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

I. Introduction

A. Overview

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

1. For dates of service beginning December 1, 2010, in-state Hospitals will be paid in accordance with this Attachment for Outpatient Services provided at Hospital Outpatient Departments, and at those Hospital-Licensed Health Centers (HLHCs) and other Satellite Clinics that are provider-based in accordance with 42 CFR 413.65.

2. The supplemental payments specified in **Section III.G** apply to dates of service from October 1, 2010 through September 30, 2011.

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

4. Payment for out-of-state acute outpatient hospital services is made in accordance with the Medicaid (or equivalent) fee schedule of that state.

B. Non-Covered Services

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

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

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

Hospitals are not entitled to, and may not claim for, any 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.

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3. **Air Ambulance Services**

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

4. **Ambulatory Services Not Governed by this Attachment**

The following services provided by Hospitals to MassHealth Members on an outpatient basis are not paid pursuant to this Attachment: audiology dispensing, vision care dispensing, ambulance services, psychiatric day treatment, dental, early intervention, home health, adult day health and adult foster care.

II. Definitions

Acute Hospital – See Hospital.

Ambulatory Patient Group (APG) — A group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation's APG version 2.1 Grouper.

Ambulatory Patient Group Payment System (APG Payment System) — MassHealth's APG payment system as in effect on February 1, 2002.

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.

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.

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

Emergency Department – A Hospital's emergency room or level I trauma center which is located at the same site as the Hospital's inpatient facility.

Episode — all Outpatient Services, except those described in **Sections I.B and III.D through F**, delivered to a MassHealth Member where the services were delivered on a single calendar day.

Episode Cost — a Hospital's cost for delivering an Episode of care as determined by MassHealth. Episode Cost is the product of the Hospital's charges for those claim lines of an Episode that adjudicate to pay and the outpatient cost-to-charge ratio as calculated by DHCFP.

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.

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 Outpatient Hospital Services to Members at a site for which the Hospital is otherwise eligible for payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.

Hospital-Licensed Health Center (HLHC) — A Satellite Clinic that (1) meets MassHealth requirements for payment as a HLHC as provided at 130 CMR 410.413; and (2) is approved by and enrolled with MassHealth as a HLHC.

Inflation Factors for Operating Costs — For price changes between RY08 and RY09 for the period October 1, 2008 through December 6, 2008, the CMS market basket. For price changes between RY08 and RY11 for the period beginning December 7, 2008, a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factors for Operating Costs between RY08 and RY11 are as follows:

3.000% reflects price changes between RY08 and RY09 for the period October 1, 2008 through December 6, 2008

1.424% reflects price changes between RY08 and RY09 for the period December 7, 2008 through September 30, 2009

0.719% reflects the price changes between RY09 and RY10

1.820% reflects the price changes between RY10 and RY11

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

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

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

Observation Services — Outpatient Hospital Services provided anywhere in an Acute Hospital to evaluate a Member's condition and determine the need for admission to an Acute Hospital. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outpatient Department (also referred to as **Hospital Outpatient Department)** — A department or unit located at the same site as the Hospital's inpatient facility, or a School-Based Health Center that operates under the Hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, primary care clinics, specialty clinics and Emergency Departments.

Outpatient Services (also **Outpatient Hospital Services**) — Preventive, diagnostic, therapeutic or palliative services provided to a Member on an outpatient basis, by or under the direction of a physician or dentist, in a Hospital Outpatient Department, Hospital-Licensed Health Center or other Satellite Clinic. Such services include, but are not limited to, emergency services, primary care services, Observation Services, ancillary services, day surgery services, and recovery room services. Payment rules regarding Outpatient Services are found in 130 CMRParts 410 and 450, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions and the RFA.

Payment Amount Per Episode (PAPE) — a Hospital-specific payment for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode. (See **Section III.C**)

PAPE Base Year — the PAPE Base Year is RY08, paid as of June 3, 2009.

