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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 22-0024

This file contains the following documents in the order listed:

1) Approval Letter

2) Summary Form (with 179-like data)

3) Approved SPA Pages

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

March 24, 2023

Kathleen E. Walsh, Secretary
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

Re: Massachusetts Disaster Relief SPA 22-0024

Dear Secretary Walsh:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 22-0024. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid State Plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq*.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6 PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Massachusetts also requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is required under 42 C.F.R. §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. §440.386 for changes to Alternative Benefit Plans (ABPs). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

The State of Massachusetts also requested a waiver to modify the tribal consultation timeline applicable to this SPA submission process. Pursuant to section 1135(b)(5) of the Act, CMS is also allowing states to modify the timeframes associated with tribal consultation required under section 1902(a)(73) of the Act, including shortening the number of days before submission or conducting consultation after submission of the SPA.

These waivers or modifications of the requirements related to SPA submission timelines, public notice, and tribal consultation apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Massachusetts Medicaid SPA Transmittal Number 22-0024 is approved effective November 1, 2020. This SPA is in addition to those previously approved Disaster Relief SPAs and does not supersede anything approved in those SPAs.

Enclosed is a copy of the CMS-179 summary form and the approved State Plan pages.

Please contact Marie DiMartino at (617) 565-9157 or by email at Marie.DiMartino@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Massachusetts and the health care community.

Sincerely,

Alissa M. Deboy -S

Digitally signed by Alissa M. Deboy -S
Date: 2023.03 24 08 56:11 -04'00'

Alissa Mooney DeBoy
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

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: 22-0024

2. STATE: MA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
11/01/2020

5. FEDERAL STATUTE/REGULATION CITATION
Title 19 of the Social Security Act; Section 1135 of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 22 $ ~~87,680,000~~ 93,240,000
b. FFY 23 $ ~~0~~ 2,600,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency

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

9. SUBJECT OF AMENDMENT

Supplemental payments to hospitals during the COVID-19 public health emergency. An amendment to the rates to family planning services. An amendment to the rates for sterilzation planning services. Coverage for certain formula thickening agents dispensed at pharmacies.

10. 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)

11. SIGNATURE [redacted]

12. TYPED NAME
Marylou Sudders

13. TITLE
Secretary

14. DATE SUBMITTED
8/04/22

15. RETURN TO

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

FOR CMS USE ONLY

16. DATE RECEIVED
08/04/2022

17. DATE APPROVED
March 24, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
11/1/2020

19. SIGNATURE OF APPROVING OFFICIAL
Alissa M Deboy -S
Digitally signed by Alissa M. Deboy -S
Date: 2023.03.24 08:56:53 -04'00'

20. TYPED NAME OF APPROVING OFFICIAL
Alissa Mooney DeBoy

21. TITLE OF APPROVING OFFICIAL
On Behalf of Anne Marie Costello, Deputy Director
Center for Medicaid and CHIP Services

22. REMARKS

Instructions on Back

State/Territory: _Massachusetts_____

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.
Except as provided in Section E, the policies and procedures described below shall be effective 1/27/2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

___X__ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. ___X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by December 31, 2020, to obtain a SPA effective date during the fourth calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. __X___ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing),

and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X___ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Massachusetts Medicaid state plan, as described below:

Please describe the modifications to the timeline. The timeframe for tribal consultation in the State Plan is at least 30 days prior to SPA submission and an allowance of at least 14 days for feedback. We request to change the tribal consultation timeframe during the emergency period to conduct consultation the same date as submission of the SPA with an allowance of a week for feedback. The Massachusetts Executive Office of Health and Human Services (EOHHS) consulted with the Massachusetts Indian Tribes by email on August 4, 2022 about the proposed state plan amendments included in this COVID-19 Disaster SPA Template. The Tribes were asked to respond with any advice or feedback regarding this state plan amendment by August 11, 2022.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. _____ The agency adopts a total of _____ months (not to exceed 12 months) continuous eligibility for children under age enter age _____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

a. _____ The agency uses a simplified paper application.

b. _____ The agency uses a simplified online application.

c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

a. _____ All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. _____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. _____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. _____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

a. ____ Published fee schedules –

Effective date (enter date of change):

Location (list published location):

b. ___ Other:

Increases to state plan payment methodologies:

2. __X___ The agency increases payment rates for the following services:

Please list all that apply.
1. Acute Inpatient Hospital Supplemental Payments
2. Psychiatric Inpatient Hospital Supplemental Payments
3. Chronic Disease and Rehabilitation Inpatient Hospital Supplemental Payments
4. Substance Abuse Treatment Hospital Supplemental Payments
5. Rates for Family Planning Clinics
6. Rates for Sterilization Clinics

Effective dates for each of these payments are set forth hereinafter.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. __X__ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

1. Acute Inpatient Hospital Supplemental Payments

a. Supplemental Payment for Fiscally Distressed Hospitals

i. Eligibility Criteria

1. In order to qualify for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 1 level, a Hospital must satisfy each of the following criteria:

a. the Hospital must have received (a) more than 24% of its gross patient service revenue (GPSR) in FY19 from MassHealth, and (b) less than 50% of its GPSR in FY19 from commercial payers, with both figures as determined by EOHHS based on the Hospital's FY19 Massachusetts Hospital Cost Report; and

b. the Hospital must be part of a hospital health system that reported system-level financials to CHIA which demonstrated a total margin loss exceeding 4%, as determined by EOHHS based on FY21 quarterly data through March 31, 2021 submitted by the Hospital to the Center for Health Information and Analysis (CHIA).

2. In order to qualify for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 2 level, a Hospital must satisfy each of the following criteria:

a. The Hospital must satisfy all of the eligibility criteria set forth in **Section E.2.b.i.1.a.i.1**; and

b. The Hospital must be located in a town or city that has experienced a COVID-19 case count greater than 20,000 per 100,000 residents, as determined by EOHHS based on COVID-19 Response Reporting as of July 8, 2021

3. In order to qualify for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 3 level, a Hospital must satisfy each of the following criteria:

a. The Hospital must not be eligible for a Supplemental Payment for Distressed Hospitals at either the Tier 1 or Tier 2 levels pursuant to **Section E.2.b.i.1.a.i.1** or **E.2.b.i.1.a.i.2**; and

b. the Hospital's FY19 public payer percentage, which is the ratio of the Hospital's FY19 Gross Patient Service Revenue from government payers and free care to the Hospital's FY19 Gross Patient Service Revenue, must exceed 78%, as determined by EOHHS based on the Hospital's FY19 Massachusetts Hospital Cost Report.

4. In order to qualify for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 4 level, a Hospital must satisfy one or more of the following criteria:

    a. The Hospital is eligible a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 1 level pursuant to **Section E.2.b.i.1.a.i.1;**
    b. The Hospital is eligible a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 2 level pursuant to **Section E.2.b.i.1.a.i.2; or**
    c. The Hospital is eligible a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 3 level pursuant to **Section E.2.b.i.1.a.i.3**

5. In addition, to qualify for a Supplemental Payment for Fiscally Distressed Hospitals at either the Tier 1, Tier 2, Tier 3, or Tier 4 levels, a Hospital meeting the eligibility criteria set forth above must: enter into a separate payment agreement or agreements with EOHHS relating to receipt of such payment.

ii. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.1**, **E.2.b.i.1.a.i.2**, **E.2.b.i.1.a.i.3**, and/or **E.2.b.i.1.a.i.4** according to the methodology that follows.

