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State/Territory Name: MA

State Plan Amendment (SPA) #: 11-015

This file contains the following documents in the order listed:

1) Approval Letter

2) CMS 179 Form/Summary Form (with 179-like data)

3) Approved SPA Pages

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

Center for Medicaid and CHIP Services (CMCS)

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

SEP 19 2012

RE: TN 11-015

Dear Dr. Bigby:

We have reviewed the proposed amendment to Attachments 4.19-A, of your Medicaid State plan submitted under transmittal number (TN) 11-015. This amendment updates the methodologies used to calculate payment rates for inpatient hospital services. Specifically, it proposes the FY 2012 updates to the reimbursement methodology for acute inpatient hospital services.

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. We are pleased to inform you that Medicaid State plan amendment 11-015 is approved effective October 1, 2011. 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, CMCS

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: **011-015**

2. STATE: **MA**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **10/01/11**

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:
a. FFY12 $ ~~31,694,959~~ 9,090,000.
b. FFY13 $ ~~31,830,790~~ 15,800,000.

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A (1), pages 1-35

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-A (1), pages 1- 32

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 CFR 430.12(b)(2)(ii)**

12. SIGNATURE OF STATE AGENCY OFFICIAL:

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

14. TITLE: **Secretary**

15. DATE SUBMITTED: **12/28/11**

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: **SEP 19 2012**

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

Pen & ink change made to box #7

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

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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 this Attachment apply to:

   - admissions at in-state Acute Hospitals beginning on or after October 1, 2011, and
   - inpatient payments made to in-state Acute Hospitals on a per diem basis for dates of service on or after October 1, 2011.

2. The supplemental payments specified in **Sections III.I.1 through III.I.4**, apply to dates of service from October 1, 2011 through September 30, 2012.

3. The Pay-for-Performance payment methodology specified in **Section III.J** is effective October 1, 2011.

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

5. Payment for out-of-state acute inpatient hospital services is governed by 130 CMR 450.233 as in effect on February 15, 2010.

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 APR-DRG Version 26 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 RY10 HDD. Casemix Index is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.

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

Contract – See RFA and Contract

Critical Access Hospital (CAH) – An acute hospital that is designated by CMS as a Critical Access Hospital

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. FY12 begins on October 1, 2011, and ends on September 30, 2012

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 as of May 2, 2011, for the period October 1, 2009 through September 30, 2010.

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 FY_2012_Proposed_Rule_Wage_Index_PUFs file, downloaded July 5, 2011. 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 5, 2011. 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 or an Excluded Unit. 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. RY12 will begin on October 1, 2011 and end on September 30, 2012. 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
RY11	12/01/2010 – 09/30/2011
RY12*	10/01/2011 -09/30/2012

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

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.

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

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

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. SFY12 begins on July 1, 2011, and ends on June 30, 2012

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**.

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.**

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 SPAD Adjustments 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 (except for Critical Access Hospitals – see subsection 2.a.ii below), b. adjusted by Hospital-specific casemix and wage area	$8,108.80 (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	$516.58 (statewide) Hospital-specific
SPAD Adjustments **(subsection 5)**	a percentage increase or decrease in the SPAD for qualifying Hospitals	Hospital-specific percentage (does not apply to per diem rates, except for purposes of capping the transfer per diem rate at the Hospital-specific 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. For Critical Access Hospitals, the statewide average payment amount per discharge component in the Base SPAD calculation is replaced by the formula set forth in subsection 2.a.ii, below.

a. The Statewide Average Payment Amount Per Discharge

i. 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 93.0% 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 $8,108.80.

ii. For Critical Access Hospitals, rather than using the statewide average payment amount per discharge formula (subsection 2.a.i., above) in the calculation of the Base SPAD, the following calculation is used in its place. Multiply:

- the Critical Access Hospital's SPAD Base Year standardized cost per discharge, calculated using 101% of the hospital's SPAD Base Year costs; 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.

iii. 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.

iv. 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 $8,910.68.

v. 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%
RY10 and RY11		1.820%
RY11 and RY12		1.665%

** 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.

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 RY10 DHCFP 403 cost report as screened and updated by DHCFP as of July 13, 2011.

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	$476.13
trended to the current rate year using the Inflation Factors for Capital Costs **(subsection b)**,		$516.58
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%
RY10 and RY11	1.5%
RY11 and RY12	1.5%

** 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. **SPAD Adjustments**

a. EOHHS will make an adjustment to the SPAD as calculated in **Sections III.B.2** through **III.B.4** for certain Hospitals as specified below.

