2) Massachusetts Ambulatory Surgical Centers for the purchase of Ambulatory Surgical Center Services.
2. payments made by national health insurance plans operated by foreign governments; and payments made by an embassy on behalf of a foreign national not employed by the embassy.

(c) Payments not subject to surcharge. Payments not subject to surcharge include:

1. payments, settlements and judgments arising out of third party liability claims for bodily injury that are paid under the terms of property or casualty insurance policies;
2. payments made on behalf of Medicaid recipients, Medicare beneficiaries, persons enrolled in Commonwealth Care, or persons enrolled in policies issued pursuant to M.G.L. c. 176K or similar policies issued on a group basis;
3. payments made by a Hospital to a second Hospital for services that the first Hospital billed to a Surcharge Payer;
4. payments made by a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, to member Hospitals or Ambulatory Surgical Centers for services that the group billed to an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I;
5. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act at 5 U.S.C. 8901 et seq.;
6. payments made on behalf of an individual covered under the workers compensation program under M.G.L. c. 152; and
7. payments made on behalf of foreign embassy personnel who hold a Tax Exemption Card issued by the United States Department of State.

(d) The surcharge shall be distinct from any other amount paid by a Surcharge Payer for the services provided by a Hospital or Ambulatory Surgical Center. Surcharge amounts paid shall be deposited in the Health Safety Net Trust Fund.

(2) Calculation of the Surcharge Percentage. The Health Safety Net Office will use the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to Hospitals and Ambulatory Surgical Centers, established in M.G.L. c.118G, § 38. The Health Safety Net Office will establish the Surcharge Percentage before September 1 of each year, as follows:

(a) The Health Safety Net Office will determine the total amount to be collected by adjusting $160,000,000 for any over or under collections from Institutional Payers and individuals in previous years, including audit adjustments, as well as

any over or under collections projected for October or November of the coming year.

(b) The Health Safety Net Office will project annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Health Safety Net Office deems necessary.

(c) The Health Safety Net Office will divide the amount determined in 114.6 CMR 14.05(2)(a) by the amount determined in 114.6 CMR 14.05(2)(b).

(3) Payer Registration.

(a) Except for non-United States national insurers that have made less than ten payments per year in the prior three years to Massachusetts Hospitals and/or Ambulatory Surgical Centers, all Institutional Payers must register with the Health Safety Net Office by completing and submitting the Surcharge Payer Registration form. Institutional Payers must register only once. These payers shall submit the Registration form to the Health Safety Net Office within 30 days after making a payment to any Massachusetts Hospital or Ambulatory Surgical Center.

(b) Registered Payer List. The Health Safety Net Office will compile lists of registered Institutional Payers, and will update the lists quarterly. The Health Safety Net Office will distribute these lists to Hospitals and Ambulatory Surgical Centers upon request.

(c) Institutional Payers must register only once. A Registered Payer is automatically registered for the next Fiscal Year.

(4) Billing Process for Institutional Payers.

(a) Each Hospital and Ambulatory Surgical Center shall send a bill for the Health Safety Net surcharge to Surcharge Payers, as required by c.118G, § 38. Hospitals and Ambulatory Surgical Centers shall send this bill to Surcharge Payers from whom they have received payment for services in the most recent four quarters for which data is available. The bill will state the Surcharge Percentage. Hospitals and Ambulatory Surgical Centers shall send this bill to payers before September 1 of each Fiscal Year and before the effective date of any Surcharge Percentage.

(b) Each Hospital and Ambulatory Surgical Center shall also send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers who have not registered with the Health Safety Net Office pursuant to 114.6 CMR 14.05(3)(a) and from whom they have received payment. The bill must be sent within 30 days of receiving the payment from the unregistered payer. The bill shall state the Surcharge Percentage, but not the dollar amount owed, and shall include notification of the surcharge payment process set forth below, as well as a registration form specified by the Health Safety Net Office. Until the Hospital or Ambulatory Surgical Center receives the Registered Payer List, it shall send a bill for the surcharge at the same time as the bill for services

provided to Institutional Payers which it did not already bill pursuant to 114.6 CMR 14.05(4)(a).

(5) Payment Process for Institutional Payers

(a) Monthly Surcharge Liability. After the end of each calendar month, each Institutional Payer shall determine the surcharge amount it owes to the Health Safety Net Trust Fund for that month. The amount owed is the product of the amount of payments subject to surcharge, as defined in 114.6 CMR 14.02, by the Surcharge Percentage in effect during that month. The Institutional Payer may adjust the surcharge amount owed for any surcharge over- or under-payments in a previous period.

1. Institutional Payers that pay a global fee or capitation for services that include Hospital or Ambulatory Surgical Center services, as well as other services not subject to the surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by Hospitals or Ambulatory Surgical Centers. Such Institutional Payers must file this allocation method by October 1 of each Fiscal Year. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the Institutional Payer must file the new method with the Health Safety Net Office before the new payment arrangement takes effect. Institutional Payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

a. The Health Safety Net Office will review allocation plans within 90 days of receipt. During this review period the Health Safety Net Office may require an Institutional Payer to submit supporting documentation or to make changes in this allocation method if it finds that the method does not reasonably allocate the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers.

b. An Institutional Payer must include the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers, as determined by this allocation method, in its determination of payments subject to surcharge.

2. An Institutional Payer must include all payments made as a result of settlements, judgments or audits in its determination of payments subject to surcharge. An Institutional Payer may include payments made by Massachusetts Hospitals or Ambulatory Surgical Centers to the Institutional Payer as a result of settlements, judgments or audits as a credit in its determination of payments subject to surcharge.

(b) Monthly Payments. Institutional Payers shall make payments to the Health Safety Net Trust Fund monthly. Each Institutional Payer shall remit the

surcharge amount it owes to the Fund, determined pursuant to 114.6 CMR 14.05(5)(a), to the Health Safety Net Office for deposit in the Fund. Institutional Payers shall remit the surcharge payment by the first business day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to Hospitals and Ambulatory Surgical Centers in January are due by March 1.

(c) Biannual Surcharge Payment Option. An Ambulatory Surgical Center may request a biennial surcharge payment option if:

1. it has remitted 4 or fewer payments during the previous fiscal year:
2. it has remitted all required surcharge payments and submitted all monthly coupons;
3. it submitted a Surcharge Verification Form for the previous fiscal year; and
4. it has reported less than $10,000 in surcharge payments in the Surcharge Verification Form.

The Health Safety Net Office will notify payers eligible for the biannual option. The Payer may elect to receive biannual surcharge notices or to continue to receive monthly notices. Each biannual surcharge payment will equal (1) the appropriate surcharge percentage times (2) payments made to Massachusetts hospitals and ambulatory surgical centers for the prior six months.

(d) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) Any Institutional Payer, except Third Party Administrators, that has a surcharge liability of less than five dollars in any month or biannual payment period may delay payment until its surcharge liability is at least five dollars. For example, XYZ Company's surcharge liability for July is $3.50 and its liability for August is $2.00. XYZ Company may delay payment in July but must remit a check for $5.50 in August.

(6) Payment Process for Individual Payers (Self-pay). There is a surcharge on certain payments made by Individual Payers to Hospitals and Ambulatory Surgical Centers.

(a) Billing.

1. Hospitals and Ambulatory Surgical Centers shall include the surcharge amount on all bills to Individual Payers unless:
   a. the patient's liability is less than the individual payment threshold determined by the Health Safety Net Office. The individual payment threshold is a payment of $10,000 or more.
   b. the patient is a non-Massachusetts resident for whom the Hospital or Ambulatory Surgical Center can verify that the patient's family income would otherwise qualify the patient as a Low Income Patient under 114.6 CMR 13.04.
   c. the patient is approved for Medical Hardship in accordance with the requirements of 114.6 CMR 13.05. The bill shall direct

Individual Payers to pay the surcharge to the Hospital or Ambulatory Surgical Center when making payment for services.