1. For Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 1 level, EOHHS shall calculate each such eligible Hospital's payment as follows:

a. First, EOHHS will divide such Hospital's Total Net Patient Service Revenue, as reported in the Hospital's FY19 Massachusetts Hospital Cost Report, by the Total Net Patient Service Revenue of all Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 1 level, as reported in such Hospitals' FY19 Massachusetts Hospital Cost Reports, with all such figures as determined by EOHHS (Tier 1 Pro Rata Share).

b. Second, EOHHS will calculate each such Hospital's Tier 1 Payment by multiplying such Hospital's Tier 1 Pro Rata Share by $20 million.

2. For Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 2 level, EOHHS shall calculate each such eligible Hospital's payment as follows:

a. First, EOHHS will divide such Hospital's Total Net Patient Service Revenue, as reported in the Hospital's FY19 Massachusetts Hospital Cost Report, by the Total Net Patient Service Revenue of all Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 2 level, as reported in such Hospitals' FY19 Massachusetts Hospital Cost Reports, with all such figures as determined by EOHHS (Tier 2 Pro Rata Share).

b. Second, EOHHS will calculate each such Hospital's Tier 2 Payment by multiplying such Hospital's Tier 2 Pro Rata Share by $13 million.

3. For Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 3 level, EOHHS shall calculate each such eligible Hospital's payment as follows:

a. First, EOHHS will divide such Hospital's Total Net Patient Service Revenue, as reported in the Hospital's FY19 Massachusetts Hospital Cost Report, by the Total Net Patient Service Revenue of all Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 3 level, as reported in such Hospitals' FY19 Massachusetts Hospital Cost Report, with all such figures as determined by EOHHS (Tier 3 Pro Rata Share).

b. Second, EOHHS will calculate each such Hospital's Tier 3 Payment by multiplying such Hospital's Tier 3 Pro Rata Share by $10 million.

4. For Hospitals eligible for a Supplemental Payment for Fiscally Distressed Hospitals at the Tier 4 level, EOHHS shall calculate each such eligible Hospital's payment as the sum of its Pot 1 Payment, if any; its Pot 2 Payment, if any; and its Pot 3 Payment, if any; in accordance with the methodologies that follow:

a. For each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.4.a**, EOHHS shall calculate such Hospital's Pot 1 Payment by:

1. First, dividing such Hospital's Total Net Patient Service Revenue, as reported in the Hospital's FY19 Massachusetts Hospital Cost Report, by the Total Net Patient Service Revenue of all Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.4.a**, as reported in such Hospitals' FY19 Massachusetts Hospital Cost Report, with all such figures as determined by EOHHS (Pot 1 Pro Rata Share).

2. Second, calculating each such Hospital's Pot 1 Payment by multiplying such Hospital's Pot 1 Pro Rata Share by $3,255,814.

b. For each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.4.b**, EOHHS shall calculate such Hospital's Pot 2 Payment by:

1. First, dividing such Hospital's Total Net Patient Service Revenue, as reported in the Hospital's FY19 Massachusetts Hospital Cost Report, by the Total Net Patient Service Revenue of all Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.4.b**, as reported in such Hospitals' FY19 Massachusetts Hospital Cost Report, with all such figures as determined by EOHHS (Pot 2 Pro Rata Share).

2. Second, calculating each such Hospital's Pot 2 Payment by multiplying such Hospital's Pot 2 Pro Rata Share by $2,116,279.

c. For each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.4.c**, EOHHS shall calculate such Hospital's Pot 3 Payment by:

1. First, dividing such Hospital's Total Net Patient Service Revenue, as reported in the Hospital's FY19 Massachusetts Hospital Cost Report, by the Total Net Patient Service Revenue of all Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.1.a.i.4.c**, as reported in such Hospitals' FY19 Massachusetts Hospital Cost Report, with all such figures as determined by EOHHS (Pot 3 Pro Rata Share).

2. Second, calculating each such Hospital's Pot 3 Payment by multiplying such Hospital's Pot 3 Pro Rata Share by $1,627,907.

(Effective July 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

b. Supplemental Payments to Support Staffing DMH-Licensed Beds

i. Eligibility Criteria

In order to qualify for a Supplemental Payment to Support Staffing DMH-Licensed Beds, a Hospital must:

1. have rendered inpatient BH services in its DMH-Licensed Beds to at least one MassHealth Member during RY21, as determined by EOHHS;

2. enter into a separate payment agreement with EOHHS relating to receipt of such payment; and

3. agree to use any supplemental payment pursuant to this **Section E.2.b.i.1.b** solely for the purpose of increasing payments for the clinical and direct care personnel who staff such Hospital's DMH-Licensed Beds.

ii. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.1.b.i** through two tranches, in accordance with the methodology that follows.

1. EOHHS shall calculate each eligible Hospital's Tranche One payment as follows:

a. First, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Beds as of July 27, 2021 (Tranche One Number of DMH-Licensed Beds). This figure shall be as determined by EOHHS using data supplied by DMH.

b. Second, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Beds serving patients over the age of 65 as of July 27, 2021 (Tranche One Number of Geriatric DMH-Licensed Beds). This figure, which is a subset of the Hospital's Tranche One Number of DMH-Licensed Beds, shall be as determined by EOHHS using data supplied by DMH.

c. Third, EOHHS will calculate each eligible Hospital's total number of non-geriatric DMH-Licensed beds by subtracting each eligible Hospital's Tranche One Number of Geriatric

DMH-Licensed Beds from its Tranche One Number of DMH-Licensed Beds (Tranche One Number of Non-Geriatric DMH-Licensed Beds). This figure, which is a subset of the Hospital's Tranche One Number of DMH-Licensed Beds, shall be as determined by EOHHS using data supplied by DMH.

d. Fourth, EOHHS shall determine each eligible Hospital's Tranche One MassHealth Payer Mix, as that term is defined in this section, as of fiscal year 2019 (FY19), using data reported by each such Hospital to CHIA. For any eligible Hospital for which such data is unavailable, EOHHS shall assign such Hospital a Tranche One MassHealth Payer Mix of 25%. Tranche One MassHealth Payer Mix as of FY19, as determined by EOHHS, is the ratio of all dates of service during FY19 in which a Member received inpatient BH services from the Hospital in a DMH-Licensed Bed, to all dates of service during FY19 in which the Hospital's patients received such services in such beds, provided, further, that such dates of service include any dates of service on which a Member or patient was discharged to AD status from such DMH-Licensed Bed following such inpatient BH admission. For purposes of this definition, the numerator includes any date of service during FY19 in which any of the following Members received services in such beds:

i. Members receiving services on a fee-for-service basis,

ii. Members enrolled with a Managed Care Entity, and

iii. Members with Third-Party Insurance.

e. Fifth, EOHHS shall calculate each eligible Hospital's Tranche One Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Beds by multiplying such Hospital's Tranche One MassHealth Payer Mix by such Hospital's Tranche One Number of Non-Geriatric DMH-Licensed Beds.

f. Sixth, EOHHS shall calculate each eligible Hospital's Tranche One Adjusted DMH-Licensed Bed Count by summing such Hospital's Tranche One Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Beds and such Hospital's Tranche One Number of Geriatric DMH-Licensed Beds.

g. Seventh, EOHHS shall calculate the Tranche One Aggregate Adjusted DMH-Licensed Bed Count in Eligible Hospitals by summing the Tranche One Adjusted DMH-Licensed Bed Counts of each Hospital eligible for payment pursuant to **Section E.2.b.i.1.b.i**.

h. Eighth, EOHHS shall calculate each eligible Hospital's Tranche One Payment by multiplying $7,182,152 by the ratio of such Hospital's Tranche One Adjusted DMH-Licensed Bed Count to the Tranche One Aggregate Adjusted DMH-Licensed Bed Count in Eligible Hospitals.