PAPE Covered Services – MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, except those services described in **Sections I.B and III.D through F.**

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. RY11 will begin on December 1, 2010 and end on September 30, 2011.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 –11/30/2010
RY 11*	12/01/2010 – 09/30/2011

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

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

Satellite Clinic — A facility that operates under a Hospital's license, is subject to the fiscal, administrative, and clinical management of the Hospital, provides services to Members solely on an outpatient basis, is not located at the same site as the Hospital's inpatient facility, and demonstrates to EOHHS's satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

School-Based Health Center (SBHC) — A center located in a school setting which: (1) provides health services to MassHealth Members under the age of 21; (2) operates under a Hospital's license; (3) is subject to the fiscal, administrative, and clinical management of a Hospital Outpatient Department or HLHC; and (4) provides services to Members solely on an outpatient basis.

Total APG Payment — an adjusted calculation of total payment for PAPE Covered Services provided to MassHealth Members in the PAPE Base Year using MassHealth's APG Payment System, calculating the Episode Cost using the RY08 outpatient cost-to-charge ratio, and defining an Episode as any PAPE Covered Service(s) provided to a MassHealth Member in the Hospital Outpatient Department or Satellite Clinic in a calendar day.

Usual and Customary Charges — Routine fees that Hospitals charge for Outpatient Services rendered to patients regardless of payer sources.

III. Payment for Outpatient Services

A. Overview

Except as otherwise provided for Outpatient Services specified in **Sections I.B.4 and III.D through F**, Hospitals will receive a Hospital-specific payment for each Episode, known as the Payment Amount Per Episode (PAPE).

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

B. RY11 Payment Amount Per Episode (PAPE)

The RY11 PAPE is calculated by applying an inflation factor of 1.820% to the Hospital's RY10 PAPE rate. The RY10 PAPE Rate is calculated as described below.

C. RY10 (PAPE)

Each Hospital's RY10 PAPE is the product of the outpatient statewide standard and the Hospital-specific outpatient casemix index. The methodology is summarized in the following table, and the components are described in more detail below.

Payment Amount Per Episode		
outpatient statewide standard	PAPE Base Year outpatient statewide standard, adjusted for inflation, volume, and casemix changes between the PAPE Base Year and the current Rate Year (This reflects the payment for an episode with an APG weight of 1.0)	$159.27
x Hospital-specific casemix index	average of the projected monthly APG weights per episode for each hospital for the federal fiscal year	Hospital-specific

1. Outpatient Statewide Standard

The PAPE Base Year Outpatient Statewide Standard is set so that the total payment for PAPE Covered Services provided in the PAPE Base Year using the PAPE system would equal the Total APG Payment. The result of this calculation is a PAPE Base Year Outpatient Statewide Standard of $120.01.

The PAPE Base Year Outpatient Statewide Standard is then adjusted to account for volume and casemix changes between the PAPE Base Year and the current Rate Year. The adjusted amount was multiplied by the Inflation Factors for Operating Costs. The resulting Outpatient Statewide Standard is $159.27

2. Hospital-specific Outpatient Casemix Index

The hospital-specific outpatient casemix index for RY10 is an average across the federal fiscal year of the projected average monthly APG weights per Episode for each Hospital.

The projected average monthly APG weights per Episode are trended from monthly average APG weights from January 1, 2004 through September 30, 2008, projected to the current federal fiscal year. The monthly average APG weights are calculated for the relevant period by dividing the relevant payment by the number of Episodes and then, by the conversion factor for the relevant period. For the PAPE Base Year, the standard APG conversion factor was $119.26.

D. Physician Payments

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

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

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

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

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

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

E. Outpatient Hospital Services Payment Limitations

1. Payment Limitations on Hospital Outpatient Services Preceding an Admission

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

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2. Payment Limitations on Outpatient Services to Inpatients

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

F. Laboratory Services

1. Payment for Laboratory Services

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

2. Physician Services

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

G. 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 BMC, the Federal Fiscal Year payment amount will be $1,200 times the total number of Episodes with dates of service during the applicable Federal Fiscal Year, not to exceed $35,000,000.

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 $1,200 times the total number of Episodes with dates of service during the applicable Federal Fiscal Year, not to exceed $80,000,000.

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 $7,500,000.

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. 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 outpatient Medicaid payment and outpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Acute Hospital with High Medicaid Discharges payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

IV. Other Provisions

A. Federal Limits

If any portion of the payment methodology is not approved by CMS or is in excess of applicable federal limits, EOHHS may recoup 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. Any FFP associated with such overpayments will be returned to CMS.

B. Future Rate Years

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

C. New Hospitals/Hospital Change of Ownership

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

D. Data Sources

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