2. The amount of the surcharge billed is the product of (a) the patient's liability to the Hospital or Ambulatory Surgical Center, and (b) the Surcharge Percentage in effect on the billing date.

3. The amount of the surcharge owed by an Individual Payer is the product of (a) the total amount paid by the individual to a Hospital or Ambulatory Surgical Center; and (b) the Surcharge Percentage in effect on the payment date. Payments greater than or equal to the threshold received by Hospitals and Ambulatory Surgical Centers from Individual Surcharge Payers are subject to the surcharge.

(b) Hospitals and Ambulatory Surgical Centers must remit to the Health Safety Net Office the surcharge amount owed by Individual Payers for every payment greater than or equal to the threshold made by Individual Payers. If an Individual Payer makes separate payments over a twelve month period that are equal to or greater than the threshold and relate to an outpatient visit or inpatient stay, the surcharge amount due applies to the aggregate amount paid for the outpatient visit or inpatient stay. The first surcharge payment is due to the Health Safety Net Office when the total Individual Payer payment amount reaches the threshold.

(c) Hospitals and Ambulatory Surgical Centers shall remit such surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by Hospitals and Ambulatory Surgical Centers in January are due to the Pool on March 1. Hospitals and Ambulatory Surgical Centers may deduct collection agency fees for the collection of surcharge payments from Individual Payers from the total amount of surcharge payments forwarded to the Pool.

(d) All payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) If an embassy of a foreign government pays a Hospital or Ambulatory Surgical Center bill on behalf of an individual, the Provider may either: (a) bill the embassy for the individual's surcharge according to the billing and payment process for individual payers set forth in 114.6 CMR 14.05(6) or (b) bill the embassy according to the billing process for Institutional Payers as set forth in 114.6 CMR 14.05(4). If the Provider chooses to bill the embassy as an Institutional Payer and the embassy is not listed on the Registered Payer List, the Provider shall include the embassy on the Unmatched Payer Report and send surcharge payer registration information to the embassy.

(7) Penalties. If a Hospital, Ambulatory Surgical Center, or Surcharge Payer fails to forward surcharge payments pursuant to 114.6 CMR 14.05, the Health Safety Net Office shall impose an additional 1.5% interest penalty on the outstanding balance. The interest shall be calculated from the due date. For each month a payment remains delinquent, an

additional 1.5% penalty shall accrue against the outstanding balance, including prior penalties.

(a) The Health Safety Net Office will credit partial payments first to the current outstanding liability, and second to the amount of the penalties.

(b) The Health Safety Net Office may reduce the penalty at the Health Safety Net Office's discretion. In determining a waiver or reduction, the Health Safety Net Office's consideration will include, but will not be limited to, the entity's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.

(8) Administrative Review. The Health Safety Net Office may conduct an administrative review of surcharge payments at any time.

(a) The Health Safety Net Office will review data submitted by Hospitals, Ambulatory Surgical Centers, and Institutional Payers pursuant to 114. CMR 14.08, the Surcharge Payer Registration forms submitted by Institutional Payers pursuant to 114.6 CMR 14.05(3)(a), and any other pertinent data. All information provided by, or required from, any Surcharge Payer, pursuant to 114.6 CMR 14.00 shall be subject to audit by the Health Safety Net Office. For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Health Safety Net Office pursuant to 114.6 CMR 14.05(5)(a)(1), the Health Safety Net Office's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(b) The Health Safety Net Office may require the Surcharge Payer to submit additional documentation reconciling the data it submitted with data received from Hospitals.

(c) If the Health Safety Net Office determines through its review that a Surcharge Payer's payment to the Pool was materially incorrect, the Health Safety Net Office may require a payment adjustment. Payment adjustments shall be subject to interest penalties and late fees, pursuant to 114.6 CMR 14.05(7), from the date the original payment was owed to the Pool.

(d) Processing of Payment Adjustments.

1. Notification. The Health Safety Net Office shall notify a Surcharge Payer of its proposed adjustments. The notification shall be in writing and shall contain a complete listing of all proposed adjustments, as well as the Health Safety Net Office's explanation for each adjustment.

2. Objection Process. If a Surcharge Payer wishes to object to a Health Safety Net Office proposed adjustment contained in the notification letter, it must do so in writing, within 15 business days of the mailing of the notification letter. The Surcharge Payer may request an extension of this period for cause. The written objection must, at a minimum, contain:

a. each adjustment to which the Surcharge Payer is objecting,

b. the Fiscal Year for each disputed adjustment,

c. the specific reason for each objection, and

d. all documentation that supports the Surcharge Payer's position.

3. Upon review of the Surcharge Payer's objections, the Health Safety Net Office shall notify the Surcharge Payer of its determination in writing. If the Health Safety Net Office disagrees with the Surcharge Payer's objections, in whole or in part, the Health Safety Net Office shall provide the Surcharge Payer with an explanation of its reasoning.

4. The Surcharge Payer may request a conference on objections after receiving the Health Safety Net Office's explanation of reasons. The Health Safety Net Office will schedule such conference on objections only when it believes that further articulation of the Surcharge Payer's position is beneficial to the resolution of the disputed adjustments.

(e) Payment of Adjustment Amounts. Adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Notification letter. If the Surcharge Payer submitted a written objection, then adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Health Safety Net Office's determination. The Health Safety Net Office may establish a payment schedule for adjustment amounts.

14.06 Payments to Hospitals.

(1) General Provisions.

(a) The Health Safety Net Office will pay Hospitals based on claims in accordance with the requirements of 114.6 CMR 13.00.

1. The Health Safety Net Office will monitor the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the Provider's service delivery patterns and/or billing activity, including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

2. If the Provider submitted Term Bills to the Uncompensated Care Pool or the Health Safety Net during Fiscal Year 2006 and Fiscal Year 2008, it must continue to submit Term Bills for Fiscal Year 2009.

(b) Payment Types. The Health Safety Net Office will calculate Health Safety Net payments for each Hospital for the following categories of claims for which the Health Safety Net is the primary payer:

Inpatient - Medical
Inpatient - Psychiatric
Inpatient - Rehabilitation
Outpatient
Emergency Bad Debt - Inpatient Medical
Emergency Bad Debt - Inpatient Psychiatric
Emergency Bad Debt - Outpatient

The Health Safety Net Office will also establish payments for inpatient claims for which the Health Safety Net is the secondary payer. The Health Safety Net Office will reduce payments by the amount of co-payments and deductibles required by 114.6 CMR 13.00, Emergency Bad Debt recoveries, and investment income on free care endowment funds. The Health Safety Net Office will determine the offset of free care endowment funds by allocating free care endowment income between Massachusetts residents and non-residents using the best data available and offsetting the Massachusetts portion against Health Safety Net claims.

(c) Method of Payment. The Health Safety Net Office may make payments to Hospitals for Eligible Services through a safety net care payment under the Massachusetts Section 1115 Demonstration Waiver, a MassHealth supplemental hospital rate payment, or a combination thereof. The Health Safety Net Office may limit a Hospital's Payment for Eligible Services to comply with requirements under the Massachusetts Section 1115 Demonstration Waiver governing safety net care, or any other federally required limit on payments under 42 U.S.C. § 1396a(a)(13) or 42 CFR 447.

