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State/Territory Name: MA

State Plan Amendment (SPA) #:18-0017

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

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

RE: Massachusetts 18-0017

Dear Secretary Sudders:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 18-0017. For rate year 2019, this amendment proposes comprehensive changes to the reimbursement for acute inpatient hospital services. Specifically, RY19 is divided into the 1st RY19 Period (October 1, 2018 to October 31, 2018) and the 2nd RY19 Period (November 1, 2018 to September 30, 2019) for purposes of updating the base year for the state's Adjudicated Payment Amount per Discharge (APAD) payment methodology. Other reimbursement changes made are related to: out-of-state APAD carve-out drugs; supplemental and pay-for-performance programs; and a thirty-day readmission policy.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447. We are pleased to inform you that Medicaid State plan amendment 18-0017 is approved effective October 1, 2018. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

[redacted]

Kristin Fan
Director

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: 18 — 0 1 7

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: 10/01/2018

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 440.10

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 12,953,000
b. FFY 2020 $ 12,953,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A(1) pages 1-69, Exhibit 1 pages 1-3

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-A(1) pages 1-65, Exhibit 1 pages 1-3

10. SUBJECT OF AMENDMENT

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

11. GOVERNOR'S REVIEW *(Check One)*

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

[redacted]

13. TYPED NAME
Marylou Sudders

14. TITLE
Secretary

15. DATE SUBMITTED
12/31/2018

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

18. DATE APPROVED MAR 08 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
OCT 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL

[redacted]

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

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 Inpatient Hospital Services

I. Introduction

A. Overview

This attachment describes methods used to determine rates of payment for acute inpatient hospital services for RY19.

1. Except as provided in subsection 2, and in subsection 6, below, the payment methodologies specified in this Attachment 4.19-A(1) apply to:

   - RY19 admissions at in-state Acute Hospitals beginning on or after October 1, 2018 through September 30, 2019, and

   - inpatient payments made to in-state Acute Hospitals on an administrative day, psychiatric or rehabilitation per diem basis for RY19 dates of service on or after October 1, 2018 through September 30, 2019.

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 inpatient admissions occurring in RY19 on or after October 1, 2018 through September 30, 2019.

3. The supplemental payments for FY19 specified in **Sections III.J.1 through III.J.7** apply to dates of service from October 1, 2018 through September 30, 2019.

4. The Pay-for-Performance payment methodology specified in **Section III.K** is effective in RY19 beginning October 1, 2018 through September 30, 2019.

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

6. This **Section I.A.6** describes the payment methods to out-of-state acute hospitals for inpatient hospital services. Components of the out-of-state payment methods that are based on the in-state methods will simultaneously adjust effective with the 2nd RY19 Period (as defined in **Section II**) to reflect updates implemented effective with the 2nd RY19 Period to the in-state method, as applicable.

   Except if **subsection 6(e)** applies, below, payment for out-of-state acute inpatient hospital services is as follows:

   (a) Payment Amount Per Discharge.
   (i) Out-of-State APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge ("Out-of-State APAD") for inpatient services; provided that the out-of-state APAD is not paid for inpatient services that are paid on a per diem basis under **subsections 6(b) or (c)** and that payment for certain APAD carve-out services (as described in **subsection 6(d)**, below) is governed by **subsection 6(d)**, and not this **subsection 6(a)**. The discharge-specific Out-of-State APAD is equal to the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute

hospitals, multiplied by the MassHealth DRG Weight assigned to the discharge using information on the claim.

(ii) Out-of-State Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, the out-of-state acute hospital is also paid an outlier payment for that discharge ("Out-of-State Outlier Payment"). The Out-of-State Outlier Payment is equal to the Marginal Cost Factor in effect for in-state acute hospitals multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The "calculated cost of the discharge" equals the out-of-state acute hospital's allowed charges for the discharge, multiplied by the applicable inpatient cost-to-charge ratio. For High MassHealth Volume Hospitals, the inpatient cost-to-charge ratio is hospital-specific. For all other out-of-state acute hospitals, the median in-state acute hospital inpatient cost-to-charge ratio in effect, based on MassHealth discharge volume, is used. An out-of-state acute hospital's charges for any APAD carve-out services (as described in **subsection 6(d),** below) will not be included in this calculation.
b. The "discharge-specific outlier threshold" equals the sum of the hospital's Out-of-State APAD corresponding to the discharge, and the Fixed Outlier Threshold in effect for in-state acute hospitals.

(b) Out-of-State Transfer Per Diem:

(i) Out-of-state acute hospitals are paid the out-of-state transfer per diem for inpatient services as calculated and capped as set forth in **subsection 6(b)(ii)** ("Out-of-State Transfer Per Diem") in the following circumstances.

a. If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid the Out-of-State Transfer Per Diem for the period during which the Member was an inpatient at the transferring hospital.
b. MassHealth will pay the Out-of-State Transfer Per Diem in such other additional circumstances as MassHealth determines in-state acute hospitals would be paid the in-state Transfer Per Diem, as applicable.

(ii) The out-of-state transfer per diem equals the sum of the hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment, that would have otherwise applied for the period during which the transfer per diem is payable, as calculated by EOHHS, divided by the mean in-state acute hospital all payer length of stay for the applicable APR-DRG that is assigned. Total out-of-state transfer per diem payments for a given hospital stay are capped at the sum of the hospital's Out-of-State APAD plus, if applicable, any Out-of-State Outlier Payment that would have otherwise applied for the transfer per diem period.

(c) Out-of-State Psychiatric Per Diem: If an out-of-state acute hospital admits a MassHealth patient primarily for Behavioral Health Services, the out-of-state acute hospital will be paid an all-inclusive psychiatric per diem equal to the psychiatric per diem most recently in effect for in-state acute hospitals ("Out-of-State Psychiatric Per Diem"), and no other payment methods apply.

(d) Payment for APAD Carve-Outs.

(i) Long-Acting Reversible Contraception (LARC) devices: Out-of-state acute hospitals will be paid for LARC Devices (as defined in **Section II)** in accordance with Section 8.d. of Attachment 4.19-B of the State Plan if the LARC procedure occurs immediately post-labor and delivery during the same inpatient hospital labor and delivery stay for clinically appropriate members. No other payment methods apply to such devices.

(ii) APAD Carve-Out Drugs: Out-of-state acute hospitals will be paid for APAD Carve-Out Drugs (as defined in **Section II**) in accordance with the payment method applicable to such drugs as in effect for in-state acute hospitals on the date of service.

(e) For medical services payable by MassHealth that are not available in-state, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid 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.

(f) For purposes of this **Section I.A.6**, a "High MassHealth Volume Hospital" is any out-of-state acute hospital provider that (i) as applicable to the 1st RY19 Period, had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available, and (ii) as applicable to the 2nd RY19 Period had at least 100 MassHealth discharges during the most recent federal fiscal year for which complete data is available.

(g) The payment methods in this **Section I.A.6** 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 Inpatient Hospital Services:

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

MassHealth contracts with a Behavioral Health (BH) Contractor to provide Behavioral Health Services to Members enrolled with the BH Contractor. Hospitals are not entitled to, and may not claim for, any 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.

3. Air Ambulance Services

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

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

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

II. Definitions

The definitions set forth in the "**1st RY19 Period**" column, below, apply during the **1st RY19 Period** (as defined below). The definitions set forth in the "**2nd RY19 Period**" column, below, apply during the **2nd RY19 Period** (as defined below), unless (i) that column specifies that there is no change to the definition, or (ii) for purposes of the APAD, Outlier Payment, and Transfer Per Diem payment methodologies set forth in **Sections III.B** through **III.D**, below, the admission occurred in the 1st RY19 Period, in which case the definitions in the **1st RY19 Period** column continue to apply.

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
1st RY19 Period	The "1st RY19 Period" is the portion of RY19 from October 1, 2018 through October 31, 2018.	No change to definition.
2nd RY19 Period	The "2nd RY19 Period" is the portion of RY19 from November 1, 2018 through the end of RY19.	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, where in 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 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.	No change to definition.

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

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Actual Acquisition Cost	For purposes of **Section III.I.2**, the Hospital's "actual acquisition cost" of the Drug is the Hospital's invoice price for the Drug, net of all on- or off- invoice reductions, discounts, rebates, charge backs and similar adjustments that the Hospital has or will receive from the drug manufacturer or other party for the Drug that was administered to the Member while the Member was admitted in the Hospital, including any efficacy-, outcome-, or performance-based guarantee (or similar arrangements), whether received pre- or post-payment.	No change to definition.
Acute Hospital	See Hospital.	No change to definition.
Adjudicated Payment Amount Per Discharge (APAD)	A Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge, which is the complete fee-for-service payment for such acute hospitalization, excluding the additional payment of any Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a Transfer Per Diem, Psychiatric Per Diem or Rehabilitation Per Diem basis under this Attachment. The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in **Section III.I**. Calculation of the APAD is discussed in **Section III.B** (utilizing the 1st RY19 Period methodology).	A Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge, which is the complete fee-for-service payment for such acute hospitalization, excluding the additional payment of any Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a Transfer Per Diem, Psychiatric Per Diem or Rehabilitation Per Diem basis under this Attachment. The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in **Section III.I**. Calculation of the APAD is discussed in **Section III.B** (utilizing the 2nd RY19 Period methodology).

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Administrative Day (AD)	A day of inpatient hospitalization on which a Member's care needs can be provided in a setting other than an Acute Hospital, and on which the Member is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available.	No change to definition.
All Patient Refined–Diagnostic Related Group (APR-DRG or **DRG)**	The All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned using the 3M APR-DRG Grouper, version 34, unless otherwise specified.	No change to definition.
APAD Base Year	The hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY16, using FY16Massachusetts Hospital cost reports as screened and updated as of June 30, 2017.	The hospital-specific base year for the Adjudicated Payment Amount per Discharge (APAD) is FY17, using FY17Massachusetts Hospital cost reports as screened and updated as of July 24, 2018 .
APAD Carve-Out Drugs	Drugs that are carved out of the APAD payment and separately paid pursuant to **Section III.I.2.** APAD Carve-Out Drugs are identified on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List.	No change to definition.
Average (or Mean) Length of Stay	The sum of non-psychiatric acute inpatient days for relevant discharges, divided by the number of discharges. Average Length of Stay is determined based on MassHealth discharges or all-payer discharges, as specified in this Attachment.	No change to definition.
Behavioral Health (BH) Contractor	The entity with which EOHHS contracts to provide, arrange for and coordinate Behavioral Health Services to enrolled Members on a capitated basis, and which meets the	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	definition of prepaid inpatient health plan at 42 C.F.R. § 438.2.	
Behavioral Health Services (or Behavioral Health)	Services provided to Members who are being treated for psychiatric disorders or substance use disorders.	No change to definition.
Casemix Index	A measure of intensity of services provided by a Hospital to a group of patients, using the APR-DRG methodology, as specified in this Attachment. A Hospital's Casemix Index is calculated by dividing a Hospital's APR-DRG cumulative MassHealth or all-payer weights (using Massachusetts weights) by the Hospital's MassHealth or all-payer discharges. The weight for each APR-DRG is based on Massachusetts data.	No change to definition.
Center for Health Information and Analysis (CHIA)	The Center for Health Information and Analysis established under M.G.L. c. 12C.	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 (CAH)	An acute hospital that, prior to October 1, 2017, was designated by CMS as a Critical Access Hospital, and that continues to maintain that status.	An acute hospital that, prior to October 1, 2018, was designated by CMS as a Critical Access Hospital, and that continues to maintain that status.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
DMH-Licensed Bed	A bed in a Hospital that is located in a unit licensed by the Massachusetts Department of Mental Health (DMH).	No change to definition.
Discharge-Specific Case Cost	The product of the Hospital's MassHealth allowed charges for a specific discharge and the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY16 Massachusetts Hospital cost report. For applicable discharges, a Hospital's charges corresponding to LARC Devices or APAD Carve-Out Drugs are excluded in calculating the Discharge-Specific Case Cost.	The product of the Hospital's MassHealth allowed charges for a specific discharge and the Hospital's inpatient cost to charge ratio as calculated by EOHHS using the Hospital's FY17 Massachusetts Hospital cost report. For applicable discharges, a Hospital's charges corresponding to LARC Devices or APAD Carve-Out Drugs are excluded in calculating the Discharge-Specific Case Cost.
Discharge-Specific Outlier Threshold	The sum of the Pre-Adjusted APAD for a specific discharge (utilizing the methodology applicable to the 1st RY19 Period), and the Fixed Outlier Threshold.	The sum of the APAD for a specific discharge (utilizing the methodology applicable to the 2nd RY19 Period), and the Fixed Outlier Threshold.
Drugs	Drugs and biologics (including, e.g., cell and gene therapies), or any other similar substance containing one or more active ingredients in a specified form and strength. Each dosage form and strength is a separate Drug.	No change to definition.
Excluded Units	Non-Acute Units as defined in this section; any unit which has a separate license from the Hospital; psychiatric and substance use disorder units; and non-distinct observation units.	No change to definition.
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	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	XXI of the Social Security Act and other applicable laws and waivers.	
Fiscal Year (FY)	The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the immediately following calendar year. This period coincides with the federal fiscal year (FFY). FY19 begins on October 1, 2018 and ends on September 30, 2019.	No change to definition.
Fixed Outlier Threshold	For the 1st RY19 Period, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $25,500.00.	For the 2nd RY19 Period, the Fixed Outlier Threshold for purposes of calculating any Outlier Payment is $27,200.00.
Freestanding Pediatric Acute Hospital	A Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.	No change to definition.
Gross Patient Service Revenue	The total dollar amount of a Hospital's charges for services rendered in a Fiscal Year.	No change to definition.
High Medicaid Volume Freestanding Pediatric Acute Hospital	A Freestanding Pediatric Acute Hospital with more than 1,000 Medicaid discharges in FY12 for which a SPAD was paid, as determined by paid claims in MMIS as of May 11, 2013, and for which MassHealth was the primary payer.	No change to definition.
High Medicaid Volume Safety Net Hospital	An Acute Hospital which had a ratio of Medicaid inpatient days to total inpatient days that was greater than 45% in FY14 based on the Hospital's FY14 403 cost report.	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
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.	No change to definition.
Hospital-Based Physician	Any physician, or physician group practice, excluding interns, residents, fellows, and house officers, who contracts with a Hospital to provide Inpatient Services to Members at a site for which the Hospital is otherwise eligible to receive payment under the RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.	No change to definition.

