Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid

Rate Year 2027 Acute Hospital

Request for Applications

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Section 1 Introduction

The Massachusetts Executive Office of Health and Human Services (EOHHS) is issuing this Request for Applications (RFA) to solicit applications from eligible, in-state Acute Hospitals wishing to participate as Massachusetts MassHealth Providers. An Acute Hospital's Contract will apply to covered Acute Hospital Inpatient and Outpatient Services provided to MassHealth Members and recipients of Emergency Aid to the Elderly, Disabled and Children at any Acute Hospital Inpatient Departments, Outpatient Departments, and Satellite Clinics for which a reimbursement method is described in **Sections 5** through **8**.

EOHHS intends to reimburse Hospitals for Inpatient and Outpatient Services according to the methodologies outlined in this RFA. For out-of-state acute hospital payment, see 130 CMR 450.233, 415.404, and 410.404.

To be a MassHealth Provider of Hospital services other than Emergency Services, a Hospital must accept the rates of payment outlined in this RFA in accordance with the reimbursement methodology specified in this RFA as payment in full. EOHHS will contract with all eligible Hospitals that agree to accept these rates and reimbursement methodologies, and otherwise comply with requirements applicable to Acute Hospitals.

Acceptance of this level of reimbursement, and compliance with all other requirements of this RFA and Contract, including completion and submission of a response to this RFA, is a condition of participation as a Provider in the MassHealth program for provision of non-Emergency Services by Massachusetts Acute Hospitals.

Failure to respond to this RFA by any Massachusetts Acute Hospital may result in its termination as a MassHealth Provider of non-Emergency Services, and in the termination of its Satellite Clinics. However, any inpatient unit within an Acute Hospital for which reimbursement is provided under another contract shall not be terminated as a MassHealth Provider.

Section 2 Definitions

The following terms appearing capitalized throughout this RFA and its appendices shall be defined as follows unless the context clearly indicates otherwise.

30-day Readmissions Policy (30-Day RP) – the MassHealth Acute Hospital 30-day Readmissions Policy, which is a quality-based program intended to encourage participating in-state MassHealth Acute Hospital Providers to establish immediate measures and actions to improve performance in patient care and reduce potentially preventable readmissions.

Accountable Care Organization (ACO) – an entity that enters into a population-based payment model contract with EOHHS as an Accountable Care Organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans (ACPPs), and Primary Care ACOs.

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.

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 inpatient Hospital Outlier Payment. The APAD is not paid for Administrative Days or for Inpatient Services that are paid on a per diem basis under this RFA (for example, Transfer per diem). The APAD is also not payment for LARC Devices or for APAD Carve-Out Drugs, which may be paid separately as described in **Section 5.B.8**. The APAD is calculated as set forth in **Section 5.B.1**.

Adjudicated Payment per Episode of Care (APEC) – a Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services provided by a Hospital to a MassHealth Member on an outpatient basis in one Episode. The APEC is not payment for those outpatient services described in **Section 4.C** and **Sections 5.C.3** through **5.C.14**, as such services are excluded from the definitions of "APEC-Covered Services" and "Episode" under this RFA. The APEC is calculated as set forth in **Section 5.C.1**.

Adjusted EAPG Weight – the EAPG weight that is multiplied by the Hospital's Wage Adjusted APEC Outpatient Standard in determining each of the Episode's claim detail line EAPG payment amounts for purposes of calculating the Episode-Specific Total EAPG Payment. The Solventum (formerly known as 3M) EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight.

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.

Administrative Psychiatric Day – an Administrative Day that is a day of inpatient hospitalization on which a Member's clinical presentation would typically call for discharge to a lower level of care (e.g., an appropriate community-based location) but an appropriate placement has not yet been secured, the clinical barriers to discharge have been sufficiently addressed and the discharge plan is ready to be executed when an appropriate discharge placement has been secured, and the patient does not require a high degree of clinical resources daily. Administrative Psychiatric Day does not include a day on which a Member is receiving active stabilization efforts or requires inpatient hospital care to prevent further regression of the Member's condition.

Adult Mobile Crisis Intervention (AMCI) – a community-based Behavioral Health Service available 24 hours per day, 7 days per week, 365 days per year and providing short-term mobile, on-site, face-to-face crisis assessment, intervention, and stabilization to individuals 21 years of age and older experiencing a Behavioral Health Crisis. Services may be provided by a Community Behavioral Health Center (CBHC) in community-based settings outside a CBHC, at a CBHC, or in emergency department sites of services when necessary. Services may also be provided via telehealth. The purpose is to identify, assess, treat, and stabilize the situation and reduce the immediate risk of danger to the individual or others consistent with the individual's risk management or safety plan, if any. AMCI service is not an outpatient hospital service and is not a payable service under this RFA.

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 Solventum APR-DRG Grouper, Version 43, unless otherwise specified.

APAD Base Year – The hospital-specific base year for the APAD is FY21, using the FY21 Massachusetts Hospital cost reports as screened and updated as of March 14, 2023.