(d) Data Sources. The Health Safety Net Office will use the following Medicare payment data sources to determine Inpatient Payments. Unless otherwise specified, the Health Safety Net Office will use values established by CMS. The Division will update these values as needed to conform with changes implemented by the Medicare program during FY2009:

1. DRG Weight. The Version 26 Medicare severity diagnostic related group (MS-DRG) weight for a particular MS-DRG as published in the *Federal Register*.
2. DSH Factor. The hospital-specific operating and capital factors calculated pursuant to 42 CFR 412.106. For hospitals classified by CMS as Pickle Hospitals, the DSH factor for operating expenses is 0.35 and the DSH factor for capital expenses is 0.125.
3. Geographic Adjustment Factor (GAF). The GAF varies by hospital and is the Medicare wage index raised to 0.6848 pursuant to 42 CFR 412.316(a).
4. Indirect Medical Education (IME) Adjustment. A hospital-specific CMS adjustment to the Medicare payment calculated pursuant to 42 CFR 412.105.
5 Pass through add-on. A hospital-specific CMS adjustment to the Medicare payment.
6. Standardized Amount - Labor. $3,574.50, the FY2009 amount for hospitals with wage indices above 1.0, as published by CMS on September 29, 2008.
7. Standardized Amount - Non-Labor. $1,553.91, the FY2009 amount for hospitals with wage indices above 1.0, as published by CMS on September 29, 2008.

8. Standardized Capital Amount. $424.17, the FY2009 amount as published by CMS on September 29, 2008.
9. Wage Index. The hospital-specific wage index used to determine Medicare payments.

(2) Payments for Inpatient Services. The Health Safety Net Office will pay hospitals in accordance with Medicare FY2009 Inpatient Prospective Payment System (IPPS) for non-psychiatric claims, and the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for psychiatric claims. Hospitals classified by Medicare as Critical Access Hospitals (CAHs), PPS-Exempt Hospitals, Medicare Dependent Rural Hospitals, and Sole Community Hospitals will be paid in accordance with 114.6 CMR 14.06(2)c.

(a) Inpatient Medical Payment - Standard.

1. Calculation of the HSN Medical Inpatient Payment. For all Hospitals except Medicare-designated Critical Access Hospitals, PPS-Exempt Hospitals, Sole Community Hospitals and Medicare Dependent Rural Hospitals, the Health Safety Net Office will calculate an Inpatient Medical Payment as follows:

a. Adjusted Standard Amount (ASA). The ASA equals:

(Standard Labor Amount*Wage Index) +(Standard Non-Labor Amount)

b. DRG weight. The DRG weight is determined on a per claim basis using the Medicare version 26 MS-DRG grouper.

c. Operating DRG Payment. The Operating DRG Payment equals:

ASA*DRG Weight*(1+DSH Operating Factor)*(1+IME Operating Factor)

d. Capital DRG Payment. The Capital DRG Payment equals:

(Standard Capital Amount)*DRG Weight*GAF*
(1+DSH Capital Factor)*(1+IME Capital Factor)

e. Pass through Payment: The Pass through Payment equals:

Pass through per diem*length of stay

f. Outlier Payment. The Health Safety Net Office will calculate an additional outlier payment for qualifying cases. A case qualifies for an outlier payment if the estimated case cost exceeds the outlier threshold. The estimated case cost is determined by discounting total charges, less hospital-based physician charges, by a cost to charge ratio. The fixed outlier

threshold is $20,045, adjusted for the hospital-specific wage index, DSH, IME, and GAF amounts. The total outlier payment is the marginal cost factor of 80% of the difference between the estimated cost and the outlier threshold

g. Inpatient Medical Payment. The hospital-specific total case payment for each discharge is the sum of the Operating DRG Payment, the Capital DRG Payment and the Pass through Payment. It may be further adjusted, as applicable, by an Outlier Payment, or adjustment under 114.6 CMR 14.06(2)(b).

(b) Adjustments to Inpatient Medical Payment.

1. Transfer Case Payments. If a case qualifies as a transfer case under Medicare rules, the Health Safety Net Office will calculate a per diem rate, capped at the full discharge payment. The per diem rate is the hospital-specific DRG payment calculated under 114.6 CMR 14.05(2)(b)(1)(e), divided by the length of stay for the DRG. For qualifying cases, transfer payments may also include a per diem outlier payment.

2. Special Pay Post-Acute DRGs. If a case would qualify as a "special pay DRG" under Medicare rules, the Health Safety Net Office will calculate a rate as follows: Day 1 is set at 50% of the full DRG payment, plus a single transfer payment per diem. Subsequent days are set at 50% of the transfer per diem. In no case will the calculated payment exceed the full DRG payment. For qualifying cases, special pay post-acute DRGs may also include a per diem outlier payment.

3. Partially-eligible stays. If a patient is eligible for the Health Safety Net for part of an inpatient stay, the hospital will receive the transfer per diem rate for the number of eligible inpatient days, not to exceed the full discharge payment.

(c) Inpatient Medical Payment - Other Hospitals

1. Critical Access Hospitals. The Health Safety Net Office will calculate a per discharge payment for all discharges occurring at Medicare Critical Access Hospitals as follows:

a. The Division will determine the average charge per discharge using FY2008 adjudicated and eligible HSN claims data as of June 27, 2008.

b. The Division will determine an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using FY2007 HCF-403 data.

c. The average cost per discharge will be increased by a cost adjustment factor of 1.0404, and an additional factor of 1.01. The product of this calculation is the per discharge payment applicable to all discharges occurring in FY2009, except that

partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)3.

2. PPS-Exempt Hospitals. The Health Safety Net Office will calculate a per discharge payment for all discharges occurring at PPS-exempt cancer and Pediatric Hospitals as follows:

a. The Division will determine the average charge per discharge using FY2008 adjudicated and eligible HSN claims data as of June 27, 2008.

b. The Division will determine an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using FY2007 HCF-403 data.

c. The average cost per discharge will be increased by a cost adjustment factor of 1.0404. The product of this calculation is the per discharge payment applicable to all discharges occurring in FY2009, except that partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)3.

3. Sole Community Hospitals. The Health Safety Net Office will calculate a hospital-specific per discharge amount for Hospitals classified by Medicare as Sole Community Hospitals, rather than the Adjusted Standardized Amount. This amount is based on the hospital-specific rate provided by the Medicare fiscal intermediary, adjusted for inflation. The payments may include transfer, outlier, and special pay amounts, using the hospital-specific rate in these calculations, for qualifying cases. Partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)3.

4. Medicare Dependent Rural Hospitals. The Health Safety Net Office will calculate a will receive a blended payment consisting of 75% of a hospital-specific payment and 25% of the Operating DRG Payment for Hospitals classified by Medicare as Medicare Dependent Rural Hospitals The payments may include transfer, outlier, and special pay amounts, using the hospital-specific blended rate in these calculations, for qualifying cases. Partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)(4).

(d) Inpatient Psychiatric Payment.

1. Psychiatric Case. A case is classified as psychiatric if

a. the Hospital has a Medicare psychiatric unit;

b. the primary diagnosis is related to a psychiatric disorder with an ICD-9 code beginning with 29, 30 or 31; and

c. the claim includes psychiatric accommodation charges.

2. Psychiatric Payment. The Health Safety Net Office will calculate a per diem payment as follows:

a. Base Rate. The Adjusted Rate equals:

(Labor share of the Medicare Federal Per Diem psychiatric rate, $482.36*Wage Index) +
(Non-labor share of the Medicare Federal Per Diem, $155.42)

3. Teaching Adjustment. There is an additional teaching adjustment for Hospitals with Medicare approved teaching programs. The teaching adjustment equals:

$(1+(\text{number of psych resident FTEs/Average daily census})^{**0.5150})$

4. Other Adjustments. Other adjustments will be included in the payment rate in accordance with the Medicare payment provisions identified in the May 7, 2008 *Federal Register*. These include adjustments for specific DRGs, the presence of comorbidities, patient age, and length of stay.