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

Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Hospital Discharge Data (HDD)	Hospital discharge filings for FY16 provided and verified by each hospital, submitted to CHIA, and screened and updated by CHIA. HDD is used for determining casemix as part of the APAD rate development for purposes of **Section III.B**, as applicable to the 1st RY19 Period.	Hospital discharge filings for FY17 provided and verified by each hospital, submitted to CHIA, and screened and updated by CHIA. HDD is used for determining casemix as part of the APAD rate development for purposes of **Section III.B**, as applicable to the 2nd RY19 Period.
Inflation Factors for Administrative Days	An inflation factor that is a blend of the Centers for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factor for Administrative Days is as follows: • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18.	An inflation factor that is a blend of the Centers for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. The Inflation Factor for Administrative Days is as follows: • 1.937% reflects the price changes between RY16 and RY17. • 2.26% reflects the price changes between RY17 and RY18. • 2.183% reflects the price changes between RY18 and RY19.
Inflation Factors for Capital Costs	The inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index. The Inflation Factors for Capital Costs between RY04 and RY18 are as follows: • 0.7% reflects the price changes between RY04 and RY05 • 0.7% reflects the price changes between RY05 and RY06	For price changes between RY04 and RY18, the inflation factors for capital costs are the factors used by CMS to update capital payments made by Medicare, and are based on the CMS Capital Input Price Index. For price changes between RY18 and RY19, the inflation factors for capital cost are the factors used by CMS to update capital payments made by Medicare and are based on the CMS Capital Input Price Index; plus a RY19 capital enhancement factor of 0.9%, The Inflation

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	• 0.8% reflects the price changes between RY06 and RY07 • 0.9% reflects the price changes between RY07 and RY08 • 0.7% reflects the price changes between RY08 and RY09 • 1.4% reflects the price changes between RY09 and RY10 • 1.5% reflects the price changes between RY10 and RY11 • 1.5% reflects the price changes between RY11 and RY12 • 1.2% reflects the price changes between RY12 and RY13 • 1.4% reflects the price changes between RY13 and RY14 • 1.5% reflects the price changes between RY14 and RY15 • 1.3% reflects the price changes between RY15 and RY16 • 0.9% reflects the price changes between RY16 and RY17. • 1.3% reflects the price changes between RY17 and RY18.	Factors for Capital Costs between RY04 and RY19 are as follows: • 0.7% reflects the price changes between RY04 and RY05 • 0.7% reflects the price changes between RY05 and RY06 • 0.8% reflects the price changes between RY06 and RY07 • 0.9% reflects the price changes between RY07 and RY08 • 0.7% reflects the price changes between RY08 and RY09 • 1.4% reflects the price changes between RY09 and RY10 • 1.5% reflects the price changes between RY10 and RY11 • 1.5% reflects the price changes between RY11 and RY12 • 1.2% reflects the price changes between RY12 and RY13 • 1.4% reflects the price changes between RY13 and RY14 • 1.5% reflects the price changes between RY14 and RY15 • 1.3% reflects the price changes between RY15 and RY16 • 0.9% reflects the price changes between RY16 and RY17. • 1.3% reflects the price changes between RY17 and RY18. • 2.1% reflects the price changes between RY18 and RY19.
Inflation Factors for Operating Costs	For price changes between RY04 and RY07, and between RY09 (starting with admissions beginning December 7, 2008) and RY18, the inflation factor for operating costs is a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component	For price changes between RY04 and RY07, and between RY09 (starting with admissions beginning December 7, 2008) and RY19, the inflation factor for operating costs is a blend of the CMS market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY09 (for admissions through December 6, 2008), the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY18 are as follows: • 1.186% reflects price changes between RY04 and RY05 • 1.846% reflects price changes between RY05 and RY06 • 1.637% reflects price changes between RY06 and RY07 • 3.300% reflects price changes between RY07 and RY08 • 3.000% reflects price changes between RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008 • 1.424% reflects price changes between RY08 and RY09 for admissions beginning from 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 • 1.665% reflects the price changes between RY11 and RY12 • 1.775% reflects the price changes between RY12 and RY13 • 1.405% reflects the price changes between RY13 and RY14 • 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.	of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY09 (for admissions through December 6, 2008), the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY19 are as follows: • 1.186% reflects price changes between RY04 and RY05 • 1.846% reflects price changes between RY05 and RY06 • 1.637% reflects price changes between RY06 and RY07 • 3.300% reflects price changes between RY07 and RY08 • 3.000% reflects price changes between RY08 and RY09 for admissions beginning from October 1, 2008 through December 6, 2008 • 1.424% reflects price changes between RY08 and RY09 for admissions beginning from 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 • 1.665% reflects the price changes between RY11 and RY12 • 1.775% reflects the price changes between RY12 and RY13 • 1.405% reflects the price changes between RY13 and RY14 • 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.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	* The Inflation Factor for Operating Costs reflecting price changes between RY09 and RY10 was calculated based on the RY09 rate in effect for admissions beginning from December 7, 2008 through September 30, 2009.	• 2.183% reflects the price changes between RY18 and RY19. * The Inflation Factor for Operating Costs reflecting price changes between RY09 and RY10 was calculated based on the RY09 rate in effect for admissions beginning from December 7, 2008 through September 30, 2009.
Inpatient Services (also Inpatient Hospital Services)	Medical services, including Behavioral Health Services, provided to a Member admitted to a Hospital.	No change to definition.
Long-Acting Reversible Contraception (LARC) device (LARC Device)	Long-acting reversible contraception (LARC) device refers to intrauterine devices and contraceptive implants. LARC Device does not refer to the procedure, itself.	No change to definition.
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, MCO also includes Accountable Care Partnership Plans (ACPPs).	No change to definition.
Marginal Cost Factor	As used in the calculation of an Outlier Payment, the percentage of payment made for the difference between the Discharge-Specific Case Cost and the Discharge-Specific Outlier Threshold (utilizing the 1st RY19 Period methodology). For the 1st RY19 Period, the Marginal Cost Factor is 80%.	As used in the calculation of an Outlier Payment, the percentage of payment made for the difference between the Discharge-Specific Case Cost and the Discharge-Specific Outlier Threshold (utilizing the 2nd RY19 Period methodology). For the 2nd RY19 Period, the Marginal Cost Factor is 50%.
Massachusetts-specific Wage Area Index	Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage.	Each wage area's Wage Index is the average hourly wage divided by the statewide average hourly wage.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	Massachusetts Hospitals' wages and hours were determined based on CMS's FY2018 April-28-17-Wage Index_PUFs(5) zip file, downloaded May 1, 2017. Wage areas were assigned according to the same CMS file unless re-designated in a written decision from CMS to the Hospital provided to EOHHS by May 12, 2017.	Massachusetts Hospitals' wages and hours were determined based on CMS's FY2019-April-27-2018-Wage-Index-PUF zip file, downloaded May 1, 2018 (the "CMS File"). Wage areas were assigned according to the same CMS File, except that BayState Franklin Medical Center was assigned to (and its wages and hours included in) the Springfield wage area, and PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined from their hospital's license. The area's Wage Index is the Massachusetts-specific Wage Area Index for each Hospital assigned to the area, except for any Hospital that was re-designated in a written decision from CMS to the Hospital provided to EOHHS by March 30, 2018. For any such redesignated Hospital, its Massachusetts-specific Wage Area Index was calculated based on the wages and hours, determined from the CMS File, of (i) the redesignated Hospital, (ii) all other Hospitals redesignated to that same area, and (iii) all Hospitals assigned to that area, combined.
MassHealth (also Medicaid)	The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions.	No change to definition.
MassHealth DRG Weight	The MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG	The MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	and severity of illness (SOI), applicable to the 1st RY19 Period.	and severity of illness (SOI), applicable to the 2nd RY19 Period.
Medicaid Management Information System (MMIS)	The state-operated system of data processes, certified by CMS that meets federal guidelines in Part 11 of the State Medicaid Manual.	No change to definition.
Member	A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.	No change to definition.
Non-Acute Unit	A chronic care, Rehabilitation, or skilled nursing facility unit within a Hospital.	No change to definition.
Outlier Payment	A hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section III.C,** utilizing the methodology applicable to the 1st RY19 Period.	A hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section III.C,** utilizing the methodology applicable to the 2nd RY19 Period.
Pediatric Specialty Unit	A designated pediatric unit, pediatric intensive care unit, or neonatal intensive care unit in an Acute Hospital other than a Freestanding Pediatric Acute Hospital, in which the ratio of licensed pediatric beds to total licensed Hospital beds as of July 1, 1994, exceeded 0.20.	No change to definition.
Pre-Adjusted APAD	The amount calculated by EOHHS utilizing the APAD payment methodology applicable to the 1st RY19 Period set forth in **Section III.B**, below, for a specific discharge, but excluding the final step of applying any adjustment for Potentially Preventable Readmissions pursuant to **Section**	Not Applicable.

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<table>
<tr><th>Defined Term</th><th>Definition Applicable During 1st RY19 Period</th><th>Definition Applicable During 2nd RY19 Period</th></tr>
<tr><td></td><td>IV, utilizing the 1st RY19 Period methodology.</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><tr><td>RY16</td><td>10/1/2015 – 9/30/2016</td></tr><tr><td>RY17</td><td>10/1/2016 – 9/30/2017</td></tr><tr><td>RY18</td><td>10/1/2017 – 9/30/2018</td></tr><tr><td>RY19</td><td>10/1/2018 - 9/30/2019</td></tr></table>*In future rate years, Hospitals will be paid in in accordance with this Attachment (until amended).</td><td>No change to definition.</td></tr>
</table>

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
Rehabilitation Services	Services provided in an Acute Hospital that are medically necessary to be provided at a hospital level of care, to a Member with medical need for an intensive rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his/her ability to function with a reasonable expectation of significant improvement that will be of practical value to the Member measured against his/her condition at the start of the rehabilitation program.	No change to definition.
Rehabilitation Unit	A distinct unit of rehabilitation beds licensed by the Department of Public Health (DPH) as rehabilitation beds, in a licensed Acute Hospital that provides comprehensive Rehabilitation Services to Members with appropriate medical needs.	No change to definition.
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.
State Fiscal Year (SFY)	The time period of 12 months beginning on July 1 of any calendar year and ending on June 30 of the immediately following calendar year. SFY19 begins on July 1, 2018, and ends on June 30, 2019.	No change to definition.
Standard Payment Amount Per Discharge (SPAD)	A payment methodology that was utilized in prior Rate Years. The SPAD was a Hospital-specific all-inclusive payment for the first twenty cumulative acute days of an	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	inpatient hospitalization, which was the complete fee-for-service payment for an acute episode of illness, excluding additional fee-for-service payment for services as described in prior acute inpatient hospital SPAs, including TN-013-020. Calculation of the SPAD was discussed in **Section III.B** of TN-013-020. This payment methodology was replaced by the APAD payment methodology in RY15.	
Total Case Payment	The sum, as determined by EOHHS, of the Pre-Adjusted APAD and, if applicable, any Outlier Payment, adjusted for Potentially Preventable Readmissions pursuant to **Section IV** (applying the 1st RY19 Period methodology(ies)).	The sum, as determined by EOHHS, of the APAD and, if applicable, any Outlier Payment (applying the 2nd RY19 Period methodology(ies)).
Total Transfer Payment Cap	The Total Case Payment amount calculated by EOHHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in **Section III.B and III.C**, respectively, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis under **Section III.D** (applying the 1st RY19 Period methodology(ies)).	The Total Case Payment amount calculated by EOHHS utilizing the APAD and, if applicable, Outlier Payment methodology(ies) set forth in **Section III.B and III.C**, respectively, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis under **Section III.D** (applying the 2nd RY19 Period methodology(ies)).
Transferring Hospital	an Acute Hospital that is being paid on a Transfer Per Diem basis, pursuant to **Section III.D**.	No change to definition.
Wholesale Acquisition Cost (WAC)	The wholesale acquisition cost (WAC) of the Drug as published by First Data Bank or other national	No change to definition.

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Defined Term	Definition Applicable During 1st RY19 Period	Definition Applicable During 2nd RY19 Period
	price compendium designated by EOHHS.	

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III. Payment for Inpatient Services

A. Overview

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

   For qualifying discharges, Hospitals may also be paid an Outlier Payment in addition to the APAD, under the conditions set forth in, and calculated as described in, **subsection C**, below.