APAD Carve-Out Drugs – Drugs designated by EOHHS that are carved out of the APAD payment and separately paid pursuant to **Section 5.B.8.b**.

APEC Base Year – the APEC Base Year is FY21.

APEC Carve-Out Drugs – Drugs designated by EOHHS that are carved out of the APEC payment and are separately paid pursuant to **Section 5.C.9**.

APEC-Covered Services – MassHealth-covered Outpatient Services provided by Hospital Outpatient Departments or Satellite Clinics, except those services described in **Section 4.C** and **Sections 5.C.3** through **5.C.14**.

APEC Outlier Component – A Hospital-specific, Episode-specific component of the APEC

which is calculated by EOHHS as described in **Section 5.C.1.b.(2)**, and added to the Episode-Specific Total EAPG Payment to result in the APEC for that Episode. The APEC Outlier Component may equal $0.

APEC Outpatient Statewide Standard – The outpatient statewide standard determined by EOHHS as described in **Section 5.C.1.b.(1).(a).1**, that is utilized in the calculation of the APEC.

Baseline ED Psychiatric Services – The following services:

1. Family support and education.
2. Screening for substance use disorder (i.e., Screening, Brief Intervention, and Referral to Treatment), including medication-assisted treatment initiation when appropriate.
3. Referring members to community-based providers for ongoing care after discharge, as necessary.
4. Observation for those with suicidal ideation and/or homicidal ideation.

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.

Behavioral Health Crisis – A situation in which an individual demonstrates signs or symptoms of a mental health disorder, substance use disorder, co-occurring mental health and substance use disorder, or co-occurring behavioral health and medical condition that led to significant impairment in the individual's functioning and/or to behavior that puts the individual at risk of harming themselves, harming others, or being unable to appropriately care for themselves.

Behavioral Health Crisis Management Services – A set of services provided in an Emergency Department or on a medical/surgical floor by qualified clinical professionals to members experiencing a Behavioral Health Crisis in need of ongoing supports on days subsequent to receiving the initial Behavioral Health Crisis Evaluation. The crisis management services include ongoing crisis interventions, ongoing determination and coordination of appropriate disposition, and ongoing required reporting and community collaboration activities.

Behavioral Health Diversionary Services – Those mental health and substance use disorder services provided outside of this RFA as clinically appropriate alternatives to Behavioral Health Inpatient Services, to support an Enrollee returning to the community following a 24-hour acute placement, or to provide intensive support to maintain functioning in the community. There are two categories of Diversionary Services: those services which are provided in a 24-hour facility, and those services which are provided in a non-24-hour setting or facility.

Behavioral Health Crisis Evaluations – An evaluation provided in an Emergency Department or on a medical/surgical floor by qualified clinical professionals to members experiencing a Behavioral Health Crisis during the first calendar day of their readiness to receive such an evaluation. The evaluation includes the initial comprehensive assessment of risk, diagnosis, and treatment needs, the initial crisis interventions, the initial determination and coordination of appropriate disposition, and required reporting and community collaboration activities.

Behavioral Health Services (or Behavioral Health) – Services provided to Members who are

being treated for psychiatric disorders or substance use disorders.

Behavioral Health Treatment and Referral Platform (BHTRP) – Technology to support automation of the ED Behavioral Health referral screening, evaluation and referral process, enables the electronic transmission of standardized admissions information, and creates a real-time, transparent view of patients seeking behavioral health treatment for participant organizations.

Calendar Year (CY) – The time period of 12 months beginning on January 1 of any given year and ending on December 31 of the same year.

Casemix – The description and categorization of a hospital's patient population according to criteria approved by EOHHS including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

Center for Health Information and Analysis (CHIA) – The Center for Health Information and Analysis established under M.G.L. c. 12C.

Centers for Medicare & Medicaid Services (CMS) – the federal agency under the Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

Certified Event Notification Service Vendor or Certified ENS Vendor – An ENS vendor that is certified by EOHHS in compliance with 101 CMR 20.00: *Health Information Exchange*.

Charge – the uniform price for each specific service within a Revenue Center of an Acute Hospital.

Clinical Laboratory Service – Microbiological, serological, chemical, hematological, biophysical, radio bioassay, cytological, immunohematological, immunological, pathological, or other examinations of materials derived from the human body, to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Coinsurance – a percentage of cost or a fee established by a Third-Party Insurance carrier for a specific service or item for which an individual is responsible when the service or supply is delivered. This cost or fee varies according to the individual's insurance carrier.

Community-Based Acute Treatment (CBAT) – 24-hour-per-day, seven-day-per-week, staff-secure treatment settings for children and adolescents up to the age of 18 with serious behavioral health disorders that provide short-term crisis stabilization, therapeutic intervention, and specialized programming.

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.

