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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 13-003

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
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



Division of Medicaid and Children's Health Operations / Boston Regional Office

September 19, 2014

John Polanowicz, Secretary
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, Massachusetts 02108

Dear Mr. Polanowicz:

We are pleased to enclose a copy of approved Massachusetts State Plan Amendment (SPA) No. 13-003 submitted to CMS on March 29, 2013. This SPA was submitted to revise your approved Title XIX State plan to update the outpatient payment methodologies for acute hospital services, critical access hospital services, and Shriners Hospital services for the portion of Hospital Rate Year 2013 beginning January 1, 2013 and ending September 30, 2013. This SPA has been approved effective January 1, 2013.

Enclosed are copies of the following approved State plan pages.

- Attachment 4.19-B(1), pages 1 – 16; and
- Attachment 4.19-B(1), Exhibits 1 (pages 1-2) and 2 (page 1).

If you have any questions regarding this matter you may contact Julie McCarthy at (617) 565-1244 or by e-mail at Julie.McCarthy@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure/s

cc: Kristin Thorn, Medicaid Director
Michael Coleman, State Plan Coordinator

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 013-003	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 01/01/13	

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 440.20	7. FEDERAL BUDGET IMPACT: a. FFY13 \$4,510,000 b. FFY14 \$12,530,000 <i>o</i>
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8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B (1), pages 1-16 Exhibit 1 Exhibit 2	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 4.19-B (1), pages 1- 16 Exhibit 1 Exhibit 2
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10. SUBJECT OF AMENDMENT:

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

11. GOVERNOR'S REVIEW (Check One):

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

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/	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
13. TYPED NAME: John Polanowicz	
14. TITLE: Secretary	
15. DATE SUBMITTED: 03/28/13	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 03/29/2013	18. DATE APPROVED: 09/19/2014
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/2013	20. SIGNATURE OF REGIONAL OFFICIAL: /s/
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Operations, Boston, MA

23. REMARKS:

State Plan Under Title XIX of the Social Security Act

State: Massachusetts

Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services
Portion of Rate Year 2013 from January 1, 2013 to September 30, 2013

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute outpatient hospital services for the portion of RY13 from January 1, 2013 through September 30, 2013. (See TN-012-014 for the RY13 period from October 1, 2012 through December 31, 2012).

1. Except as provided in subsections 2 and 3, below, for dates of service in RY13 beginning January 1, 2013, in-state Hospitals will be paid in accordance with this Attachment for Outpatient Services provided at Hospital Outpatient Departments, and at those Hospital-Licensed Health Centers (HLHCs) and other Satellite Clinics that are provider-based in accordance with 42 CFR 413.65.
2. In-state Critical Access Hospitals will be paid in accordance with the methods set forth in **Exhibit 1**, which is attached hereto and incorporated by reference into this Attachment, for dates of service in RY13 beginning November 1, 2012 through April 30, 2013. (See TN-012-014 for the RY13 period November 1, 2012 through December 31, 2012). For dates of service beginning May 1, 2013 during RY13, payment to Critical Access Hospitals is specified in this **Attachment 4.19-B(1)**, and **Exhibit 1** does not apply.
3. For dates of service in RY13 beginning January 1, 2013 through September 30, 2013, the following two newly-enrolled in-state Hospitals will be paid in accordance with the methods set forth in **Exhibit 2**, which is attached hereto and incorporated by reference into this Attachment: (i) The Shriners' Hospital for Children (Boston, MA) and (ii) The Shriners' Hospital for Children (Springfield, MA) (the "Shriners Hospitals").
4. The supplemental payments specified in **Section III.F** apply to dates of service from October 1, 2012 through September 30, 2013. The other Acute Hospital payment methods that apply during this time period are the methods under the remainder of Attachment 4.19-B(1) in effect for the portion of Rate Year 2013 beginning October 1, 2012 through December 31, 2012 (TN-012-014), and for the portion of Rate Year 2013 beginning January 1, 2013 through September 30, 2013 (TN-013-003).
5. In-state Acute Hospitals are defined in **Section II**.
6. Effective May 25, 2012, payment for out-of-state acute outpatient hospital services is as follows. MassHealth will pay out-of-state acute outpatient hospitals a payment per episode of care equal to the median Payment Amount Per Episode (PAPE) in effect for in-state acute hospitals on the date of service, or in accordance with the applicable fee schedule promulgated by the Division of Health Care Finance and Policy for services for which in-state acute hospitals are not paid a PAPE.

