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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP and Survey & Certification (CMCS)

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

SEP 2 8 2010

RE: TN 09-014

Dear Dr. Bigby:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-014. This amendment revises the methodology used to calculate payment rates for inpatient hospital services. Specifically, it modifies the acute inpatient hospital reimbursement methodology for hospital rate year (RY) 2010. In addition, it allows a one-time supplemental payment of $5.9 million to qualified providers.

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. With regard to the supplemental payments authorized through this SPA, we also wish to remind the State that, based on the timely claims filing requirements as described in section 1132 of the Social Security Act, supplemental payments for Medicaid services made subsequent to the year in which the services were provided are not a current quarter claim and can only be claimed as a prior period adjustment. Therefore, the prior period adjustment for the supplemental payment must occur within two years of the end of the quarter in which the regular Medicaid expenditure for the Medicaid service occurred. Under no circumstances the approval of this plan amendment grants authority to make any payment, including supplemental payments that violate section 1132 of the Social Security Act. We are pleased to inform you that Medicaid State plan amendment 09-014 is approved effective October 1, 2009. 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 CHIP and Survey & Certification (CMSC)

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: **09-014**

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: **10/01/09**

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:

42 USC 1396a(a)(13); 42 USC 1315; 42CFR Part 447; 42CFR 440.10

7. FEDERAL BUDGET IMPACT:* (330,000)
a. FFY10 ~~$10,990,000~~ (3,990,000)
b. FFY11 ~~$2,140,000~~ 2,260,000 ~~*based on 50% FMAP~~

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A (1), pages 1-30
Exhibit 1

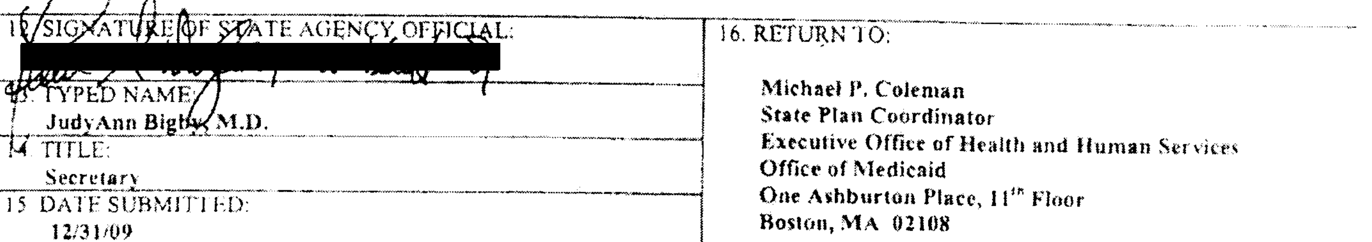
9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A (1), pages 1- 30
Exhibits 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:

13. TYPED NAME:
JudyAnn Bigby, M.D.

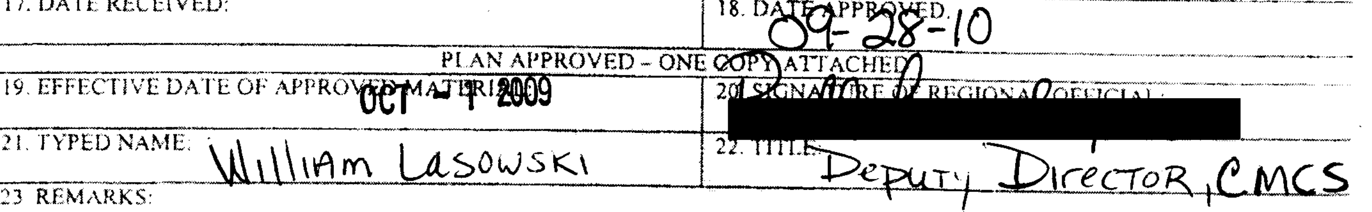
14. TITLE:
Secretary

15. DATE SUBMITTED:
12/31/09

16. RETURN TO:

Michael P. Coleman
State Plan Coordinator
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

FOR REGIONAL OFFICE USE ONLY



17. DATE RECEIVED:

18. DATE APPROVED: 09-28-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

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

---

I. Introduction

A. Overview

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

1. The payment methodologies specified in Exhibit 1 to this Attachment (TN 08-015) apply to:
   - admissions at in-state Acute Hospitals beginning prior to November 1, 2009, and
   - inpatient payments made to in-state Acute Hospitals on a per diem basis for dates of service prior to November 1, 2009.
2. The payment methodologies specified in the remainder of this Attachment apply to:
   - admissions at in-state Acute Hospitals beginning on or after November 1, 2009, and
   - inpatient payments made to in-state Acute Hospitals on a per diem basis for dates of service on or after November 1, 2009.
3. The supplemental payments specified in **Sections III.I.1 through III.I.4**, apply to dates of service from October 2, 2009 through September 30, 2010.
4. The Pay-for-Performance payment methodology specified in **Section III.J** is effective November 1, 2009.
5. In-state Acute Hospitals are defined in **Section II**.
6. Payment for out-of-state acute inpatient hospital services is governed by 130 CMR 450.233 as in effect on October 2, 2009.

B. Non-Covered Services

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

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

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

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

---

2. MCO Services

MassHealth contracts with Managed Care Organizations (MCOs) to provide medical services, including Behavioral Health Services, to Members enrolled with the MCO.

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

3. Air Ambulance Services

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

4. Non-Acute Units and Other Separately Licensed Units in Acute Hospitals

This Attachment shall not govern payment to Acute Hospitals for services provided to Members in separately licensed units within an Acute Hospital or in Non-Acute Units other than Rehabilitation Units (see **Section III.H below**).

II. Definitions

Acute Hospital – see Hospital.

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.

Average Length of Stay – the sum of non-psychiatric inpatient days (including Outlier Days) for relevant discharges, divided by the number of discharges, based on HDD. Average Length of Stay is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.

