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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 17-016

This file contains the following documents in the order listed:

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

March 8, 2018

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

Dear Secretary Sudders:

We are pleased to enclose a copy of approved Massachusetts State Plan Amendment (SPA) No. 17-016 submitted to CMS on December 29, 2017. This SPA was submitted to revise your approved Title XIX State plan to describe changes to the reimbursement methodologies for acute hospital outpatient services effective for hospital rate year 2018. This SPA has been approved effective October 1, 2017.

Enclosed are copies of the following approved State plan pages.

- Attachment 4.19-B(1), pages 1-31; and
- Attachment 4.19-B(1), Exhibit 1, pages 1-3.

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 (via e-mail): Daniel Tsai, Assistant Secretary for MassHealth, Medicaid Director
Kaela Konefal, Federal Authority Policy Analyst/State Plan Coordinator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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: 17-016

2. STATE: MA

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

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

4. PROPOSED EFFECTIVE DATE: 10/1/17

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 CFR Part 447; 42 CFR 440.20

7. FEDERAL BUDGET IMPACT
a. FFY 2018 $ (14.2 million)
b. FFY 2019 $ (14.2 million)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B (1), pages 1-31
Exhibit 1, page 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B (1), pages 1-29
Exhibit 1, page 1-3

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
☐ 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)(i)

12. SIGNATURE
/s/

13. TYPED NAME
Marylou Sudders

14. TITLE
Secretary

15. DATE SUBMITTED
12/29/17

16. RETURN TO
Kaela Konefal
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 12/29/2017

18. DATE APPROVED 03/08/2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL 10/01/2017

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

FORM CMS-179 (07/92)

Instructions on Back

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

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute outpatient hospital services for RY18.

1. Except as provided in subsection 2, below, for dates of service in RY18 (October 1, 2017 through September 30, 2018), 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 RY18 beginning October 1, 2017 through September 30, 2018.

3. The supplemental payments specified in **Section III.F** apply to dates of service from October 1, 2017 through September 30, 2018.

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

5. This **Section I.A.5** describes the payment methods to out-of-state acute outpatient hospitals for acute outpatient hospital services.

a. Except as provided in **subsection 5.c**, below, all out-of-state acute outpatient hospitals are paid utilizing an adjudicated payment per episode of care (APEC) payment methodology ("Out-of-State APEC") as described in **subsection 5.b,** below, for APEC-covered services, and in accordance with the applicable MassHealth fee schedule for services for which in-state acute hospitals are not paid the APEC. "APEC-covered services" are outpatient services for which in-state acute hospitals are paid the APEC.

b. The Out-of-State APEC for each payable episode will equal the sum of (i) the episode-specific total EAPG payment and (ii) the APEC outlier component (if applicable), as further described in **subsections 5.b.(1) and (2)**, below. Components of the Out-of-State APEC that are based on the in-state method will simultaneously adjust effective with the 2nd RY18 Period (as defined in **Section II**) to reflect updates being implemented effective with the 2nd RY18 Period to the in-state method, as applicable.

(1) The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC outpatient statewide standard in effect for in-state acute hospitals, and the claim detail line's Adjusted EAPG Weight. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line's MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight for this purpose.

(2) The "APEC outlier component" is equal to the Marginal Cost Factor in effect for in-state acute hospitals multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold. If the episode-specific case cost is less than the episode-specific outlier threshold, the APEC outlier component is $0.

(i) The "episode-specific case cost" is determined by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the applicable outpatient cost-to-charge ratio. For High MassHealth Volume Hospitals (as defined in **subsection 5.c**, below), the outpatient cost-to-charge ratio is hospital-specific. For all other out-of-state acute hospitals, the median in-state acute outpatient hospital cost-to-charge ratio in effect based on MassHealth episode volume is used.

(ii) The "episode-specific outlier threshold" is equal to the sum of the episode-specific total EAPG payment corresponding to the episode, and the Fixed Outpatient Outlier Threshold in effect for in-state acute hospitals.

(iii) An APEC outlier component is not payable if the episode-specific total EAPG payment is $0.

c. If an inpatient service payable by MassHealth is not available in-state, payment for the related acute hospital outpatient services will be made at the rate of payment established for the medical service under the other state's Medicaid program (or equivalent), or such other rate as MassHealth determines necessary to ensure member access to services. This provision does not apply to "High MassHealth Volume Hospitals", which are defined as any out-of-state acute hospital that, during the most recent federal fiscal year for which complete data is available, had at least 150 MassHealth discharges.

d. The payment methods in this **Section I.A.5** are the same for private and governmental providers.