Community Behavioral Health Center (CBHC) – an entity that serves as a hub of coordinated

and integrated behavioral health disorder treatment for individuals of all ages, including routine and urgent behavioral health outpatient services, mobile crisis intervention services for adults and youth, and community crisis stabilization services for adults and youth.

Community Crisis Stabilization (CCS) – A community-based program that serves as a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides short-term staff-secure, safe, and structured crisis stabilization and treatment services for individuals 18 years of age and older with mental health and/or substance use disorders. Stabilization and treatment also include the capacity to provide induction onto and bridging for medication for the treatment of opioid use disorders (MOUD) and withdrawal management for opioid use disorders (OUD) as clinically indicated.

Community Partners – entities certified by EOHHS to work with ACOs to ensure integration of care, as further specified by EOHHS. There are two types of CPs – Long-Term Services and Supports CPs (LTSS CPs) and Behavioral Health CPs (BH CPs).

Community Partner Assigned Member – An ACO-enrolled Member who is assigned to a BH or LTSS CP.

Contract (also Hospital Contract or Agreement) – the agreement executed between each selected Hospital and EOHHS, which is contained in **Appendix A** attached hereto, and incorporates all of the provisions of this RFA. Unless the context indicates that the term "RFA" refers exclusively to the procurement document as such, references to RFA shall constitute references to the Contract (or Agreement).

Contractor – each Hospital that is selected by EOHHS after submitting a satisfactory application in response to this RFA and that enters into a Contract with EOHHS to meet the purposes specified in this RFA.

Copayment – a predetermined fee that the Member is responsible for paying directly to the Provider for specific services.

Critical Access Hospital (CAH) – an Acute Hospital that, prior to October 1, 2026, was certified by CMS and designated as a Critical Access Hospital under 42 U.S.C. 1395i-4, and that continues to maintain that status.

Deductible – the amount an individual is required to pay in each Calendar Year, as specified in their insurance plan, before any payments are made by the insurer.

Department of Mental Health (DMH) – a department of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

Department of Public Health (DPH) – a department of the Commonwealth of Massachusetts, Executive Office of Health and Human Services.

Discharge-Specific Case Cost – the product of (1) the Hospital's MassHealth allowed Charges for a specific discharge, as determined by EOHHS, and (2) the Hospital's inpatient cost to

Charge ratio as calculated by EOHHS using the Hospital's FY22.

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 APAD for a specific discharge, as determined by EOHHS, and the inpatient Fixed Outlier Threshold.

DMH-Licensed Bed – a bed in a Hospital that is located in a unit licensed by the Department of Mental Health (DMH), pursuant to 104 CMR 27.00 et seq.

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 dosage form and strength. Each dosage form and strength is a separate Drug.

ED-Presenting Psychiatric Member – A Member who presents to a Hospital's ED for clinical psychiatric evaluation and treatment.

Electronic Health Record (EHR) – A digital version of a patient's medical history. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users, often including a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and/or laboratory and test results.

Eligibility Verification System (EVS) [**formerly known as the Recipient Eligibility Verification System (REVS**)] – the online and telephonic system Hospitals must access to verify eligibility, managed care enrollment, and available third party liability information about Members.

Emergency Aid to the Elderly, Disabled and Children (EAEDC) – the program operated by the Department of Transitional Assistance, pursuant to M.G.L. c. 117A, that furnishes and pays for limited medical services to eligible persons.

Emergency Department (ED) – a Hospital's Emergency Room or Level I Trauma Center which is located at the same site as the Hospital's inpatient department, or at a separate site included in the Hospital's DPH license.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of a Member or another person or, in the case of a pregnant individual, the health of the individual or their unborn child, in serious jeopardy, serious impairment to body function, or serious dysfunction of any bodily organ or part, or, with respect to a pregnant individual, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services – covered Inpatient and Outpatient Services, including Behavioral Health

Services, which are furnished to a Member by a Provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize a Member's Emergency Medical Condition.

Emergency Services Program (ESP) Services – Medically necessary services provided through designated ESP providers, and which are available seven (7) days per week, twenty-four (24) hours per day to provide treatment of any individual who is experiencing a mental health or substance use disorder crisis, or both. An ESP encounter includes, at a minimum, crisis assessment, intervention and stabilization. ESP Services include Mobile Crisis Intervention for members under the age of 21.

Enhanced Ambulatory Patient Group (EAPG) – a group of Outpatient Services that have been bundled for purposes of categorizing and measuring Casemix. It is based on the Solventum's EAPG Grouper Version 3.18.

Episode – all MassHealth-covered Outpatient Services, except those described in **Section 4.C** and **Sections 5.C.3** through **5.C.14**, delivered to a MassHealth Member on a single calendar day, or if the services extend past midnight in the case of Emergency Department or Observation Services, on consecutive days. (See also definition of Observation Services). Additionally, in limited circumstances, APEC-Covered Services delivered to a MassHealth Member during a second distinct and independent visit on the same calendar day may be considered a separate Episode for payment purposes if the services are for unrelated purposes and conditions as determined by EOHHS.