Behavioral Health (BH) Contractor – The entity with which EOHHS contracts to provide Behavioral Health Services to enrolled Members on a capitated basis, and which meets the definition of prepaid inpatient health plan at 42 C.F.R. § 438.2.

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

Casemix Index – a measure of a Hospital's relative casemix. The Casemix Index is calculated by dividing a Hospital's APR20 Casemix Weight (using Massachusetts weights) by the Hospital's HDD discharges, not including discharges from Excluded Units. Unless otherwise stated, Casemix Index is calculated using RY08 HDD. Casemix Index is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.

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

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

Contract – See RFA and Contract

DMH-Licensed Bed – a bed in a Hospital that is located in a unit licensed by the Massachusetts 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.

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. FY10 begins on October 1, 2009, and ends on September 30, 2010.

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

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

Hospital – Any health care facility which:

a. operates under a hospital license issued by the Massachusetts Department of Public Health (DPH) pursuant to M.G.L. c. 111 § 51;

b. is Medicare certified and participates in the Medicare program; and

c. has more than fifty percent (50%) of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds, as determined by DPH and currently utilizes more than fifty percent (50%) of its beds exclusively as such, as determined by EOHHS.

Hospital-Based Physician – Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Inpatient Services to Members at a site for which the Hospital is otherwise eligible to receive payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists,

podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.

Hospital Discharge Data (HDD) – Merged Casemix/Billing Tapes as accepted into DHCFP's database. Unless otherwise stated, HDD refers to RY08 data as accepted into DHCFP's database as of September 2, 2009.

Inpatient Services (also Inpatient Hospital Services) – Medical services, including Behavioral Health Services, provided to a Member admitted to a Hospital.

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.

Massachusetts-specific Wage Area Index – Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage. Massachusetts Hospitals' wages and hours were determined based on CMS's FY10_2010_Proposed_Rule_Wage_Index_PUFs file, downloaded June 18, 2009. Wage areas were assigned according to the same CMS file unless redesignated in a written decision from CMS to the Hospital provided to EOHHS by June 8, 2009. For the calculation of the Springfield area index, Baystate Medical Center's wages and hours were included.

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.

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

Non-Acute Unit – a chronic care, Rehabilitation, or skilled nursing facility unit within a Hospital.

Outlier 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. See **Section III.E**.

Pass-Through Costs – Organ acquisition and malpractice costs described in **Section III.B.3**.

Pediatric Specialty Unit – a designated pediatric unit, pediatric intensive care unit, or neonatal intensive care unit in an Acute Hospital other than a Freestanding Pediatric Acute Hospital, in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20.

Pediatric Standard Payment Amount Per Discharge – a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of a pediatric inpatient hospitalization in a Pediatric Specialty Unit, which is complete fee-for-service payment for an acute episode of illness, excluding additional fee-for-service payment for services described in **Sections III.C through H**.

Primary Care Clinician Plan (PCC Plan) – A comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive primary care, behavioral health, and other medical services.

Public Service Hospital – Any public Acute Hospital or any Acute Hospital operating pursuant to Chapter 147 of the Acts & Resolves of 1995 which has a private sector payer mix that constitutes less than 35% of its Gross Patient Service Revenue (GPSR) and where uncompensated care comprises more than 5% of its GPSR.

Rate Year (RY) – Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table:

Rate Year	Dates
RY04	10/1/2003 – 9/30/2004
RY05	10/1/2004 – 9/30/2005
RY06	10/1/2005 – 9/30/2006
RY07	10/1/2006 – 10/31/2007
RY08	11/1/2007 – 9/30/2008
RY09	10/1/2008 – 10/31/2009
RY10	11/1/2009 – 10/31/2010

*In future rate years, Hospitals will be paid in accordance with the this Attachment (until amended).

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

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.

RFA and Contract – The Request for Applications and the agreement executed between each selected Hospital and EOHHS that incorporates all of the provisions of the RFA.

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. SFY10 begins on July 1, 2009, and ends on June 30, 2010.

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 additional fee-for-service payment for services described in **Sections III.C through H**. Calculation of the SPAD is discussed in **Section III.B**.

Transition Buffer – an adjustment to the Standard Payment Amount Per Discharge as described in **Section III.B.5.a**.

III. Payment for Inpatient Services

A. Overview

1. Except as otherwise provided in **subsections C through H** below, fee-for-service payments for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be a Hospital-specific Standard Payment Amount per Discharge (SPAD) (see **subsection B** below).

2. For Hospitals with Pediatric Specialty Units, payment for admissions to the Pediatric Specialty Unit for which a SPAD is otherwise payable will be made using the Pediatric SPAD. The Pediatric SPAD is calculated using the same methodology as the SPAD, except that the casemix index, discharges, and average length of stay are based on data from the Pediatric Specialty Unit. In such cases, the Hospital's SPAD is calculated by excluding data from the Pediatric Specialty Unit for these components.

3. 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.

4. **Subsections C through H** describe non-SPAD fee-for-service payments for psychiatric services, transfer patients, Outlier Days, Hospital-Based Physician services, Administrative Days, and Rehabilitation Unit services in Acute Hospitals. Payment for other unique circumstances is described in **subsection I**. Pay-for-Performance payments are described in **subsection J.**

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

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

1. Overview

The Standard Payment Amount per Discharge for each Hospital is the sum of the Base SPAD, the Pass-through Amount per Discharge, and the Capital Payment Amount per Discharge, adjusted by the Transition Buffer and the SPAD Adjustment for qualifying Hospitals. Each of these components is noted in the table below, and described in greater detail in the following sections.

The SPAD Base Year is RY05.