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 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 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, outpatient covered drugs processed through the MassHealth Pharmacy On-Line Processing System (POPS), and services of designated emergency mental health providers / emergency services programs (DEPs/ESPs).

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

II. Definitions

The definitions set forth in the "**1st RY18 Period**" column, below, apply during the **1st RY18 Period** (as defined below). The definitions set forth in the **"2nd RY18 Period**" column, below, apply during the **2nd RY18 Period** (as defined below), unless (i) that column specifies that there is no change to the definition, or (ii) for purposes of the APEC payment methodology set forth in **Section III.B**, the Episode's first date of service for Emergency Department or Observation Services that extend past midnight occurred in the 1st RY18 Period, in which case, the definitions set forth in the **1st RY18 Period** column continue to apply.

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
1st RY18 Period	The "1st RY18 Period" is the portion of RY18 from October 1, 2017 through February 28, 2018.	No change to definition.
2nd RY18 Period	The "2nd RY18 Period" is the portion of RY18 from March 1, 2018 through the end of RY18.	No change to definition.
3M EAPG Grouper	The 3M Corporation's EAPG Grouper version 3.10, configured for the MassHealth APEC payment method.	No change to definition.
Accountable Care Organization (ACO)	An entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans (ACPPs), Primary Care ACOs, and MCO-Administered ACOs.	No change to definition.
Accountable Care Partnership Plan (ACPP)	A type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and which is	No change to definition.

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), and which is organized primarily for the purpose of providing health care services.	
Acute Hospital	See Hospital.	No change to definition.
Adjudicated Payment per Episode of Care (APEC)	A Hospital-specific,Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in **Sections I.B and III.C through E**. The APEC is calculated as set forth in **Section III.B**, utilizing the methodology applicable to the 1st RY18 Period**.**	A Hospital-specific,Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in **Sections I.B and III.C through E**. The APEC is calculated as set forth in **Section III.B**, utilizing the methodology applicable to the 2nd RY18 Period**.**
Adjusted EAPG Weight	The EAPG weight that is multiplied by the APEC Outpatient Statewide Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating the Episode-Specific Total EAPG Payment, utilizing the methodology applicable to the 1st RY18 Period. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight, including as follows: • **consolidation** is the collapsing of multiple identical or related significant procedure EAPGs into a single EAPG for payment	The EAPG weight that is multiplied by the APEC Outpatient Statewide Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating the Episode-Specific Total EAPG Payment, utilizing the methodology applicable to the 2nd RY18 Period. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight, including as follows: • **consolidation** is the collapsing of multiple identical or related significant procedure EAPGs into a single EAPG for payment

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	purposes, with the additional procedures weighted at zero percent; • **packaging** applies to ancillary service EAPGs present with a significant procedure EAPG or medical visit EAPG, with the ancillary service EAPGs weighted at zero percent; • **discounting** applies to multiple unrelated significant procedures, repeat ancillary procedures, terminated procedures, and bilateral procedures. All discounting rates are 50%, with the exception of terminated procedures (75% of full weight) and the third and subsequent ancillary procedures (25% of full weight).	purposes, with the additional procedures weighted at zero percent; • **packaging** applies to ancillary service EAPGs present with a significant procedure EAPG or medical visit EAPG, with the ancillary service EAPGs weighted at zero percent; • **discounting** applies to multiple unrelated significant procedures, repeat ancillary procedures, terminated procedures, and bilateral procedures. All discounting rates are 50%, with the exception of terminated procedures (75% of full weight) and the third and subsequent ancillary procedures (25% of full weight).
APEC Base Year	The APEC Base Year is FY14.	No change to definition.
APEC-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**.	No change to definition.
APEC Outlier Component	A Hospital-specific, Episode-specific component of the APEC which is calculated by EOHHS as described in **Section III.B.2.b**, utilizing the methodology applicable to the 1st RY18 Period, and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.	A Hospital-specific, Episode-specific component of the APEC which is calculated by EOHHS as described in **Section III.B.2.b**, utilizing the methodology applicable to the 2nd RY18 Period, and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.

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

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
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.	No change to definition.
Behavioral Health Services	Services provided to Members who are being treated for psychiatric disorders or substance-related disorders.	No change to definition.
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.	No change to definition.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.	No change to definition.
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.	No change to definition.
Contract	see RFA and Contract.	No change to definition.
Critical Access Hospital	An acute hospital that, prior to October 1, 2017, was designated by CMS as a Critical Access Hospital and that continues to maintain that	No change to definition.