- Hospitals that have greater than 63% of Gross Patient Service Revenue (GPSR) from government payers and free care will receive an increase of 5% to their SPAD (including Pediatric SPAD).
- Hospitals with a rate of potentially preventable readmissions (PPR) exceeding the statewide average PPR rate (based on FY2009 data), as calculated in accordance with **Section IV.A.**, below, will receive a 2.20% reduction to their SPAD (including Pediatric SPAD).

b. Any Hospital eligible for both SPAD adjustments specified above will receive a single combined adjustment to its SPAD equal to 2.8%.

c. These SPAD adjustments shall not apply to the calculation of per diem rates; provided, however, that the adjustments do apply when capping the transfer per diem rate at the Hospital-specific SPAD for purposes of **subsection D**, below.

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 actual Psychiatric Per Diem Base Year patient care capital requirement for historical depreciation for building and fixed equipment, reasonable interest expenses, amortization, leases, and

rental of facilities. Any gains from the sale of property will be offset against the Hospital's capital expenses.

4. Adjustment to Base Year 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.2a.v 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.v above**) between RY08 and RY10 were then applied to the rate calculated above to determine the RY12 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 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;

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

f. the patient is under 21 years of age.

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 $198.53, which represents the median nursing facility rate that was effective September 1, 2011 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 for RY12 are $253.72 for Medicaid/Medicare Part B eligible patients and $274.37 for Medicaid-only eligible patients.

6. 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 RY12 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 $0.

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 $6,000 times the total number of inpatient days for admissions beginning during the applicable Federal Fiscal Year, not to exceed $130,000,000.

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 FFY12 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.

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 **subsection 3.c**, below.

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.

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;
- respiratory care (pneumonia and pediatric asthma);
- surgical care infection prevention; and
- racial and ethnic health disparities.

The specific clinical process 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-2a	Perioperative Antibiotics for Cesarean Section – Antibody Timing
MAT-2b	Perioperative Anitbotics for Cesarian Section – Antibiotic Selection

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

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-2	Health Disparities – Clinical Composite Measure

2. 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.

3. 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 sum 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 FY11 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.

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:

Quality Measure Category	Maximum Allocated Amount
Maternity	$33,000,000
Pediatric Asthma	$ 3,000,000
Community Acquired Pneumonia	$ 11,000,000
Surgical Care Infection Prevention	$ 11,000,000
Health Disparities -Clinical	$ 17,000,000

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

i. Individual Clinical Measure Categories

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

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

For each individual clinical 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).

For RY12, the performance score Periods are as follows:

	Comparative Measurement Period	Baseline Measurement Period
Clinical Process Measures	CY 2011	CY 2010

Performance benchmarks for the MassHealth-specific measures (maternity, 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.

If the Hospital failed validation for a measure in the previous reporting year, data from that period is considered invalid for use in calculating the baseline performance. Therefore, the Hospital would not be eligible for improvement points. However, it may be eligible for RY12 attainment points based on calculation of RY12 data for the measure if it passed validation in RY12.

(A) 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.

(B) 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.
- If a Hospital's score for a measure is greater than or equal to the benchmark, it will receive the maximum 10 points for improvement.

(C) Example

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

Statewide calculations	
Maximum allocated amount	$33,000,000
Statewide eligible Medicaid discharges	11,178
Quality measure category per-discharge amount	$33,000,000 / 11,178 = $2,952
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 $2,952 x 80% = $1,180,800**

ii Clinical Health Disparities Composite Measure Category

The clinical health disparities composite measure for each hospital is comprised of aggregate data from all individual clinical measure categories on which the hospital is eligible to report. The hospital's composite measure compares the hospital's performance among race/ethnicity groups and all groups combined, and is converted to a disparity index value. The composite measure and disparity index value are calculated only for Hospitals that report on more than one racial group in their electronic data files.

Effective for Rate Year 2012, the health disparities measure will be assessed on a target attainment level using the following methods.

(A) Setting Performance Thresholds

1. Decile Thresholds. Performance will be assessed using a method that determines the hospital's rank, relative to other hospitals, based on the decile threshold system. Hospitals that meet the measure calculation criteria are divided into ten groups or deciles based on their disparity index value, so that approximately the same number of hospitals falls into each decile group.

2. Target Attainment Threshold. The target attainment threshold represents the minimum level of performance that must be achieved to earn incentive payments. The target attainment is defined as the

boundary for a disparity index value that falls above the 2nd decile group, as shown in the "Decile Performance Thresholds" table below.