Component	Description / sub-components	Amount
Base SPAD **(subsection 2)**	a. statewide average payment amount per discharge, b. adjusted by Hospital-specific casemix and wage area	$7,416.16 (statewide) Hospital-specific
Pass-through Amount per Discharge **(subsection 3)**	a per-discharge, Hospital-specific payment amount for Hospital-specific expenses for malpractice and organ acquisition costs	Hospital-specific
Capital Payment Amount per Discharge **(subsection 4)**	a. statewide weighted average capital cost per discharge, b. adjusted by Hospital-specific casemix	$492.72 (statewide) Hospital-specific
Transition Buffer **(subsection 5.a)**	a percentage increase in the SPAD for qualifying Hospitals	Hospital-specific percentage (does not apply to per diem rates)
SPAD Adjustment **(subsection 5.b)**	a percentage increase in the SPAD for qualifying Hospitals	10% increase (does not apply to per diem rates) Any Hospital eligible for both the SPAD adjustment and the Transition Buffer will receive a single combined adjustment to its SPAD.

2. Base SPAD

The base standard payment amount per discharge (Base SPAD) is Hospital-specific, calculated by multiplying the statewide average payment amount per discharge by the Hospital's MassHealth Casemix Index and adjusted by the Hospital's Massachusetts-specific Wage Area Index.

a. The Statewide Average Payment Amount Per Discharge

The statewide average payment amount per discharge is determined by multiplying

- the weighted average of the SPAD Base Year standardized cost per discharge, where any Hospital's standardized cost per discharge that exceeds the efficiency standard is limited by the efficiency standard; by

- an outlier adjustment factor of 90.2%; and by

- the Inflation Factors for Operating Costs to trend SPAD Base Year costs forward to the current Rate Year.

These elements are described in greater detail below. The statewide average payment amount per discharge is $7,416.16.

i. SPAD Base Year Standardized Cost per Discharge

The SPAD Base Year standardized cost per discharge is the average payment amount per discharge for each Hospital, adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the Hospital-specific SPAD Base Year all-payer casemix index.

The average payment amount per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. SPAD Base Year costs are determined using the SPAD Base Year DHCFP 403 cost report as screened and updated as of June 2, 2008. SPAD Base Year discharges are determined using SPAD Base Year Hospital Discharge Data (HDD). Specific costs and discharges are included and excluded as follows:

Average Payment Amount per Discharge: treatment of costs and discharges	
Included	Excluded
Total non-excluded costs of providing Inpatient Services	Costs and discharges from Excluded Units.
Routine outpatient costs associated with admissions from the Emergency Department	Professional services
Routine and ancillary outpatient costs resulting from admissions from Observation status	Malpractice costs, organ acquisition costs, capital costs and direct medical education costs.
Cost centers identified as the supervision component of physician compensation and other direct physician costs	
All other non-excluded medical and non-medical patient care-related staff expenses	

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

ii. Efficiency Standard

All Hospitals are ranked with respect to their SPAD Base Year standardized costs per discharge, and the efficiency standard is set at the 75th percentile of the cumulative frequency of discharges where MassHealth is the primary payer in the HDD. The efficiency standard is $8,745.03.

iii. Inflation Factors for Operating Costs

The inflation factors for operating costs are applied to trend SPAD Base Year costs forward to the current Rate Year.

Inflation Factors for Operating Costs

Reflecting price changes between...	Source	Inflation Factor for Operating Costs
RY04 and RY05*	A blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy.	1.186%
RY05 and RY06		1.846 %
RY06 and RY07		1.637%
RY07 and RY08	CMS market basket	3.300%
RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008		3.000%
RY08 and RY09 for admissions beginning from December 7, 2008 through September 30, 2009	A blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy.	1.424%
RY09 and RY10**		0.719%

** The Inflation Factor for Operating Costs reflecting price changes between RY04 and RY05 is not used to calculate the statewide average payment amount per discharge, but is used to calculate the psychiatric per diem (see **Section III.C** below).*
*** The Inflation Factor for Operating Costs reflecting price changes between RY09 and RY10 was calculated based on the RY09 rate in effect for admissions beginning from December 7, 2008 through September 30, 2009.*

b. Hospital-specific Adjustments

For calculating the SPAD, each Hospital's Casemix Index is calculated using HDD matched with MassHealth SPAD, transfer, and Outlier claims where MassHealth is the primary payer to ensure that only MassHealth discharges are included.

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

The Hospital's Massachusetts-specific Wage Area Index is defined in **Section II**.

3. Pass-Through Amounts per Discharge

The pass-through amount per discharge is the sum of each Hospital's per-discharge costs of malpractice and organ acquisition.

The inpatient portion of malpractice insurance and organ acquisition costs was derived from each Hospital's RY08 DHCFP 403 cost report as screened and updated by DHCFP as of May 19, 2009.

The pass-through amount per discharge 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 this cost per diem by the Hospital-specific MassHealth Average Length of Stay, omitting such costs and days related to services in Excluded Units.

4. Capital Payment Amount per Discharge

The capital payment amount per discharge is a standard, prospective payment for all Hospitals. The capital payment amount is calculated based on the SPAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the base year and the current rate year, and adjusted for Hospital-specific casemix. The calculation is summarized in the following chart:

Capital Payment Amount per Discharge		
Base year statewide capital cost per discharge (**subsection a**),	a. the base year capital cost per discharge b. adjusted by casemix index c. capped at the capital efficiency standard d. multiplied by the Hospital-specific MassHealth discharge e. summed and divided by the total statewide MassHealth discharges	$467.87
trended to the current rate year using the Inflation Factors for Capital Costs (**subsection b**),		$492.72
adjusted by the Hospital-specific casemix index (**subsection c**).		Hospital-specific

a. Base year statewide capital cost per discharge

The base year statewide capital cost per discharge is the discharge-weighted average over all Hospitals of the casemix-adjusted capital cost per discharge capped at the capital efficiency standard.

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 are omitted to derive net inpatient capital costs. Each Hospital's capital cost per discharge is calculated using SPAD Base Year cost reports and SPAD Base Year HDD by dividing total net inpatient capital costs by the Hospital's total days, net of Excluded Unit days, multiplied by the Hospital-specific all-payer Average Length of Stay.

Each Hospital's capital cost per discharge is then adjusted by the all-payer Casemix Index.