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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.

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, and outpatient covered drugs processed through the MassHealth Pharmacy On-Line Processing System (POPS).

II. Definitions

Acute Hospital – See Hospital.

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.

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

Casemix — the description and categorization of a hospital’s patient population including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

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

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

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.

Enhanced Ambulatory Patient Group (EAPG) — a group of Outpatient Services that have been bundled for purposes of categorizing and measuring casemix. It is based on the 3M Corporation’s EAPG Grouper Versions, as follows:

Version	Dates of PAPE Services
EAPG Version 3.4	10/1/10 to 12/31/10
EAPG Version 3.5	1/1/11 to 6/30/11
EAPG Version 3.6	7/1/11 to 9/30/11

Episode — all Outpatient Services, except those described in **Sections I.B and III.C through E**, 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.

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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.

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 RY13 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 RY13 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

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1.665% reflects the price changes between RY11 and RY12

1.775% reflects the price changes between RY12 and RY13.¹

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 CMR Parts 410 and 450, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions and the RFA.

¹ Applied in RY13 starting January 1, 2013.

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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.B**)

PAPE Base Year — the PAPE Base Year is October 1, 2010 through September 30, 2011 paid as of July 16, 2012.

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

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

Rate Year	Dates
RY04	10/1/2003 – 9/30/2004
RY05	10/1/2004 – 9/30/2005
RY06	10/1/2005 – 9/30/2006
RY07	10/1/2006 – 10/31/2007
RY08	11/1/2007 – 9/30/2008
RY09	10/1/2008 – 10/31/2009
RY10	11/1/2009 – 11/30/2010
RY 11	12/01/2010 – 09/30/2011
RY12	10/01/2011 – 9/30/2012
RY13*	10/1/2012 – 9/30/2013

*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 EAPG Payment — an adjusted calculation of total payment for PAPE Covered Services provided to MassHealth Members in the PAPE Base Year using the EAPG grouper and calculating the Episode Cost using the FY11 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.

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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.C through E**, and in **Exhibits 1 and 2**, Hospitals will receive a Hospital-specific payment for each Episode, known as the Payment Amount Per Episode (PAPE). This payment methodology is applicable to all public and private providers.

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

For dates of service in RY13 beginning November 1, 2012 through April 30, 2013, Critical Access Hospitals are paid in accordance with **Exhibit 1**. (See TN-012-014 for the RY13 period November 1, 2012 through December 31, 2012). For dates of service beginning May 1, 2013 during RY13, payment to Critical Access Hospitals is as specified in this **Attachment 4.19-B(1)**, and **Exhibit 1** does not apply.

For the two Shriners Hospitals, payment for Outpatient Services is described in **Exhibit 2**.

B. RY13 Payment Amount per Episode (PAPE) for the 9-Month Period of RY13 Beginning January 1, 2013

For the nine-month period of RY13 beginning January 1, 2013, each hospital's RY13 PAPE is a blended rate that equally weights the Hospital's RY12 PAPE and the "preliminary RY13 PAPE" determined and calculated as described below, provided, however that no hospital's RY13 PAPE shall be less than 90% of the hospital's RY12 PAPE in effect on September 30, 2012.

The "preliminary RY13 PAPE" is the product of the Hospital- Specific Outpatient Casemix Index and the Outpatient Statewide Standard, as summarized in the following table, and the components are described in more detail below.

Preliminary RY13 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 EAPG weight of 1.0)	\$162.89
x Hospital-specific casemix index	average of the monthly EAPG weights per episode for each hospital for the PAPE Base Year	Hospital-specific

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1. Hospital-specific Outpatient Casemix Index

The hospital-specific outpatient casemix index is an average of the monthly Average EAPG Weights per Episode for the PAPE Base Year for each Hospital.