Episode's Total Allowed Charges – the sum of the MassHealth allowed Charges for all of the claim detail lines with APEC-Covered Services in an Episode that adjudicate to pay, as determined by EOHHS based on a properly submitted APEC claim.

Episode-Specific Case Cost – the product of (1) the Episode's Total Allowed Charges, and (2) the Hospital's FY22 outpatient cost-to-charge ratio, as calculated by EOHHS using the Hospital's FY22 Massachusetts Hospital Cost Report.

Episode-Specific Outlier Threshold – the sum of (1) the Episode-Specific Total EAPG Payment, as determined by EOHHS, and (2) the Fixed Outpatient Outlier Threshold.

Episode-Specific Total EAPG Payment – an Episode-specific payment amount, which summed with the APEC Outlier Component (as applicable) results in the APEC for that Episode. The Episode-Specific Total EAPG Payment is calculated as set forth in **Section 5.C.1.b.(1)**.

Event Notification Service (ENS) – A specialized form of Health Information Exchange (HIE) alerts for existing care providers that occurs after admissions, discharges, and transfers (ADT) to and from Emergency Departments (EDs), hospitals and post-acute care facilities. ADT alerts can include some clinical data through a Certified ENS Vendors.

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.

Executive Office of Health and Human Services (EOHHS) – the single state agency that is responsible for the administration of the MassHealth Program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

Expedited Psychiatric Inpatient Admission (EPIA) – The escalation protocol for securing appropriate placement for individuals awaiting psychiatric placement longer than 24 hours.

Fiscal Year (FY) – The time period of 12 consecutive months, typically beginning on October 1 of any Calendar Year and ending on September 30 of the immediately following Calendar Year, but which 12-month consecutive month period may vary by Hospital (e.g. a Hospital may have an FY beginning on July 1 of any Calendar Year and ending on June 30 of the immediately following Calendar Year).

Fixed Outlier Threshold (inpatient) – the Fixed Outlier Threshold for purposes of calculating any inpatient Hospital Outlier Payment is $42,430.

Fixed Outpatient Outlier Threshold – the Fixed Outpatient Outlier Threshold for purposes of calculating the APEC Outlier Component is $4,460.

Freestanding Pediatric Acute Hospital – an Acute Hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.

Gross Patient Service Revenue (GPSR) – the total dollar amount of a Hospital's Charges for services rendered in a fiscal year.

Health Information Exchange (HIE) – A secure connection which allows health care professionals and patients to appropriately access and share a patient's medical information. The Mass HIway is a secure Health Information Exchange (HIE) for all healthcare systems in Massachusetts.

High Medicaid Volume Freestanding Pediatric Acute Hospital – the Freestanding Pediatric Acute Hospital with the largest volume of inpatient discharges in fiscal year 2019, as determined by EOHHS using Massachusetts hospital cost report data.

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.

Hospital (also Acute Hospital – any Hospital licensed under M.G.L. c. 111, § 51 and which meets the eligibility criteria set forth in **Section 3** of this RFA.

Hospital at Home – Inpatient Hospital Services provided in a Member's home or residence in accordance with MassHealth's Acute Inpatient Hospital Bulletin 180, or any successor bulletins thereto.

Hospital-Based Physician – Any physician or physician group practice (excluding interns,

residents, fellows, and house officers) who contracts with a Hospital to provide Hospital Services to Members at a site for which the hospital is otherwise eligible for reimbursement under this RFA. For purposes of this definition and related provisions, the term physician includes dentists, podiatrists, and osteopaths. Nurse practitioners, nurse midwives, physician assistants, and other allied health professionals are not Hospital-Based Physicians.

Hospital Discharge Data (HDD) – Hospital discharge filings for FY21 provided and verified by each hospital, submitted to CHIA and screened and updated by CHIA as of April 7, 2023. HDD is used for determining Casemix as part of the APAD rate development, as set forth in **Section 5.B.1**.

Hospital-Licensed Health Center (HLHC) – A Satellite Clinic that (1) meets MassHealth requirements for reimbursement as an HLHC as provided at 130 CMR 410.413; and (2) is approved by and enrolled with MassHealth's Provider Enrollment Unit as an HLHC.

Induction (or Initiation) – The process of initial dosing with medication treatment for OUD, until the patient reaches a state of stability.