All Hospitals are then ranked with respect to their casemix-adjusted capital cost per discharge, and the capital efficiency standard is set at the 75th percentile of the cumulative frequency of discharges in the HDD. Each Hospital's capital cost per discharge that exceeds the capital efficiency standard is then limited by the capital efficiency standard.

The base year statewide capital cost per discharge is the statewide average of these adjusted costs per discharge, weighted based on each Hospital's number of MassHealth discharges in the HDD.

b. Inflation Factors for Capital Costs

The Inflation Factors for Capital Costs are applied to trend the SPAD Base Year statewide capital cost per discharge forward to the current Rate Year. These Inflation Factors are the factors used by CMS to update payments made by Medicare.

Inflation Factors for Capital Costs

Reflecting price changes between...	Inflation Factor for Capital Costs
RY04 and RY05*	0.7%
RY05 and RY06	0.7%
RY06 and RY07	0.8%
RY07 and RY08	0.9 %
RY08 and RY09	0.7%
RY09 and RY10	1.4%

** The Inflation Factor for Capital Costs reflecting price changes between RY04 and RY05 is not used to calculate the Capital Payment Amount per Discharge, but is used to calculate the psychiatric per diem (see **Section III.C** below).*

c. Hospital-specific capital payment per discharge

The Hospital-specific capital payment per discharge is determined by multiplying the trended statewide capital cost per discharge by the Hospital's Casemix Index.

5. Transition Buffer and SPAD Adjustment

a. Transition Buffer

In order to mitigate changes in payment from RY09 to RY10, EOHHS is providing a Transition Buffer as specified below that increases the SPAD as calculated in **Sections III.B.2 through III.B.4**.

- Freestanding Pediatric Acute Hospitals will receive a Transition Buffer of 12.11%.
- Hospitals that have more than a cumulative total of 125 licensed pediatric, pediatric ICU/CCU, and NICU beds and which accounted for at least 25% of the Hospital's total MassHealth RY08 matched HDD discharges will receive

a Transition Buffer of 12.11%. This Transition Buffer will only apply to the Pediatric SPAD at such Hospitals (see **Section III.A.2**).

- Public Service Hospitals which provide more than 10% of the statewide inpatient Medicaid days will receive a Transition Buffer of 4.61%.

b. SPAD Adjustment

i. Eligibility

In order to qualify for a payment adjustment under this section, a Hospital must have greater than 63% of its Gross Patient Service Revenue (GPSR) from governmental payers and free care.

ii. Payment Methodology

The SPAD for qualified Hospitals will be increased by 10% of the amount calculated in **Sections III.B.2 through III.B.4**.

c. Application

Any Hospital eligible for both the SPAD adjustment and the Transition Buffer will receive a single combined adjustment to its SPAD equal to the sum of the applicable percentages specified below.

Neither the Transition Buffer nor the SPAD adjustment shall apply to the calculation of per diem rates.

C. Payments for Psychiatric Services

1. Overview

a. Services provided to MassHealth Members in DMH-licensed Beds who are not enrolled with the BH Contractor or an MCO shall be paid on an all-inclusive Psychiatric Per Diem basis.

b. The Statewide Standard Psychiatric Per Diem Rate is the sum of the three Psychiatric Per Diem Base Year Operating Standards (see **subsection 2**) and the Psychiatric Per Diem Base Year Capital Standard (see **subsection 3**), adjusted for the current Rate Year (see **subsection 4**).

c. Payment for psychiatric services provided in beds that are not DMH-licensed Beds shall be made on a transfer per diem basis, as described in **Section III.D** below. See **Sections III.D.2.d and e** for payment rules involving transfers to and from DMH-licensed Beds and BH managed care status.

d. The Psychiatric Per Diem Base Year is RY04. MassHealth utilizes the costs, statistics, and revenue reported in the 2004 DHCFP-403 cost reports as screened and updated as of March 10, 2006.

2. Determination of the Psychiatric Per Diem Base Year Operating Standards

a. Standard for Inpatient Psychiatric Overhead Costs

The Standard for Inpatient Psychiatric Overhead Costs is the median of the inpatient psychiatric overhead costs per day for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Overhead Costs is $363.28.

b. Standard for Inpatient Psychiatric Direct Routine Costs

The Standard for Inpatient Psychiatric Direct Routine Costs is the median of the inpatient psychiatric direct routine costs per day (minus direct routine physician costs) for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Direct Routine Costs is $325.13.

c. Standard for Inpatient Psychiatric Direct Ancillary Costs

The Standard for Inpatient Psychiatric Direct Ancillary Costs is the median of the inpatient psychiatric direct ancillary costs per day for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Direct Ancillary Costs is $56.83.

3. Determination of the Psychiatric Per Diem Base Year Capital Standard

The Standard for Inpatient Psychiatric Capital Costs is the median of the inpatient psychiatric capital costs per day for the array of Acute Hospitals providing mental health services in DMH-licensed beds. The median is determined based upon inpatient psychiatric days. The base year Standard for Inpatient Psychiatric Capital Costs is $30.73.

a. Each Hospital's base year psychiatric capital cost per day equals the base year psychiatric capital cost divided by the greater of: the actual base year psychiatric days or eighty-five percent (85%) of the base year maximum licensed psychiatric bed capacity, measured in days.

b. Each Hospital's base year capital costs consist of the Hospital's reasonable Psychiatric Per Diem Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and rental of facilities. Any gains from the sale of property will be offset against the Hospital's capital expenses.

4. Adjustment to Base Year Standards

The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see **Section III.B.2.a.iii above**). The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see **Section III.B.4.b above**).

The Inflation Factors for Operating Costs (see **Section III.B.2.a.iii above**) between RY08 and RY10 were then applied to the rate calculated above to determine Statewide Standard Psychiatric Per Diem Rate.

The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs to RY10 for the Psychiatric Per Diem is $53.49. The Statewide Standard Psychiatric Per Diem Rate is $829.46.