2. EOHHS shall calculate each eligible Hospital's Tranche Two payment as follows:

a. First, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Operational Beds as of December 31, 2021 (Tranche Two Number of DMH-Licensed Operational Beds). This figure shall be as determined by EOHHS using data supplied by DMH.

Tranche Two Operational Beds are DMH-Licensed Beds available and staffed for immediate occupancy, subject to the hospital's standard operating procedures for referral and intake.

b. Second, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Operational Beds serving patients over the age of 65 as of December 31, 2021 (Tranche Two Number of Geriatric DMH-Licensed Operational Beds). This figure, which is a subset of the Hospital's Tranche Two Number of DMH-Licensed Operational Beds, shall be as determined by EOHHS using data supplied by DMH.

c. Third, EOHHS will calculate each eligible Hospital's total number of non-geriatric DMH-Licensed Operational Beds by subtracting each eligible Hospital's Tranche Two Number of Geriatric DMH-Licensed Operational Beds from its Tranche Two Number of DMH-Licensed Operational Beds (Tranche Two Number of Non-Geriatric DMH-Licensed Operational Beds). This figure, which is a subset of the Hospital's Tranche Two Number of DMH-Licensed Operational Beds, shall be as determined by EOHHS using data supplied by DMH.

d. Fourth, EOHHS shall determine each eligible Hospital's Tranche Two MassHealth Payer Mix as of FY19, using data reported by each such Hospital to CHIA. For any eligible Hospital for which such data is unavailable, EOHHS shall assign such Hospital a Tranche Two MassHealth Payer Mix of 25%. Tranche Two MassHealth Payer Mix as of FY19, as determined by EOHHS, is the ratio of all dates of service during FY19 in which a Member received inpatient BH services from the Hospital in a DMH Licensed Bed, to all dates of service during FY19 in which the Hospital's patients received such services in such beds, provided, further, that such dates of service include any dates of service on which a Member or patient was discharged to AD status from such DMH-Licensed Bed following such inpatient BH admission. For purposes of this definition, the numerator includes any date of service during FY19 in which any of the following Members received services in such beds:

i. Members receiving services on a fee-for-service basis,

ii. Members enrolled with a Managed Care Entity, and

iii. Members with Third-Party Insurance.

e. Fifth, EOHHS shall calculate each eligible Hospital's Tranche Two Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Operational Beds by multiplying such Hospital's Tranche Two MassHealth Payer Mix by such Hospital's Tranche Two Number of Non-Geriatric DMH-Licensed Operational Beds.

f. Sixth, EOHHS shall calculate each eligible Hospital's Tranche Two Adjusted DMH-Licensed Operational Bed Count by summing such Hospital's Tranche Two Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Operational Beds and such Hospital's Tranche Two Number of Geriatric DMH-Licensed Operational Beds.

g. Seventh, EOHHS shall calculate the Tranche Two Aggregate Adjusted DMH-Licensed Operational Bed Count in Eligible Hospitals by summing the Tranche Two Adjusted DMH-Licensed Operational Bed Counts of each Hospital eligible for payment pursuant to this **Section E.2.b.i.1.b.i**.

h. Eighth, EOHHS shall calculate each eligible Hospital's Tranche Two Payment by multiplying $7,381,926 by the ratio of such Hospital's Tranche Two Adjusted DMH-Licensed Operational Bed Count to the Tranche Two Aggregate Adjusted DMH-Licensed Operational Bed Count in Eligible Hospitals.

(Effective July 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

c. Acute Inpatient Hospital Expansion of Inpatient Behavioral Health Capacity Supplemental Payment

1. For purposes of this **Section E.2.b.i.1.c**, the following terms shall have the following meanings:

a. Baseline – The number of DMH-Licensed Beds operated by the Hospital as of January 1, 2022, or, in the event that the Hospital acquired an inpatient facility after January 1, 2022, and prior to December 31, 2022 the number of DMH-Licensed Beds operated by the Hospital's predecessor at such inpatient facility as of January 1, 2022.

b. Bed Increase – The aggregate number of DMH-Licensed Beds above the Baseline that the Hospital commits to Operationalize during the Bed Increase Period, including obtaining all necessary licensure and approval from DMH and DPH. In the event that the Hospital acquired an inpatient facility in the middle of the Bed Increase Period, its Bed Increase for the Bed Increase Period for such inpatient facility shall be the number of DMH-Licensed Beds above the Baseline for the Bed Increase Period that the Hospital commits to Operationalize during the Bed Increase Period, including obtaining all necessary licensure and approval from DMH and DPH, inclusive of any DMH-Licensed Beds Operationalized at such inpatient facility by the predecessor Hospital during the Bed Increase Period prior to the acquisition.

c. Bed Increase Period – The period beginning January 1, 2022, and ending no later than September 30, 2023.

d. Deoperationalize – Hospital activities to make Operationalized DMH-Licensed Beds no longer available for immediate occupancy.

e. Managed Care Entity (MCE) – An MCO or the BH Contractor.

f. MassHealth Payer-Mix – As determined by EOHHS, the ratio of all dates of service on which a Member received inpatient BH services from the Hospital in a DMH-Licensed Bed, to all dates of service on which the Hospital's patients received such services in such beds, provided, further, that such dates of service include any dates of service on which a Member or patient was

discharged to AD status from such DMH-Licensed Bed following such inpatient BH admission. For purposes of this definition, the numerator includes any date of service on which any of the following Members received services in such beds:

i. Members receiving services on a fee-for-service basis;

ii. Members enrolled with a Managed Care Entity;

iii. Members with Third-Party Insurance.

g. Operationalize – Hospital activities to make available licensed and staffed DMH-Licensed Beds for immediate occupancy, subject to the hospital's standard operating procedures for referral and intake.

2. Eligibility Criteria

A Hospital is eligible for an Expansion of Inpatient Behavioral Health Capacity Supplemental Payment if the Hospital:

a. Enters into a separate payment agreement with EOHHS relating to receipt of such payment;
b. Is privately-owned and operated;
c. Attests no later than June 1, 2022, in a form and format prescribed by EOHHS, to:

i. The Hospital's Baseline; and
ii. The Hospital's Bed Increase during the Bed Increase Period;

d. Agrees:

i. Not to delicense or Deoperationalize any of its DMH-Licensed Beds, whether currently licensed or otherwise, and whether included in the Hospital's Baseline or the Hospital's Bed Increase, through the end of RY25, unless EOHHS grants the hospital a written exemption from this requirement, provided that a Hospital's transfer of some or all of its Operational DMH-Licensed Beds to another hospital owned by or affiliated with the transferor Hospital, or owned by or affiliated with the same entity that owns the transferor Hospital, shall not be considered a delicensure or Deoperationalization of those beds, so long as such transfer does not result in a net decrease to the total number of Operational DMH-Licensed beds operated by the transferor and transferee hospitals combined.
ii. That any supplemental payments made pursuant to this **Section E.2.b.i.1.c** are subject to recoupment, in whole or in part, if the Hospital fails to license and Operationalize its Bed Increase in a timely fashion, or otherwise fails to comply with any term, condition, or agreement described in this **Section E.2.b.i.1.c;**
iii. To maintain a MassHealth Payer-Mix of at least 20% in each of RY23, RY24, and RY25, provided that, for purposes of this **Section E.2.b.i.1.c.2.d.iii,** the Hospital's MassHealth Payer-Mix shall be calculated using only the Hospital's Bed Increase pursuant to this **Section E.2.b.i.1.c**;

iv. That if the Hospital is part of a system of Hospitals, that all DMH-licensed units within such system, and all psychiatric inpatient hospitals within such system, in the aggregate, will maintain a MassHealth Payer Mix in each of RY23, RY24, and RY25 that is no less than its MassHealth Payer Mix in FY19, as determined by EOHHS, provided that, for purposes of this **Section E.2.b.i.1.c.2.d.i**, the system's MassHealth Payer-Mix shall be calculated using such system's current DMH-Licensed Beds, exclusive of any Bed Increase pursuant to this **Section E.2.b.i.1.c;**

v. To notify EOHHS in writing no later than the day following the last day of the Bed Increase Period of:

1. The number of beds included in the Hospital's Bed Increase attestation pursuant to **Section E.2.b.i.1.c.2.c** that the Hospital Operationalized by the last day of the Bed Increase Period; and
2. The number of beds included in the Hospital's Bed Increase attestation pursuant to **Section E.2.b.i.1.c.2.c** that the Hospital did not Operationalize by the last day of the Bed Increase Period;

vi. To expend any supplemental payments pursuant to this **Section E.2.b.i.1.c** solely for the purpose of licensing and Operationalizing the Bed Increase described in this **Section E.2.b.i.1.c.**

3. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make one or more supplemental payments to each Hospital that qualifies for this payment pursuant to **Section E.2.b.i.1.c.2**, in accordance with the methodology that follows. EOHHS will pay each qualifying Hospital $60,000 multiplied by the Hospital's Bed Increase.

(Effective January 1, 2022 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

d. Supplemental Payment for Acute Inpatient Hospitals Accepting COVID-Positive MassHealth Members Needing Inpatient BH Services

1. Eligibility Criteria - A Hospital is eligible for a Supplemental Payment for Hospitals Accepting COVID-Positive MassHealth Members Needing Inpatient BH Services if the Hospital:

a. Agrees to:
   i. Comply with all applicable DMH requirements, including DMH infection control standards; and
   ii. Provide periodic reports in a form and on a cadence to be prescribed by EOHHS.

b. Admits at least one Member after December 15, 2021, and prior to May 1, 2022, who satisfies each of the following criteria:
   i. The Hospital admits the Member into a DMH-Licensed Bed for the primary purpose of rendering inpatient BH services;

ii. The Member is confirmed to have been positive for SARS-CoV-2 at the time of admission to the DMH-Licensed Bed based on a SARS-CoV-2 Molecular Diagnostic test or an FDA-approved rapid antigen test administered before admission or within 96 hours after admission; and

iii. The Member is not suspected to have become COVID-positive from exposure occurring within the admitting hospital or from interactions with any member of the hospital's staff or other currently COVID-positive patients at the hospital.

2. Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments within RY22 to each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.1.d.1**. Each eligible Hospital's payment shall be $954.59 for each date of service between January 1, 2022, and May 1, 2022, on which the Hospital rendered:

a. Services reimbursed through the Psychiatric Per Diem rate to a Member described in **Section E.2.b.i.1.d.1.b**, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation; or

b. Services reimbursed through the Administrative Day Per Diem rate to a Member described in **Section E.2.b.i.1.d.1.b**, who was discharged to AD status from a DMH-Licensed Bed following an inpatient BH admission, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation, inclusive of the Member's preceding inpatient BH stay.

(Effective January 1, 2022 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

e. Supplemental Payment for Acute Inpatient Hospitals with Temporary Dedicated COVID Units Admitting COVID-Positive MassHealth Members

1. Definitions

For purposes of this **E.2.b.i.1.e**, the following terms shall have the following meanings:

a. Dedicated COVID Unit – A DMH-approved psychiatric unit within a Hospital into which the Hospital will admit only COVID-Positive Patients in need of inpatient BH services. Units will only meet this definition during the period specifically approved by DMH.

b. COVID-Positive Patient – A patient who is confirmed to be infected with SARS-CoV-2 upon admission to a Hospital through a Molecular Diagnostic test or an FDA-approved rapid antigen test.

c. COVID-Positive MassHealth Member – A COVID-Positive Patient who is a Member.

2. Eligibility Criteria

A Hospital is eligible to receive a Supplemental Payment for Hospitals with Temporary Dedicated COVID Units Admitting COVID-Positive MassHealth Members if the Hospital:

a. Demonstrates that DMH has approved the creation of a Dedicated COVID Unit within the Hospital;
b. Agrees:
    i. To comply with all applicable DMH requirements, such as any conditions of approval for the Dedicated COVID Unit; and
    ii. Not to admit or transfer-in non-COVID-Positive Patients to the Dedicated COVID Unit while the unit remains a Dedicated COVID Unit, unless the non-COVID-Positive Patient had previously tested positive for Sars-CoV-2 within 60 days prior to admission; and
c. Admits at least one COVID-Positive MassHealth Member to the Dedicated COVID Unit during the period in which DMH has approved the unit as a Dedicated COVID Unit, but no later than May 1, 2022.

3. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments within RY22 to each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.1.e.2** for each period beginning on or after December 21, 2021, in which the Hospital operated a Dedicated COVID Unit. Each eligible Hospital's payment shall be calculated by multiplying $300 by the number of days that the Hospital operated the DMH-approved Dedicated COVID Unit by the number of beds in that DMH-approved Dedicated COVID Unit, for all dates of service the hospital operates the DMH-approved Dedicated Unit prior to May 1, 2022, with each figure as determined by EOHHS

(Effective January 27, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

f. MassHealth Targeted Hospital Supplemental Payments

1. General Information

The state will pay a targeted hospital supplemental payment to eligible hospitals, as described in **Section E.2.b.i.1.f.2**, in accordance with the methodologies described in **Section E.2.b.i.1.f.3**.

2. Eligibility Criteria

In order to be eligible for a targeted hospital supplemental payment, a hospital must be either:

a. A non-profit teaching acute hospital that provides medical, surgical, emergency and obstetrical services and is affiliated with a Commonwealth-owned medical school, as determined by EOHHS, or,
b. A freestanding Pediatric Acute Hospital, as determined by EOHHS

3. Methodology

The state will make the targeted hospital supplemental payments described in **Section E.2.b.i.1.f.1** as follows:

a. For hospitals eligible for a targeted hospital supplemental payment under **Section E.2.b.i.1.f.2.a**, EOHHS shall make a payment of $25,000,000.

b. For hospitals eligible for a targeted hospital supplemental payment under **Section E.2.b.i.1.f.2.b**, EOHHS shall pay $22,500,000 to the hospital with the largest volume of inpatient discharges in fiscal year 2019, as determined by EOHHS using Massachusetts hospital cost report data; and shall pay $2,500,000, divided among the remaining eligible hospitals using each hospital's pro-rata share of Medicaid inpatient discharges in fiscal year 2019 for all such eligible hospitals, as determined by EOHHS using Massachusetts hospital cost report data.

(Effective September 30, 2022 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

g. Supplemental Payments to Support Hospital Financial Stability

i. General Information

The state will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.1.g.ii**, according to the methodology set forth in **Section E.2.b.i.1.g.iii**.

ii. Eligibility Criteria

1. In order to qualify for a Supplemental Payment to Support Hospital Financial Stability at the Tier 1 level, a Hospital must satisfy each of the following criteria:

    a. the Hospital must be part of a Hospital Health System that reported system-level financials to CHIA which demonstrated a total margin loss at or above 6%, as determined by the state based on the Massachusetts June 2022 Massachusetts Acute Hospital and Health System Financial Performance report that includes data through March 31, 2022; and

    b. the Hospital must have received at least 20% of its gross patient service revenue (GPSR) in FY20 from MassHealth, Self-Pay and the Health Safety Net ("Medicaid and Uninsured"), as determined by the state based on the Hospital's FY20 Massachusetts Hospital Cost Report.