5. Outlier Payments. Additional outlier payments will be included in the payment rate for qualifying cases that exceed the outlier threshold. Outlier payments are calculated as follows:

a. Outlier Threshold. The psychiatric outlier threshold is the fixed threshold adjusted for the hospital's wage index, plus the psychiatric payment calculated above.

b. Outlier Per Diem. The outlier per diem is the difference between the psychiatric case costs estimated using the cost to charge ratio and the outlier threshold, divided by the length of stay.

c. Outlier Payment. If the length of stay is less than or equal to 9 days, the additional outlier payment is 80% of the outlier per diem times the length of stay. For Day 9 and additional days, the outlier payment is 60% of the outlier per diem.

6. Total Case Payment. The total case payment is the sum of the base payment, teaching adjustment, other adjustments, and outlier payments.

(e) Inpatient Rehabilitation Payment.

1. Rehabilitation Case. A case is classified as rehabilitation if:

a. the Hospital has a Medicare rehabilitation unit; and

b. the claim includes rehabilitation accommodation charges.

2. Payment. Rehabilitation cases are paid on a per diem basis. The payment is determined using the Hospital's most recently filed CMS-2552 Cost Report. The rate is the sum of total rehabilitation PPS payments and reimbursable bad debts, divided by total rehabilitation days.

(f) Physician Payments.

1. The Health Safety Net Office will calculate payments for hospital-based physician services provided to inpatients by multiplying the billed

charges by the payment on account factor calculated pursuant to 114.6 CMR 14.06(3).

2. Effective January 1, 2009, the Health Safety Net Office will calculate payments for hospital-based physician services provided to inpatients using the Medicare fee schedule.

(g) Hospital-Acquired Conditions.

1. All hospitals, including but not limited to PPS-Exempt Hospitals, are required to report the Present on Admission indicator for all diagnosis codes on inpatient claims.

2. The Health Safety Net Office will not assign an inpatient case to a higher paying MS-DRG if a Hospital-Acquired Condition that was not present on admission occurs during the stay. For hospital services paid pursuant to 114.6 CMR 14.06(2)(a) and (b), the DRG payment will be reduced in accordance with Medicare principles.

(h) Serious Reportable Events. The Health Safety Net Office will not pay for services related to Serious Reportable Events as defined by the National Quality Forum. The Office may issue Administrative Bulletins clarifying billing requirements and payment specifications for these Events.

(3) Payments for Outpatient Services. The Health Safety Net Office will pay a per visit amount for each outpatient visit. An outpatient visit includes all outpatient services, including hospital-based physician services, provided in a single day, except for dental services. The outpatient per visit amount is determined as follows:

(a) For each hospital, the Division will calculate an average outpatient charge per visit, using FY2008 adjudicated and eligible Health Safety Net claims as of June 27, 2008. Charges for dental claims and charges for outpatient claims within 72 hours of an inpatient admission will be excluded. For Critical Access Hospitals and PPS-Exempt Hospitals, only charges for claims within 24 hours of an inpatient admission will be excluded.

(b) The Division will determine an outpatient payment per visit by multiplying the average outpatient charge per visit by a Medicare Payment on Account Factor, calculated using the best available data and subject to review and adjustment by the Division. This product is further increased by a cost adjustment factor of 4.04%.

(c) Disproportionate Share Hospitals and non-teaching Hospitals will receive a transitional add-on of 25% of the outpatient per visit payment rate.

(d) The payment for PPS-exempt Pediatric and cancer Hospitals and Medicare Critical Access Hospitals will be determined using the ratio of costs to charges from the FY 2007 HCF-403 cost report.

(4) Dental Services. The Health Safety Net Office will pay hospitals for dental services provided at hospitals and hospital-licensed health centers using the fees established in 114.3 CMR 14.00: Dental Services. No additional outpatient per visit payment will be paid for dental services.

(5) Hospital Outpatient Pharmacies.

(a) Prescribed Drugs. For Hospitals with outpatient pharmacies, the Health Safety Net Office will pay for prescribed drugs using rates set forth in 114.3 CMR 31.00. The payment will be reduced by the amount of patient cost-sharing set forth in 114.6 CMR 13.00. Claims will be adjudicated by the MassHealth Pharmacy Online Payment System.

(b) Part B Covered Services. Medical supplies normally covered by the Medicare Part B program that are dispensed by Hospital outpatient pharmacies that are not Part B providers will be paid at 20% of the rates set forth in 114.3 CMR 22.00 and 114.3 CMR 31.00.

(6) Secondary Payer. The Health Safety Net Office will pay claims for which it is not the primary payer as follows:

(a) Medicare as primary payer. For any allowable claim for which Medicare is the primary payer, the Health Safety Net Office will pay the amount of the patient deductible or co-insurance.

(b) Other primary payers. For any allowable claim for which a payer other than Medicare is the primary payer. For allowable claims for which the Health Safety Net is the secondary payer, the payment is the product of the net billed charges and the Medicare Payment on Account Factor.

(7) Bad Debt Payments. The Health Safety Net Office will calculate Emergency Bad Debt payments for Inpatient Medical, Psychiatric, and Outpatient Services, using the methodology in 114.6 CMR 14.06 (2) and (3), except that the Emergency Bad Debt outpatient rate does not include the transitional add-on cited in 114.6 CMR 14.06(3)(c).

(8) Other. The Health Safety Net Office will make an additional payment of $3.85 million for freestanding pediatric hospitals. The Health Safety Net Office may make an additional payment adjustment for the two Disproportionate Share Hospitals with the highest relative volume of free care costs in FY 2006.

(9) Transition Payments. The Health Safety Net Office will make monthly Transition Payments to Hospitals for the months of October 2008 through January 2009. Each Hospital will be paid the average of two payment bases: adjudicated monthly claims using a date of service basis and adjudicated claims using a date of submission basis. These payment bases will exclude remediated FY2008 claims as defined in 114.6 CMR 14.06(9)(d).

(a) Date of Service Basis. The Office will determine the total payment amounts for Primary and Bad Debt claims according to the following schedule:

Payment Cycle Month	Primary and secondary claims, with existing HSN eligibility	Pharmacy claims	Bad Debt claims

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October 2008	Claims with dates of service between April 1, 2008 – April 30, 2008	Claims with dates of service between June 1, 2008 and June 30, 2008	Written off during April 2008
November 2008	Claims with dates of service between May 1, 2008 and May 31, 2008	Claims with dates of service between July 1, 2008 and July 31, 2008	Written off during May 2008
December 2008	Claims with dates of service between June 1, 2008 and June 30, 2008	Claims with dates of service between August 1, 2008 and August 31, 2008	Written off during June 2008
January 2009	Claims with dates of service between July 1, 2008 and July 31, 2008	Claims with dates of service between September 1, 2008 and September 30, 2008	Written off during July 2008

(b) Date of Submission basis. The Office will determine the total payment amounts for Primary and pharmacy claims according to the following schedule:

Payment Cycle Month	Primary secondary and pharmacy claims	Bad Debt Claims
October 2008	Eligible claims submitted during August 2008	Written off during August 2008
November 2008	Eligible claims submitted during September 2008	Written off during September 2008
December 2008	Eligible claims submitted during October 2008	Written off during October 2008
January 2009	Eligible claims submitted during November 2008	Written off during November 2008

(c) For the payment cycle months of October 2008 through January 2009, the payment will be the average of the amounts determined pursuant to 114.6 CMR 14.06(9)(a) and 114.6 CMR 14.06(9)(b),.
(d) FY2008 Remediated Claims. FY2008 Remediated Claims include claims with dates of service prior to April 1, 2008 that were previously denied or paid,

but, due to hospital resubmission or Division action, were remediated and paid or voided in the payment cycle months of October 2008 through January 2009. The Division will price these claims, multiply the total value of the priced claims by a factor of 2, to treat these claims consistently with the payment basis for FY2008, and include this amount in hospital payments for the payment cycles of October 2008 through January 2009. Any FY2008 claim remediated after the January 31, 2009 will be paid as priced, without the additional factor of 2

(10) Basis of Payment. For the monthly payment cycles beginning with February 2009, payments will be made using claims submitted for two months prior to the payment cycle month.