D. Transfer Per Diem Payments

Hospitals will be paid a transfer per diem, calculated as follows, under the circumstances specified in this section.

In general, total payments made on a transfer per diem basis are capped at the Hospital-specific SPAD; the payment per day is calculated as follows:

- the statewide average payment amount per discharge adjusted by the Hospital-specific Casemix Index and Massachusetts-specific Wage Area Index
- divided by the SPAD Base Year all-payer Average Length of Stay of 4.59 days,
- plus the Hospital-specific capital 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).

1. Transfer Between Hospitals

In general, when a patient is transferred from one Acute Hospital to another, the Hospital that is transferring the patient will be be paid at the transfer per diem rate, up to the Hospital-specific SPAD.

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 **Section III.B above**, 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 transfer per diem rate, up to the Hospital-specific SPAD. 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 III.E below**.

2. 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 paid at the transfer per diem rate, up to the Hospital-specific SPAD. This section outlines payment under some specific transfer circumstances.

Hospitals receiving a transfer per diem may be eligible for Outlier payments specified in **Section III.E below**, subject to all of the conditions set forth therein.

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

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

b. MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment in the PCC Plan, Fee-for-Service, or MCO, 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, the 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 III.G**. 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 Hospital-specific SPAD.

c. 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.

d. Transfer between a DMH-licensed Bed and Any Other Bed within the Same Hospital

Payment for a transfer between a DMH-licensed Bed and any other bed within a Hospital will vary depending on the circumstances involved, such as managed care status, whether the Hospital is part of the BH network, and the type of service provided. See also **subsection (e)** below.

When a Member who is not enrolled with the BH Contractor transfers between a DMH-licensed Bed and a non-DMH-licensed Bed in the same Hospital during a

single admission, EOHHS will pay the Hospital at the transfer per diem rate, up to the Hospital-specific SPAD for the non-DMH-licensed bed portion of the stay, and on a Psychiatric Per Diem basis (see **Section III.C above**) for the DMH-licensed bed portion of the stay.

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-licensed bed portion of the stay only if it is for medical treatment. In that case, such payment will be at the transfer per diem rate, up to the Hospital-specific SPAD.

e. Change of BH Managed Care Status during a Behavioral Health Hospitalization

When a Member is enrolled with the BH Contractor during a behavioral health admission, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor is payable by the BH Contractor. The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS on a Psychiatric Per Diem basis (see **Section III.C above**) for psychiatric services in a DMH-licensed Bed, or at the transfer per diem rate, up to the Hospital-specific SPAD, for substance-related disorder services and for psychiatric services in a non-DMH-licensed Bed.

E. Outlier Payments

A Hospital qualifies for an Outlier per diem payment equal to 75% of the Hospital's transfer per diem in addition to the SPAD (**Section III.B above**) or transfer per diem payment (**Section III.D above**) 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 MassHealth's regulations;

c. the patient continues to need acute level care and is therefore not on Administrative Day status (see **Section III.G below**) 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 the Hospital.

F. Physician Payment

1. For physician services provided by Hospital-Based Physicians to MassHealth patients, the Hospital will be paid for the professional component of Hospital-Based Physician services in accordance with Section 8.d. of Attachment 4.19B of the State Plan.

2. Hospitals will be paid for Hospital-Based Physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Inpatient Service(s) on the billed date(s) of service.

3. Physician services provided by residents and interns are not reimbursable separately. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

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

G. Payments for Administrative Days

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

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

3. 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.

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

5. These ratios are 0.278 and 0.382, respectively. The resulting AD rates (base and ancillary) were then updated by the inflation factor for Administrative Days – a blend of the Centers for Medicare & 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 reflecting price changes between SFY 2008 and RY 2010 is 1.548%.

6. The resulting AD rates for RY10 are $242.71 for Medicaid/Medicare Part B eligible patients and $262.46 for Medicaid-only eligible patients.

7. 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.

H. 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 in the Rehabilitation Unit.

The per diem rate for such Rehabilitation Services will equal the median MassHealth RY10 Rehabilitation Hospital rate for Chronic Disease and Rehabilitation hospitals. Acute Hospital Administrative Day rates (see **Section III.G above**) will be paid for all days that a patient remains in the Rehabilitation Unit while not at hospital level of care.

I. Payment for Unique Circumstances

1. Public Service Hospitals

a. Eligibility

Based on the definition of Public Service Hospitals, Boston Medical Center (BMC) and Cambridge Health Alliance (CHA) are the only Hospitals eligible for this payment.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Public Service Hospitals.

This payment is based on approval by EOHHS of the Hospital's accurately submitted and certified EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report (UCCR) for the hospital fiscal year corresponding with the payment.

For the BMC, the Federal Fiscal Year payment amount will be $4,000 times the total number of inpatient days for admissions beginning during the applicable Federal Fiscal Year, not to exceed $15,000,000.

For CHA, the Federal Fiscal Year payment amount will be the difference between the non-state-owned hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $0.

Public Service Hospital payments will be made after EOHHS' receipt of the hospital's certified UCCR, finalization of payment data and applicable payment amounts, and receipt of any necessary approvals, but no later than 1 year after receipt of the hospital's final reconciliation UCCR (which must be submitted by 45 days after the Hospital's Medicare 2552 Report for the payment year has been finalized by Medicare's Fiscal Intermediary).

2. Essential MassHealth Hospitals

a. Eligibility

In order to qualify for payment as an Essential MassHealth Hospital, a Hospital must itself meet, or be within a system of Hospitals, any one of which meets, at least four of the following criteria, as determined by EOHHS, provided that all Hospitals within such system are owned or controlled, directly or indirectly, by a single entity that (i) was created by state legislation prior to 1999; and (ii) is mandated to pursue or further a public mission:

(1) The Hospital is a non-state-owned public Acute Hospital.

(2) The Hospital meets the current MassHealth definition of a non-profit teaching Hospital affiliated with a Commonwealth-owned medical school.