   Payment separate from the APAD may also be made to Hospitals for LARC Devices and APAD Carve-Out Drugs, respectively, as described in **subsection I.1** and **I.2**, respectively.

2. **Subsections C through I** describe non-APAD fee-for-service payments, including, as applicable, Outlier Payments, and payment for Behavioral Health Services, transfer patients, Hospital-Based Physician services, Administrative Days, Rehabilitation Unit services in Acute Hospitals, LARC Devices and APAD Carve-Out Drugs. Payment for other unique circumstances is described in **subsection J**, and **Exhibit 1**. Pay-for-Performance payments are described in **subsection K.**

3. For Inpatient Services paid on a per diem basis, MassHealth pays the lesser of (i) the per diem rate, or (ii) 100% of the Hospital's actual charge submitted.

B. Calculation of the Adjudicated Payment Amount Per Discharge (APAD)

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the APAD payment methodology. The APAD methodology is set forth in **Section III.B** below. The **"1st RY19 Period"** column applies to admissions occurring in the 1st RY19 Period, and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The **"2nd RY19 Period"** column applies to admissions occurring in the 2nd RY19 Period, and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. The 1st RY19 Period APAD methodology is the same methodology that applied during the 2nd RY18 Period, effective March 1, 2018, under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
1. APAD Overview The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge (exclusive of any separate payment for LARC Devices or APAD Carve-Out Drugs, if applicable, as described in **Section III.I)**. The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific Wage Area Index; (2) the Statewide Capital Standard per Discharge; (3) the discharge-specific MassHealth DRG Weight; and (4) a Hospital-specific adjustment, where applicable, for Potentially Preventable Readmissions (PPR) pursuant to **Section IV**. Each of these components, and the calculation of the APAD, is described more fully below. The APAD Base Year is FY16.	**1. APAD Overview** The Adjudicated Payment Amount per Discharge (APAD) is a Hospital-specific, DRG-specific all-inclusive facility payment for an acute inpatient hospitalization from admission through discharge (exclusive of any separate payment for LARC Devices or APAD Carve-Out Drugs, if applicable, as described in **Section III.I)**. The components that make up the APAD include (1) the Statewide Operating Standard per Discharge, adjusted for the Hospital's Massachusetts-specific Wage Area Index; (2) the Statewide Capital Standard per Discharge; and (3) the discharge-specific MassHealth DRG Weight. Each of these components, and the calculation of the APAD, is described more fully below. The APAD Base Year is FY17.
2. Statewide Operating Standard per Discharge The Statewide Operating Standard per Discharge is determined by multiplying: • the weighted average of the APAD Base Year standardized cost per discharge, where any Hospital's standardized cost per discharge that exceeds the efficiency standard is limited by the efficiency standard; by • an outlier adjustment factor of 93.0% and by	**2. Statewide Operating Standard per Discharge** The Statewide Operating Standard per Discharge is determined by multiplying: • the weighted average of the APAD Base Year standardized cost per discharge, where any Hospital's standardized cost per discharge that exceeds the efficiency standard is limited by the efficiency standard; by • an outlier adjustment factor of 96.8%; and by

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<table>
<tr><th>1st RY19 Period
(for admissions occurring
in the 1st RY19 Period)</th><th>2nd RY19 Period
(for admissions occurring
in the 2nd RY19 Period)</th></tr>
<tr><td>• the Inflation Factors for Operating Costs to trend APAD Base Year costs forward to RY18.

These elements are described in greater detail below. The Statewide Operating Standard per Discharge is $10,998.11.</td><td>• the Inflation Factors for Operating Costs to trend APAD Base Year costs forward to the current Rate Year.

These elements are described in greater detail below. The Statewide Operating Standard per Discharge is $11,176.16.</td></tr>
<tr><td>a. APAD Base Year Standardized Cost per Discharge

The APAD Base Year standardized cost per discharge is based on the average all-payer cost per discharge for each Hospital, adjusted as described below.

The average cost per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. APAD Base Year costs and discharges are determined using the Hospital's APAD Base Year Massachusetts Hospital cost report as screened and updated as of June 30, 2017. Specific costs and discharges are included and excluded as follows:

Average Cost per Discharge: treatment of costs and discharges

<u>Included</u>
Total non-excluded costs of providing Inpatient Services

Routine outpatient costs associated with admissions from the Emergency Department

Routine and ancillary outpatient costs

<u>Excluded</u>
Costs and discharges from Excluded Units.

Professional services

Capital costs and direct medical education costs.</td><td>a. APAD Base Year Standardized Cost per Discharge

The APAD Base Ycar standardized cost per discharge is based on the average all-payer cost per discharge for each Hospital, adjusted as described below.

The average cost per discharge for each Hospital is derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges. APAD Base Year costs and discharges are determined using the Hospital's APAD Base Year Massachusetts Hospital cost report as screened and updated as of July 24, 2018. Specific costs and discharges are included and excluded as follows:

Average Cost per Discharge: treatment of costs and discharges

<u>Included</u>
Total non-excluded costs of providing Inpatient Services

Routine outpatient costs associated with admissions from the Emergency Department

Routine and ancillary outpatient costs

<u>Excluded</u>
Costs and discharges from Excluded Units.

Professional services

Capital costs and direct medical education costs.</td></tr>
</table>

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
resulting from admissions from Observation status Cost centers identified as the supervision component of physician compensation and other direct physician costs All other non-excluded medical and non-medical patient care-related staff expenses Malpractice costs and organ acquisition costs — Costs associated with postpartum LARC Devices The APAD Base Year average cost per discharge for each Hospital is then adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the APAD Base Year all-payer Casemix Index. This adjusted value is the APAD Base Year standardized cost per discharge.	resulting from admissions from Observation status Cost centers identified as the supervision component of physician compensation and other direct physician costs All other non-excluded medical and non-medical patient care-related staff expenses Malpractice costs and organ acquisition costs — Costs associated with postpartum LARC Devices The APAD Base Year average cost per discharge for each Hospital is then adjusted by the Hospital's Massachusetts-specific Wage Area Index and by the APAD Base Year all-payer Casemix Index. This adjusted value is the APAD Base Year standardized cost per discharge.
b. **Efficiency Standard** All Hospitals are ranked with respect to their APAD Base Year standardized costs per discharge, and the efficiency standard is set at the 67th percentile of the cumulative frequency of FY16 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $13,127.31.	b. **Efficiency Standard** All Hospitals are ranked with respect to their APAD Base Year standardized costs per discharge, and the efficiency standard is set at the 60th percentile of the cumulative frequency of FY17 discharges where MassHealth is the primary payer in MMIS. The efficiency standard is $12,397.19.

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
c. **Outlier Adjustment Factor and Inflation Factors for Operating Costs** The weighted average of the APAD Base Year standardized cost per discharge, as limited by the efficiency standard, is multiplied by the outlier adjustment factor referenced above, and by the Inflation Factors for Operating Costs reflecting price changes between RY16 and RY18, to result in the Statewide Operating Standard per Discharge.	c. **Outlier Adjustment Factor and Inflation Factors for Operating Costs** The weighted average of the APAD Base Year standardized cost per discharge, as limited by the efficiency standard, is multiplied by the outlier adjustment factor referenced above, and by the Inflation Factors for Operating Costs reflecting price changes between RY17 and RY19, to result in the Statewide Operating Standard per Discharge.
3. Statewide Capital Standard per Discharge The Statewide Capital Standard per Discharge is calculated based on the APAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the APAD Base Year and RY18. The calculation is summarized in the following chart:	**3. Statewide Capital Standard per Discharge** The Statewide Capital Standard per Discharge is calculated based on the APAD Base Year statewide capital cost per discharge, updated by the Inflation Factors for Capital Costs between the APAD Base Year and the current Rate Year. The calculation is summarized in the following chart:

Statewide Capital Standard per Discharge		
APAD Base Year statewide capital cost per discharge (**subsection a**),	a. the APAD Base Year all-payer capital cost per discharge b. adjusted by the APAD Base Year all payer casemix index c. capped at the capital efficiency standard d. multiplied by the FY16 Hospital-specific MassHealth discharges e. summed and divided by the total FY16 statewide	$758.22

Statewide Capital Standard per Discharge		
APAD Base Year statewide capital cost per discharge (**subsection a**),	a. the APAD Base Year all-payer capital cost per discharge b. adjusted by the APAD Base Year all payer casemix index c. capped at the capital efficiency standard d. multiplied by the FY17 Hospital-specific MassHealth discharges e. summed and divided by the total FY17 statewide	$716.03

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)			2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)		
	MassHealth discharges			MassHealth discharges	
trended to RY18 using the Inflation Factors for Capital Costs (**subsection b**),		$774.99	trended to the current rate year using the Inflation Factors for Capital Costs (**subsection b**),		$740.65

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a. **APAD Base Year statewide capital cost per discharge** The APAD Base Year statewide capital cost per discharge is the discharge-weighted average over all Hospitals of the all payer casemix-adjusted capital cost per discharge capped at the capital efficiency standard. For each Hospital, the total inpatient capital costs include the Buildings and Fixtures and Movable Equipment categories reported on the APAD Base Year Massachusetts Hospital cost report. Total capital costs for Buildings and Fixtures are allocated to inpatient services through the square-footage-based allocation formula, and total capital costs for Movable Equipment are allocated to inpatient services through the dollar-value-based allocation formula, of the APAD Base Year Massachusetts Hospital cost report. Capital costs for Excluded Units are omitted to derive net inpatient capital costs. Each Hospital's capital cost per discharge is calculated using APAD Base Year Massachusetts Hospital cost reports by dividing total net inpatient capital costs by the Hospital's total all-payer discharges, net of Excluded Unit discharges. Each Hospital's capital cost per discharge is then adjusted by the APAD Base Year all-payer Casemix Index. All Hospitals are then ranked with respect to their casemix-adjusted capital cost per discharge, and the capital efficiency standard is set at the 67th percentile of the cumulative frequency of FY16 discharges where MassHealth is the primary payer in MMIS. Each Hospital's capital cost per discharge that exceeds the capital efficiency standard is then limited by the capital efficiency standard.	a. **APAD Base Year statewide capital cost per discharge** The APAD Base Year statewide capital cost per discharge is the discharge-weighted average over all Hospitals of the all payer casemix-adjusted capital cost per discharge capped at the capital efficiency standard. For each Hospital, the total inpatient capital costs include the Buildings and Fixtures and Movable Equipment categories reported on the APAD Base Year Massachusetts Hospital cost report. Total capital costs for Buildings and Fixtures are allocated to inpatient services through the square-footage-based allocation formula, and total capital costs for Movable Equipment are allocated to inpatient services through the dollar-value-based allocation formula, of the APAD Base Year Massachusetts Hospital cost report. Capital costs for Excluded Units are omitted to derive net inpatient capital costs. Each Hospital's capital cost per discharge is calculated using APAD Base Year Massachusetts Hospital cost reports by dividing total net inpatient capital costs by the Hospital's total all-payer discharges, net of Excluded Unit discharges. Each Hospital's capital cost per discharge is then adjusted by the APAD Base Year all-payer Casemix Index. All Hospitals are then ranked with respect to their casemix-adjusted capital cost per discharge, and the capital efficiency standard is set at the 60th percentile of the cumulative frequency of FY17 discharges where MassHealth is the primary payer in MMIS. Each Hospital's capital cost per discharge that exceeds the capital efficiency standard is then limited by the capital efficiency standard.