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	status.	
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.	No change to definition.
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 EAPG Grouper.	No change to definition.
Episode	All MassHealth-covered Outpatient Services, except those set forth in **Section I.B and III.C through E** delivered to a MassHealth Member on a single calendar day, or if the services extend past midnight in the case of Emergency Department or Observation Services, on consecutive days. Additionally, in limited circumstances, APEC-Covered Services delivered to a MassHealth Member during a second distinct and independent visit on the same calendar day may be considered a separate Episode for payment purposes if the services are for unrelated purposes and conditions as determined by EOHHS.	No change to definition.
Episode's Total Allowed Charges	the sum of the MassHealth allowed charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.	the sum of the MassHealth allowed charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.
Episode-Specific Case Cost	The product of the Episode's Total Allowed Charges, and the Hospital's FY14 outpatient cost-to-charge ratio	The product of the Episode's Total Allowed Charges, and the Hospital's FY16 outpatient cost-to-charge ratio

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	as calculated by EOHHS using the Hospital's FY14 -403 cost report.	as calculated by EOHHS using the Hospital's FY16 Massachusetts Hospital cost report.
Episode-Specific Outlier Threshold	the sum of the Episode-Specific Total EAPG Payment, as determined by EOHHS, and the Fixed Outpatient Outlier Threshold.	the sum of the Episode-Specific Total EAPG Payment, as determined by EOHHS, and the Fixed Outpatient Outlier Threshold.
Episode-Specific Total EAPG Payment	An Episode-specific payment amount, which summed with the APEC outlier Component (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in **Section III.B.2.a**, utilizing the methodology applicable to the 1st RY18 Period.	An Episode-specific payment amount, which summed with the APEC outlier Component (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in **Section III.B.2.a**, utilizing the methodology applicable to the 2nd RY18 Period.
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.	No change to definition.
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.	No change to definition.
Fixed Outpatient Outlier Threshold	For the 1st RY18 Period, the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $2,100.	For the 2nd RY18 Period, the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $2,750.
Hospital	Any health care facility which: a. operates under a hospital license issued by the	No change to definition.

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	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.	No change to definition.
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	No change to definition.

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	approved by and enrolled with MassHealth as a HLHC.	
Inflation Factors for Operating Costs	For price changes between RY14 and RY17, 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 RY14 and RY17 are as follows: • 1.611% reflects the price changes between RY14 and RY15. • 1.573% reflects the price changes between RY15 and RY16. • 1.937% reflects the price changes between RY16 and RY17.	For price changes between RY14 and RY18, 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 RY14 and RY18 are as follows: • 1.611% reflects the price changes between RY14 and RY15. • 1.573% reflects the price changes between RY15 and RY16. • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18.
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. For clarity purposes, MCOs also include Accountable Care Partnership Plans (ACPPs).	No change to definition.
Marginal Cost Factor	As used in the calculation of the APEC Outlier Component, the percentage of payment made for the difference between the Episode-Specific Case Cost and the Episode-	As used in the calculation of the APEC Outlier Component, the percentage of payment made for the difference between the Episode-Specific Case Cost and the Episode-

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Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	Specific Outlier Threshold. For the 1st RY18 Period, the Marginal Cost Factor is 80%.	Specific Outlier Threshold. For the 2nd RY18 Period, the Marginal Cost Factor is 80%.
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.	No change to definition.
MassHealth EAPG Weight	The MassHealth relative weight developed by EOHHS for each unique EAPG.	No change to definition.
Member	A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.	No change to definition.
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.	No change to definition.
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	No change to definition.

Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	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.	No change to definition.
PAPE Covered Services	MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics that were paid utilizing the PAPE payment methodology under prior Acute Outpatient Hospital SPAs (including SPA 016-016 for the period up through December 29, 2016).	No change to definition.
Payment Amount Per Episode (PAPE)	An outpatient payment methodology that was utilized in prior Acute Outpatient Hospital SPAs. The PAPE was a fixed Hospital-specific all-inclusive facility payment that was made for all PAPE Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode (as defined in prior Acute Outpatient	No change to definition.