(3) The Hospital has at least 7% of its total patient days as Medicaid days.

(4) The Hospital is an acute care general Hospital located in Massachusetts which provides medical, surgical, emergency and obstetrical services.

(5) The Hospital enters into a separate contract with EOHHS relating to payment as an Essential MassHealth Hospital.

Based on these criteria, Cambridge Health Alliance (CHA) and the UMass Memorial Health Care, Inc. Hospitals (UMass Hospitals) are the only Hospitals eligible for this payment.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Essential MassHealth Hospitals.

This payment is based on approval by EOHHS of the Hospital's accurately submitted and certified EOHHS Office of Medicaid Uniform Medicaid and Low Income Uncompensated Care Cost & Charge Report (UCCR) for the hospital fiscal year corresponding with the payment.

For the UMass hospitals, the Federal Fiscal Year payment amount will be $4,000 times the total number of inpatient days for admissions beginning during the applicable Federal Fiscal Year, not to exceed $90,000,000.

For CHA, the Federal Fiscal Year payment amount will be the difference between the non-state-owned hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $12,000,000.

Essential MassHealth Hospital payments will be made after EOHHS' receipt of the hospital's certified UCCR, finalization of payment data and applicable payment amounts, and receipt of any necessary approvals, but no later than 1 year after receipt of the hospital's final reconciliation UCCR (which must be submitted by 45 days after the Hospital's Medicare 2552 Report for the payment year has been finalized by Medicare's Fiscal Intermediary).

3. Freestanding Pediatric Acute Hospitals

a. Eligibility

Based on the definition of Pediatric Specialty Hospitals, Children's Hospital is the only Hospital eligible for this payment.

b. Supplemental Payment Methodology

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

The supplemental payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the hospital Rate Year. The FFY10 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. Freestanding Pediatric Acute Hospital payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

4. Acute Hospitals with High Medicaid Discharges

a. Eligibility

In order to qualify for payment as an Acute Hospital with High Medicaid Discharges, a Hospital must be an Acute Hospital that has more than 2.7% of the statewide share of Medicaid discharges, determined by dividing each Hospital's total Medicaid discharges as reported on the Hospital's HCF-403 cost report by the total statewide Medicaid discharges for all Hospitals.

b. Supplemental Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment to Acute Hospitals that have higher Medicaid discharges when compared with other participating MassHealth Hospitals.

The payment amount is based on Medicaid payment and charge data for the federal fiscal year. 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 for the federal fiscal year. Acute Hospital with High Medicaid Discharges payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

5. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for inpatient services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay based on the prior year's claims data from the Medicaid Management Information System (MMIS).

i. Eligibility

In order to qualify for an infant outlier payment, a Hospital must provide services to infants less than one year of age, and must have one of the following during the Rate Year for individuals less than one year of age:

- An average Medicaid inpatient length of stay that equals or exceeds the statewide weighted average plus two standard deviations; or
- An average cost per inpatient Medicaid discharge that equals or exceeds the Hospital's average cost per Medicaid inpatient discharge plus two standard deviations for individuals of all ages.

ii. Payment to Hospitals

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

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual pediatric outlier payment adjustment to Acute Hospitals for inpatient services furnished to children greater than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay based on the prior year's discharge data from MMIS.

i. Eligibility

In order to qualify for a pediatric outlier payment, a Hospital must provide services to children greater than one year of age and less than six years of age,

and must have one of the following during the Rate Year for individuals within this age range:

- An average Medicaid inpatient length of stay that equals or exceeds the statewide weighted average plus two standard deviations; or
- An average cost per inpatient Medicaid discharge that equals or exceeds the Hospital's average cost per Medicaid inpatient discharge plus two standard deviations for individuals of all ages.

ii. Payment to Hospitals

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

6. Additional Payment for FFY 2010.

For services rendered between October 2, 2009 and September 30, 2010, each Hospital will receive a supplemental payment as indicated in the following table:

Hospital	Amount
Anna Jaques Hospital	$ 40,271.70
Baystate Franklin Medical Center	$ 39,504.62
Baystate Medical Center	$ 312,585.10
Berkshire Medical Center	$ 51,777.90
Beth Israel Deaconess Hospital-Needham	$ 767.08
Beth Israel Deaconess Medical Center	$ 142,293.34
Boston Medical Center	$ 604,459.04
Brigham and Women's Hospital	$ 447,974.72
Brockton Hospital	$ 189,085.22
Cambridge Health Alliance	$ 319,105.28
Cape Cod Hospital	$ 140,375.64
Caritas Good Samaritan Medical Center	$ 134,239.00
Caritas Holy Family Hospital and Medical Center	$ 77,091.54
Caritas St Elizabeth's Medical Center	$ 115,445.54
Children's Hospital Boston	$ 54,846.22
Clinton Hospital	$ 2,301.24
Emerson Hospital	$ 23,395.94
Falmouth Hospital	$ 47,942.50
Faulkner Hospital	$ 4,986.02
Hallmark Health System	$ 58,681.62
Harrington Memorial Hospital	$ 19,944.08
Health Alliance Hospitals, Inc	$ 75,940.92
Jordan Hospital	$ 70,954.90
Lahey Clinic	$ 18,409.92
Lawrence General Hospital	$ 207,111.60

Hospital		Amount
Lowell General Hospital	$	185,633.36
Marlborough Hospital	$	1,917.70
Martha's Vineyard Hospital	$	25,313.64
Mary Lane Hospital	$	17,259.30
Massachusetts General Hospital	$	382,389.38
Mercy Medical Center	$	79,392.78
Merrimack Valley Hospital	$	8,437.88
MetroWest Medical Center	$	251,602.24
Milford Regional Medical Center	$	69,804.28
Mount Auburn Hospital	$	141,909.80
Nantucket Cottage Hospital	$	22,245.32
Newton-Wellesley Hospital	$	43,723.56
Noble Hospital	$	1,917.70
North Adams Regional Hospital	$	19,560.54
North Shore Medical Center, Inc	$	236,644.18
Quincy Medical Center	$	6,136.64
Saint Anne's Hospital	$	16,492.22
Saint Vincent Hospital	$	93,967.30
South Shore Hospital	$	102,405.18
Southcoast Hospitals Group	$	312,968.64
Sturdy Memorial Hospital	$	56,763.92
Tufts Medical Center	$	194,454.78
UMass Memorial Medical Center	$	428,797.72
Winchester Hospital	$	50,627.28
Wing Memorial Hospital and Medical Centers	$	1,150.62
	$	5,951,007

J. Pay-for-Performance (P4P) Payment

Pay-for-Performance (P4P) is 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.