Inflation Factors for Capital Costs – For price changes between RY04 and RY18 and between RY19 and RY24, 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 costs 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 Factors for Capital Costs between RY04 and RY24 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
- 2.1108% reflects the price changes between RY18 and RY19
- 1.5% reflects the price changes between RY19 and RY20
- 1.5% reflects the price changes between RY20 and RY21
- 1.0% reflects the price changes between RY21 and RY22
- 1.7% reflects the price changes between RY22 and RY23
- 3.5% reflects the price changes between RY23 and RY24

Inflation Factors for Operating Costs – For price changes between RY04 and RY07, and between RY08 and RY24, a blend of the Center for Medicare and Medicaid Services (CMS) market basket and the Massachusetts Consumer Price Index (CPI) in which the CPI replaces the labor-related component of the CMS market basket to reflect conditions in the Massachusetts economy. For price changes between RY07 and RY08, the inflation factor for operating costs is the CMS market basket. The Inflation Factors for Operating Costs between RY04 and RY24 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 the period October 1, 2008, through December 6, 2008
- 1.424% reflects price changes between RY08 and RY09 for the period December 7, 2008, through September 30, 2009
- 0.719% reflects the price changes between RY09 and RY10
- 1.820% reflects the price changes between RY10 and RY11
- 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
- 2.183% reflects the price changes between RY18 and RY19
- 2.236% reflects the price changes between RY19 and RY20
- 1.854% reflects the price changes between RY20 and RY21
- 1.433% reflects the price changes between RY21 and RY22
- 2.451% reflects the price changes between RY22 and RY23
- 2.599% reflects the price changes between RY23 and RY24

Inpatient Admission – the admission of a Member to an Acute Hospital for the purpose of receiving Inpatient Services in that Hospital.

Inpatient Services – medical services, including Behavioral Health Services, provided to a Member admitted to an Acute Hospital or Hospital at Home services provided in a Member's home or residence in accordance with MassHealth's Acute Inpatient Hospital Bulletin 180, or any successor bulletins thereto. Payment rules regarding Inpatient Services are found in 130 CMR Parts 415 and 450, the regulations referenced therein, Appendix F to the MassHealth Acute Inpatient Hospital Manual, MassHealth billing instructions, and this RFA.

Insurance Payment – a payment received from any entity or individual legally responsible for paying all or part of the medical claims of MassHealth Members. Sources of payments include, but are not limited to: commercial health insurers, Medicare, MCOs, personal injury insurers, automobile insurers, and Workers' Compensation.

Liability – the obligation of an individual to pay, pursuant to the individual's Third-Party Insurance, for the services or items delivered (i.e., Coinsurance, Copayment or Deductible).

Long-Acting Injectable (LAI) Antipsychotics – Antipsychotic medications that are administered through intramuscular injection and provide medication coverage for a period of weeks to months. LAI Antipsychotics does not refer to the administration of the medications. The EOHHS-designated LAI Antipsychotics are identified on the *Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units* document maintained on the MassHealth Drug List (MHDL). The MassHealth Drug List is published on the MassHealth website at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do.

Long-Acting Reversible Contraception (LARC) Device – Long-acting reversible contraception (LARC) device refers, specifically, to intrauterine devices and contraceptive implants. LARC Device does not refer to the procedure, itself.

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 as set forth in 42 CFR Part 438.2. MCOs include "traditional" MCOs, Senior Care Organizations (SCOs) and

Accountable Care Partnership Plans (ACPPs). In addition, MCOs include One Care plans for all purposes under this RFA, except for **Sections 4.A.2**, **4.B.4**, **5.D.1** and **Section 7**. When historical MCO data is used in a methodology, the term MCO will also include CarePlus MCOs, to the extent CarePlus MCOs existed during the period for which the MCO data is used in such methodology, as applicable.

Marginal Cost Factor – The Marginal Cost Factor is 60% (inpatient) and 60% (outpatient).

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.

MassHealth DRG Weight – The MassHealth relative weight developed by EOHHS for each unique combination of APR-DRG and severity of illness (SOI). See **Chart C** to **Appendix C** for the MassHealth DRG Weights.

MassHealth EAPG Weight – The MassHealth relative weight developed by EOHHS for each unique EAPG (See **Chart D** to **Appendix D** for the RY27 MassHealth EAPG Weights for the APEC methodology). The Solventum EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight as part of the APEC payment methodology. See also the definition of "Adjusted EAPG Weight."

Mass HIway – A secure statewide network that facilitates the transmission of healthcare data and health information among providers, hospitals, and other healthcare entities as allowed by applicable state and federal laws.

Medicaid Management Information System (MMIS) – The state-operated system of automated and manual processes, certified by CMS, that meets the federal guidelines in Part 11 of the State Medicaid Manual, used to process Medicaid claims from providers of medical care and services furnished to Members, and to retrieve and produce service utilization and management information for program administration and audit purposes.

Medication for the Treatment of Opioid Use Disorder (OUD) – Use of a medication approved by the FDA for the treatment of an opioid use disorder.

Member – A person determined by EOHHS to be eligible for medical assistance under the MassHealth program.

Mobile Crisis Intervention (MCI) – Services provided by designated ESP providers to members under age 21. MCI services include a short-term mobile, on-site, and face-to-face therapeutic service provided for youth experiencing a Behavioral Health Crisis and for the purpose of identifying, assessing, treating, and stabilizing the situation and reducing the immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, if any. Mobile Crisis Intervention utilizes a multidisciplinary model, with both professional and paraprofessional staff. Services are available 24 hours a day, 7 days a

week.