<table>
<tr><th>Defined Term</th><th>Definition Applicable During 1st RY18 Period</th><th>Definition Applicable During 2nd RY18 Period</th></tr>
<tr><td></td><td>Hospital SPAs, including SPA 016-016 for the RY17 period up through December 29, 2016), with the exception of those services that were excluded from the PAPE payment methodology as described in those prior SPAs. . The PAPE methodology was replaced by the APEC payment methodology during RY17, effective with dates of service on or after December 30, 2016.</td><td></td></tr>
<tr><td>Primary Care ACO</td><td>A type of ACO with which the MassHealth agency contracts under its ACO program.</td><td>No change to definition.</td></tr>
<tr><td>Primary Care Clinician Plan (PCC Plan)</td><td>A comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive primary care, behavioral health, and other medical services.</td><td>No change to definition.</td></tr>
<tr><td>Rate Year (RY)</td><td>Generally, a twelve month period beginning October 1 and ending the following September 30. For specific rate years, refer to the following table:
<table>
<tr><th>Rate Year*</th><th>Dates</th></tr>
<tr><td>RY04</td><td>10/1/2003 – 9/30/2004</td></tr>
<tr><td>RY05</td><td>10/1/2004 – 9/30/2005</td></tr>
<tr><td>RY06</td><td>10/1/2005 – 9/30/2006</td></tr>
<tr><td>RY07</td><td>10/1/2006 – 10/31/2007</td></tr>
<tr><td>RY08</td><td>11/1/2007 – 9/30/2008</td></tr>
<tr><td>RY09</td><td>10/1/2008 – 10/31/2009</td></tr>
<tr><td>RY10</td><td>11/1/2009 – 11/30/2010</td></tr>
<tr><td>RY11</td><td>12/01/2010–09/30/2011</td></tr>
<tr><td>RY12</td><td>10/01/2011 --9/30/2012</td></tr>
<tr><td>RY13</td><td>10/01/2012 –09/30/2013</td></tr>
<tr><td>RY14</td><td>10/1/2013 – 09/30/2014</td></tr>
<tr><td>RY15</td><td>10/1/2014 – 9/30/2015</td></tr>
</table></td><td>No change to definition.</td></tr>
</table>

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State: Massachusetts
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Defined Term	Definition Applicable During 1st RY18 Period	Definition Applicable During 2nd RY18 Period
	RY16 10/1/2015 – 9/30/2016 RY17 10/1/2016 – 9/30/2017 RY18 10/1/2017 – 9/30/2018 *In future rate years, Hospitals will be paid in 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.	No change to definition.
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.	No change to definition.
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.	No change to definition.
Usual and Customary Charges	Routine fees that Hospitals charge for Outpatient Services rendered to patients regardless of payer sources.	No change to definition.

III. Payment for Outpatient Services

A. Overview

Except as otherwise provided for Outpatient Services specified in **Sections I.B and III.C through E**, and in **Exhibit 1**, Hospitals will receive a Hospital-specific, Episode-specific payment for each Episode known as the Adjudicated Payment per Episode of Care (APEC), calculated as set forth in **Section III.B**, below. 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 RY18 beginning October 1, 2017 through September 30, 2018, Critical Access Hospitals are paid in accordance with **Exhibit 1**.

B. Adjudicated Payment per Episode of Care (APEC)

1. Rate Year 2018 APEC Payment Methodology

RY18 is bifurcated into the 1st RY18 Period and the 2nd RY18 Period for purposes of applying the APEC payment methodology. The APEC methodology is set forth in **Section III.B.2**, below. The **"1st RY18 Period'** column applies to dates of service in the 1st RY18 Period, and incorporates applicable definitions in **Section II** that apply to the 1st RY18 Period. The "**2nd RY18 Period"** column applies to dates of service in the 2nd RY18 Period, and incorporates applicable definitions in **Section II** that apply to the 2nd RY18 Period. As an exception, for Episodes that extend past midnight in the case of Emergency Department or Observation Services, if the Episodes' first date of service occurs in the 1st RY18 Period, then the 1st RY18 Period APEC methodology applies to the entire Episode. The 1st RY18 Period APEC methodology is the same methodology that applied during RY17, effective beginning December 30, 2016, under approved SPA TN-016-016.