A Hospital will qualify to earn P4P payments if it meets data validation requirements and achieves performance thresholds for P4P measures listed below. Each measure is evaluated using the methods outlined below to produce measure rates which result in performance scores that are converted into incentive payments. A Hospital's performance scores are calculated as described in section 4.c.

The P4P program applies to inpatient services for MassHealth Members where Medicaid is the primary payer, which includes individuals enrolled in the Primary Care Clinician (PCC) Plan and with fee-for-service coverage. The P4P payments are for services provided in the current rate year.

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

1. Performance Measures

Quality performance goals and measures focus on areas where improvement is likely to have most impact on the health outcomes for this Member population:

- maternity and newborn care,
- respiratory care (pneumonia and pediatric asthma)
- surgical care, and
- racial and ethnic health disparities.

The specific performance measures are identified in the following tables, organized by Quality Measure Category:

Measure ID#	Maternity
MAT-1	Intrapartum Antibiotic Prophylaxis for Group B Streptococcus
MAT-2	Perioperative Antibiotics for Cesarean Section

Measure ID#	Neonate
NICU-1	Neonatal Intensive Care – Administration of Antenatal Steroids

Measure ID#	Pediatric Asthma
CAC-1a	Children's Asthma Care - Inpatient Use of Relievers
CAC-2a	Children's Asthma Care - Inpatient Use of Corticosteroids
CAC-3	Children's Asthma Care – Home management plan of care **note: For RY10 CAC-3 data are being collected solely to establish a performance baseline. CAC-3 data will not affect RY10 P4P calculations or payments.*

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

Measure ID#	Community Acquired Pneumonia
PN-3b	Blood culture performed in ED prior to first antibiotic received in hospital
PN-4	Adult smoking cessation advice/counseling
PN-5c	Initial antibiotic received within 6 hrs of hospital arrival
PN-6	Appropriate antibiotic selection for CAP in immuno-competent patients

Measure ID#	Surgical Care Infection Prevention
SCIP-1a	Prophylactic antibiotic received within 1 hour prior to surgical incision
SCIP-2a	Appropriate antibiotic selection for surgical prophylaxis
SCIP-3a	Prophylactic antibiotic discontinued w/in 24 hrs after surgery end time

Measure ID#	Health Disparities
HD-1	Health Disparities – CLAS Structural Measure
HD-2	Health Disparities – Clinical Composite Measure

All measures with the exception of HD-1 are clinical process measures.

2. **Reporting Schedule**

Hospitals will report performance measure data on the following schedule:

Hospital Discharge Periods	Hospital Submission Deadlines
January 1, 2009 – March 31, 2009	September 18, 2009
April 1, 2009 – June 30, 2009	Nov 13, 2009
July 1, 2009– September 30, 2009	February 12, 2010
October 1, 2009 – December 31, 2009	May 14, 2010
January 1, 2010 – March 31, 2010 **CY 2010 data will not affect RY10 P4P calculations or payments.*	August 13, 2010

3. Data Validation Requirements

In order to ensure the accuracy and reliability of the submitted data, all reported measures are subject to data validation requirements. The submitted electronic data must meet a minimum reliability standard. The minimum reliability standard is based on a comparison between the submitted electronic data and the selected hospital medical records for a sample of discharges. The minimum reliability standard is defined as an 80 percent match for data elements. Hospitals are considered to have "passed" validation if the overall agreement score of 80 percent has been met.

4. Payment Methodology

Incentive payments are calculated by multiplying the Hospital's eligible Medicaid discharges by the quality measure category per discharge amount and the total performance score.

Incentive payments will be made as lump sump payments to eligible hospitals, after finalization of the performance measure data and applicable payment amounts.

a. Eligible Medicaid Discharges

Eligible Medicaid discharges are a Hospital's discharges that are eligible for Pay-for-Performance payment, and will be based on the following:

- For the individual clinical process measures other than the clinical health disparities measure (HD-2), the eligible Medicaid discharges will be based on the FY09 MassHealth HDD that meet specific ICD requirements for each measure category. For the national measures (SCIP and PN), the ICD requirements are published in the *Specifications Manual for National Hospital Inpatient Quality Measures* (available at www.qualitynet.org). Specifications for the remaining measures are available on the MassHealth Quality Exchange website at www.mass.gov/masshealth/massqex.

- For the clinical health disparities composite measure (HD-2), the eligible Medicaid discharges will be the sum of all of the Hospital's eligible Medicaid discharges for the individual clinical process measures as described above.

- For the CLAS measure (HD-1), the eligible Medicaid discharges will be based on the Hospital's total MassHealth discharges from the FY09 HDD.

b. Quality Measure Category per Discharge Amount

The final per-discharge amounts will be determined by dividing the **maximum allocated amount** for each measure by the **statewide eligible Medicaid discharges** for each measure.

i. Maximum Allocated Amount

Incentive payments under the RFA will cumulatively total no more than the maximum amount allotted for each quality measure category in the following table:

Maternity	$ 30,000,000
Neonate	$ 4,000,000
Pediatric Asthma	$ 5,000,000
Community Acquired Pneumonia	$ 14,000,000
Surgical Care Infection Prevention	$ 15,000,000
Health Disparities -Clinical	$ 12,000,000
Health Disparities - CLAS	$ 20,000,000

ii. Statewide Eligible Medicaid Discharges

The statewide eligible Medicaid discharges for each measure category are the sum of all eligible Medicaid discharges (see **subsection a** above) for Acute Hospitals.

c. Total Performance Score

The total performance score is a percentage of **quality points** earned out of the total possible points for each measure category.