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
The APAD Base Year statewide capital cost per discharge is the statewide average of these adjusted costs per discharge, weighted based on each Hospital's number of FY16 MassHealth discharges.	The APAD Base Year statewide capital cost per discharge is the statewide average of these adjusted costs per discharge, weighted based on each Hospital's number of FY17 MassHealth discharges.
b. **Inflation Factors for Capital Costs** The Inflation Factors for Capital Costs reflecting price changes between RY16 and RY18 are applied to trend the APAD Base Year statewide capital cost per discharge forward to RY18.	b. **Inflation Factors for Capital Costs** The Inflation Factors for Capital Costs reflecting price changes between RY17 and RY19 are applied to trend the APAD Base Year statewide capital cost per discharge forward to the current Rate Year.
4. MassHealth DRG Weights The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). The discharge-specific MassHealth DRG Weight is assigned to the discharge based on information contained in a properly submitted inpatient Hospital claim and determined using the 3M APR-DRG Grouper and Massachusetts weights applicable to the 1st RY19 Period.	**4. MassHealth DRG Weights** The MassHealth DRG Weight is the MassHealth relative weight determined by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). The discharge-specific MassHealth DRG Weight is assigned to the discharge based on information contained in a properly submitted inpatient Hospital claim and determined using the 3M APR-DRG Grouper and Massachusetts weights applicable to the 2nd RY19 Period.
5. Potentially Preventable Readmissions (PPR) Adjustment The hospital-specific adjustment for PPRs, if applicable, is calculated as set forth in **Section IV**, below, utilizing the PPR methodology applicable to the 1st RY19 Period.	**5. [Reserved]**
6. Calculation of the APAD Each APAD is determined by the following steps: (1) multiplying the labor portion of	**6. Calculation of the APAD** Each APAD is determined by the following steps: (1) multiplying the labor portion of

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1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
the Statewide Operating Standard per Discharge by the Hospital's Massachusetts-specific Wage Area Index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to result in the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "**APAD Base Payment**"), (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight, and (5) then adjusting that result, where applicable, for Potentially Preventable Readmissions under **Section IV**. For purposes of step (1) in this **subsection 6**, above, the Hospital's Massachusetts-specific Wage Area Index which is multiplied by the labor portion of the Statewide Operating Standard per Discharge, is determined as specified in the definition of "Massachusetts-specific Wage Area Index" in **Section II** as applicable to the 1st RY19 Period, except that for this purpose, Baystate Medical Center's wages and hours were also included in the Springfield area index. For discharges from Freestanding Pediatric Acute Hospitals for which the MassHealth DRG Weight assigned to the discharge is 3.5 or greater, the APAD Base Payment will be adjusted to include an additional 45% for purposes of step (4), above, in this **subsection 6**, in the calculation of the APAD.	the Statewide Operating Standard per Discharge by the Hospital's Massachusetts-specific Wage Area Index, (2) adding this amount to the non-labor portion of the Statewide Operating Standard per Discharge to result in the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding the Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge (which result is referred to as the "**APAD Base Payment**"), and (4) multiplying the APAD Base Payment by the discharge-specific MassHealth DRG Weight. For purposes of step (1) in this **subsection 6**, above, the Hospital's Massachusetts-specific Wage Area Index which is multiplied by the labor portion of the Statewide Operating Standard per Discharge, is determined as specified in the definition of "Massachusetts-specific Wage Area Index" in **Section II** as applicable to the 2nd RY19 Period. For qualifying discharges from Freestanding Pediatric Acute Hospitals and the Hospital with a Pediatric Specialty Unit for which the MassHealth DRG Weight assigned to the discharge is 3.5 or greater, the APAD Base Payment will be adjusted to include an additional 45% for purposes of step (4), above, in this **subsection 6**, in the calculation of the APAD. A qualifying discharge for this purpose is one that (i) meets this minimum MassHealth DRG Weight requirement, and (ii) in the case of the Hospital with a Pediatric Specialty Unit, is for a Member who is under the age of 21 at the time of admission.

The following is an illustrative example of the calculation of the Total Case Payment for a standard APAD claim that does not also qualify for an Outlier Payment under **Section III.C**, below. The example assumes the 2nd RY19 Period applies.

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

Table 1: Standard APAD claim - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	Sample Hospital		
DRG:	203, Chest Pain. Severity of Illness (SOI) = 2.		
Line	Description	Value	Calculation or Source
1	Statewide Operating Standard per Discharge	$11,176.16	Section III.B.2 (2nd RY19 Period)
2	Hospital's Masschusetts-specific wage area index	1.0728	Varies by hospital
3	Labor Factor	0.68257	Determined annually
4	Hospital's Wage Adjusted Operating Standard per Discharge	$11,731.52	(Line 1 * Line 2 * Line 3) + (Line 1 * (1.0-Line 3))
5	Statewide Capital Standard per Discharge	$740.65	Section III.B.3 (2nd RY19 Period)
6	APAD Base Payment	$12,472.17	Line 4 + Line 5
7	MassHealth DRG Weight	0.3598	Determined based on claim information
8	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$4,487.49**	Line 6 * Line 7

C. Outlier Payment

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the Outlier Payment methodology. The Outlier Payment methodology is set forth in this **Section III.C**; provided that, (i) the "1st RY19 Period" column applies to admissions occurring in the 1st RY19 Period, and incorporates applicable definitions from **Section II** that apply to the 1st RY19 Period; (ii) the "2nd RY19 Period" column applies to admissions occurring in the 2nd RY19 Period, and incorporates applicable definitions from **Section II** that apply to the 2nd RY19 Period; and (iii) all references in this **Section III.C** to the APAD method (or any component of the APAD) shall refer to the APAD (or APAD component) as calculated utilizing the methodology that applies to the specific admission (1st RY19 Period method for admissions in the 1st RY19 Period, or 2nd RY19 Period method for admissions in the 2nd RY19 Period). The 1st RY19 Period Outlier Payment methodology is the same methodology that applied during the 2nd RY18 Period, effective March 1, 2018, under approved SPA TN-017-015, as amended by approved SPA TN 018-001.

1st RY19 Period (for admissions occurring in the 1st RY19 Period)	**2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)**
A Hospital will be paid a discharge-specific Outlier Payment for a discharge in addition to the APAD (see **Section III.B.**, above) if all of the following conditions are met: 1. the Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge;	A Hospital will be paid a discharge-specific Outlier Payment for a discharge in addition to the APAD (see **Section III.B.**, above) if all of the following conditions are met: 1. the amount of the APAD for the discharge exceeds $0.

1st RY19 Period (for admissions occurring in the 1st RY19 Period)	2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)
2. the Hospital continues to fulfill its discharge planning duties as required in MassHealth's regulations; 3. the patient is not in a DMH-licensed bed on any part of the discharge; and 4. the patient is not a patient in an Excluded Unit within the Hospital. In cases where an Outlier Payment applies, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold. In such a case, the adjustment under **Section IV** for Potentially Preventable Readmissions (PPR), if applicable, is applied against the sum of the Pre-Adjusted APAD and the Outlier Payment.	2. the Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge; 3. the patient is not in a DMH-licensed bed on any part of the discharge; and 4. the patient is not a patient in an Excluded Unit within the Hospital. In cases where an Outlier Payment applies, the Outlier Payment will equal the product of the Marginal Cost Factor and the amount by which the Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold.

The following is an illustrative example of the calculation of the Total Case Payment for a claim that also involves an Outlier Payment. The example assumes the 2nd RY19 Period applies.

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

Table 2: Claim with Outlier Payment - 2nd RY19 Period
(Values are for demonstration purposes only)
Hospital: Sample Hospital
DRG: 203, Chest Pain. Severity of Illness (SOI) = 2.

Line	Description	Value	Calculation or Source
1	APAD (must be > $0)	$4,487.49	Table 1, Line 8, above
2	Allowed charges	$50,000.00	Determined from claim
3	Hospital's Inpatient Cost-to-Charge Ratio	72.00%	FY17 Massachusetts Hospital Cost Report
4	Discharge-Specific Case Cost	$36,000.00	Line 2 * Line 3
5	Fixed Outlier Threshold	$27,200	Section II Definition (2nd RY19 Period)
6	Discharge-Specific Outlier Threshold	$31,687.49	Line 1 + Line 5
7	Does Discharge-Specific Case Cost exceed Discharge-Specific Outlier Threshold?	TRUE	Is Line 4 > Line 6? If TRUE, then Outlier Payment is due
8	Marginal Cost Factor	50%	Determined annually
9	Outlier Payment	$2,156.26	(Line 4 - Line 6) * Line 8
10	**Total Case Payment = APAD plus Outlier Payment**	**$6,643.74**	Line 1 + Line 9

D. Transfer Per Diem Payments

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the Transfer Per Diem payment methodology. The Transfer Per Diem payment methodology is set forth in this **Section III.D**; provided that, (i) for admissions in the 1st RY19 Period, applicable definitions from **Section II** that apply to the 1st RY19 Period are incorporated; (ii) for admissions in the 2nd RY19 Period, applicable definitions from **Section II** that apply to the 2nd RY19 Period are incorporated; (iii) all references in this **Section III.D** to the APAD and Outlier Payment methodologies in **Sections III.B** and **III.C** shall refer to the methodology that applies to the specific admission (1st RY19 Period method for admissions in the 1st RY19 Period or 2nd RY19 Period method for admissions in the 2nd RY19 Period); and (iv) any other differences in the Transfer Per Diem methodology as between the 1st RY19 Period and the 2nd RY19 Period are as specified below. The 1st RY19 Period Transfer Per Diem payment methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

Hospitals will be paid a Transfer Per Diem under the circumstances specified in this section. In general, total payments made on a Transfer Per Diem basis are capped at the Hospital's Total Transfer Payment Cap.

The Transfer Per Diem rate is case-specific and is calculated as set forth in **Section III.D.1**, below.

1. Transfer between Hospitals

In general, a Hospital that transfers a patient to another Acute Hospital will be paid at the Transfer Per Diem rate, up to the Transferring Hospital's Total Transfer Payment Cap.

In general, the Hospital that is receiving the patient will be paid (a) on a per discharge basis in accordance with the APAD, and, if applicable, Outlier Payment methodology(ies) specified in **Sections III.B and III.C, above**, if the patient is actually discharged from that Hospital; or (b) on a Transfer Per Diem basis, capped at the Hospital's Total Transfer Payment Cap, if the Hospital transfers the patient to another Acute Hospital or back to the Acute Hospital from which it received the patient.

The Transfer Per diem rate will equal the following. For admissions in the 1st RY19 Period, the "1st RY19 Period" column applies. For admissions in the 2nd RY19 Period, the "2nd RY19 Period" column applies.

1st RY19 Period (for admissions occurring in the 1st RY19 Period)	**2nd RY19 Period (for admissions occurring in the 2nd RY19 Period)**
The Transfer Per Diem rate equals the Transferring Hospital's Total Case Payment amount, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG Massachusetts-specific weight file applicable to the 1st RY19 Period. For purposes of this calculation, the Total Case Payment amount is calculated utilizing the APAD, and if applicable, Outlier Payment methodology(ies) set forth in **Section III.B.** and **III.C.**, above, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis pursuant to this **Section III.D**. Payment on a Transfer Per Diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap.	The Transfer Per Diem rate equals the Transferring Hospital's Total Case Payment amount, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG Massachusetts-specific weight file applicable to the 2nd RY19 Period. For purposes of this calculation, the Total Case Payment amount is calculated utilizing the APAD, and if applicable, Outlier Payment methodology(ies) set forth in **Section III.B.** and **III.C.**, above, for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis pursuant to this **Section III.D**. Payment on a Transfer Per Diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap.

See **Table 3: Claim with Transfer (APAD only)** and **Table 4: Claim with Transfer (APAD and Outlier)**, respectively, below, for illustrative examples of the calculation of the Transfer Per Diem, Total Transfer Payment Cap, and corresponding Total Transfer Case Payment, that would apply to the case. These illustrative examples apply to all subsections of **Section III.D**, and assume that the 2nd RY19 Period applies.

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Table 3: Claim with Transfer (APAD only) - 2nd RY19 Period
(Values are for demonstration purposes only)
Hospital: **Sample Hospital**
DRG: **203, Chest Pain. Severity of Illness (SOI) = 2.**

Line	Description	Value	Calculation or Source
1	APAD (Total Case Payment Amount)	$4,487.49	Table 1, line 8, above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.08	Determined from Massach. weight file (2nd RY19 Period)
4	Transfer per diem	$2,161.35	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	$4,322.69	Line 4 * Line 2
6	Total Transfer Payment Cap	$4,487.49	Table 3, Line 1
7	**Total Transfer Case Payment**	**$4,322.69**	**Lower of Line 5 or Line 6**

Table 4: Claim with Transfer (APAD and Outlier) - 2nd RY19 Period
(Values are for demonstration purposes only)
Hospital: **Sample Hospital**
DRG: **203, Chest Pain. Severity of Illness (SOI) = 2.**

Line	Description	Value	Calculation or Source
1	Total Case Payment amount (Claim with Outlier Payment)	$6,643.74	Table 2, Line 10 above
2	Patient length of stay (# of days)	2	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.08	Determined from Massach. weight file (2nd RY19 Period)
4	Transfer per diem	$3,199.88	Line 1 / Line 3
5	Transfer per diem x Patient length of stay (# of days)	$6,399.76	Line 4 * Line 2
6	Total Transfer Payment Cap	$6,643.74	Table 4, Line 1
7	**Total Transfer Case Payment**	**$6,399.76**	**Lower of Line 5 or Line 6**

2. Transfers within a Hospital

In general, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be paid on a Transfer Per Diem basis, capped at the Hospital's Total Transfer Payment Cap. This section outlines payment under some specific transfer circumstances.

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

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

b. **MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment from the PCC Plan, Primary Care ACO, or Fee-for-Service to an MCO (or vice versa) during a Hospital Stay, or in the Event of Exhaustion of (or eligibility for) Other Insurance**

When a patient becomes MassHealth-eligible (or loses MassHealth eligibility), after the date of admission and prior to the date of discharge, changes enrollment from the PCC Plan, a Primary Care ACO, or Fee-for-Service to an MCO (or vice versa) during the course of a Hospital stay, or exhausts other insurance benefits (or becomes eligible for other insurance benefits) after the date of admission and prior to the date of discharge, the MassHealth-covered portion of the acute stay will be paid at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap, or if the patient is at the Administrative Day level of care, at the applicable AD per diem rate, in accordance with **Section III.G.**

c. **Admissions Following Outpatient Surgery or Procedure**

If a patient who requires Inpatient Hospital Services is admitted following an outpatient surgery or procedure at the Hospital, the Hospital shall be paid at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap.

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

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

When a Member who is not enrolled with the BH Contractor transfers between a DMH-licensed Bed and a non-DMH-licensed Bed in the same Hospital during a single admission, EOHHS will pay the Hospital at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap for the non-DMH-licensed bed portion of the stay, and on a Psychiatric Per Diem basis (see **Section III.E**, below) for the DMH-licensed bed portion of the stay.

If the Member is enrolled with the BH Contractor, EOHHS will pay for the non-DMH-licensed bed portion of the stay only if it is for medical (i.e., non-Behaviorial Health) treatment. In that case, such payment will be at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap.