The monthly Average EAPG Weight per Episode for each month is the Hospital's PAPE payments divided by the number of Episodes and then divided by the applicable conversion factor. PAPE payments are based on claims for MassHealth Episodes residing in MMIS for the PAPE Base Year, with a status of adjudicated and paid and for which MassHealth is the primary payer. The applicable standard EAPG conversion factor for the PAPE Base Year is \$136.12.

The sum of the monthly Average EAPG Weights Per Episode for the PAPE Base Year divided by 12 is the Hospital-Specific Outpatient Casemix Index for the nine-month period of the current Rate year (RY13) from January 1, 2013 through September 30, 2013.

2. 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 EAPG grouper would equal the Total EAPG Payment. The result of this calculation is a PAPE Base Year Outpatient Statewide Standard of \$126.09.

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 is then multiplied by the Inflation Factors for Operating Costs. The resulting RY13 Outpatient Statewide Standard for the portion of RY13 from January 1, 2013 through September 30, 2013 is \$162.89.

For Critical Access Hospitals, the Outpatient Statewide Standard is 120% of the Outpatient Statewide Standard noted above. The Resulting RY13 Outpatient Statewide Standard for Critical Access Hospitals is \$195.47.

C. Physician Payments

1. A Hospital may receive payment for the professional component of physician services provided by Hospital-Based Physicians to MassHealth members.
2. Such payment shall be as specified in Attachment 4.19B, section 8.d. of the State Plan. Hospitals will not be paid separately for professional fees for practitioners other than Hospital-Based Physicians as defined in **Section II**.
3. Hospitals will be paid for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient

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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.

D. Outpatient Hospital Services Payment Limitations

1. Payment Limitations on Hospital Outpatient Services Preceding an Admission

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

2. Payment Limitations on Outpatient Services to Inpatients

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

E. Laboratory Services

1. Payment for Laboratory Services

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

2. Physician Services

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

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F. Payment for Unique Circumstances

1. [Reserved]
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 \$30,000,000.

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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 \$ 14,000,000.

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. 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 DHCFF-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. Reserved

V. Other Provisions

A. Federal Limits

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

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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. Incorrect Determination of Casemix

In the event of an error in the calculation of casemix made by EOHHS for Outpatient Services resulting in an amount not consistent with the methodology, and where the effect of the error is a decrease in the Hospital's PAPE of 2% or more, a Hospital may request a correction, consistent with the RFA and contract, which shall be at the sole discretion of EOHHS.

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

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.

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VI. Other Quality and Performance Based Payment Methods

A. Provider Preventable Conditions

Citation

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

Payment Adjustment for Provider Preventable Conditions

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

Other Provider-Preventable Conditions

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

Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

Additional Other Provider-Preventable Conditions identified below:

- The following Hospital Acquired Conditions as identified by Medicare, as they may be updated by CMS:
 1. Foreign object retained after surgery.
 2. Air Embolism
 3. Blood incompatibility
 4. Stage III and IV Pressure Ulcers
 5. Falls and Trauma, related to:
 - fractures
 - dislocations
 - intracranial injuries
 - crushing injuries
 - burns
 - other injuries
 - In addition, the following:
 1. Intraoperative or immediately postoperative / post procedure death in a ASA class 1 patient
 2. Patient death or serious injury associated with the use of contaminated drugs, devices or biologics provided by the healthcare setting.
-

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

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

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

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

Payment Method:

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

Provider preventable conditions (“PPCs”) are defined as those conditions that are identified as Other Provider-Preventable Conditions (“OPPCs”) above. The OPPCs include the three National Coverage

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Determinations (the “NCDs”) and the Additional Other Provider Preventable Conditions (“Additional OPPCs”) that are listed above.