2. In order to qualify for a Supplemental Payment to Support Hospital Financial Stability at the Tier 2 level, a Hospital must satisfy each of the following criteria:

    a. the Hospital must be part of a Hospital Health System that reported system-level financials to CHIA which demonstrated a total margin loss at or above 15%, as determined by EOHHS based on CHIA's June 2022 Massachusetts Acute Hospital and Health System Financial Performance report that includes data through March 31, 2022; and

    b. the Hospital must have received at least 30% of its gross patient service revenue (GPSR) in FY20 from MassHealth, Self-Pay and the Health Safety Net ("Medicaid and Uninsured"), as determined by the state based on the Hospital's FY20 Massachusetts Hospital Cost Report.

3. In addition, to qualify for a Supplemental Payment to Support Hospital Financial Stability at either the Tier 1 or Tier 2 level, a Hospital meeting the eligibility criteria set forth above must:

    a. enter into a separate payment agreement or agreements with the state relating to receipt of such payment; and

    b. satisfy any conditions of such payment agreement(s), including by providing any attestation(s) that the state may require, in a form and format to be prescribed by the state.

iii. Methodology

1. For Hospitals eligible for a Supplemental Payment to Support Hospital Financial Stability at the Tier 1 level, the state shall calculate each such eligible Hospital's payment as follows:

    a. First, the state will divide such Hospital's Medicaid Gross Patient Service Revenue, as reported in the Hospital's FY20 Massachusetts Hospital Cost Report, by the Medicaid Gross Patient Service Revenue of all Hospitals eligible for a Supplemental Payment to Support Hospital Financial Stability at the Tier 1 level, as reported in such Hospitals' FY20 Massachusetts Hospital Cost Reports, with all such figures as determined by EOHHS (Tier 1 Pro Rata Share).

    b. Second, the state will calculate each such Hospital's Tier 1 Payment by multiplying such Hospital's Tier 1 Pro Rata Share by $5 million.

2. For Hospitals eligible for a Supplemental Payment to Support Hospital Financial Stability at the Tier 2 level, the state shall calculate each such eligible Hospital's payment as criteria:

    a. First, the state will divide such Hospital's Medicaid Gross Patient Service Revenue, as reported in the Hospital's FY20 Massachusetts Hospital Cost Report, by the Medicaid Gross Patient Service Revenue of all Hospitals eligible for a Supplemental Payment to Support Hospital Financial Stability at the Tier 2 level, as reported in such Hospitals' FY20 CHIA Cost Reports, with all such figures as determined by the state (Tier 2 Pro Rata Share).

    b. Second, the state will calculate each such Hospital's Tier 2 Payment by multiplying such Hospital's Tier 2 Pro Rata Share by $9.5 million.

3. A Hospital may be eligible to receive both a Tier 1 and a Tier 2 payment, if it meets the criteria for both.

(Effective December 21, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

2. Psychiatric Inpatient Hospital Supplemental Payments

a. Supplemental Payments to Support Staffing DMH-Licensed Beds

i. Eligibility Criteria

In order to qualify for a Supplemental Payment to Support Staffing DMH-Licensed Beds, a Hospital must:

1. have rendered inpatient BH services in its DMH-Licensed Beds to at least one MassHealth Member during RY21, as determined by EOHHS;
2. enter into a separate payment agreement with EOHHS relating to receipt of such payment; and

3. agree to use any supplemental payment pursuant to this **Section E.2.b.i.2.a** solely for the purpose of increasing payments for the clinical and direct care personnel who staff such Hospital's DMH-Licensed Beds.

ii. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in **Section E.2.b.i.2.a.i** through two tranches, in accordance with the methodology that follows.

1. EOHHS shall calculate each eligible Hospital's Tranche One payment as follows:

a. First, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Beds as of July 27, 2021 (Tranche One Number of DMH-Licensed Beds). This figure shall be as determined by EOHHS using data supplied by DMH.

b. Second, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Beds serving patients over the age of 65 as of July 27, 2021 (Tranche One Number of Geriatric DMH-Licensed Beds). This figure, which is a subset of the Hospital's Tranche One Number of DMH-Licensed Beds, shall be as determined by EOHHS using data supplied by DMH.

c. Third, EOHHS will calculate each eligible Hospital's total number of non-geriatric DMH-Licensed beds by subtracting each eligible Hospital's Number of Geriatric DMH-Licensed Beds from its Number of DMH-Licensed Beds (Tranche One Number of Non-Geriatric DMH-Licensed Beds). This figure, which is a subset of the Hospital's Tranche One Number of DMH-Licensed Beds, shall be as determined by EOHHS using data supplied by DMH.

d. Fourth, EOHHS shall determine each eligible Hospital's Tranche One MassHealth Payer Mix, as that term is defined in this section, as of fiscal year 2019 (FY19), using data reported by each such Hospital to CHIA. For any eligible Hospital for which such data is unavailable, EOHHS shall assign such Hospital a Tranche One MassHealth Payer Mix of 35%. Tranche One MassHealth Payer Mix as of FY19, as determined by EOHHS, is the ratio of all dates of service during FY19 in which a Member received inpatient BH services from the Hospital in a DMH-Licensed Bed, to all dates of service during FY19 in which the Hospital's patients received such services in such beds, provided, further, that such dates of service include any dates of service on which a Member or patient was discharged to AD status from such DMH-Licensed Bed following such inpatient BH admission. For purposes of this definition, the numerator includes

any date of service during FY19 in which any of the following Members received services in such beds:

i. Members receiving services on a fee-for-service basis,

ii. Members enrolled with a Managed Care Entity, and

iii. Members with Third-Party Insurance.

e. Fifth, EOHHS shall calculate each eligible Hospital's Tranche One Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Beds by multiplying such Hospital's Tranche One MassHealth Payer Mix by such Hospital's Tranche One Number of Non-Geriatric DMH-Licensed Beds.

f. Sixth, EOHHS shall calculate each eligible Hospital's Tranche One Adjusted DMH-Licensed Bed Count by summing such Hospital's Tranche One Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Beds and such Hospital's Tranche One Number of Geriatric DMH-Licensed Beds.

g. Seventh, EOHHS shall calculate the Tranche One Aggregate Adjusted DMH-Licensed Bed Count in Eligible Hospitals by summing the Tranche One Adjusted DMH-Licensed Bed Counts of each Hospital eligible for payment pursuant to **Section E.2.b.i.2.a.i**.

h. Eighth, EOHHS shall calculate each eligible Hospital's Tranche One Payment by multiplying $7,872,653.18 by the ratio of such Hospital's Tranche One Adjusted DMH-Licensed Bed Count to the Tranche One Aggregate Adjusted DMH-Licensed Bed Count in Eligible Hospitals.