14.07 Payments to Community Health Centers

(1) General Provisions.

(a) The Health Safety Net Office will pay Community Health Centers based on claims submitted to the Office, less applicable cost sharing amount, in accordance with the requirements of 114.6 CMR 13.00 and claims specifications determined by the Office. The Health Safety Net Office will monitor the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the Provider's service delivery patterns, including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

(b) The Health Safety Net Office will pay a Community Health Center for prescribed drugs only if the Center is also providing prescribed drugs to MassHealth members and receiving payment from MassHealth according to 114.3 CMR 31.07.

(2) Payments for Services. Except for claims for Urgent Bad Debt, the Health Safety Net Office will pay Community Health Centers as follows:

Service	*Codes*	*Payment*
Medical Visit	CPT Evaluation and Management codes for on-site services and certain hospital visits	100% Medicare FQHC rate; limit one visit per day
Medical Visit - Urgent Care	Code 99051	Rate for 99050 in 114.3 CMR 4.00
Surgical Procedure (provided on a day separate from a Medical Visit)	CPT surgery codes clinically appropriate for office setting	100% of Medicare FQHC rate
Cardio and Pulmonary Diagnostic (technical component only)	Cardiovascular (93000 series) and Pulmonary (94000 series)	114.3 CMR 17.00
Obstetrical Services	Global OB codes	114.3 CMR 16.00
Behavioral Health (diagnostic)	CPT Behavioral Health Diagnostic codes; CHC licensed services	100% Medicare FQHC rate
Behavioral Health (treatment)	CPT Behavioral Health Treatment codes	62.5% Medicare FQHC rate for hourly individual treatment; 31.25% of Medicare FQHC rate for 30 minute codes except group codes; for group treatment and medication visit, rates in 114.3 CMR 6.00
Radiology	Applicable CPT Code	114.3 CMR 18.00
Clinical Laboratory	CPT Lab Codes	114.3 CMR 20.00
Dental	CDT - HCPC - D codes D9450 (case presentation - CHC enhancement)	114.3 CMR 14.00; payment for Code D9450 in 114.3 CMR 4.00
340B Pharmacy	MassHealth Pharmacy On-Line Payment System	114.3 CMR 31.00; $3 co-pay brand; $1 co-pay generic
Vision Care (diagnostic)	Exam, diagnostic tests	100% Medicare FQHC rate for all inclusive visit; limit one visit per day
Vision Care (dispensing, repair)	V-codes glasses; fitting/dispensing/repair	114.3 CMR 15.00
Medical Nutrition Therapy	MassHealth identified codes	114.3 CMR 17.00
Diabetes Self -Management Treatment	MassHealth identified codes	114.3 CMR 17.00
Tobacco Cessation Services	MassHealth identified codes	114.3 CMR 17.00

Preventative Services/Risk Factor Reduction	99402	114.3 CMR 12.00
Immunization visits	90471-90473	114.3 CMR 17.00
Vaccines not included in the Medical Visit or supplied by DPH	CPT codes	114.3 CMR 17.00

(3) Urgent Care Bad Debt Payments. The Health Safety Net Office will pay Community Health Centers at 75% of the payment rates in 114.6 CMR 14.07 (2) for Urgent Care Bad Debt claims that meet the requirements in 114.6 CMR 13.00.

14.08 Reporting Requirements

(1) General. Each Provider, Surcharge Payer and Ambulatory Surgical Center shall file or make available information that is required or that the Health Safety Net Office deems reasonably necessary for implementation of 114.6 CMR 14.00.

(a) The Health Safety Net Office may revise the data specifications, the data collection scheduled, or other administrative requirements from time to time by administrative bulletin.

(b) The Health Safety Net Office may audit data submitted under 114.6 CMR 14.00 to ensure accuracy. The Health Safety Net Office may adjust payments to reflect audit findings. Providers must maintain records sufficient to document compliance with all documentation requirements of 114.6 CMR 13.00 and 114.6 CMR 14.00.

(2) Hospitals

(a) The Health Safety Net Office may require Hospitals to submit interim data on revenues and costs to monitor compliance with federal Upper Limit and Disproportionate Share payment limits. Such data may include, but not be limited to, Gross and Net Patient Service Revenue for Medicaid non-managed care, Medicaid managed care, and all payers combined; and total patient service expenses for all payers combined.

(b) Surcharge Payment Data.

1. Unmatched Payer Report. Each Hospital must submit a quarterly Unmatched Payer Report. The Hospital must report the total amount of payments for services received from each Institutional Payer that does not appear on the Registered Payer List. The Hospital must report these data in an electronic format specified by the Health Safety Net Office.

2. Quarterly Report for Private Sector Payments. Each Hospital must report total payments made by the largest Institutional Surcharge Payers. The Health Safety Net Office will specify: the Institutional payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements from time to time by administrative bulletin.

(c) Penalties. The Health Safety Net Office may deny payment for Eligible Services to any Hospital that fails to comply with the reporting requirements of 114.6 CMR 13.00 or 114.6 CMR 14.00 until such Hospital complies with the requirements. The Health Safety Net Office will notify such Hospital in advance of its intention to withhold payment.

(3) Community Health Centers. The Health Safety Net Office may deny payment for Eligible Services to any Community Health Center that fails to comply with the reporting requirements of 114.6 CMR 13.00 or 114.6 CMR 14.00 until such Center complies with the requirements. The Health Safety Net Office will notify such Center in advance of its intention to withhold payment.

(4) Surcharge Payers.

(a) Monthly Surcharge Payment Report. The Health Safety Net Office may require that an Institutional Payer submit monthly reports of payments to Hospitals and Ambulatory Surgical Centers.

(b) Third Party Administrators.

1. A Third Party Administrator Surcharge Payer that makes payments to Hospitals and Ambulatory Surgical Centers on behalf of one or more insurance carriers must file an annual report with the Health Safety Net Office. The report shall include the name of each insurance carrier for which it makes surcharge payments. The Health Safety Net Office may also specify additional reporting requirements concerning payments made on behalf of self insured plans. Reports shall be in an electronic format specified by the Health Safety Net Office.
2. Third Party Administrators must submit annual reports by July 1 of each year for the time period defined by the Health Safety Net Office.

(c) Penalties. Any Surcharge Payer that fails to file data, statistics, schedules, or other information pursuant to 114.6 CMR 14.08 or which falsifies same, shall be subject to a civil penalty of not more than $5000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.6 CMR 14.00.

(5) Ambulatory Surgical Centers

(a) Unmatched Payer Report. Each Ambulatory Surgical Center must submit a Quarterly Unmated Payer Report to the Health Safety Net Office in accordance with a schedule specified by the Health Safety Net Office. The Ambulatory Surgical Center must report the total amount of payments for services received from each Institutional Surcharge Payer that does not appear on the Registered Payer List. The Ambulatory Surgical Center must report these data in an electronic format specified by the Health Safety Net Office.

(b) Quarterly Report for Private Sector Payments. Each Ambulatory Surgical Center must report total payments made by the largest Institutional Surcharge Payers. The Health Safety Net Office will specify the Institutional Payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements from time to time by administrative bulletin.
(c) Penalties. An Ambulatory Surgical Center that knowingly fails to file with the Health Safety Net Office any data required by 114.6 CMR 14.03 or knowingly falsifies the same shall be subject to a $500.00 fine.

14.09: Special Provisions

(1) Financial Hardship. A Hospital or Surcharge Payer may request a deferment or partial payment schedule due to financial hardship.

(a) In order to qualify for such relief, the Hospital or Surcharge Payer must demonstrate that its ability to continue as a financially viable going concern will be seriously impaired if payments pursuant to 114.6 CMR 14.04 or 114.6 CMR 14.05 were made.
(b) If the Health Safety Net Office finds that payments would be a financial hardship, the Health Safety Net Office may, at its discretion, establish the terms of any deferment or partial payment plan deferment. The deferment or payment schedule may include an interest charge.