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

1. PAPE:
 - a. MassHealth will not pay the PAPE if the Hospital reports that only-PPC-related services were delivered during the episode of care, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
 - b. MassHealth will pay the PAPE if the Hospital reports that non-PPC related services were also delivered during the same episode of care, but will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.
2. Outpatient Hospital Payments for Hospital-Based Physician Services: MassHealth will not pay for outpatient Hospital-based physician services reported as PPC-related services.
3. Follow-Up Care in Same Hospital: If a Hospital reports that it provided follow-up outpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license., MassHealth will not pay for the reported follow-up services. If the hospital reports that non-PPC-related services were provided during the follow-up episode of care, payment will be made, but MassHealth will exclude all PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

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

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

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

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B. Serious Reportable Events

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

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

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

1. All services provided during the outpatient visit during which a preventable SRE occurred; and
2. All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:
 - a. at a facility under the same license as the Hospital at which a non-billable SRE occurred; or
 - b. on the premises of a separately licensed hospital with common ownership or a common corporate parent of the Hospital at which a non-billable SRE occurred.
3. Charges for services, including co-payments or deductibles, deemed non-billable to MassHealth are not billable to the Member.

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

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

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Exhibit 1: RY13 Payment Method for Critical Access Hospitals
Effective November 1, 2012 through April 30, 2013

EXHIBIT 1
RY13 Payment Method Applicable to Critical Access Hospitals
Effective November 1, 2012 through April 30, 2013

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for the RY13 period November 1, 2012 through April 30, 2013. (See TN-012-014 for the RY13 period November 1, 2012 through December 31, 2012). For dates of service beginning May 1, 2013 during RY13, payment to Critical Access Hospitals is specified in **Attachment 4.19-B(1)**, and **Exhibit 1** does not apply.

Section II. Payment Method - General

EOHHS will pay Critical Access Hospitals an amount equal to 101 percent of the Hospital's allowable costs as determined by EOHHS utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services for the period November 1, 2012 through April 30, 2013, as more fully described below. Interim payments will be made to Critical Access Hospitals based on the rates and methods set forth in this **Exhibit 1**, which payments are provisional in nature and subject to the completion of a cost review and settlement for the time period beginning November 1, 2012 through April 30, 2013, as described in **Section II(B)** of this **Exhibit 1**. The interim payments made for Outpatient Services to Critical Access Hospitals will be made on the same basis as payment would be made for those same Outpatient Services to all other Hospitals (e.g., per Episode for Outpatient Services paid by the PAPE), and the timing of the interim payments will not differ from the timing that Outpatient Services are paid to all other Hospitals. Subject to this **Exhibit 1**, **Attachment 4.19-B(1)** otherwise applies to Critical Access Hospitals. If a Hospital loses its designation as a Critical Access Hospital, the payment methods for such hospital shall revert to the standard acute hospital rate methodologies, and payments may be adjusted accordingly. Reversion to any such rate methodologies shall not affect the payment rates to other participating acute hospitals for the applicable rate year.

(A) Payment for Outpatient Services

For dates of service on or after November 1, 2012 through April 30, 2013, Critical Access Hospitals will be paid for Outpatient Services in accordance with **Attachment 4.19-B(1)** with the following changes.

Critical Access Hospitals will be paid a hospital-specific Payment Amount Per Episode (PAPE) for those Outpatient Services for which all other in-state acute hospitals are paid a PAPE. Notwithstanding **Section III.B** of **Attachment 4.19-B(1)**, for dates of service on or after November 1, 2012 through April 30, 2013, the hospital-specific PAPE for each Critical Access Hospital was calculated as follows:

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Exhibit 1: RY13 Payment Method for Critical Access Hospitals
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- (1) EOHHS calculated a cost to charge ratio for outpatient services (Outpatient CCR) for each Critical Access Hospital, which was determined by dividing the amount reported on Schedule II, line 114, column 10 (Patient Expense Including Capital, Subtotal Outpatient) of the hospital's FY11 DHCFCP-403 cost report by the amount reported on Schedule II, line 114, column 11 (Gross Patient Service Revenue, Subtotal Outpatient) of such report, after setting to zero all direct expenses reported on Schedule IX, Line 51 (LAB) , and all gross patient service revenues reported on Schedule VI, Column 12 (LABORATORY).
 - (2) EOHHS then calculated 101% of the Critical Access Hospital's Medicaid (MassHealth) outpatient costs by multiplying the Outpatient CCR by the amount reported on Schedule VA, line 70, column 6 (Medicaid Non-Managed Care, Total Outpatient Gross Patient Service Revenue) of the hospital's FY11 DHCFCP-403 cost report, and then subsequently increasing that amount by an additional 1%.
 - (3) EOHHS then divided the amount that equals 101% of the hospital's Medicaid (MassHealth) outpatient costs as determined above, by the hospital's Medicaid (MassHealth) PAPE Base Year Episodes.
 - (4) The Inflation Factors for Operating Costs between RY11 and RY12 and between RY12 and RY13, as defined in Section II of Attachment 4.19-B(1), were then applied to the calculation above, to derive the Critical Access Hospital's per Episode PAPE rate that will apply for dates of service on or after November 1, 2012 through April 30, 2013.
- (B) Post RY13 Cost Review and Settlement**

EOHHS will perform a post-Rate Year 2013 review to determine whether the Critical Access Hospital received aggregate interim payments in an amount equal to 101% of allowable costs utilizing the Medicare cost-based reimbursement methodology for both inpatient and outpatient services for the period November 1, 2012 through April 30, 2013, as such amount is determined by EOHHS ("101% of allowable costs"). See also Exhibit 1 to Attachment 4.19-A(1). EOHHS will utilize the Critical Access Hospital's FY13 CMS-2552 cost reports, including completed Medicaid (Title XIX) data worksheets, and such other information that EOHHS determines is necessary, to perform this post RY13 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for the period November 1, 2012 through April 30, 2013.

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

This post RY13 review and settlement will take place within twelve (12) months after EOHHS has obtained all accurate and complete data needed to perform the review and settlement calculation. EOHHS estimates that it will have accurate and complete data by September 30, 2014. Assuming this date, the settlement will be complete by September 30, 2015.

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Exhibit 2: Payment Method for the Two Shriners Hospitals for RY13 Dates of Service
from January 1, 2013 through September 30, 2013

EXHIBIT 2

Payment Method Applicable to the Two Shriners Hospitals for RY13 Dates of Service from January 1, 2013 through September 30, 2013

Section I. Overview

The payment methods set forth in this **Exhibit 2** apply to the following two newly-enrolled in-state acute Hospitals: (i) The Shriners' Hospital for Children (Boston, MA) and (ii) The Shriners' Hospital for Children (Springfield, MA) (the "Shriners Hospitals").

Section II. Payment Method

The payment methods set forth in this **Exhibit 2** apply to the Shriners Hospitals for dates of service occurring in RY13 from January 1, 2013 through September 30, 2013. Subject to this **Exhibit 2**, **Attachment 4.19-B(1)** otherwise applies to the Shriners Hospitals for this time period.

(A) Payment for Outpatient Services

For RY13 dates of service from January 1, 2013 through September 30, 2013, the Shriners Hospitals will be paid for Outpatient Services in accordance with **Attachment 4.19-B(1)**, with the following changes.

The Shriners Hospitals will be paid a hospital-specific Payment Amount Per Episode (PAPE) for those Outpatient Services for which all other in-state acute hospitals are paid a PAPE. Notwithstanding **Section III.B** of **Attachment 4.19-B(1)**, the hospital-specific RY13 PAPE rate for dates of service from January 1, 2013 through September 30, 2013 for each Shriners Hospital shall be an amount equal to the median PAPE, as calculated by EOHHS, for all other in-state Acute Hospitals participating in MassHealth for the portion of RY13 from January 1, 2013 through September 30, 2013, which is \$284.50.

(B) Other

For any other rate adjustment or payment that is provided for under **Attachment 4.19-B(1)** not otherwise addressed in this **Exhibit 2**, if EOHHS does not have on record the required data as it pertains to the Shriners Hospital, the rate adjustment or payment shall not be applicable to the Shriners Hospital for this portion of RY13.