2. EOHHS shall calculate each eligible Hospital's Tranche Two payment as follows:

a. First, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Operational Beds as of December 31, 2021 (Tranche Two Number of DMH-Licensed Operational Beds). This figure shall be as determined by EOHHS using data supplied by DMH. Tranche Two Operational Beds are DMH-Licensed Beds available and staffed for immediate occupancy, subject to the hospital's standard operating procedures for referral and intake.

b. Second, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Operational Beds serving patients over the age of 65 as of December 31, 2021 (Tranche Two Number of Geriatric DMH-Licensed Operational Beds). This figure, which is a subset of the Hospital's Tranche Two Number of DMH-Licensed Operational Beds, shall be as determined by EOHHS using data supplied by DMH.

c. Third, EOHHS will calculate each eligible Hospital's total number of non-geriatric DMH-Licensed Operational Beds by subtracting each eligible Hospital's Tranche Two Number of Geriatric DMH-Licensed Operational Beds from its Tranche Two Number of DMH-Licensed Operational Beds (Tranche Two Number of Non-Geriatric DMH-Licensed Operational Beds). This figure, which is a subset of the Hospital's Tranche Two Number of DMH-Licensed Operational Beds, shall be as determined by EOHHS using data supplied by DMH.

d. Fourth, EOHHS shall determine each eligible Hospital's Tranche Two MassHealth Payer Mix as of FY19, using data reported by each such Hospital to CHIA. For any eligible Hospital for which such data is unavailable, EOHHS shall assign such Hospital a Tranche Two MassHealth Payer Mix of 35%. Tranche Two MassHealth Payer Mix, as determined by EOHHS, is the ratio of all dates of service during over a given period on which a Member received inpatient services from the Hospital in a DMH Licensed Bed, and all dates of a Member's inpatient hospitalization defined as Administratively Necessary Days (AND), to all dates of service during that same period on which the Hospital's patients received such services in such beds. This includes Members enrolled with a Managed Care Entity, and Members with Third-Party Insurance.

e. Fifth, EOHHS shall calculate each eligible Hospital's Tranche Two Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Operational Beds by multiplying such Hospital's Tranche Two MassHealth Payer Mix by such Hospital's Tranche Two Number of Non-Geriatric DMH-Licensed Operational Beds.

f. Sixth, EOHHS shall calculate each eligible Hospital's Tranche Two Adjusted DMH-Licensed Operational Bed Count by summing such Hospital's Tranche Two Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Operational Beds and such Hospital's Tranche Two Number of Geriatric DMH-Licensed Operational Beds.

g. Seventh, EOHHS shall calculate the Tranche Two Aggregate Adjusted DMH-Licensed Operational Bed Count in Eligible Hospitals by summing the Tranche Two Adjusted DMH-Licensed Operational Bed Counts of each Hospital eligible for payment pursuant to this **Section E.2.b.i.2.a.i**.

h. Eighth, EOHHS shall calculate each eligible Hospital's Tranche Two Payment by multiplying $7,713,145 by the ratio of such Hospital's Tranche Two Adjusted DMH-Licensed Operational Bed Count to the Tranche Two Aggregate Adjusted DMH-Licensed Operational Bed Count in Eligible Hospitals.

(Effective July 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

b. Psychiatric Hospital Expansion of Inpatient Behavioral Health Capacity Supplemental Payment

1. For purposes of this **Section E.2.b.i.2.b** the following terms shall have the following meanings:

a. Baseline – The number of DMH-Licensed Beds operated by the Hospital as of January 1, 2022, or, in the event that the Hospital acquired an inpatient facility after January 1, 2022, and prior to December 31, 2022 the number of DMH-Licensed Beds operated by the Hospital's predecessor at such inpatient facility as of January 1, 2022.

b. Bed Increase – The aggregate number of DMH-Licensed Beds above the Baseline that the Hospital commits to Operationalize during the Bed Increase Period, including obtaining all necessary licensure and approval from DMH and DPH. In the event that the Hospital acquired an Inpatient Site in the middle of the Bed Increase Period, its Bed Increase for the Bed Increase Period for such Inpatient Site shall be the number of DMH-Licensed Beds above the Baseline for the Bed Increase Period that the Hospital commits to Operationalize during the Bed Increase Period, including obtaining all necessary licensure and approval from DMH and DPH, inclusive of any DMH-Licensed Beds Operationalized at such Inpatient Site by the predecessor Hospital during the Bed Increase Period prior to the acquisition.

c. Bed Increase Period – The period beginning January 1, 2022, and ending no later than September 30, 2023.

d. Deoperationalize – Hospital activities to make Operationalized DMH-Licensed Beds no longer available for immediate occupancy.

e. Managed Care Entity (MCE) – An MCO or the BH Contractor.

f. MassHealth Payer-Mix – As determined by EOHHS, the ratio of all dates of service on which a Member received Inpatient Services from the Hospital in a DMH-Licensed Bed, and all dates of a Member's inpatient hospitalization defined as Administratively Necessary Days (AND), to all dates of service on which the Hospital's patients received such services in such beds. For purposes of this definition, the numerator includes any date of service on which any of the following Members received services in such beds:

i. Members receiving services on a fee-for-service basis;

ii. Members enrolled with a Managed Care Entity;

iii. Members with Third-Party Insurance.

g. Operationalize – Hospital activities to make available licensed and staffed DMH-Licensed Beds for immediate occupancy, subject to the hospital's standard operating procedures for referral and intake.

2. Eligibility Criteria

A Hospital is eligible for an Expansion of Inpatient Behavioral Health Capacity Supplemental Payment if the Hospital:

a. Enters into a separate payment agreement with EOHHS relating to receipt of such payment;
b. Is privately-owned and operated;
c. Attests no later than June 1, 2022, in a form and format prescribed by EOHHS, to:

i. The Hospital's Baseline; and
ii. The Hospital's Bed Increase during the Bed Increase Period.

d. Agrees:

i. Not to delicense or Deoperationalize any of its DMH-Licensed Beds, whether currently licensed or otherwise, and whether included in the Hospital's Baseline or the Hospital's Bed Increase, through the end of RY25, unless EOHHS grants the hospital a written exemption from this requirement, provided that a Hospital's transfer of some or all of its Operational DMH-Licensed Beds to another hospital owned by or affiliated with the transferor Hospital, or owned by or affiliated with the same entity that owns the transferor Hospital, shall not be considered a delicensure or Deoperationalization of those beds, so long as such transfer does not result in a net decrease to the total number of Operational DMH-Licensed beds operated by the transferor and transferee hospitals combined.

ii. That any supplemental payments made pursuant to this **Section E.2.b.i.2.b** are subject to recoupment, in whole or in part, if the Hospital fails to license and Operationalize its Bed Increase in a timely fashion, or otherwise fails to comply with any term, condition, or agreement described in this **Section E.2.b.i.2.b;**

iii. To maintain a MassHealth Payer-Mix of at least 20% in each of RY23, RY24, and RY25, provided that, for purposes of this **Section E.2.b.i.2.b.2.d.iii,** the Hospital's MassHealth Payer-Mix shall be calculated using only the Hospital's Bed Increase pursuant to this **Section E.2.b.i.2.b**;

iv. That if the Hospital is part of a system of Hospitals, that all DMH-licensed units within such system, and all psychiatric inpatient hospitals within such system, in the aggregate, will maintain a MassHealth Payer Mix in each of RY23, RY24, and RY25 that is no less than its MassHealth Payer Mix in FY19, as determined by EOHHS, provided that, for purposes of this **Section E.2.b.i.2.b.2.d.i**, the system's MassHealth Payer-Mix shall be calculated using such system's current DMH-Licensed Beds, exclusive of any Bed Increase pursuant to this **Section E.2.b.i.2.b.;**

v. To notify EOHHS in writing no later than the day following the last day of the Bed Increase Period of:

1. The number of beds included in the Hospital's Bed Increase attestation pursuant to **Section E.2.b.i.2.b.2.c** that the Hospital Operationalized by the last day of the Bed Increase Period; and
2. The number of beds included in the Hospital's Bed Increase attestation pursuant to **Section E.2.b.i.2.b.2.c** that the Hospital did not Operationalize by the last day of the Bed Increase Period;

vi. To expend any supplemental payments pursuant to this **Section E.2.b.i.2.b.** solely for the purpose of licensing and Operationalizing the Bed Increase described in this **Section E.2.b.i.2.b.**

3. **Methodology**

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make one or more supplemental payments to each Hospital that qualifies for this payment pursuant to **Section E.2.b.i.2.b.2**, in accordance with

the methodology that follows. EOHHS will pay each qualifying Hospital $60,000 multiplied by the Hospital's Bed Increase.