1. The interest rate used for the payment schedule shall not exceed the prime rate plus 2%. The prime rate used shall be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.
2. A Surcharge Payer may make a full or partial payment of its outstanding liability at any time without penalty.
3. If a Surcharge Payer fails to meet the obligations of the payment schedule, the Health Safety Net Office may assess penalties pursuant to 114.6 CMR 14.05.

(2) Severability. The provisions of 114.6 CMR 14.00 are severable. If any provision or the application of any provision to any Hospital, Community Health Center, surcharge payer or Ambulatory Surgical Center or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 14.00 or the application of such provisions to Hospitals, Community Health Centers or circumstances other than those held invalid.

(3) Administrative Bulletins. The Health Safety Net Office may issue administrative bulletins to clarify policies and understanding of substantive provisions of 114.6 CMR 14.00 and specify information and documentation necessary to implement 114.6 CMR 14.00.

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114.6 CMR 14.00 M.G.L. c. 118G.

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I. Overview

[Omitted]

II. Definitions

[Omitted unless different from TN 08-015 definitions]

Hospital-Specific Standard Payment Amount per Discharge (SPAD) – An all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete reimbursement for an acute episode of illness, excluding the additional payment of Outliers, Transfer per Diems, and Administrative Days.

Inflation Factors for Administrative Days – a blend of the Centers 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 Factor for Administrative Days is as follows:

1.968% reflects the price changes between state fiscal year 2007 and RY08

Inflation Factors for Capital Costs – the factors used by CMS to update capital payments made by Medicare. The Inflation Factors for Capital Costs between RY05 and RY08 are as follows:

0.7% reflects the price changes between RY05 and RY06
0.8% reflects the price changes between RY06 and RY07
0.9% reflects the price changes between RY06 and RY07

Inflation Factors for Operating Costs —for price changes between RY05 and RY07, a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY08, the inflation factor for operating costs is the CMS FY2008, full market basket update to the average standardized percent update for all hospitals in all areas, published in the Federal Register vol. 72, No. 162, Wednesday, August 22, 2007, Rules and Regulations, page 47415. The Inflation Factors for Operating Costs between RY05 and RY08 are as follows:

1.846% reflects price changes between RY05 and RY06
1.637% reflects price changes between RY06 and RY07
3.300% reflects price changes between RY07 and RY08

MassHealth Average Length of Stay (ALOS) – the sum of non-psychiatric inpatient days from October 1, 2005 through September 30, 2006, reported by each Hospital to DHCFP, including Outlier Days, divided by the sum of SPAD and transfer admissions, using the casemix data accepted into DHCFP's database as of June 12, 2007.

Pediatric Specialty Unit – A pediatric unit in an Acute Hospital which maintains a burn center verified by the American Burn Center and the American College of Surgeons and a level I trauma center for pediatrics verified by the American College of Surgeons as of July 1, 2006, or in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20, unless located in a facility already designated as a Specialty Hospital.

Rate Year (RY) – Generally, the period beginning October 1 and ending September 30. RY08 begins on November 1, 2007, and ends on September 30, 2008.

SPAD Base Year – the Hospital-specific base year for the Standard Payment Amount Per Discharge (SPAD) is RY05 using the RY05 DHCFP 403 cost report as screened and updated as of June 6, 2007.

III. Non-Covered Services

[Omitted]

IV. Reimbursement System

A. Data Sources

In the development of each Hospital's standard payment amount per discharge (SPAD), EOHHS used the SPAD Base Year costs; and the RY06 Merged Casemix/Billing Tapes as accepted by DHCFP, as the primary sources of data to develop base operating costs per discharge. The wage area data was derived from the CMS Hospital Wage Index Federal Fiscal Year 2008 – Wage Index final Rule Worksheet S-3 Wage Data File – Edit 9 – 050207.xls downloaded June 19, 2007.

EOHHS used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of June 21, 2007, for the period October 1, 2005, through September 30, 2006, which was then matched with MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations. The casemix data did not include discharges from Excluded Units.

B. Methodology for Inpatient Services

1. Overview

In order to implement rate adjustments, effective January 15, 2007, for Hospitals whose area wage designation was reclassified by the Geographical Classification Review Board of the Center for Medicare and Medicaid Services, a recalculation of the rates for all Hospitals was required. Effective January 15, 2007, any Hospital whose recalculated SPAD and inpatient per diem payments would otherwise be less

than such rates in effect on October 1, 2006, shall be paid at the SPAD and inpatient per diems in effect on October 1, 2006.

Except as otherwise provided herein, payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be a Hospital-specific Standard Payment Amount per Discharge (SPAD), which will consist of the sum of 1) a statewide average payment amount per discharge that is adjusted for wage area differences and the Hospital-specific MassHealth casemix; 2) a per-discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs; 3) a per-discharge, Hospital-specific payment amount for direct medical education costs, ; and 4) a per-discharge payment amount for the capital cost allowance, adjusted by Hospital-specific casemix and by a capital inflation factor. Each of these elements is described in **Sections IV.B.2** through **IV.B.4**.

Payment for psychiatric services provided in DMH-Licensed Beds to MassHealth Members who are not served either through a contract between EOHHS and its BH Contractor or an MCO shall be made through an all-inclusive Statewide Standard Psychiatric per diem. Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD (see **Sections IV.B.6** and **7**).

Payment for physician services rendered by Hospital-Based Physicians will be made as described in **Section IV.B.9**.

2. Calculation of the Standard Payment Amount Per Discharge (SPAD)

The statewide average payment amount per discharge is based on the actual statewide costs of providing Inpatient Services in the SPAD Base year cost report.

The average payment amount per discharge in each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those costs and discharges from Excluded Units. Routine outpatient costs associated with admissions from Emergency Department and routine and ancillary outpatient costs resulting from admissions from observation status were included. The cost centers that are identified as the supervision component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Malpractice costs, organ acquisition costs, capital costs and direct medical education costs were excluded from the calculation of the statewide average payment amount per discharge.

The average payment amount per discharge for each Hospital was then divided by the Hospital's Massachusetts-specific wage area index and by the Hospital-specific FY05

all-payer casemix index using the version APR20 of the 3M grouper and Massachusetts weights. For the Massachusetts Hospitals in the areas designated by the Geographical Classification Review Board of the Centers for Medicare and Medicaid Services (CMS), the average hourly wage of each area was calculated from the CMS Hospital Wage Index Federal Fiscal Year 2008 – Wage Index Final Rule Worksheet S-3 Wage Data File – Edit 9 – 050207.xls downloaded June 19, 2007.Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. For the calculation of the Springfield area index, Baystate Medical Center's wages and hours were included. This step results in the calculation of the standardized costs per discharge for each Hospital.

All Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of MassHealth discharges for the Hospitals was produced from the casemix data described above. The efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 90 percent of the total number of statewide discharges for October 1, 2005, through September 30, 2006. The RY08 efficiency standard is $10,637.85.

The statewide average payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-five percent (95%); and by c) the Inflation Factors for Operating Costs between RY05 and RY08. The resulting RY08 statewide average payment amount per discharge is $ 7,952.26.

The statewide average payment amount per discharge was then multiplied by the Hospital's MassHealth casemix index adjusted for outlier acuity (using version APR20 of the 3M Grouper and Massachusetts weights) and the Hospital's Massachusetts-specific wage area index to derive the Hospital-specific standard payment amount per discharge (SPAD). To develop the Hospital's RY08 casemix index, EOHHS used casemix discharge data submitted to DHCFP by the Hospital, as accepted into DHCFP's database as of June 21, 2007, for the period October 1, 2005, through September 30, 2006, which was then matched with the MassHealth SPAD and transfer claims for the same period to ensure that only MassHealth claims were included in the final casemix index calculations. The casemix data did not include discharges from Excluded Units. The wage area indexes were derived from the CMS Hospital Wage Index File (FY04, updated as of June 19, 2007).