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

When a Member is enrolled with the BH Contractor during a Behavioral Health admission, the portion of the Hospital stay during which the Member is enrolled with the BH Contractor is payable by the BH Contractor. The portion of the Hospital stay

during which the Member was not enrolled with the BH Contractor will be paid by EOHHS on a Psychiatric Per Diem basis (see **Section III.E,** below) for Behavioral HealthServices in a DMH-licensed Bed, or at the Transfer Per Diem rate, capped at the Hospital's Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-licensed Bed.

E. Payments for Behavioral Health Services (Psychiatric Per Diem)

1. Overview

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

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

c. Payment for Behavioral Health Services provided in beds that are not DMH-licensed Beds shall be made on a Transfer Per Diem basis, as described in **Section III.D**, above. See **Sections III.D.2.d and e** for payment rules involving transfers to and from DMH-licensed Beds and BH managed care status.

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

e. RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying this Psychiatric Per Diem payment methodology. Differences in the methodology and the final per diem rate that applies to dates of services in the 1st RY19 Period and the 2nd RY19 Period, respectively, are identified in **Section III.E.4**, below. The methodology is otherwise the same for both periods. The 1st RY19 Period methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

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

a. Standard for Inpatient Psychiatric Overhead Costs

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

b. **Standard for Inpatient Psychiatric Direct Routine Costs**

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

c. **Standard for Inpatient Psychiatric Direct Ancillary Costs**

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

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

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

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

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

4. Adjustment to Base Year Standards

In calculating the final statewide standard Psychiatric Per Diem rate applicable to dates of service in the 1st RY19 Period, the additional steps set forth in the "1st RY19 Period" column, below, are applied. In calculating the final statewide standard Psychiatric Per Diem rate applicable to dates of service in the 2nd RY19 Period, the additional steps set forth in the "2nd RY19 Period" column, below, are applied.

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)
The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see **Section II above).** The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see **Section II** above). The Inflation Factors for Operating Costs (see **Section II above**) between RY08 and RY10 and between RY12 and RY18 were then applied to the rate calculated above to determine the statewide standard Psychiatric Per Diem rate applicable to dates of service in the 1st RY19 Period. The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs for the 1st RY19 Period Psychiatric Per Diem is $145.02. The statewide standard Psychiatric Per Diem rate applicable to dates of service in the 1st RY19 Period is $920.99.	The three Psychiatric Per Diem Base Year Operating Standards are updated between the Base Year and RY2007 using the Inflation Factors for Operating Costs (see **Section II above).** The Psychiatric Per Diem Base Year Capital Standard is updated between the Base Year and RY2007 using the Inflation Factors for Capital Costs (see **Section II** above). The Inflation Factors for Operating Costs (see **Section II above**) between RY08 and RY10 and between RY12 and RY19 were then applied to the rate calculated above to determine the statewide standard Psychiatric Per Diem rate applicable to dates of service in the 2nd RY19 Period. The total adjustment to Base Year Costs from the Psychiatric Per Diem Base Year costs for the 2nd RY19 Period Psychiatric Per Diem is $165.13. The statewide standard Psychiatric Per Diem rate applicable to dates of service in the 2nd RY19 Period is $941.10.

F. Physician Payment

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

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

3. Physician services provided by residents and interns are not reimbursable separately. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in **Section II**.

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

G. Payments for Administrative Days

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the payment methodology for Administrative Days. The methodology in the "1st RY19 Period" column of this **Section III.G**, below, applies to dates of service in the 1st RY19 Period and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The methodology in the "2nd RY19 Period" column applies to dates of service in the 2nd RY19 Period and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. The 1st RY19 Period methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	**2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)**
1. Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.	1. Payments for Administrative Days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all Administrative Days in all Acute Hospitals.
2. The AD rate is a base per diem payment and an ancillary add-on.	2. The AD rate is a base per diem payment and an ancillary add-on.
3. The base per diem payment is $201.63, which represents the median nursing facility rate that was effective October 1, 2015 for all nursing home rate categories, as determined by EOHHS.	3. The base per diem payment is $201.63, which represents the median nursing facility rate that was effective October 1, 2015 for all nursing home rate categories, as determined by EOHHS.
4. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.	4. The ancillary add-on is based on the ratio of ancillary charges to routine charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using MassHealth paid claims for the period October 1, 1997 to September 30, 1998.
5. These ratios are 0.278 and 0.382, respectively. The resulting AD rates were then updated by the Inflation Factor for Administrative Days between RY16 and RY18. The resulting AD rates for the 1st RY19 Period	5. These ratios are 0.278 and 0.382, respectively. The resulting AD rates were then updated by the Inflation Factor for Administrative Days between RY16 and RY19. The resulting AD rates for the 2nd RY19 Period

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)
are $268.61 for Medicaid/Medicare Part B eligible patients and $290.47 for Medicaid-only eligible patients. 6. The Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status.	are $274.47 for Medicaid/Medicare Part B eligible patients and $296.81 for Medicaid-only eligible patients. 6. The Hospital may not bill for more than one APAD even if the patient fluctuates between acute status and AD status.

H. Rehabilitation Unit Services in Acute Hospitals

RY19 is bifurcated into the 1st RY19 Period and the 2nd RY19 Period for purposes of applying the Rehabilitation Unit per diem payment. The methodology in the "1st RY19 Period" column of this **Section III.H**, below, applies to dates of service in the 1st RY19 Period and incorporates applicable definitions in **Section II** that apply to the 1st RY19 Period. The methodology in the "2nd RY19 Period" column applies to dates of service in the 2nd RY19 Period and incorporates applicable definitions in **Section II** that apply to the 2nd RY19 Period. The 1st RY19 Period methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

1st RY19 Period (for dates of service occurring in the 1st RY19 Period)	2nd RY19 Period (for dates of service occurring in the 2nd RY19 Period)
A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Rehabilitation Unit. For dates of service in the 1st RY19 Period, the per diem rate for such Rehabilitation Services will equal the median MassHealth RY18 Rehabilitation Hospital group per diem rate for Chronic Disease and Rehabilitation hospitals. Acute Hospital Administrative Day rates (see **Section III.G above**) will be paid for all days that a patient remains in the Rehabilitation Unit while not at hospital level of care.	A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Rehabilitation Unit. For dates of service in the 2nd RY19 Period, the per diem rate for such Rehabilitation Services will equal the median MassHealth RY19 Rehabilitation Hospital group per diem rate for Chronic Disease and Rehabilitation hospitals. Acute Hospital Administrative Day rates (see **Section III.G above**) will be paid for all days that a patient remains in the Rehabilitation Unit while not at hospital level of care.

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

I. APAD Carve-Outs

1. Payment for LARC Device

A Hospital may be paid separate from the APAD for a LARC Device if the LARC procedure is performed immediately after labor and delivery during same inpatient hospital labor and delivery stay for clinically appropriate members. For qualifying discharge, Hospitals will be reimbursed for LARC Devices in accordance with Section 8.d. of Attachment 4.19-B of the State Plan.

2. Payment for APAD Carve-Out Drugs

Payment to Hospitals for APAD Carve-Out Drugs administered to Members during an inpatient admission will be the lowest of (1) the Hospital's Actual Acquisition Cost of the Drug; (2) the Wholesale Acquisition Cost (WAC) of the Drug; and (3) if available, the Medicare Part B rate for the Drug, each as determined by EOHHS.

J. 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 FY17 from government payers and uncompensated care as determined by the Hospital's FY17 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 inpatient discharges in FY19, with each qualifying hospital's FY19 MCO and Primary Care ACO discharge volume weighted at 60% and each qualifying hospital's FY19 PCC Plan discharge volume weighted at 40%.

For purposes of this calculation, "MCO, Primary Care ACO, and PCC Plan inpatient discharges in FY19" refer to paid inpatient discharges from the qualifying hospital for MassHealth Members enrolled in an MCO, a Primary Care ACO, or the PCC Plan, as determined by EOHHS utilizing, for the MCO discharge volume, MCO encounter data submitted by each MCO for FY19 and residing in the MassHealth data warehouse as of March 31, 2020, and for the PCC Plan and Primary Care ACO discharge volume, Medicaid paid claims data for FY19 residing in MMIS as of March 31, 2020, for which MassHealth is primary payer. "MCO" for purposes of this **Section III.J.1** refers to all MCOs as defined in **Section II**, except 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.J.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, including 42 CFR 447.271, 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 2019 (FFY19) inpatient payment amount will be $6,000 times the total number of inpatient days for admissions beginning during FFY19, not to exceed $18.88 million. Notwithstanding such maximum inpatient amount, EOHHS may make inpatient payments to the UMass Hospitals of up to an additional 10% of the UMass Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, and satisfying all other conditions of this **Section III.J.2.b** as it applies to the UMass Hospitals, so long as the total FFY19 inpatient and outpatient Essential MassHealth Hospital supplemental payment amounts to the UMass Hospitals under this paragraph and under **Section III.F.2** of Attachment 4.19-B(1) (TN-018-018) do not, in the aggregate, exceed the UMass Total Maximum Essential Amount. The UMass Total Maximum Essential Amount is $26.696 million.

For CHA, the Federal Fiscal Year inpatient 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 $7.5 million. Notwithstanding such maximum inpatient amount, EOHHS may make inpatient payments to CHA of up to an additional 10% of the CHA Total Maximum Essential Amount (as defined in this paragraph, below), subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, and satisfying all other conditions of this **Section III.J.2.b** 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.F.2** of Attachment 4.19-B(1) (TN-018-018) do not, in the aggregate, exceed the CHA Total Maximum Essential Amount. The CHA Total Maximum Essential Amount is $20.0 million.

The 10% provisions referenced above in this section may be invoked if, upon reconciliation, an applicable outpatient hospital limit would be exceeded if the UMass Hospitals or CHA (as applicable) were paid their maximum FFY19 outpatient Essential MassHealth Hospital Supplemental Payment amount under **Section III.F.2** of Attachment 4.19-B(1) (TN-018-018), or if the UMass Hospitals or CHA (as applicable) have insufficient outpatient utilization or otherwise to support the payment of such maximum outpatient 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. High Medicaid Volume Freestanding Pediatric Acute Hospitals

a. **Eligibility**

Based on the definition of High Medicaid Volume Freestanding Pediatric Acute Hospital as defined in **Section II**, Boston Children's Hospital is the only Hospital eligible for this payment.

b. **Supplemental Payment Methodology**

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

The supplemental payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the hospital Federal Fiscal Year. The Federal Fiscal Year payment is based on Medicaid payment and cost data. The payment equals the variance between the Hospital's inpatient Medicaid payments and inpatient Medicaid costs, not to exceed $3,850,000. High Medicaid Volume Freestanding Pediatric Acute Hospital payments will be made after finalization of payment data, applicable payment amounts, and obtaining any necessary approvals.

4. Acute Hospitals with High Medicaid Discharges

a. **Eligibility**

In order to qualify for payment as an Acute Hospital with High Medicaid Discharges, a Hospital must be an Acute Hospital that has more than 2.7% of the statewide share of Medicaid discharges, determined by dividing each Hospital's total Medicaid discharges as reported on the Hospital's 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 inpatient Medicaid payment and inpatient Medicaid costs, not to exceed the Hospital's Health Safety Net Trust Fund-funded payment amount for the federal fiscal year. Interim payments to Acute Hospitals with High Medicaid Discharges will be reconciled within 12 months after final settlement of the applicable Health Safety Net year.

5. [Reserved]

6. [Reserved]

7. High Medicaid Volume Safety Net Hospital Supplemental Payment

a. **Eligibility**

In order to qualify for this payment, a Hospital must be a High Medicaid Volume Safety Net Hospital as defined in **Section II**, and must enter into a separate payment agreement with EOHHS relating to payment as a High Medicaid Volume Safety Net Hospital. Based on these criteria, Boston Medical Center is the only hospital eligible for this payment.

b. **Payment Methodology**

Subject to compliance with all applicable federal rules and payment limits, including 42 CFR 447.271, EOHHS will make a supplemental payment to High Medicaid Volume Safety Net Hospitals to account for high Medicaid volume. The payment amount will be based on Medicaid payment and charge data for the federal fiscal year. The payment will be an amount up to the variance between the Hospital's FY19 MMIS-based inpatient hospital charges and its other inpatient hospital payments made under this Attachment for the applicable federal fiscal year, not to exceed $13.45 million.

8. Infant and Pediatric Outlier Payment Adjustments

a. **Infant Outlier Payment Adjustment**

In accordance with 42 U.S.C. § 1396a(s), EOHHS will make an annual infant outlier payment adjustment to Acute Hospitals for inpatient services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths of stay

based on the prior year's claims data from the Medicaid Management Information System (MMIS).

i. Eligibility

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

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

ii. Payment to Hospitals

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

b. **Pediatric Outlier Payment Adjustment**

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

i. Eligibility

In order to qualify for a pediatric outlier payment, a Hospital must provide services to children greater than one year of age and less than six years of age, and must have one of the following during the Rate Year for individuals within this age range:

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

ii. Payment to Hospitals

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

K. Pay-for-Performance (P4P) Payment

Pay-for-Performance (P4P) is MassHealth's method for quality scoring and converting quality scores to P4P payments contingent upon Hospital adherence to quality standards and achievement of performance thresholds and benchmarks. P4P incentive payments will be based on pay-for-performance (see **Section III.K.3**, below).