(Effective January 1, 2022 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

c. Supplemental Payment for Psychiatric Hospitals Accepting COVID-Positive MassHealth Members Needing Inpatient BH Services

1. Eligibility Criteria - A Hospital is eligible for a Supplemental Payment for Hospitals Accepting COVID-Positive MassHealth Members Needing Inpatient BH Services if the Hospital:

a. Agrees to:

i. Comply with all applicable DMH requirements, including DMH infection control standards; and

ii. Provide periodic reports in a form and on a cadence to be prescribed by EOHHS.

b. Admits at least one Member after December 15, 2021, and prior to May 1, 2022, who satisfies each of the following criteria:

iii. The Hospital admits the Member into a DMH-Licensed Bed for the primary purpose of rendering inpatient BH services;

iv. The Member is confirmed to have been positive for SARS-CoV-2 at the time of admission to the DMH-Licensed Bed based on a SARS-CoV-2 Molecular Diagnostic test or an FDA-approved rapid antigen test administered before admission or within 96 hours after admission; and

v. The Member is not suspected to have become COVID-positive from exposure occurring within the admitting hospital or from interactions with any member of the hospital's staff or other currently COVID-positive patients at the hospital.

2. Payment Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments within RY22 to each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.2.c.1**. Each eligible Hospital's payment shall be $954.59 for each date of service between January 1, 2022, and May 1, 2022, on which the Hospital rendered:

a. Services reimbursed through the Psychiatric Per Diem rate to a Member described in **Section E.2.b.i.2.c.1.b**, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation; or

b. Services reimbursed through the Administrative Day Per Diem rate to a Member described in **Section E.2.b.i.2.c.1.b**, who was discharged to AND status from a DMH-Licensed

Bed following an inpatient BH admission, provided that EOHHS will include only the first 14 days of the stay of any such Member in this calculation, inclusive of the Member's preceding inpatient BH stay.

(Effective January 1, 2022 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

d. Supplemental Payment for Psychiatric Hospitals with Temporary Dedicated COVID Units Admitting COVID-Positive MassHealth Members

1. Definitions

For purposes of this **E.2.b.i.2.d**, the following terms shall have the following meanings:

a. Dedicated COVID Unit – A DMH-approved psychiatric unit within a Hospital into which the Hospital will admit only COVID-Positive Patients in need of inpatient BH services. Units will only meet this definition during the period specifically approved by DMH.

b. COVID-Positive Patient – A patient who is confirmed to be infected with SARS-CoV-2 upon admission to a Hospital through a Molecular Diagnostic test or an FDA-approved rapid antigen test.

c. COVID-Positive MassHealth Member – A COVID-Positive Patient who is a Member.

2. Eligibility Criteria

A Hospital is eligible to receive a Supplemental Payment for Hospitals with Temporary Dedicated COVID Units Admitting COVID-Positive MassHealth Members if the Hospital:

a. Demonstrates that DMH has approved the creation of a Dedicated COVID Unit within the Hospital;

b. Agrees:

i. To comply with all applicable DMH requirements, such as any conditions of approval for the Dedicated COVID Unit; and

ii. Not to admit or transfer-in non-COVID-Positive Patients to the Dedicated COVID Unit while the unit remains a Dedicated COVID Unit, unless the non-COVID-Positive Patient had previously tested positive for Sars-CoV-2 within 60 days prior to admission; and

c. Admits at least one COVID-Positive MassHealth Member to the Dedicated COVID Unit during the period in which DMH has approved the unit as a Dedicated COVID Unit, but no later than May 1, 2022.

3. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments within RY22 to each Hospital satisfying the eligibility criteria set forth in **Section E.2.b.i.2.d.2** for each period beginning on or after December 21, 2021, in which the Hospital operated a Dedicated COVID Unit. Each eligible Hospital's payment shall be calculated by multiplying $300 by the number of days before May 1, 2022, and multiplying $875 by the number of days beginning May 1, 2022, and prior to July 1, 2022 that the Hospital operated the DMH-approved Dedicated COVID Unit by the number of beds in that DMH-approved Dedicated COVID Unit, for all dates of service the hospital operates the DMH-approved Dedicated Unit ~~prior to May 1, 2022~~, with each figure as determined by EOHHS

(Effective December 21, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

3. Chronic Disease and Rehabilitation Inpatient Hospital Supplemental Payments

a. Supplemental Payments to Support Staffing DMH-Licensed Beds

i. Eligibility Criteria

In order to qualify for a Supplemental Payment to Support Staffing DMH-Licensed Beds, a Hospital must:

1. have rendered inpatient BH services in its DMH-Licensed Beds to at least one MassHealth Member during RY21, as determined by EOHHS;
2. enter into a separate payment agreement with EOHHS relating to receipt of such payment; and

3. agree to use any supplemental payment pursuant to this **Section E.3.b.i.3.a.i.** solely for the purpose of increasing payments for the clinical and direct care personnel who staff such Hospital's DMH-Licensed Beds.

ii. Methodology

Subject to compliance with all applicable federal rules and payment limits, EOHHS will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in **Section E.3.b.i.3.a.i.** through two tranches, in accordance with the methodology that follows.

1. EOHHS shall calculate each eligible Hospital's Tranche One payment as follows:

a. First, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Beds as of July 27, 2021 (Tranche One Number of DMH-Licensed Beds). This figure shall be as determined by EOHHS using data supplied by DMH.

b. Second, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Beds serving patients over the age of 65 as of July 27, 2021 (Tranche One Number of Geriatric DMH-Licensed Beds). This figure, which is a subset of the Hospital's Tranche One Number of DMH-Licensed Beds, shall be as determined by EOHHS using data supplied by DMH.

c. Third, EOHHS will calculate each eligible Hospital's total number of non-geriatric DMH-Licensed beds by subtracting each eligible Hospital's Number of Geriatric DMH-Licensed Beds from its Number of DMH-Licensed Beds (Tranche One Number of Non-Geriatric DMH-Licensed Beds). This figure, which is a subset of the Hospital's Tranche One Number of DMH-Licensed Beds, shall be as determined by EOHHS using data supplied by DMH.

d. Fourth, EOHHS shall determine each eligible Hospital's Tranche One MassHealth Payer Mix, as that term is defined in this section, as of fiscal year 2019 (FY19), using data reported by each such Hospital to CHIA. For any eligible Hospital for which such data is unavailable, EOHHS shall assign such Hospital a Tranche One MassHealth Payer Mix of 35%. Tranche One MassHealth Payer Mix as of FY19, as determined by EOHHS, is the ratio of all dates of service during FY19 in which a Member received inpatient BH services from the Hospital in a DMH-Licensed Bed, to all dates of service during FY19 in which the Hospital's patients received such services in such beds, provided, further, that such dates of service include any dates of service on which a Member or patient was discharged to AD status from such DMH-Licensed Bed following such inpatient BH admission. For purposes of this definition, the numerator includes any date of service during FY19 in which any of the following Members received services in such beds:

i. Members receiving services on a fee-for-service basis,

ii. Members enrolled with a Managed Care Entity, and

iii. Members with Third-Party Insurance..