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

For each measure category, the quality points awarded are the sum of the higher of the **attainment** or the **improvement points** earned for each measure. These points are awarded for each measure category based on each Hospital's performance during the Comparative Measurement Period relative to the attainment threshold (the median performance of all Hospitals in the Baseline Measurement Period) and the benchmark (the mean of the top decile of all Hospitals in the Baseline Measurement Period).

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

For RY10, the performance score Periods are as follows:

Clinical Process Measures	CY 2009	CY 2008
CLAS Structural Measure (HD-1)	12/1/2008 – 12/31/2009	12/2/2007 – 12/1/2008

Performance benchmarks for the MassHealth-specific measures (maternity, neonate and pediatric asthma) are calculated based on Hospital-reported data. Performance benchmarks for the national hospital quality measures (pneumonia, surgical infection prevention) are calculated based on state-level data reported to the CMS Hospital Compare website.

i. Attainment Points

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

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

ii. Improvement Points

If a Hospital's score for a measure is above the attainment threshold but below the benchmark, the Hospital can earn points for improvement based on how much its performance score on the measure has improved from the Baseline Measurement Period as follows:

- if a Hospital's score for a measure is less than or equal to its score for the Baseline Measurement Period, it will receive zero (0) points for improvement.
- if a Hospital's score for a measure is greater than its score for the Baseline Measurement Period, it will receive 0-10 points for improvement.

d. Example

The following is an example pay-for-performance calculation for the four Maternity measures, provided for illustrative purposes only.

Statewide calculations	
Maximum allocated amount	$30,000,000
Statewide eligible Medicaid discharges	13,169
Quality measure category per-discharge amount	$30,000,000 / 13,169 = $2,278
Hospital-specific calculations	
Hospital's awarded Maternity quality points (sum of measure-specific attainment or improvement points)	16
Maximum possible Maternity quality points	20
Performance score for maternity	(16 points / 20 points) x 100% = 80%
Eligible Medicaid discharges	500
Hospital-specific total incentive payment, maternity	**500 x $2,278 x 80% = $911,200**

IV. Serious Reportable Events

Hospitals are prohibited from charging or seeking payment from MassHealth or the Member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, a serious reportable event occurring on premises covered under the Hospital license that was preventable, within the Hospital's control, and unambiguously the result of a system failure, as described in DPH regulations at 105 CMR 130.331 and 105 CMR 130.332 as in effect on the date of service. Non-reimbursable Hospital and Hospital-Based Physician services include:

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

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

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

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

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

The non-payment provision of this RFA also applies to third-party liability and/or crossover payments by MassHealth.

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

V. Other Provisions

A. Federal Limits

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

B. Future Rate Years

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

C. 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 state plan. 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 pass-through costs or capital costs, resulting in an amount not consistent with the methodology, a Hospital may request a correction, consistent with the RFA and contract, which shall be at the sole discretion of EOHHS.

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, consistent with the RFA and contract, 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.

D. New Hospitals/Hospital Change of Ownership

For any newly participating Hospital, or any Hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the Hospital during the effective period of the state plan, EOHHS, in its sole discretion, shall determine, on a case-by-case basis (1) whether the Hospital qualifies for payment under the state plan, and, if so, (2) the appropriate rates of payment. Such rates of payment shall be determined in accordance with the provisions of the state plan to the extent EOHHS deems possible. EOHHS's determination shall be based on the totality of the circumstances. Any such rate may, in EOHHS's sole discretion, affect computation of the statewide average or statewide standard payment amount and/or any efficiency standard.

E. Data Sources

When groupers used in the calculation of the SPAD and per diem rates are changed and modernized, it may be necessary to adjust the base payment rate so that overall payment levels are not affected solely by the grouper change. This aspect of "budget neutrality" has been a feature of the Medicare Diagnosis-Related Group (DRG) program since its inception. EOHHS reserves the right to update to a new grouper.

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

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

I. Overview

[Omitted]

II. Definitions

[Only definitions relevant to calculation of payment rates have been included]

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.

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.

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.

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.

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.

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 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'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

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

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' 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

[Omitted]

[Sections C through I Omitted]

OS Notification

State/Title/Plan Number: Massachusetts 09-014

Type of Action: SPA Approval

Required Date for State Notification: December 22, 2010

Fiscal Impact:

FY 2010	($330,000) FFP
FY 2011	($2,260,000) 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: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: Effective October 1, 2009, this amendment proposes to modify the acute inpatient hospital reimbursement methodology for hospital rate year (RY) 2010. The changes specified are: increase in operation and capital inflation; eliminates Direct Medical Education pass-through cost calculation; increase the statewide psychiatric per diem; increase the outlier adjustment factor used in the calculation of the statewide rate; reduces the outlier per diem for hospital transfer per diem; application of transition buffers; adjustment to the statewide rate for hospitals with high gross patient revenues from public payer and free care; and increases P4P payments. In addition there is a one-time supplemental payment to qualified providers for approximately $5.9 million. This one-time payment is based on modified RY 2009 P4P reimbursement methodology. The net payment to providers for RY 2010 is a decrease from RY 2009.

Other Considerations: CMS is satisfied that the State has met all the Federal requirements. Due to pending deferrals pertaining to the timely claims filing of supplemental payments an additional clause was added to the approval letter to ensure that the supplemental payments authorized under this amendment are paid in accordance with section 1132 of the Social Security Act. The upper payment limit demonstration was acceptable. The State is not aware of any issues with access to care. The State provided satisfactory responses to the

funding questions. 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.

CMS Contact: **Novena James-Hailey, (617) 565-1291**