Non-Acute Unit – A chronic care, rehabilitation, or skilled nursing facility unit within a Hospital.

Observation Services – Outpatient Hospital Services provided anywhere in an Acute Inpatient Hospital or Hospital Outpatient Department to evaluate a Member's condition and determine the need for admission to an Acute Hospital, prior to relocating the Member home or to another non-hospital setting. Observation Services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours. Payment rules regarding Observation Services are found in 130 CMR 410.414, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions, and this RFA.

One Care: MassHealth plus Medicare (One Care plan) – a health plan or provider-based organization contracted with EOHHS and CMS, and accountable for providing integrated care to individuals aged 21 through 64 at the time of enrollment who are eligible for both Medicare and MassHealth Standard or CommonHealth and who do not have any other comprehensive public or private health care coverage. A One Care plan is also known as an Integrated Care Organization (ICO).

Outlier Payment (inpatient) – a hospital-specific, discharge-specific inpatient Hospital payment made in addition to the APAD for qualifying discharges in accordance with **Section 5.B.2**.

Outpatient Department (also Hospital Outpatient Department) – a department or unit located at the same site as the Hospital's inpatient facility, or at a School-Based Health Center that operates under the Hospital's license and provides services to Members on an ambulatory basis. Hospital Outpatient Departments include day surgery units, Primary Care clinics, specialty clinics, and Emergency Departments.

Outpatient Services (also Outpatient Hospital Services) – medical services, including Behavioral Health Services, provided to a Member on an outpatient basis, by or under the direction of a physician or dentist, in a Hospital Outpatient Department or Satellite Clinic for which a reimbursement method is specified in **Section 5.C**. Such services include, but are not limited to, Emergency Services, Primary Care services, Observation Services, ancillary services, and day surgery services. Payment rules regarding services provided to Members on an outpatient basis are found in 130 CMR Parts 410 and 450, Appendix E to the MassHealth Acute Outpatient Hospital Manual, MassHealth billing instructions, and this RFA.

Participating PCP – See definition of Primary Care ACO Participating Primary Care Provider.

Patient – a person receiving health care services from a hospital.

Pay-for-Performance Program for Acute Hospitals (P4P) – This refers to the pay-for-performance program formerly set forth in **Section 7** of the RFA.

Primary Care – all health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, certified nurse practitioner, certified nurse midwife, or other eligible primary care provider to the extent the furnishing of those services is legally authorized in the Commonwealth.

Primary Care ACO – a type of ACO with which the MassHealth agency contracts under its ACO program.

Primary Care ACO Participating Primary Care Provider (Participating PCP) – a physician, independent certified nurse practitioner, group practice organization, community health center, Hospital-Licensed Health Center, Acute Hospital Outpatient Department, or other eligible providers, who serve as a Participating PCP with a Primary Care ACO.

Primary Care Clinician (PCC) – a physician, independent certified nurse practitioner, group practice organization, community health center, Hospital-Licensed Health Center, Acute Hospital Outpatient Department, or other eligible MassHealth providers with an executed MassHealth PCC Plan Provider contract.

Primary Care Clinician Plan (PCC Plan) – a comprehensive managed care plan, administered by EOHHS, through which enrolled MassHealth Members receive Primary Care, Behavioral Health, and other medical services. See 130 CMR 450.118.

Provider – an individual or entity that has a written contract with EOHHS to provide medical goods or services to Members.

Psychiatric Per Diem – a statewide per diem payment for Behavioral Health Services provided to members in DMH-Licensed beds who are not enrolled with the BH Contractor or MCO.

Psychiatric Per Diem Base Year – the base year for the psychiatric per diem is FY04, using FY04 -403 cost reports as screened and updated as of March 10, 2006.

Qualified Behavioral Health Professional –A qualified behavioral health professional shall include a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in the field of psychiatry (vii) advanced practice registered nurse who practices in the field of psychiatry, including but not limited to a licensed nurse practitioner or licensed psychiatric clinical nurse specialist; or (viii) healthcare provider qualified within the scope of the individual's license to conduct an evaluation of a mental health condition, including an intern, resident or fellow pursuant to the policies and practices of the hospital and medical staff.

Quality and Equity Performance Initiatives – data-driven systemic efforts, anchored on measurement-driven activities, including the Clinical Quality Initiative (CQI) described in **Section 7B** and Health Quality and Equity Incentive Program (HQEIP) described in **Section 8.A**, to improve performance of health-delivery systems that result in positive outcomes, including

quality and equity improvements.

Query and Retrieve – A method utilized in the Health Information Exchange (HIE) to allow providers to search for and retrieve patient information that was made accessible by other care providers, public agencies, and other sources.

Rate Year (RY) – generally, the period beginning October 1 and ending the following September 30. The RY27 will begin on October 1, 2026, and end on September 30, 2027.