1st RY18 Period (for dates of service in the 1st RY18 Period)	2nd RY18 Period (for dates of service in the 2nd RY18 Period)
2. Description of APEC payment method Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for each payable Episode known as the APEC. The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus (2), if	**2. Description of APEC payment method** Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for each payable Episode known as the APEC. The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus (2), if

1st RY18 Period (for dates of service in the 1st RY18 Period)	2nd RY18 Period (for dates of service in the 2nd RY18 Period)
applicable, an APEC Outlier Component, as further described below.	applicable, an APEC Outlier Component, as further described below.
a. Episode-Specific Total EAPG Payment. For each claim detail line containing APEC-Covered Services in the Episode, the APEC Outpatient Statewide Standard (as described below) is multiplied by the claim detail line's Adjusted EAPG Weight (as described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.	**a. Episode-Specific Total EAPG Payment.** For each claim detail line containing APEC-Covered Services in the Episode, the APEC Outpatient Statewide Standard (as described below) is multiplied by the claim detail line's Adjusted EAPG Weight (as described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.
(1) **APEC Outpatient Statewide Standard.** The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described below. For each Hospital, an average outpatient cost per Episode for the APEC Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all PAPE paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. The Hospital's CCR was calculated based on the Hospital's FY14 - 403 cost report, and Hospital-specific Episodes and charges were based on paid claims for Episodes residing in MMIS for the APEC Base Year, for which	(1) **APEC Outpatient Statewide Standard.** The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described below. For each Hospital, an average outpatient cost per Episode for the APEC Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient charges for all PAPE paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. The Hospital's CCR was calculated based on the Hospital's FY14 - 403 cost report, and Hospital-specific Episodes and charges were based on paid claims for Episodes residing in MMIS for the APEC Base Year, for which

1st RY18 Period (for dates of service in the 1st RY18 Period)	2nd RY18 Period (for dates of service in the 2nd RY18 Period)
MassHealth was primary payer. Each Hospital's average outpatient cost per Episode was then divided by the Hospital-Specific Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific Outpatient CMI was determined based on PAPE paid claims residing in MMIS for the APEC Base Year for which MassHealth was primary payer. For each Hospital and month of the APEC Base Year, an average EAPG weight per Episode was determined by assigning individual EAPGs and associated MassHealth-developed weights to the Hospital's PAPE paid claims for the month (using the 3M EAPG Grouper), summing the individual EAPG weights together, and dividing that sum by the number of Episodes. The sum of the Hospital's twelve monthly average EAPG weights per Episode for the APEC Base Year, divided by 12 is the Hospital-Specific Outpatient CMI. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY15 MassHealth Episodes for the Hospitals was produced from paid claims in MMIS for which MassHealth was primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 65% of the total number of statewide Episodes in MMIS. The APEC efficiency standard applicable to the 1st RY18 Period is $289.14.	MassHealth was primary payer. Each Hospital's average outpatient cost per Episode was then divided by the Hospital-Specific Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific Outpatient CMI was determined based on PAPE paid claims residing in MMIS for the APEC Base Year for which MassHealth was primary payer. For each Hospital and month of the APEC Base Year, an average EAPG weight per Episode was determined by assigning individual EAPGs and associated MassHealth-developed weights to the Hospital's PAPE paid claims for the month (using the 3M EAPG Grouper), summing the individual EAPG weights together, and dividing that sum by the number of Episodes. The sum of the Hospital's twelve monthly average EAPG weights per Episode for the APEC Base Year, divided by 12 is the Hospital-Specific Outpatient CMI. All Hospitals were then ranked from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY16 MassHealth Episodes for the Hospitals was produced from paid claims in MMIS for which MassHealth was primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 67% of the total number of statewide Episodes in MMIS. The APEC efficiency standard applicable to the 2nd RY18 Period is $291.36.

1st RY18 Period (for dates of service in the 1st RY18 Period)	2nd RY18 Period (for dates of service in the 2nd RY18 Period)
The APEC Outpatient Statewide Standard was then determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 93%; and by (c) the Inflation Factors for Operating Costs between RY14 and RY17, and then dividing that result by a conversion factor of 1.057. The APEC Outpatient Statewide Standard applicable to the 1st RY18 Period is $252.00. For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's APEC Outpatient Statewide Standard is instead $317.00.	The APEC Outpatient Statewide Standard was then determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 93%; and by (c) the Inflation Factors for Operating Costs between RY14 and RY18, and then dividing that result by a conversion factor of 1.057. The APEC Outpatient Statewide Standard applicable to the 2nd RY18 Period is $258.43. For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's APEC Outpatient Statewide Standard is instead $323.43.
(2) **Claim Detail Line's "Adjusted EAPG Weight**." EAPGs are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted Hospital claim, utilizing the 3M EAPG Grouper. EAPGs are assigned at the claim detail line level. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights (as defined in **Section II**) to produce that claim detail line's Adjusted EAPG Weight.	(2) **Claim Detail Line's "Adjusted EAPG Weight**." EAPGs are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted Hospital claim, utilizing the 3M EAPG Grouper. EAPGs are assigned at the claim detail line level. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights (as defined in **Section II**) to produce that claim detail line's Adjusted EAPG Weight.
b. APEC Outlier Component. The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then multiplied by the 1st RY18 Period Marginal Cost Factor. The Episode-Specific Case Cost is the product of the Episode's Total Allowed	**b. APEC Outlier Component.** The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then multiplied by the 2nd RY18 Period Marginal Cost Factor. The Episode-Specific Case Cost is the product of the Episode's Total Allowed Charges and