Costs for outpatient ancillary services for Members admitted from observation status are included in Hospital-specific SPADs.

An outlier adjustment is used for the payment of Outlier Days as described in **Section**

IV.B.8.

When groupers are changed and modernized, it may be necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" is an approach that EOHHS is following, and one that has been a feature of the Medicare DRG program since its inception. EOHHS reserves the right to update to a new grouper.

3. Calculation of the Pass-through Amount per Discharge

The inpatient portion of malpractice and organ acquisition costs was derived from each Hospital's FY06 DHCFP 403 cost report as screened and updated by DHCFP as of June 12, 2007. This portion of the Pass-Through amount per discharge is the sum of the Hospital's per-discharge costs of malpractice and organ acquisition. In each case, the amount is calculated by dividing the Hospital's inpatient portion of expenses by the number of total, all-payer days for the SPAD Base Year and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

This portion of the RY08 Pass-Through amount per discharge is the product of the per diem costs of inpatient malpractice and organ acquisition and the Hospital-specific MassHealth Average Length of Stay, omitting such costs related to services in Excluded Units. The days used in the denominator are also net of days associated with such units.

The inpatient portion of direct medical education costs was derived from each Hospital's FY06 DHCFP 403 cost report submitted to DCHFP, as screened and updated as of June 12, 2007. This portion of the Pass-Through amount was calculated by dividing the Hospital's inpatient portion of direct medical education expenses by the number of total inpatient days and then multiplying the cost per diem by the Hospital-specific MassHealth Average Length of Stay.

EOHHS has incorporated an incentive in favor of Primary Care training, which was factored into the recognized direct medical education costs by weighting the costs reported in FY06 DHCFP 403 cost reports in favor of Primary Care resident training. An incentive of 26% of each Hospital's costs was added to its per-discharge cost of Primary Care resident training; 19% of each Hospital's costs was subtracted from its per-discharge costs for specialty care resident training. The number of Primary Care and specialty care residents was derived from data regarding the number of residents and the distribution of residents among primary care and specialty care provided by the Hospitals, at EOHHS's request. For the purposes of this provision, Primary Care resident training is training in internal medicine for general practice, family practice, OB/GYN, or pediatrics.

4. Capital Payment Amount per Discharge

The capital payment per discharge is a standard, prospective payment for all Hospitals, except for those Hospitals with unique circumstances, as set forth in **Section IV.C.1-3**, that meet the criteria set forth in the final paragraph of this section. The capital payment is a casemix-adjusted capital cost limit, based on the SPAD Base Year costs, updated by the Inflation Factors for Capital Costs between RY05 and RY08.

For each Hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, major moveable equipment, and long- and short-term interest. Total capital costs are allocated to Inpatient Services through the square-footage-based allocation formula of the DHCFP 403 cost report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. The capital cost per discharge for was calculated by dividing total net inpatient capital costs by the Hospital's total SPAD Base Year days, net of Excluded Unit days, and then multiplying by the Hospital-specific MassHealth Average Length of Stay.

The casemix-adjusted capital efficiency standard was determined by a) dividing the cost per discharge by the All-Payer APR20 Casemix Index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. The casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 90 percent of the total number of statewide discharges.

Each Hospital's capital cost per discharge was then held to the lower of its capital cost per discharge or the casemix-adjusted efficiency standard, to arrive at a capped capital cost per discharge. Each Hospital's capped capital cost per discharge is then multiplied by the Hospital's number of MassHealth discharges. The product of the capped capital cost per discharge and the number of MassHealth discharges for each Hospital was then summed and divided by the total number of MassHealth discharges statewide, to arrive at a statewide weighted average capital cost per discharge.

The statewide weighted average capital cost per discharge was then updated by the Inflation Factors for Capital Costs between RY05 and RY08. The statewide weighted average capital cost per discharge for RY08 is $506.04.

The Hospital-specific capital payment per discharge was determined by multiplying the statewide weighted average capital cost per discharge by the Hospital's RY08 casemix index as determined in **Section IV.B.2** above.

5. Maternity and Newborn Rates

Maternity cases in which delivery occurs will be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for *all*

services (except physician services) provided in connection with such a maternity stay is included in the SPAD amount.

6. Psychiatric Per Diem Payments

Services provided to MassHealth patients in DMH-Licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid through an all-inclusive psychiatric per diem, as described below. This payment mechanism does not apply to cases in which psychiatric services are provided to Members enrolled with the BH Contractor or an MCO, except as set forth in **Sections III.A** and **B**.

Payment for psychiatric services provided in beds that are not DMH-Licensed Beds shall be made at the Transfer per diem rate, capped at the Hospital's SPAD. See **Section IV.B.7.b(4)** and **(5)** for payment rules involving transfers to and from DMH-Licensed Beds and BH managed care status.

The Statewide Standard Psychiatric Per Diem Rate is derived using the sum of the following: the Acute Hospital Psychiatric Standard for Overhead Costs, the Acute Hospital Psychiatric Standard for Direct Routine Costs, the Acute Hospital Psychiatric Standard for Direct Ancillary Cost, the Acute Hospital Psychiatric Standard for Capital Costs, plus the Adjustment to Base Year Costs.

A. Data Sources

The base year for inpatient costs is the hospital fiscal year (HFY) 2004. MassHealth utilizes the costs, statistics, and revenue reported in HFY 2004 DHCFP-403 cost reports.

B. Determinations of Base Year Operating Standards

1. The Standard for Inpatient Psychiatric Overhead Costs is the median of the Inpatient Psychiatric Overhead Costs per Day for the array of acute hospitals providing mental health services in DMH-Licensed beds. The median is determined based upon inpatient psychiatric days. The RY08 Inpatient Psychiatric Overhead Costs is $363.28.

2. The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the Inpatient Psychiatric Direct Routine Costs Per day (minus direct routine physician costs) for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The RY08 Inpatient Psychiatric Direct Routine Costs is $325.13.

3. The Standard for Inpatient Psychiatric Direct Ancillary Costs is the median

of the Inpatient Psychiatric Direct Ancillary Costs Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. RY08 Inpatient Psychiatric Direct Ancillary Costs is $56.83.

C. Determination of Base Year Capital Standards

1. Each hospital's base year capital cost consists of the hospital's actual Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the hospital's capital expenses.

2. Each hospital's base year Psychiatric Capital Cost Per Day equals the base year psychiatric capital cost divided by the greater of: the actual base year psychiatric days or eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.

3. The Standard for Inpatient Psychiatric Capital Costs is the median of the Inpatient Psychiatric Capital Cost Per Day for the array of acute hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The RY08 Inpatient Psychiatric Capital Costs is $30.73.

D. Adjustment to Base Year Costs

The Standards for Overhead Costs, Direct Routine Costs, and Direct Ancillary Costs are updated using a composite index, which is a blend of CMS's Hospital Prospective Market Basket and the Massachusetts Consumer Price Index. The CMS Capital Input Price Index adjusts the base year capital cost to determine the capital amount. The year-to-year update factors between the base year and RY07 were used in the calculation of the annual inflation rates for operating costs and capital costs. Accordingly, the RY07 adjustment to base year costs of $36.01 also applies in RY08.

7. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one Acute Hospital to another will be made on a transfer per diem basis capped at the Hospital-specific SPAD for the Hospital that is transferring the patient.

In general, the Hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in

Sections IV.B.2 through **4**, if the patient is discharged from that Hospital. This includes when a patient is transferred back and is subsequently discharged from the original hospital. If the patient is transferred to another Hospital, then the transferring Hospital will be paid at the Hospital-specific transfer per diem rate, capped at the Hospital-specific per discharge amount. Additionally, "back transferring" Hospitals (Hospitals to which a patient is first admitted and then transferred back after having been transferred to another Acute Hospital) will be eligible for outlier payments as specified in **Section IV.B.8** below.