Recovery Support Navigator – A paraprofessional or peer specialist who receives specialized training in the essentials of substance use disorder (SUD) or other addictive disorders and evidence-based techniques such as motivational interviewing, and who supports members in accessing and navigating the SUD treatment system through activities that can include care coordination, case management, and motivational support.

Recovery Support Navigator for Pregnant and Postpartum Members – A specialized recovery support navigator who receives specialized training to provide recovery support navigator services to individuals who are pregnant or have been pregnant in the last 12 months.

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 their ability to function with a reasonable expectation of significant improvement that will be of practical value to the Member measured against their condition at the start of the rehabilitation program.

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

Remote Patient Monitoring – the use of medical devices which transmit digital personal health information in a synchronous or asynchronous manner from an at-risk patient to a treating provider at a distant location. Information is generated with the expectation of responsive management for the patient and the monitored condition. Eligibility criteria and appropriate coding methods are defined by MassHealth Transmittal Letter PHY-170 or any successors thereto.

Revenue Center – a functioning unit of a Hospital that provides distinctive services to a patient for a charge.

Satellite Clinic – a facility that operates under a Hospital's license, is subject to the fiscal, administrative, and clinical management of the Hospital, provides services to Members solely on an outpatient basis, is not located at the same site as the Hospital's inpatient facility, and demonstrates to EOHHS' satisfaction that it has CMS provider-based status in accordance with 42 CFR 413.65.

School-Based Health Center (SBHC) – a center located in a school setting which: (1) provides

health services to MassHealth Members under the age of 21; (2) operates under a Hospital's license; (3) is subject to the fiscal, administrative, and clinical management of a Hospital Outpatient Department or HLHC; and (4) provides services to Members solely on an outpatient basis.

Solventum EAPG Grouper – the Solventum's EAPG Grouper Version 3.18, configured for the MassHealth APEC payment method.

Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders – An intensive level of specialized inpatient psychiatric care for youth with severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions. In addition to all the clinical service components required within Psychiatric Inpatient Hospitals, pursuant to this Contract, Specialty Inpatient Psychiatric Services for Children/Adolescents with Neurodevelopmental Disorders must be supported by specially-trained staff. Additionally, specialized components of services include specialized treatment milieu, clinical expertise, clinical interventions, and evidence-based practices and procedures.

Specialty Inpatient Psychiatric Service for Eating Disorders – an intensive level of specialized inpatient care for adults and youth with eating disorder diagnoses who require acute psychiatric and medical stabilization. In addition to all clinical service components required within Hospitals, Specialty Inpatient Psychiatric Services for Eating Disorders must be supported by specially-trained staff. Additionally, specialized components of services include specialized treatment milieu, clinical expertise, clinical interventions, and evidence-based practices and procedures for supporting the unique needs of individuals with severe eating disorders.

Specialized Pediatric Service Hospital – A High Medicaid Volume Freestanding Pediatric Acute Hospital or an Acute Hospital, other than a Freestanding Pediatric Acute Hospital, that maintains a DPH licensed pediatric unit and has a burn unit verified by the American Burn Association as of August 31, 2019, as determined by EOHHS, or an Acute Hospital that is not a Freestanding Pediatric Acute Hospital and that is designated by the Department of Public Heath (DPH) as providing Level II Pediatric Trauma care in Region I as of October 1, 2024, as determined by EOHHS.

Statewide Event Notification Service (ENS) Framework – An interoperable ENS network consisting of Certified ENS Vendors who have interconnected their ENS systems to serve all care providers in Massachusetts.

Third-Party Insurance – any insurance, including Medicare, that is or may be liable to pay all or part of the Member's medical claims. Third-Party Insurance includes a MassHealth Member's own insurance.

Title XIX – Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., or any successor statute enacted into federal law for the same purposes as Title XIX.

Total Case Payment – the sum, as determined by EOHHS, of the APAD and, if applicable, any inpatient Hospital Outlier Payment.

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 **Sections 5.B.1** and **5.B.2** for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis under **Section 5.B.3** for Inpatient Services provided to a Transfer Patient.

Transfer Patient – any inpatient who meets any of the following criteria: (1) is transferred between Acute Hospitals; (2) is transferred between a DMH-Licensed Bed and a medical/surgical unit in an Acute Hospital; (3) is receiving Behavioral Health Services and whose enrollment status with the BH Contractor changes; (4) who becomes eligible for MassHealth after the date of admission and prior to the date of discharge, or is eligible for MassHealth on the date of admission but becomes ineligible prior to the date of discharge; (5) is a Member who exhausts other insurance benefits after the date of admission and prior to the date of discharge, or who becomes eligible for other insurance benefits after the date of admission and prior to the date of discharge; (6) who transfers, after the date of admission, from the PCC Plan, Primary Care ACO or non-managed care to an MCO, or from an MCO to the PCC Plan, Primary Care ACO or non-managed care; or (7) is admitted following an outpatient surgery or procedure at the Acute Hospital.