1st RY18 Period (for dates of service in the 1st RY18 Period)	2nd RY18 Period (for dates of service in the 2nd RY18 Period)
Charges and the Hospital's FY14 Outpatient CCR (which is based on the Hospital's FY14 403 cost report). The Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section III.B.2.a,** above), and the 1st RY18 Period Fixed Outpatient Outlier Threshold of $2,100. If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor for the 1st RY18 Period set at 80%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.	the Hospital's FY16 Outpatient CCR (which is based on the Hospital's FY16 Massachusetts Hospital cost report). The Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section III.B.2.a,** above), and the 2nd RY18 Period Fixed Outpatient Outlier Threshold of $2,750. If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor for the 2nd RY18 Period set at 80%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0. In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.
c. Calculation of the APEC. The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section III.B.2.a,** above) and the APEC Outlier Component (calculated as set forth in **Section III.B.2.b.**, above).	**c. Calculation of the APEC.** The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section III.B.2.a**, above) and the APEC Outlier Component (calculated as set forth in **Section III.B.2.b**., above).

See **Tables 1 and 1.1**, below, for an illustrative example of the calculation of a Hospital's APEC for Episode claim with multiple EAPGs. The example assumes the 2nd RY18 Period applies.

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

Table 1 -- Example of Hospital's APEC Calculation for a Single Episode -- 2nd RY18 Period			
(Values are for demonstration purposes only)			
Line	**Description**	**Value**	**Notes/ Source**
Calculation of Episode-Specific Total EAPG Payment			
1	Episode-Specific Total EAPG Payment	$1,521.06	Sum of Episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #1 through #5 from Table 1.1, below)
Calculation of APEC Outlier Component -- (only calculated if Line 1 > $0)			
2	Episode's Total Allowed Charges	$13,700.00	Sum of Episode's claim detail line MassHealth allowed charges (sum of Line 2 from claim detail lines #1 through #5, from Table 1.1, below)
3	Hospital's Outpatient Cost-to-Charge Ratio	36.40%	Hospital's FY16 Massachusetts Hospital Cost Report
4	Episode-Specific Case Cost	$4,986.80	Line 2 * Line 3
5	Fixed Outpatient Outlier Threshold	$2,750	Section II Definition (2nd RY18 Period)
6	Episode-Specific Outlier Threshold	$4,271.06	Line 1 + Line 5
7	Does Episode-Specific Cost exceed Episode-Specific Outlier Threshold? If Line 7 = True, then APEC Outlier Component is payable.	TRUE	Is Line 4 > Line 6
8	Marginal Cost Factor	80%	Determined annually
9	APEC Outlier Component	$572.59	(Line 4 - Line 6) * Line 8
APEC for the Episode			
10	APEC	$2,093.65	Line 1 + Line 9