Except as otherwise provided in the following paragraph, the RY08 payment per day for Transfer Patients shall equal the statewide average payment amount per discharge divided by the SPAD Base Year average all-payer length of stay of 4.59 days, to which is added the Hospital-specific capital, direct medical education and Pass-Through per diem payments which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay.

For Hospitals with unique circumstances reimbursed in accordance with the methodology specified in **Sections IV.C.1** through **3**, the RY08 payment amount per day for Transfer Patients shall equal the individual Hospital's standard inpatient payment amount per discharge divided by the FY05 average all-payer length of stay, to which is added the Hospital-specific capital, direct medical education and Pass-Through per diem payments which are derived by dividing the per-discharge amount for each of these components by the Hospital-specific MassHealth Average Length of Stay.

b. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be reimbursed on a per diem basis capped at the Hospital-specific SPAD. This section outlines reimbursement under some specific transfer circumstances.

Hospitals receiving a transfer per diem may be eligible for outlier payments specified in **Section IV.B.8** below, subject to all of the conditions set forth therein.

(1) Transfer to/from a Non-Acute, Skilled Nursing, or other Separately Licensed Unit within the Same Hospital

If a patient is transferred from an acute bed to a Non-Acute, Skilled Nursing, or other separately licensed unit in the same Hospital, the transfer is considered a discharge. EOHHS will pay the Hospital-specific SPAD for the portion of the stay before the patient is transferred to any such unit.

(2) MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment in the PCC Plan, MCO, or Fee-for-Service during a Hospital Stay, or in the Event of Exhaustion of Other Insurance

When a patient becomes MassHealth-eligible, enrolls in or disenrolls from an MCO during the course of a Hospital stay, or exhausts other insurance benefits after the date of admission and prior to the date of discharge, MassHealth-covered portion of the acute stay will be paid at the transfer per diem rate, up to the Hospital-specific SPAD, or, if the patient is at the Administrative Day level of care, at the AD per diem rate, in accordance with **Section IV.B.10**. When a patient enrolls in or disenrolls from an MCO during the Hospital stay, the non-MCO days will be paid at the transfer per diem rate up to the SPAD.

(3) Admissions Following Outpatient Surgery or Procedure

If a patient requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure, the Hospital shall be paid at the transfer per diem rate up to the Hospital-specific SPAD.

(4) Transfer between a DMH-Licensed Bed and Any Other Bed within the Same Hospital

Reimbursement for a transfer between a DMH-Licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, BH Network or Non-Network Hospital, or the type of service provided. See also **Section IV.B.7.b(5).**

When a Member who is not enrolled with the BH Contractor transfers between a DMH-Licensed Bed and a non-DMH-Licensed Bed in the same Hospital, during a single admission, EOHHS will pay the Hospital at the transfer per diem capped at the Hospital-specific SPAD for the non-DMH-Licensed Bed portion of the stay, and at the psychiatric per diem for the DMH-Licensed Bed portion of the stay. (See **Section IV.B.6.)**

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-Licensed Bed portion of the stay, and only if it is for medical (i.e., non-psychiatric/substance-related disorder) treatment. In that case, such payment will be at the transfer per diem rate capped at the Hospital-specific SPAD.

(5) Change of BH Managed Care Status during a Behavioral Health Hospitalization

(a) Payments to Hospitals *without* Network Provider Agreements with EOHHS's BH Contractor

When a Member is enrolled with the BH Contractor during an Emergency or Post-Stabilization behavioral health admission at a non-network Hospital, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor shall be paid by the BH Contractor.
The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem rate for psychiatric services in a DMH-Licensed Bed, or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

(b) Payments to Hospitals that are in the BH Contractor's Provider Network

When a Member is enrolled with the BH Contractor during an emergency or non-emergency behavioral health Hospital admission, the portion of the Hospital stay during which the Member was enrolled with the BH Contractor shall be paid by EOHHS's BH Contractor, provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures. The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the psychiatric per diem for psychiatric services in a DMH-Licensed Bed or at the transfer per diem rate, capped at the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-Licensed Bed.

8. Outlier Payments

A Hospital qualifies for an outlier per diem payment equal to 85% of the Hospital's transfer per diem, in addition to the Hospital-specific standard payment amount per discharge or transfer per diem payment if ***all*** of the following conditions are met:

a. the Medicaid non-MCO length of stay for the Hospitalization exceeds 20 cumulative *acute* days at that Hospital (not including days in a DMH-Licensed Bed or days paid by a third party);

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

c. the patient continues to need acute level care and is therefore ***not*** on Administrative Day status on any day for which an outlier payment is claimed;

d. the patient is not a patient in a DMH-Licensed Bed on any day for which an outlier payment is claimed; and

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

9. Physician Payment

For physician services provided by Hospital-based physicians to MassHealth patients, the Hospital will be reimbursed for the professional component of physician services in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 et seq. Such reimbursement shall be at the lower of (1) the fee established in the most current promulgation of the DHCFP regulations at 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00(Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)[1] (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual charge submitted.

Hospitals will be reimbursed for such physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the direct medical education (DME) portion of the SPAD payment and, as such, are not reimbursable separately. The Hospital-based Physician may not bill for any professional component of the service that is billed by the Hospital.

Hospitals shall not be reimbursed for inpatient physician services provided by Community-Based Physicians.

10. Payments for Administrative Days

Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is $181.27, which represents the median September 2006 nursing home rate for all nursing home rate categories, as determined by DHCFP.

The ancillary add-on is based on the ratio of ancillary charges to routine charges,

[1] The regulations referred to in this paragraph are voluminous, and will be provided upon request.

calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.

These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated by the Inflation Factors for Administrative Days. The resulting AD rates for RY08 are $236.22 for Medicaid/Medicare Part B eligible patients and $255.45 for Medicaid-only eligible patients.

A Hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative MassHealth non-MCO acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the Hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the Hospital is eligible for outlier payments. The Hospital may not bill for more than one SPAD if the patient fluctuates between acute status and AD status; the Hospital may only bill for one SPAD (covering 20 cumulative MassHealth non-managed care acute days), and then for Outlier Days, as described above.

11. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay. Hospitals will be reimbursed by EOHHS pursuant to the DHCFP Regulations at 114.1 CMR 36.05(3)(c) (attached as **Exhibit 5**).

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for Inpatient Services furnished to children greater than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay Hospitals will be reimbursed by EOHHS pursuant to the DHCFP Regulations at 114.1 CMR 36.05(3)(b) (attached as **Exhibit 5**).

12. Rehabilitation Unit Services in Acute Hospitals

A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided at an Acute Hospital.

The per diem rate for such rehabilitation services will equal the medianMassHealth RY08 Rehabilitation Hospital rate, for Chronic Disease and Rehabilitation Hospitals. Acute Hospital Administrative Day rates will be paid for all days that a patient remains in the rehabilitation unit while not at acute or rehabilitation hospital level of care, in accordance with **Section IV.B.10**.

Such units shall be subject to EOHHS's screening program for Chronic Disease and Rehabilitation Hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410-411 (attached as **Exhibit 6**).

13. Pay-for-Performance (P4P) Payment

[Omitted]

[Sections C through I Omitted]

OS Notification

State/Title/Plan Number:	**Massachusetts 08-015**
Type of Action:	**SPA approval**
Required Date for State Notification:	**September 1, 2009**
Fiscal Impact:	**FY 2009 ($52,670,000) FFP** **FY 2010 $4,720,000 FFP**

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: Yes

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: **Effective October 1, 2008, this amendment updates the acute inpatient hospital payment methods for hospital rate year (RY) 2009.**

Other Considerations: **This amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.**

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