A Hospital will qualify to earn P4P payments if it meets data accuracy and completeness requirements, including data validation requirements where applicable, and achieves performance thresholds for the P4P measures listed below. Each measure is evaluated using the methods outlined below to produce measure rates or values which result in performance scores that are converted into incentive payments. A Hospital's performance scores are calculated as described in **Section III.K.3.c**, below.

The P4P program applies to inpatient services for MassHealth Members where Medicaid is the primary payer. In general, payment calculations are based on a combination of performance scores, which utilize all-Medicaid payer data for certain measures and all payer data for other measures, and the number of eligible discharges, which includes only individuals enrolled in the Primary Care Clinician (PCC) Plan or a Primary Care ACO, and members with fee-for-service coverage.

1. Performance Measures

Quality performance goals and measures focus on areas where improvement is likely to have most impact on the health outcomes for this Member population. The specific hospital quality performance measures for which RY19 P4P incentive payments will be based are identified in the following **Table K-1**, organized by Quality Measure Category, which may then be broken down further into Subcategories or Components.

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

Table K-1: Hospital Quality Performance Measures

Measure ID#	Measure Name	Quality Measure Category
	Obstetric/Neonate Clinical Process Measure Subcategory (2 measures)	Clinical Process
MAT-4	Cesarean Birth, NTSV	
NEWB-1	Exclusive breast milk feeding	
	Care Coordination Clinical Process Measure Subcategory (3 measures)	
CCM-1	Reconciled medication list received by discharged patient	
CCM-2	Transition record with specified data elements received by discharge patient	
CCM-3	Timely transmission of transition record within 48 hours at discharge	
HD-2	Health Disparities Composite	
PSI-90 HAI	**Component 1-** Patient Safety and Adverse Events Composite **Component 2-** Healthcare-Associated Infections *5 measures*: 1. Central Line-Associated Bloodstream Infection 2. Catheter-Associated Urinary Tract Infection 3. Methicillin-Resistant Staphylococcus Aureus bacteremia 4. Clostridium difficile infection 5. Surgical Site Infections (colon and abdominal hysterectomy surgeries)	Safety Outcomes
HCAHPS	Hospital Consumer Assessment of Healthcare Provider and Systems Survey (HCAHPS) *7 survey dimensions* (1. nurse communication, 2. doctor communication, 3. responsiveness of hospital staff, 4. communication about medicines, 5. discharge information, 6. overall rating, and 7. three-item care transition)	Patient Experience and Engagement

2. Data Accuracy and Completeness Requirements

a. Clinical Process Measure Category

The measures in the Clinical Process Measure Category include five individual clinical process measures, and one composite measure (HD-2). For RY19, the individual clinical process measures (MAT-4, NEWB-1, CCM-1, CCM-2 and CCM-3) are grouped into two Clinical Process Measure Subcategories as identified on **Table K-1:** (1) the "Obstetric / Neonate Clinical Process Measure Subcategory" - consisting of two measures MAT-4 and NEWB-1; and (2) the Care Coordination Clinical Process Measure Subcategory - consisting

of three measures CCM-1, CCM-2 and CCM-3. Hospitals collect and report all Medicaid payer data on the clinical process measures to EOHHS.

In order to ensure the accuracy and reliability of the submitted data, all reported clinical process measures are subject to data validation requirements. The submitted electronic data must meet a minimum reliability standard. The minimum reliability standard is defined as an 80 percent match for data elements. Hospitals are considered to have "passed" validation if the overall agreement rate of 80 percent has been met, based on the two quarters of CY2018 data (Q3-2018 and Q4-2018) required for performance evaluation.

b. Safety Outcomes Measure Category

The Safety Outcomes Measure Category consists of two components:

Component 1: *Patient Safety and Adverse Events Composite Measure (PSI-90)* -- The PSI-90 composite measure consists of ten (10) Agency for Healthcare Research and Quality (AHRQ) quality indicators (PSI-3, PSI-6, PSI-8, PSI-9, PSI-10, PSI-11, PSI-12, PSI-13, PSI-14 and PSI-15) that represent potentially preventable complications and adverse events. This measure is claims-based and will be collected by EOHHS on all Medicaid payer data from MMIS and the MassHealth Data Warehouse. Data accuracy and completeness requirements apply.

Component 2: Healthcare-Associated Infections (HAI) Measures -- The five HAI measures listed in **Table K-1**, are reported by Hospitals to the National Healthcare Safety Network (NHSN) registry surveillance tracking system maintained by the Centers for Disease Control and Prevention (CDC). EOHHS will access the relevant information for these measures, which are based on all payer data, for each Hospital from the NHSN system for the relevant period. EOHHS will rely on data accuracy and completeness of the data as accessed from this system.

c. Patient Experience and Engagement Measure Category

The Patient Experience and Engagement Measure Category includes a modified Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measure comprised of seven (7) national survey-based dimensions (see **Table K-1**, above) developed by AHRQ for CMS. Survey results are collected and submitted by Hospitals to CMS. EOHHS will collect the relevant archived data results for each Hospital, which are based on all payer data, from the CMS Hospital Compare website. EOHHS will rely on data accuracy and completeness of the data as set forth on the CMS Hospital Compare website.

3. <u>Payment Methodology</u>

P4P incentive payments will be based on pay-for-performance, and are available with respect to each **P4P Category** listed in **Table K-2** (see Section **III.K.3.b.i**, below). The term "P4P Category" or "P4P Categories" will refer to the P4P Category(s) listed in such Table K-2.

Formula: Incentive payments for each P4P Category are calculated by multiplying:

- the Hospital's eligible Medicaid discharges for the P4P Category, by
- the P4P Category per Discharge Amount, by
- the Total Performance Score for the P4P Category.

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

a. **Eligible Medicaid Discharges**

For purposes of this **Section III.K.3.a.,** "FY18 MMIS Discharge Data" refers to Hospital discharge data from MMIS paid claims for FY18 PCC Plan, Primary Care ACO and Fee-for-Service discharges, only, for which MassHealth is the primary payer.

Eligible Medicaid discharges are used to determine the volume of a Hospital's discharges that are included in the RY19 Pay-for-Performance payment calculations. The volume of eligible Medicaid discharges is determined as follows utilizing FY18 MMIS Discharge Data as the data source:

i. **Obstetric/Neonate Clinical Process Measure Subcategory and Care Coordination Clinical Process Measure Subcategory.** For the P4P Categories that are the two Clinical Process Measure Subcategories (i.e., the Obstetric/Neonate Clinical Process Measure Subcategory; and the Care Coordination Clinical Process Measure Subcategory), the eligible Medicaid discharges will be determined based on the number of Hospital discharges in the FY18 MMIS Discharge Data that meet the specific ICD requirements corresponding to the individual clinical process measures in that P4P Category. For certain individual clinical process measures (MAT-4 and NEWB-1), the ICD requirements are published in the *Specifications Manual for National Hospital Inpatient Quality Measures* (available at www.qualitynet.org), or the *Specifications Manual for the Joint Commission National Quality Measures* (available at https://manual.jointcommission.org/bin/view/Manual/WebHome). Specifications for the care coordination (CCM-1, CCM-2 and CCM-3) measures are available on the MassHealth Quality Exchange website at www.mass.gov/masshealth/massqex.

ii. **Health Disparities Composite Measure (HD-2).** For the P4P Category that is the Health Disparities Composite Measure (HD-2), the eligible Medicaid discharges will be determined based on the total number of "unique discharges" for the underlying individual clinical process measures considered as a whole, so that each unique discharge is only counted once. A unique discharge is a single paid claim from the FY18 MMIS Discharge Data for a Hospital discharge that meets the ICD population requirement for one or more of the underlying individual clinical process measures (MAT-4, NEWB-1, CCM-1, CCM-2 and CCM-3), and that meets the criteria for the HD-2 composite measure calculation.

iii. **Safety Outcomes Measure.** For the Safety Outcomes Measure (PSI-90 and HAI) P4P Category, the eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY18 MMIS Discharge Data that meet the medical and surgical All Payer Refined Diagnosis Related Group (APR-DRG) codes associated with the specified AHRQ clinical measure specification manuals.

iv. **Patient Experience and Engagement Measure:** For the Patient Experience and Engagement Measure (HCAHPS) P4P Category, the eligible Medicaid discharges will be determined based on the total number of Hospital discharges in the FY18 MMIS Discharge Data that meet the specified medical, surgical, and cesarean All Payer Refined Diagnosis Related Group (APR-DRG) service line codes.

b. **P4P Category per Discharge Amount**

The P4P Category per Discharge Amount for each P4P Category will be determined by dividing the **maximum allocated amount** for the P4P Category by the **statewide eligible Medicaid discharges** for that P4P Category.

i. **Maximum Allocated Amount**

P4P incentive payments will cumulatively total no more than the maximum amount allotted for each P4P Category in the following table:

Table K-2: P4P Categories & Maximum Allocated Amounts

P4P Category	Maximum Allocated Amount
Obstetric/Neonate Clinical Process Measure Subcategory (MAT-4 and NEWB-1)	$ 5,500,000
Care Coordination Clinical Process Measure Subcategory (CCM-1, CCM-2, and CCM-3)	$ 7,000,000
Health Disparities Composite Measure (HD-2)	$ 1,500,000
Safety Outcomes Measure (PSI-90 and HAI)	$ 5,000,000
Patient Experience and Engagement Measure (HCAHPS)	$ 6,000,000
TOTAL	**$25,000,000**

ii. Statewide Eligible Medicaid Discharges

The statewide eligible Medicaid discharges for each P4P Category, are the sum of all eligible Medicaid discharges (see **Section III.K.3.a**, above) across all Hospitals for that category.

c. Total Performance Score

i. Obstetric/Neonatal Clinical Process Measure Subcategory (MAT-4 and NEWB-1) and Care Coordination Clinical Process Measure Subcategory (CCM-1, CCM-2 and CCM-3)

The Total Performance Score for each of these P4P Categories (Obstetric/Neonate Clinical Process Measure Subcategory; and Care Coordination Clinical Process Measure Subcategory) is a percentage of **quality points** awarded out of the total possible points for that P4P Category, based on the following formula:

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

The quality points awarded for each individual clinical process measure in the relevant P4P Category is the higher of the **attainment** or the **improvement points** earned, and all quality points awarded for each individual clinical process measure in that P4P Category are then summed together to determine the total awarded quality points for the P4P Category.

Quality points are awarded for the individual clinical process measures based on each Hospital's performance during the Comparative Measurement Period relative to the attainment threshold (the median performance of all Hospitals in the Baseline Measurement Period) and the benchmark (the mean of the top decile of all Hospitals in the Baseline Measurement Period).

The **Comparative Measurement Period** and the **Baseline Measurement Period** for the individual clinical process measures are as follows:

	Comparative Measurement Period	Baseline Measurement Period
Individual Clinical Process Measures	7/1/2018 - 12/31/2018	CY 2017

Performance benchmarks for the individual clinical process measures are calculated based on Hospital data reported to MassHealth.

If the Hospital failed validation for a measure in the previous reporting year, data from that period is considered invalid for use in calculating year over year performance.

Therefore, the Hospital would not be eligible for improvement points. However, it may be eligible for attainment points in the current reporting year based on calculation of the current reporting year's data reported for the measure if it passed validation in the current year and if the hospital has passed validation and established a baseline rate for the measure in a prior year.

(A) Attainment Points

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

- if a Hospital's score for a measure is equal to or less than the attainment threshold, it will receive zero points for attainment,
- if a Hospital's score for a measure is greater than the attainment threshold but below the benchmark, it will receive 1-9 points for attainment, and
- if a Hospital's score for a measure is greater than or equal to the benchmark, it will receive the maximum 10 points for attainment.

(B) Improvement Points

The Hospital can earn points for improvement based on how much its performance score on the measure has improved from the Baseline Measurement Period as follows:

- if a Hospital's score for a measure is less than or equal to its score for the Baseline Measurement Period, it will receive zero (0) points for improvement.
- if a Hospital's score for a measure is greater than its score for the Baseline Measurement Period, it will receive 0-9 points for improvement.

(C) Example

The following is an example pay-for-performance calculation for the P4P Category that is the Obstetric/Neonatal Clinical Process Measure Subcategory, provided for illustrative purposes only.

Example for P4P Category: Obstretric / Neonatal Clinical Process Measure Subcategory

Statewide calculations	
Maximum allocated amount	$5,500,000
Statewide eligible Medicaid discharges	13,551
P4P Category per Discharge Amount	$5,500,000/13,551 = $406
Hospital-specific calculations	
Hospital's awarded quality points for the P4P Category (sum of the measure-specific attainment or improvement points corresponding to the P4P Category)	32
Maximum possible P4P Category quality points	40
Total Performance Score for P4P Category	(32 points / 40 points) x 100% = 80%
Eligible Medicaid discharges	500
Hospital-specific total incentive payment for the P4P Category	**500 x $406 x 80% = $162,400**

ii. Health Disparities Composite Measure (HD-2)

For each Hospital, the Health Disparities Composite Measure (HD-2) is comprised of aggregate data from all of the individual clinical process measures (i.e., MAT-4, NEWB-1, CCM-1, CCM-2 and CCM-3) on which the Hospital reports. The Hospital's composite measure compares the Hospital's performance among race/ethnicity groups and all groups combined, and is converted to a disparity composite value. The composite measure and disparity composite value are calculated only for Hospitals that report on more than one racial group in their electronic data files.