Table 1.1 -- Claim Detail Line EAPG Payment Amounts (Example)			
(Values are for demonstration purposes only)			
Claim Detail Line #1 EAPG Payment Amount Calculation			
299	**EAPG 299 (CAT SCAN - BRAIN)**		
Line	**Description**	**Value**	**Notes/ Source**
1	APEC Outpatient Statewide Standard	$258.43	Section III.B.2.a.(1) (2nd RY18 Period)
2	Claim detail line allowed charges	$4,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	2.557377	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	2.557377	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$660.90	Line 1 * Line 4
Claim Detail Line #2 EAPG Payment Amount Calculation			
220	**EAPG 220 (LEVEL II NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP)**		
Line	**Description**	**Value**	**Notes/ Source**
1	APEC Outpatient Statewide Standard	$258.43	Section III.B.2.a.(1) (2nd RY18 Period)
2	Claim detail line allowed charges	$3,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	2.218947	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	2.218947	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$573.44	Line 1 * Line 4
Claim Detail Line #3 EAPG Payment Amount Calculation - DISCOUNTED			
220	**EAPG 220 (LEVEL II NERVOUS SYSTEM INJECTIONS, STIMULATIONS OR CRANIAL TAP)**		
Line	**Description**	**Value**	**Notes/ Source**
1	APEC Outpatient Statewide Standard	$258.43	Section III.B.2.a.(1) (2nd RY18 Period)
2	Claim detail line allowed charges	$3,000.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	2.218947	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	1.109473	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$286.72	Line 1 * Line 4
Claim Detail Line #4 EAPG Payment Amount Calculation - CONSOLIDATED			
298	**EAPG 298 (CAT SCAN BACK)**		
Line	**Description**	**Value**	**Notes/ Source**
1	APEC Outpatient Statewide Standard	$258.43	Section III.B.2.a.(1) (2nd RY18 Period)
2	Claim detail line allowed charges	$3,500.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	2.925734	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	0.000000	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	Line 1 * Line 4
Claim Detail Line #5 EAPG Payment Amount Calculation - PACKAGED			
400	**EAPG 400 (LEVEL I CHEMISTRY TESTS)**		
Line	**Description**	**Value**	**Notes/ Source**
1	APEC Outpatient Statewide Standard	$258.43	Section III.B.2.a.(1) (2nd RY18 Period)
2	Claim detail line allowed charges	$200.00	Determined from claim
3	Claim detail line MassHealth EAPG Weight	0.696963	Determined based on claim information
4	Claim detail line Adjusted EAPG Weight	0.000000	Determined by 3M EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	Line 1 * Line 4

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 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.

F. Payment for Unique Circumstances

1. High Public Payer Hospital Supplemental Payment

a. Eligibility

In order to qualify for this supplemental payment, a Hospital must have received greater than 63% of its Gross Patient Service Revenue (GPSR) in FY2016 from government payers and uncompensated care as determined by the Hospital's FY2016 Massachusetts Hospital Cost Report.

b. Supplemental Payment Methodology

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

The supplemental payment amount for each qualifying hospital will be determined by apportioning a total of $6.5 million to qualifying hospitals on a pro rata basis according to each qualifying hospital's number of MCO, Primary Care ACO and PCC Plan outpatient episodes in FY18, with each qualifying hospital's FY18 MCO and Primary Care ACO episode volume weighted at 60% and each qualifying hospital's FY18 PCC Plan episode volume weighted at 40%.

For purposes of this calculation, "MCO, Primary Care ACO and PCC Plan outpatient episodes in FY18" refer to paid outpatient episodes of care delivered by the qualifying hospital to MassHealth Members enrolled in an MCO, a Primary Care ACO or the PCC Plan, as determined by EOHHS utilizing, for the MCO episode volume, MCO encounter data submitted by each MCO for FY18 and residing in the MassHealth data warehouse as of March 31, 2019, and for the PCC Plan and Primary Care ACO episode volume, Medicaid paid claims data for FY18 residing in MMIS as of March 31, 2019, for which MassHealth is primary payer. "MCO" for purposes of this **Section III.F.1** refers to all MCOs as defined in **Section II**, except for Senior Care Organizations and One Care plans. Only MCO encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section III.F.1.a**) is considered in determining the pro rata share.

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 2018 (FFY18) outpatient payment amount will be $1,200 times the total number of Episodes with dates of service during FFY18, not to exceed $15.97 million. Notwithstanding such maximum amount, EOHHS may make outpatient payments to the UMass Hospitals of up to an additional 10% of such amount, subject to compliance with all applicable federal rules and payment limits, and satisfying all other conditions of this **Section III.F.2** as it applies to the UMass Hospitals, so long as the total FFY18 inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to the UMass Hospitals under this paragraph and under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-017-015) do not exceed $68.0 million in the aggregate.

For CHA, the Federal Fiscal Year outpatient payment amount will be the difference between the non-state-owned public hospital Upper Payment Limit (calculated on an annual basis) and other payments made under this Attachment, not to exceed $14.06 million. Notwithstanding such maximum amount, EOHHS may make outpatient payments to CHA of up to an additional 10% of such amount, subject to compliance with all applicable federal rules and payment limits, and satisfying all other conditions of this **Section III.F.2** as it applies to CHA, so long as the total inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to

CHA for the Federal Fiscal Year under this paragraph and under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-017-015) do not exceed $20.0 million in the aggregate.

The 10% provisions referenced above in this section may be invoked if, upon reconciliation, an applicable inpatient hospital limit would be exceeded if the UMass Hospitals or CHA (as applicable) were paid their maximum FFY18 inpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.J.2.b** of Attachment 4.19-A(1) (TN-017-015), or if the UMass Hospitals or CHA (as applicable) have insufficient inpatient utilization or otherwise to support such maximum inpatient payment amount.