e. Fifth, EOHHS shall calculate each eligible Hospital's Tranche One Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Beds by multiplying such Hospital's Tranche One MassHealth Payer Mix by such Hospital's Tranche One Number of Non-Geriatric DMH-Licensed Beds.

f. Sixth, EOHHS shall calculate each eligible Hospital's Tranche One Adjusted DMH-Licensed Bed Count by summing such Hospital's Tranche One Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Beds and such Hospital's Tranche One Number of Geriatric DMH-Licensed Beds.

g. Seventh, EOHHS shall calculate the Tranche One Aggregate Adjusted DMH-Licensed Bed Count in Eligible Hospitals by summing the Tranche One Adjusted DMH-Licensed Bed Counts of each Hospital eligible for payment pursuant to **Section E.3.b.i.3.a.i**.

h. Eighth, EOHHS shall calculate each eligible Hospital's Tranche One Payment by multiplying $445,194.00 by the ratio of such Hospital's Tranche One Adjusted DMH-Licensed Bed Count to the Tranche One Aggregate Adjusted DMH-Licensed Bed Count in Eligible Hospitals.

2. EOHHS shall calculate each eligible Hospital's Tranche Two payment as follows:

a. First, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Operational Beds as of December 31, 2021 (Tranche Two Number of DMH-Licensed Operational Beds). This figure shall be as determined by EOHHS using data supplied by DMH. Tranche Two Operational Beds are DMH-Licensed Beds available and staffed for immediate occupancy, subject to the hospital's standard operating procedures for referral and intake.

b. Second, EOHHS will calculate each eligible Hospital's total number of DMH-Licensed Operational Beds serving patients over the age of 65 as of December 31, 2021 (Tranche Two Number of Geriatric DMH-Licensed Operational Beds). This figure, which is a subset of the Hospital's Tranche Two Number of DMH-Licensed Operational Beds, shall be as determined by EOHHS using data supplied by DMH.

c. Third, EOHHS will calculate each eligible Hospital's total number of non-geriatric DMH-Licensed Operational Beds by subtracting each eligible Hospital's Tranche Two Number of Geriatric DMH-Licensed Operational Beds from its Tranche Two Number of DMH-Licensed Operational Beds (Tranche Two Number of Non-Geriatric DMH-Licensed Operational Beds). This figure, which is a subset of the Hospital's Tranche Two Number of DMH-Licensed Operational Beds, shall be as determined by EOHHS using data supplied by DMH.

d. Fourth, EOHHS shall determine each eligible Hospital's Tranche Two MassHealth Payer Mix as of FY19, using data reported by each such Hospital to CHIA. For any eligible Hospital for which such data is unavailable, EOHHS shall assign such Hospital a Tranche Two MassHealth Payer Mix of 35%. Tranche Two MassHealth Payer Mix, as determined by EOHHS, is the ratio of all dates of service during over a given period on which a Member received inpatient services from the Hospital in a DMH Licensed Bed, and all dates of service during that same period in which the Hospital's patients received such services in such beds, and all dates of a Member's inpatient hospitalization defined as Administratively Necessary Days (AND), to all dates of service during that same period on which the Hospital's patients received such services in such beds. This includes Members enrolled with a Managed Care Entity, and Members with Third-Party Insurance.

e. Fifth, EOHHS shall calculate each eligible Hospital's Tranche Two Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Operational Beds by multiplying such Hospital's Tranche Two MassHealth Payer Mix by such Hospital's Tranche Two Number of Non-Geriatric DMH-Licensed Operational Beds.

f. Sixth, EOHHS shall calculate each eligible Hospital's Tranche Two Adjusted DMH-Licensed Operational Bed Count by summing such Hospital's Tranche Two Payer Mix-Adjusted Number of Non-Geriatric DMH-Licensed Operational Beds and such Hospital's Tranche Two Number of Geriatric DMH-Licensed Operational Beds.

g. Seventh, EOHHS shall calculate the Tranche Two Aggregate Adjusted DMH-Licensed Operational Bed Count in Eligible Hospitals by summing the Tranche Two Adjusted DMH-Licensed Operational Bed Counts of each Hospital eligible for payment pursuant to this **Section E.3.b.i.3.a.i**.

h. Eighth, EOHHS shall calculate each eligible Hospital's Tranche Two Payment by multiplying $404,929 by the ratio of such Hospital's Tranche Two Adjusted DMH-Licensed Operational Bed Count to the Tranche Two Aggregate Adjusted DMH-Licensed Operational Bed Count in Eligible Hospitals.

(Effective July 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

4. Substance Abuse Treatment Hospital Supplemental Payments

a. Supplemental Payments to Hospitals Rendering Medically Managed Intensive Inpatient Detoxification Services through Department of Public Health Bureau of Substance Abuse Services Licensed Level 4 Beds

i. Eligibility Criteria

In order to qualify for a Supplemental Payment for rendering medically managed intensive inpatient detoxification services through DPH/BSAS Licensed Level 4 Beds (Level 4 Beds), a Hospital must:

1. Be contracted as a Substance Abuse Treatment Hospital as of October 1, 2021, under the Thirteenth Amendment to MassHealth Program Provider Agreement Appendix A: Special Conditions for Substance Abuse Treatment Hospitals.
2. Have rendered services to at least one MassHealth Member in its Level 4 Beds during Hospital Rate Year 2021
3. Enter into a separate payment agreement with EOHHS relating to receipt of such payment; and
4. Agree in the payment agreement referenced in this **Section E.4.a.i.1.3** to:

a. Use any supplemental payment pursuant to this **Section E.4.a.i** solely for the purpose of increasing payments for the clinical and direct care personnel who staff such Hospital's Level 4 Beds, in accordance with standards to be set forth in such payment agreement; and;

b. Submit a spending report and attestation to EOHHS that demonstrates how such Hospital expended such supplemental payments, in accordance with standards to be set forth in such payment agreement.

ii. Payment Methodology

1. Subject to compliance with all applicable federal rules and payment limits requirements for full federal financial participation,, EOHHS will make $1,100,000 in total aggregate supplemental payments to Hospitals satisfying the eligibility criteria set forth in **E.4.a.i**, divided equally among all qualifying hospitals.

(Effective October 1, 2021 through the last day of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof))

ii. __X__ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

__X__ Through a modification to published fee schedules –

Effective date (enter date of change):

Rates for Family Planning Services: February 1, 2022 through March 31, 2022
Rates for Sterilization Clinics: February 1, 2022 through March 31, 2022

Location (list published location):

Rates for Family Planning Services: https://www.mass.gov/regulations/101-CMR-31200-rates-for-family-planning-services
Rates for Sterilization Clinics: https://www.mass.gov/doc/101-cmr-31300-rates-for-freestanding-clinics-providing-abortion-and-sterilization-services-1/download

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. _____ Are not otherwise paid under the Medicaid state plan;

b. _____ Differ from payments for the same services when provided face to face;

c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _X___ Other payment changes:

Effective for dates of service on or after December 16, 2021, EOHHS pays for Pediatric Enteral Special Formula and Thickening Agents dispensed at pharmacies at the lower of the wholesale acquisition cost or the usual and customary charge. Effective for dates of service on or after May 17, 2022, EOHHS pays for all medically necessary formula dispensed at pharmacies at the lower of the wholesale acquisition cost or the usual and customary charge.

Section F – Post-Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

a. _____ The individual's total income

b. _____ 300 percent of the SSI federal benefit rate

c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.