(A) Performance Assessment

Performance for the Health Disparities Composite Measure (HD-2) will be assessed using the following methodology.

1. Decile Rank Method. Disparity composite values are calculated for Hospitals that meet the measure calculation criteria. Performance will be assessed using a method that determines the Hospital's rank, relative to other Hospitals, based on the decile ranking system.

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

3. Target Attainment Threshold. The target attainment threshold represents the minimum level of performance that must be achieved to earn incentive payments. The target attainment is defined as the boundary for a disparity composite value that falls above the 2nd decile group, as shown in the "Decile Performance Thresholds" table below.

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

Decile Group Thresholds

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

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

(B) Total Performance Score for Health Disparities Composite Measure (HD-2).

A Hospital's Total Performance Score for the Health Disparities Composite (HD-2) Measure P4P Category is the assigned conversion factor as shown in the Decile Group Thresholds table, above, multiplied by 100%. Performance scores are calculated only for Hospitals that meet the measure calculation criteria and validation requirements, using only the Hospital's current year reported data for the period July 1, 2018 through December 31, 2018.

iii. Safety Outcomes Measure (PSI-90 and HAI)

For the Safety Outcomes Measure, each Hospital will be evaluated using both the Hospital's PSI-90 composite value and the Hospital's SIR output values for each of the five HAI measures, as applicable.

Component 1: The PSI-90 composite value is calculated as a weighted average of the risk-adjusted and reliability adjusted rates for the ten AHRQ quality indicators, combined, for the Hospital. The relevant evaluation period is discharges in the 24 month period from October 1, 2013 through September 30, 2015. If a Hospital has fewer than 3 eligible discharges for the ten indicators combined, a PSI-90 composite value will not be calculated.

Component 2 -- For each of the five HAI measures, EOHHS will obtain the Hospital's standard infection ratio (SIR) output value for each measure, as calculated by the CDC, from the NHSN system. The relevant evaluation period is the 24 month period of January 1, 2015 through December 31, 2016. The Hospital will not have a SIR output value for an HAI measure(s) if the CDC was unable to calculate a SIR output value for the Hospital for that HAI measure based on its criteria.

(A) Winsorization Method

Each Hospital's performance will be assessed in comparison to all eligible Hospital's values for the PSI-90 composite and each of the HAI measures using a Winsorization method, which transforms each Hospital's measure values into a standardized score. The Winsorization method evaluates performance using the defined period(s) only and does not use comparison year data.

1. A Winsorized measure result is obtained by creating a continuous rank distribution of all eligible Hospitals' measure values, and truncating the outliers to determine the relative position of where each measure value falls in the distribution. This Winsorization process is performed separately with respect to each measure (i.e., for the PSI-90 composite measure value and for each SIR output value for the HAI measures).

   i. If *the Hospital's measure value* falls between the minimum and the 5th percentile, then *the Hospital's Winsorized measure result* is equal to the measure value that corresponds to the 5th percentile.
   ii. If the Hospital's measure value falls between the 95th percentile and the maximum, then *the Hospital's Winsorized measure result* is equal to the measure value that corresponds to the 95th percentile.
   iii. If the Hospital's measure value falls between the 5th and 95th percentiles, then *the Hospital's Winsorized measure result* is equal to the Hospital's measure value.

2. A Winsor Z-score will be calculated for each Hospital for each measure; it is the difference between a Hospital's Winsorized measure result from #1 above and the mean of the Winsorized measure results across all eligible hospitals, which difference is divided by the standard deviation of the Winsorized measure results from all eligible Hospitals' data.

The Hospital's **Overall Safety Outcomes Measure score** is calculated as the weighted average of the Hospital's Winsor z-score for Component 1 (PSI-90) and the Hospital's z-score for Component 2 (HAI), which contribute 60% and 40%, respectively, unless the Hospital has a score for only one of the two components, in which case that one component contributes 100% to the Hospital's Overall Safety Outcomes Measure score. The Hospital's z-score for Component 2 (HAI) is equal to the average of the Hospital's five HAI Winsor z-

scores; if the Hospital has Winsor z-scores for less than the five HAI measures, then the average is computed based on the number of HAI measures that do have a Winsor z-score.

(B) Setting Performance Thresholds

The Hospital's Overall Safety Outcomes Measure score will be assessed using the methods described below.

1. *Interquartile Rank Method.* Performance will be assessed using a method that determines the Hospital's rank with respect to its Overall Safety Outcomes Measure score, relative to other Hospitals, and divides the ranked results into four approximately equal quartile groups. The Hospitals' Overall Safety Outcomes Measure scores are rounded to eight decimal points and ranked highest (worse) to lowest (best) in performance.

2. *Minimum Attainment Threshold.* The minimum attainment threshold represents the minimum level of performance that must be attained to earn incentive payments. Subject to the exception for RY19 specified below, the minimum attainment threshold is defined as the boundary for the Overall Safety Outcomes Measure score that falls above the 1st quartile group, as shown in the "Quartile Group Thresholds" table, below.

3. *Conversion Factor.* Each quartile group is assigned a conversion factor as shown in the table below:

Quartile Group Thresholds

Performance Threshold	Quartile Group	Conversion Factor
Top Quartile (Lowest score)	4th quartile	1.0
	3th quartile	.75
Target Attainment	2nd quartile	.50
Lowest Quartile (Highest score)	1st quartile	(zero)*

All Overall Safety Outcome Measure scores that fall within the same quartile group are assigned the same conversion factor.

*For RY19 only, the minimum attainment threshold will not apply, and Hospital Overall Safety Outcome Measure scores falling within the 1st quartile will be assigned a weight of .25 instead of zero.

(C) Total Performance Score for Safety Outcomes Measure (PSI-90 and HAI).

A Hospital's Total Performance Score for the Safety Outcomes Measure (PSI-90 and HAI) P4P Category is the assigned conversion factor as shown in the Quartile

Group Thresholds table, above, multiplied by 100%. As noted, for RY19, the conversion factor that applies to the Lowest Quartile will be .25 instead of zero for purposes of this calculation.

iv. Patient Experience and Engagement Measure (HCAHPS)

EOHHS will obtain the Hospitals' archived HCAHPS measure "top box" results corresponding to the relevant periods directly from the CMS Hospital Compare Website for each of the seven survey dimensions in the Patient Engagement and Experience Measure (HCAHPS) category. The "top box" results reflect the percentage of a Hospital's patients who chose the most positive (top box) response to a survey item, as adjusted and calculated by CMS. If CMS was not able to calculate results for a Hospital due to insufficient volume of completed surveys, the Hospital will not receive performance scores or incentive payments for this P4P Category.

The **Total Performance Score** for the Patient Experience and Engagement (HCAHPS) Measure P4P Category is a percentage of **quality points** awarded out of the total possible points for the P4P Category, based on the following formula:

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

The quality points awarded for each survey dimension in the HCAHPS measure is the higher of the **attainment** or the **improvement points** earned for that dimension. The quality points awarded for the seven survey dimensions, as applicable, are then summed together to determine the total awarded quality points for the P4P Category.

Quality points are awarded for the seven survey dimensions based on each Hospital's performance during the Comparison Year Period relative to the attainment threshold (the median performance of all Hospitals in the Prior Year Period) and the benchmark (the mean of the top decile of all Hospitals in the Prior Year Period).

The **Comparison Year Period** and the **Prior Year Period** are as follows:

	Comparison Year Period	Prior Year Period
Patient Experience and Engagement (HCAHPS) Measure	CY 2017	CY 2016

All attainment and improvement points earned on each survey dimension will be calculated using the same formulas for calculating attainment points and improvement points as described in **Section III.K.3.c.i.(A) and (B)**. For these calculations, the "Baseline Measurement Period" refers instead to the "Prior Year Period" referenced above.

Attainment and benchmark performance thresholds on the HCAHPS survey dimensions are calculated using HCAHPS state-level data obtained from the CMS Hospital Compare website corresponding to the Prior Year Period for this measure.

Attainment and improvement points cannot be calculated and, if applicable, awarded to a Hospital unless it has previously established a baseline rate for each survey dimension, based on evidence from data files downloaded by EOHHS from the CMS Hospital Compare website

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IV. Potentially Preventable Readmissions (PPRs) *(1st RY19 Period Only)*

The Potentially Preventable Readmission (PPR) adjustment (if applicable) described in this **Section IV** that is incorporated into the 1st RY19 Period APAD, Outlier Payment and Transfer Per Diem payment methodologies set forth in **Sections III.B** through **III.D**, above, applies solely to the 1st RY19 Period, and does not apply to the 2nd RY19 Period. The PPR methodology set forth below applies when the 1st RY19 Period APAD, Outlier Payment or Transfer Per Diem payment methodology(ies) apply. The 1st RY19 Period PPR methodology is the same methodology that applied during the 2nd RY18 Period (effective March 1, 2018) under approved SPA TN-017-015, as amended by approved SPA TN-018-001.

Hospitals with a greater number of Actual Potentially Preventable Readmission (PPR) Chains than Expected PPR Chains, based on data specified in **Section IV.B**, below, will be subject to a percentage payment reduction per discharge calculated using the methodology described below. This reduction will be applied to Hospitals identified using the methodology described below.

A. Definitions

Actual PPR Chains: The actual number of PPR Chains for a specific Hospital.

Actual PPR Volume: The number of Actual PPR Chains for the time period.

Actual PPR Rate: The number of Initial Admissions with one or more qualifying Clinically Related PPRs within a 30-day period divided by the total number of At-risk Admissions.

APR-DRG: The All Patient Refined-Diagnostic Related Group and Severity of Illness (SOI) combination assigned using the 3M PPR Grouper, version 33.

At-risk Admissions: The number of Total Admissions considered at risk for readmission, as determined by the 3M PPR methodology, excluding mental health and substance abuse primary diagnoses.

Clinically Related: A requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following a prior Hospital admission.

Expected PPR Chains: The number of PPR Chains a Hospital, given its mix of patients as defined by APR-DRG category, would have experienced had its rate of PPRs been identical to that experienced by a reference or normative set of Hospitals.

Expected PPR Rate: The number of Expected PPR Chains divided by the total number of At-risk Admissions. The expected rate for each APR-DRG is the statewide average Actual PPR Rate for that APR-DRG.

Excess PPR Volume: The number of Actual PPR Chains above the number of Expected PPR Chains, as calculated by the 3M PPR methodology, for a specific Hospital. For a Hospital for which the

number of Actual PPR Chains is equal to or less than the number of Expected PPR Chains, there is no Excess PPR Volume.

Hospital Discharge Volume: The number of Hospital discharges in FY16 for which an APAD was paid, as determined by EOHHS based on claims in MMIS as of June 7, 2017 and for which MassHealth is the primary payer.

Initial Admission: An admission that is followed by a Clinically Related readmission within a specified readmission time interval. Subsequent readmissions relate back to the care rendered during or following the Initial Admission. The Initial Admission initiates a PPR Chain.

Potentially Preventable Readmission (PPR): A readmission chain (return hospitalization within the specified readmission time interval) that is Clinically Related to the Initial Admission.

PPR Chain: A PPR or a sequence of PPRs. A PPR Chain can extend beyond 30 days, as long as the time between each discharge and subsequent readmission is within the 30-day time frame. Therefore, if Patient X is admitted on October 4th, readmitted on October 20th, and readmitted again on November 18th, that sequence is calculated as one (1) PPR Chain.

Readmission: A return hospitalization to an acute care Hospital that follows a prior Initial Admission from an acute care Hospital. Intervening admissions to non-acute care facilities are not considered readmissions. A readmission may be to an in-state or out-of-state acute care Hospital.

Total Admissions: The total number of Medicaid Fee For Service/PCC Plan admissions for the time period.

B. Determination of Readmission Rates and Volumes

PPRs are identified in adjudicated and paid inpatient Hospital claims residing in MMIS as of June 7, 2017, for which MassHealth is the primary payer, by using the 3M PPR software version 33. The time period for identifying Total and At-risk Admissions was from October 1, 2015 to August 31, 2016, based on date of discharge. The time period for identifying PPRs associated with these At-risk Admissions was from October 1, 2015 to September 30, 2016 based on date of admission.

1. Statewide Average PPR Rate

The statewide average Actual PPR Rate for each APR-DRG is calculated and represents the PPR benchmark for that APR-DRG.

2. Hospital-specific Actual PPR Volume

Each Hospital's Actual PPR Volume is the number of PPR Chains in the specified time period.

3. Hospital-specific Expected PPR Volume

In order to derive the Hospital-specific Expected PPR Volume, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions by APR-DRG for the time period specified above and summed across all of the Hospital's APR-DRGs.

The Expected PPR Volume therefore reflects how a given Hospital should have performed on each APR-DRG recorded in their MMIS claims, as specified in **Section IV.B.**

4. Hospital-specific Excess PPR Volume

The Hospital-specific Excess PPR Volume is calculated as the number of Actual PPR Chains in excess of the number of Expected PPR Chains, as calculated by the 3M PPR methodology, for a specific Hospital. For a Hospital for which the number of Actual PPR Chains is equal to or less than the number of Expected PPR Chains, there is no Excess PPR Volume.

5. Hospital-specific Actual PPR Rate

Each Hospital's Actual PPR Rate is derived by dividing the number of Actual PPR Chains in the specified time period by the total number of At-risk Admissions.