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 Massachusetts hospital 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, cost 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.

B. Future Rate Years

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

C. New Hospitals/Hospital Change of Ownership

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

D. Data Sources

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

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.

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

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

1. APEC:
    a. MassHealth will not pay the APEC 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 APEC, as adjusted to exclude PPC-related costs/services, if the Hospital reports that non-PPC related services were also delivered during the same 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.

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 adjusted in the case of an APEC payment to exclude PPC-related costs/services, and 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.

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. .

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services
Exhibit 1: RY18 Payment Method for Critical Access Hospitals
Effective October 1, 2017 through September 30, 2018

EXHIBIT 1
RY18 Payment Method Applicable to Critical Access Hospitals
Effective October 1, 2017 through September 30, 2018

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY18 (October 1, 2017 through September 30, 2018).

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 in RY18, 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 October 1, 2017 through September 30, 2018, 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 APEC), 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

Critical Access Hospitals will be paid for Outpatient Services in accordance with **Attachment 4.19-B(1)** with the following changes.

For dates of service in RY18, Critical Access Hospitals will be paid a Hospital-specific, Episode-specific Adjudicated Payment per Episode of Care (APEC) for those Outpatient Services for which all other in-state Hospitals are paid an APEC.

Notwithstanding **Section III.B** of this **Attachment 4.19-B(1)**, for dates of service in the 1st RY18 Period, the hospital-specific, episode-specific APEC for each Critical Access Hospital was calculated as follows:

State Plan under Title XIX of the Social Security Act
State: Massachusetts
Methods Used to Determine Rates of Payment for Acute Outpatient Hospital Services
Exhibit 1: RY18 Payment Method for Critical Access Hospitals
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(1) EOHHS calculated a cost per Episode for outpatient services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 21 of the Hospital's FY15 CMS-2552-10 cost report, by the Hospital's number of FY15 Medicaid (MassHealth) Episodes. Episode volume was derived from FY15 paid claims data residing in MMIS for which MassHealth was primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY15 and RY17, as defined in **Section II** of **Attachment 4.19-B(1)**, to derive the Critical Access Hospital's 1st RY18 Period inflation-adjusted cost per Episode.

(3) EOHHS then divided each Critical Access Hospital's 1st RY18 Period inflation-adjusted cost per Episode by each Hospital's FY15 outpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 1st RY18 Period CAH-specific Outpatient Standard Rate per Episode.

(5) The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the 1st RY18 Period CAH-specific Outpatient Standard Rate per Episode for the APEC Outpatient Statewide Standard and calculating a CAH APEC payment as otherwise described in **Section III.B.2** of this Attachment 4.19-B(1), utilizing the methodology applicable to the 1st RY18 Period.

Notwithstanding **Section III.B** of this **Attachment 4.19-B(1)**, for dates of service in the 2nd RY18 Period, the hospital-specific, episode-specific APEC for each Critical Access Hospital was calculated as follows:

(1) EOHHS calculated a cost per Episode for outpatient services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 21 of the Hospital's FY16 CMS-2552-10 cost report, by the Hospital's number of FY16 Medicaid (MassHealth) Episodes. Episode volume was derived from FY16 paid claims data residing in MMIS for which MassHealth was primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY16 and RY18, as defined in **Section II** of **Attachment 4.19-B(1)**, to derive the Critical Access Hospital's 2nd RY18 Period inflation-adjusted cost per Episode.

(3) EOHHS then divided each Critical Access Hospital's 2nd RY18 Period inflation-adjusted cost per Episode by each Hospital's FY16 outpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 2nd RY18 Period CAH-specific Outpatient Standard Rate per Episode.

(5) The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the 2nd RY18 Period CAH-specific Outpatient Standard Rate per Episode for the APEC Outpatient Statewide Standard and calculating a CAH APEC payment as otherwise described in **Section III.B.2** of this Attachment 4.19-B(1), utilizing the methodology applicable to the 2nd RY18 Period.

(B) Post RY18 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2018 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 FY18, 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 FY18 CMS-2552-10 cost reports, including completed Medicaid (Title XIX) data worksheets, and such other information that EOHHS determines is necessary, to perform this post RY18 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for RY18, but excluding, if applicable, any state plan supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in **Section III.F.1 o**f **Attachment 4.19-B(1)**.

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 RY18 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, 2019. Assuming this date, the settlement will be complete by September 30, 2020.