(B) Assessing Performance.

The Hospital's clinical health disparity performance score will be calculated using the following methods:

1. Disparity Index Value Ranking. All Hospital disparity index values are rounded to six decimal places. All index values are then divided into ten equal groups and ranked from highest to lowest so approximately the same number of hospitals falls in each decile group.

2. Conversion Factor. Each decile group is assigned a weighted conversion factor associated with the decile threshold, as shown in the table below:

Decile Performance Thresholds

Performance Threshold	Decile Group	Conversion Factor
Top Decile	10th decile	1.0
	9th decile	.90
	8th decile	.80
	7th decile	.70
	6th decile	.60
	5th decile	.50
	4th decile	.40
Target Attainment	3rd decile	.30
Lower Deciles	2nd decile	0
	1st decile	(zero)

To meet the target attainment threshold the Hospital's disparity index value must exceed the value above the 2nd decile cut-off point to fall in the next decile. Index values that fall into the 1st and 2nd decile group are assigned a conversion factor of zero. A disparity index value that falls within the same given decile group are assigned the same conversion factor.

(C) Clinical Health Disparities Composite Total Performance Score.

The total performance score for the health disparities composite measure is the assigned conversion factor as shown in the preceding table. Performance scores are calculated only for Hospitals that meet the measure calculation criteria and validation requirements, using only the Hospital's current year reported data.

IV. Other Quality and Performance Based Payment Methods

A. Potentially Preventable Readmissions (PPRs)

In general, hospitals with a rate of PPRs exceeding the statewide average PPR rate (based on FY 2009 data), as adjusted to reflect hospital-specific casemix and severity of illness during the initial admission, will receive a reduction to their Standard Payment Amount per Discharge (SPAD). This reduction will be applied to hospitals identified using the methodology described below.

1. Determination of Readmission Rates

PPRs are identified in 2009 HDD for MassHealth Primary Care Clinician and Fee-for-Service non-psychiatric discharges (payer types 103 and 104 as reported by the hospital) by using the 3M PPR software version 28.0.

a. Hospital-specific Actual PPR Rate

A hospital's PPR rate is calculated as:

$$\frac{\text{\# of initial admissions with one or more qualifying readmissions}}{\text{\# of initial admissions at risk for a PPR.}}$$

The numerator is the number of initial admissions with one or more qualifying clinically related readmissions within a 30-day period. The denominator is the number of initial admissions at risk for a potentially preventable readmission, excluding deaths and admissions that meet the criteria for one or more global exclusions occurring in the index hospitalization, for the related population for the same time period.

b. Statewide Average PPR Rates

In order to determine the statewide average PPR rates, the average actual PPR rate in each All-Patient Refined Diagnosis Related Group (APR-DRG) and severity of illness is calculated to establish a PPR norm for each APR-DRG.

c. Hospital-specific Expected PPR Rate (based on the Statewide Average PPR Rates)

To account for a hospital's mix of patient types and patient severity of illness during the initial admission, hospital-specific expected PPR rates are adjusted for casemix and severity of illness (SOI). The expected number of PPRs for each APR-DRG and SOI in a hospital is calculated by multiplying the statewide average PPR rate for the APR-DRG and SOI by the number of initial admissions at risk for a PPR in the Hospital for that APR-DRG and SOI.

Expected # of PPRs (by APR-DRG and SOI) =
Statewide average rate (by APR-DRG and SOI)
x
hospital-specific # of initial admissions at risk for a PPR (by APR-DRG and SOI)

The hospital-specific expected PPR rate is determined by dividing the total expected number of PPRs across all APR-DRGs for that hospital by the total number of initial admissions at risk for a PPR.

Hospital-specific Expected PPR Rate =

$$\frac{\text{Sum of expected \# of PPRs (by APR-DRG)}}{\text{Hospital-specific \# of initial admissions at risk for a PPR}}$$

2. Calculation of payment reduction

Hospitals with a Hospital-specific actual PPR rate exceeding the hospital-specific expected PPR rate (based on the statewide average PPR rates) receive a 2.20% reduction to their Standard Payment Amount per Discharge (SPAD) (including Pediatric SPAD). Only hospitals with more than 40 initial admissions at risk for a PPR are subject to this reduction.

B. Provider Preventable Conditions

EOHHS will pay hospitals in accordance with the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions, effective July 1, 2012.

C. 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. Incorrect Determination 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.