6. Hospital-specific Expected PPR Rate

In order to derive the Hospital-specific Expected PPR Rate, the statewide average Actual PPR Rates for each APR-DRG are applied to each Hospital's volume of At-risk Admissions by APR-DRG casemix. The Expected PPR Rate is therefore risk-adjusted and reflects how a given Hospital should have performed on each APR-DRG for the time period specified above.

7. Hospital-specific Actual-to-Expected (A:E) PPR Ratio

Each Hospital's Actual-to-Expected (A:E) ratio is calculated as:

$$\frac{\text{Actual PPR Rate}}{\text{Expected PPR Rate}}$$

C. Calculation of PPR Percentage Payment Reduction Per Discharge

1. General Initial Calculation

Hospitals with Excess PPR Volume are subject to a PPR Percentage Payment Reduction per Discharge, applied as set forth in **Section IV.F**, below. Only Hospitals with more than 40 At-Risk Admissions are subject to a PPR Percentage Payment Reduction per Discharge, if applicable.

Each Hospital's PPR Percentage Payment Reduction per Discharge will initially be calculated as follows:

$$-\frac{\left(\text{Hospital-Specific Excess PPR Volume} \times \text{Adjustment Factor}\right)}{\left(\text{Hospital Discharge Volume}\right)} = \text{Hospital's Non-Improvement-Adjusted PPR Percentage Payment Reduction per Discharge}$$

The result will be reflected as a negative value. The negative value illustrates this is a rate reduction.

The "Adjustment Factor" is 3 and is a multiplier intended to provide incentive for Hospitals to identify and implement methods to reduce PPRs.

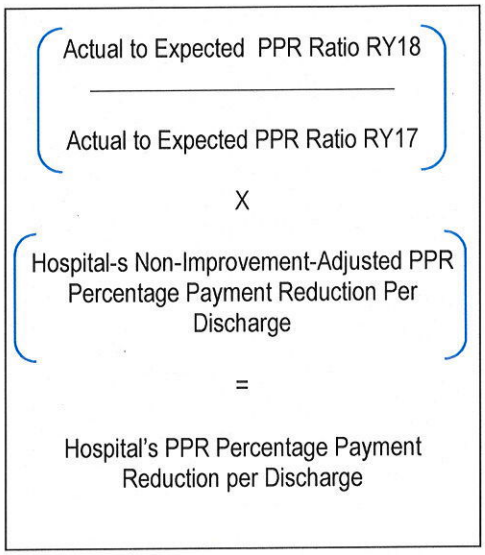
The remainder of the calculation depends on whether a Hospital qualifies for an Improvement Adjustment in accordance with **Section IV.D** below.

2. Hospitals not Qualifying for Improvement Adjustment

A Hospital with Excess PPR Volume that does not qualify for an Improvement Adjustment in accordance with **Section IV.D** below, will be subject to a "PPR Percentage Payment Reduction per Discharge" equal to the amount calculated as the Hospital's Non-Improvement-Adjusted PPR Payment Reduction per Discharge under **Section IV.C.1** above.

3. Hospitals Qualifying for Improvement Adjustment

A Hospital with Excess PPR Volume that qualifies for an Improvement Adjustment in accordance with **Section IV.D**, below, will be subject to a "PPR Percentage Payment Reduction per Discharge" that is calculated as follows:



The result will be reflected as a negative value. The negative value illustrates that this is a rate reduction.

D. Improvement Adjustment

If a Hospital has Excess PPR Volume for RY18 but has achieved an improvement as indicated by a decrease to its Actual-to-Expected PPR Ratio for RY18 compared to RY17, EOHHS shall adjust downward the PPR Percentage Payment Reduction per Discharge that the Hospital would otherwise receive. This "Improvement Adjustment" is calculated by applying the percent decrease in the Hospital's RY18 Actual-to-Expected PPR Ratio from RY17 to the Hospital's Non-Improvement Adjusted PPR Percentage Payment Reduction per Discharge. For example, if a Hospital had a RY17 Actual-to-Expected PPR Ratio of 1.30 and a RY18 Actual-to-Expected PPR Ratio of 1.17, which is a decrease of 10%, and a RY18 Non-Improvement Adjusted PPR Percentage Payment Reduction of -3%, its RY18 PPR Percentage Payment Reduction per Discharge would be adjusted as follows:

Hospital's PPR Percentage Payment Reduction per Discharge =

1.17 / 1.30 x -3% = 90% x -3% = -2.7% per Discharge.

The negative value illustrates this is a rate reduction.

E. Maximum per-Discharge Adjustment

Notwithstanding **Sections IV.C** and **IV.D**, a Hospital's PPR Percentage Payment Reduction per Discharge due to the Hospital's Excess PPR Volume is capped at -4.4%.

F. Application of PPR Percentage Payment Reduction per Discharge

The Hospital's PPR Percentage Payment Reduction per Discharge for the 1st RY19 Period is applied against the sum of the Pre-Adjusted APAD and Outlier Payment for discharges that qualify for an Outlier Payment under the 1st RY19 Period methodology (see **Section III.C**). It is applied against the Pre-Adjusted APAD for discharges that are paid under the 1st RY19 Period methodology and which do not qualify for an Outlier Payment (see **Section III.B**). These reductions apply when calculating the Transfer Per Diem rate, and when capping the Transfer Per Diem at the Total Transfer Payment Cap under **Section III.D**, as applicable to the 1st RY19 Period. As noted, this **Section IV** does not apply in calculating the 2nd RY19 Period APAD, Outlier Payment or Transfer Per Diem rates.

V. 30-Day Readmissions Policy *(2nd RY19 Period only)*

After a transitional period of not less than six months after the start of the 2nd RY19 Period, with the exception of certain exempt readmissions, MassHealth will deem claims to be non-payable for MassHealth Member readmissions to an in-state Acute Hospital occurring within 30 days of the date of discharge from an index admission to the same Acute Hospital for which MassHealth determines, after clinical review, are both clinically related to an index admission within a readmission chain and potentially preventable. This **Section V** does not apply to the 1st RY19 Period.

VI. Other Provisions

A. Federal Limits

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

B. Future Rate Years

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

C. [Reserved]

D. New Hospitals/Hospital Change of Ownership

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

computation of the statewide average or statewide standard payment amount and/or any efficiency standard.

E. Data Sources

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

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

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VII. Provider Preventable Conditions

Citation	Payment Adjustment for Provider Preventable Conditions
42 CFR 447,434,438 and 1902(a) (4), 1902 (a) (6) and 1903	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.

Health Care-Acquired Conditions

The State identifies the following Health-Care Acquired Conditions for non-payment under Attachment 4.19-A(1), (Acute Inpatient Hospital Services) under this State plan.

☒ Hospital Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Attachment 4.19-A(1), (Acute Inpatient Hospital Services) under this State plan.

☒ 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.

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 delivery.
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 Health Care-Acquired Conditions ("HCACs") and Other Provider-Preventable Conditions ("OPPCs") listed 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 that the Hospital indicates was not present on admission, MassHealth will reduce payments to the Hospital as follows:

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1. APAD, Outlier Payment, and Transfer per diem payments:
   a. MassHealth will not pay the APAD, Outlier Payment, or Transfer per diem payment if the Hospital reports that only PPC-related services were delivered during the inpatient admission, 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 APAD, Outlier Payment, or Transfer per diem payment, in each case as adjusted to exclude PPC-related costs or services, if the Hospital reports that non-PPC related services were also delivered during the inpatient admission, 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. Psychiatric, Rehabilitation, or Administrative Day Per Diem payments:
   a. MassHealth will not pay the per diem if the Hospital reports that only PPC-related services were delivered on that day, 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 per diem if the Hospital reports that non-PPC related services were also delivered on that day, 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.

3. Inpatient Hospital payments for Hospital-Based Physician Services: MassHealth will not pay for inpatient Hospital-based physician services reported as PPC-related services.

4. Follow-up Care in Same Hospital: If a hospital reports that it provided follow-up inpatient 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 stay, payment will be made, but adjusted in the case of APAD, Outlier payment, or Transfer per diem payments to exclude the PPC-related costs or services, and MassHealth 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.

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

Charges for service, 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.

VIII. Serious Reportable Events

The non-payment provisions set forth in this Section VIII apply to the following serious reportable events (SREs):

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 inpatient admission 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: RY19 Payment Method for Critical Access Hospitals Effective
October 1, 2018 through September 30, 2019

EXHIBIT 1
Rate Year 2019 Payment Method Applicable to Critical Access Hospitals Effective October 1, 2018 through September 30, 2019

Section I. Overview

The payment methods set forth in this **Exhibit 1** apply to Critical Access Hospitals for RY19 (October 1, 2018 through September 30, 2019).

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 the hospital's state plan services in RY19 (October 1, 2018 through September 30, 2019), 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, 2018 through September 30, 2019, as described in **Section II(B)** of this **Exhibit 1**, below. Subject to this **Exhibit 1**, **Attachment 4.19-A(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 Inpatient Services

For inpatient admissions occurring in RY19, Critical Access Hospitals (CAHs) will be paid for Inpatient Services in accordance with **Attachment 4.19-A(1)** with the following changes.

Critical Access Hospitals will be paid an Adjudicated Payment Amount per Discharge (APAD) for those Inpatient Services for which all other in-state acute hospitals are paid an APAD.

Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring in the 1st RY19 Period, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY16 cost and discharge data:

(1) EOHHS calculated a cost per discharge for inpatient services for each Critical Access Hospital, which was determined by dividing the amount reported on worksheet E-3, part VII, column 1, line 21, of the Hospital's FY16 CMS-2552-10 cost report, by the Hospital's number of FY16 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY16 paid claims data residing in MMIS as of May 23, 2017 for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY16 and RY18, resulting in the 1st RY19 Period cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's 1st RY19 Period cost per discharge, as determined above, by each Hospital's FY16 inpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 1st RY19 Period CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the APAD Base Payment used in the APAD calculations for all other Hospitals for admissions in the 1st RY19 Period.

(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the 1st RY19 Period CAH-Specific Total Standard Rate per Discharge by the applicable 1st RY19 Period discharge-specific MassHealth DRG Weight.

(6) Critical Access Hospitals will not be subject to any adjustment under **Section IV** of **Attachment 4.19-A(1)**.

Notwithstanding **Section III.B** of **Attachment 4.19-A(1)**, for inpatient admissions occurring in the 2nd RY19 Period, the APAD for each Critical Access Hospital is calculated, as follows, utilizing FY17 cost and discharge data:

(1) EOHHS calculated a cost per discharge for inpatient services for each Critical Access Hospital, which was determined by dividing the amount reported on worksheet E-3, part VII, column 1, line 21, of the Hospital's FY17 CMS-2552-10 cost report, by the Hospital's number of FY17 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY17 paid claims data residing in MMIS as of March 21, 2018, for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY17 and RY19, resulting in the inflation-adjusted 2nd RY19 Period cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's 2nd RY19 Period inflation-adjusted cost per discharge, as determined above, by each Hospital's FY17 inpatient casemix index (CMI), as determined by EOHHS.

(4) That result is the 2nd RY19 Period CAH-Specific Total Standard Rate per Discharge. This is an all-inclusive rate that replaces the APAD Base Payment used in the APAD calculations for all other Hospitals for admissions in the 2nd RY19 Period.

(5) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the 2nd RY19 Period CAH-Specific Total Standard Rate per Discharge by the applicable 2nd RY19 Period discharge-specific MassHealth DRG Weight.

The following is an illustrative example of the calculation of the Total Case Payment for a CAH's standard APAD claim that does not also qualify for an Outlier Payment. This example assumes the 2nd RY19 Period applies.

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Table 5: Critical Access Hospital Interim APAD claim - 2nd RY19 Period			
(Values are for demonstration purposes only)			
Hospital:	**Sample Critical Access Hospital**		
DRG:	**203, Chest Pain. Severity of Illness (SOI) = 2.**		
Line	**Description**	**Value**	**Calculation or Source**
1	2nd RY19 Period CAH-Specific Total Standard Rate per Discharge	$14,543.22	Exhibit 1 to Attachment 4.19-A(1)
2	MassHealth DRG Weight	0.3598	Determined based on claim information
3	Total Case Payment = Adjudicated Payment Amount per Discharge (Interim APAD)	$5,232.65	Line 1 * Line 2

Outlier Payments and Transfer Per Diem rates for Critical Access Hospitals are calculated and paid as described in **Sections III.C and III.D of Attachment 4.19-A(1),** respectively, except that the APAD used for purposes of those calculations is the CAH's APAD as calculated as set forth in **Section II.A of Exhibit 1**, above, utilizing the appropriate methodology that applies to the admission (1st RY19 Period or 2nd RY19 Period, as applicable), and that **Section IV** of **Attachment 4.19-A(1)** does not apply to CAHs.

(B) Post RY19 Cost Review and Settlement

EOHHS will perform a post-Rate Year 2019 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 the hospital's state plan services for FY19 as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY19 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 RY19 review. "Aggregate interim payments" for this purpose shall include all state plan payments to the hospital for FY19, but excluding, if applicable, any state plan payments to a Critical Access Hospital under Section III.K of Attachment 4.19-A(1), and any supplemental payments made to a Critical Access Hospital based on its status as a qualifying Hospital as defined in Section III.J.1 of Attachment 4.19-A(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 or offset against future payments, the amount that equals the difference between the aggregate interim payments and 101% of allowable costs.

This post Rate Year 2019 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, 2020. Assuming this date, the settlement will be complete by September 30, 2021.