Transferring Hospital – an Acute Hospital that is being paid on a Transfer Per Diem basis, pursuant to **Section 5.B.3**.

Usual and Customary Charge – a routine fee that Hospitals charge for Acute Inpatient and Outpatient Services, regardless of payer source.

Wholesale Acquisition Cost (WAC) – The Wholesale Acquisition Cost (WAC) of the Drug as published by First Data Bank or other national price compendium designated by EOHHS.

Youth Community Crisis Stabilization (YCCS) – staff-secure, safe, and structured crisis stabilization and treatment services in a community-based program that provides active treatment that includes restoration of functioning; strengthening the resources and capacities of the youth, family, and other natural supports; and ensuring a timely return to previous living environment to individuals up to and including 18 years of age.

Youth Mobile Crisis Intervention (YMCI) – a community-based Behavioral Health Service available 24 hours per day, seven days per week, and 365 days per year providing short-term mobile, on-site, face-to-face crisis assessment, intervention, and stabilization to individuals younger than 21 years of age experiencing a Behavioral Health Crisis. Transition-aged youth older than 17 years of age and younger than 21 years of age may be served by adult-trained clinicians with a certified peer specialists instead of a family partner based on an individual's clinical needs. Services may be provided by CBHCs in community-based settings outside the CBHC or at the CBHC. Services may be provided via telehealth. The purpose is to identify, assess, treat, and stabilize the situation and reduce the immediate risk of danger to the youth or

others consistent with the youth's risk management/safety plan, if any.

Section 3 Eligible Applicants

A. In-state Acute Hospitals are eligible to apply for a Contract pursuant to this RFA if they:

1. Operate under a Hospital license issued by the Massachusetts Department of Public Health (DPH);

2. Are Medicare-certified and participate in the Medicare program;

3. Have more than 50% of their beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by DPH; and

4. Currently utilize more than 50% of their beds exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by EOHHS.

In determining whether a Hospital satisfies the utilization requirement set forth in **Section 3.A.4**, EOHHS may evaluate, pursuant to an on-site audit or otherwise, a number of factors including, but not limited to, the average length of patient stay (see **Section 11.B.5**) at that Hospital.

B. The Hospital shall apply on behalf of all Inpatient Departments, Outpatient Departments, Emergency Departments and Satellite Clinics.

C. The Hospital is not permitted to apply on behalf of, or claim payment for services provided by, any other related clinics, Provider groups, or other entities, except as otherwise provided in **Sections 5.B.5** and **5.C**.

D. For public state-owned hospitals that contract under the RFA, EOHHS may waive these or any other requirements and may, at its discretion, agree to requirements and conditions of participation that differ from those set forth in this RFA to address specific situations. Any such requirements and conditions of participation may be documented in any resulting contract or may be specified through other such means as may be agreed to by the parties.

Section 4 Non-Covered Services, Program Initiatives, Non-RFA Ambulatory Services, and Requirements Regarding Hospital Notifications and Discharge Planning Coordination

A. Non-Covered Services

EOHHS will reimburse MassHealth-participating Hospitals at the rates established in this RFA and accompanying Contract for all covered Inpatient, Outpatient, and Emergency Services provided to MassHealth Members except for the following:

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

EOHHS' BH Contractor contracts with providers to form a network through which Behavioral Health Services are delivered to MassHealth Members enrolled with the BH Contractor. Hospitals in the BH Contractor's network qualify for payments solely by the BH Contractor for services to Members enrolled with the BH Contractor, pursuant to contracts between the BH Contractor and each contracting Hospital.

Hospitals that are not in the BH Contractor's network (hereinafter "non-network Hospitals") do not qualify for payment from MassHealth or the BH Contractor for Members enrolled with the BH Contractor who receive BH Contractor-covered services, except in accordance with a service-specific agreement with the BH Contractor.

Hospitals are not entitled to any payment from EOHHS, and may not claim such reimbursement for any services that are BH Contractor-covered services or are otherwise reimbursable by the BH Contractor. Any such payment by EOHHS shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

2. MCO Services

a. Hospitals that provide medically necessary MCO-covered services, including Emergency and Post-Stabilization Services, qualify for payment solely by the MCO for services to Members enrolled with the MCO pursuant to contracts between the MCO and each contracting Hospital.

b. In accordance with 42 USC 1396u-2(b)(2), 42 CFR 438.114, 42 CFR 422.113(c), and 42 CFR 422.214(b), if an MCO offers to pay a non-network Hospital a rate equal to the Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the MCO's MassHealth enrollees, that non-network Hospital must accept the MCO's rate offer as payment in full. This requirement does not prohibit an MCO from negotiating to pay any non-network Hospital at rates lower than the non-network Hospital's applicable fee-for-service RFA rate less any amount for graduate medical education

for Emergency and Post-Stabilization Services.

c. For purposes of this **Section 4.A.2.c**, "MCO" refers to all MCOs as defined in **Section 2**, except Senior Care Organizations (SCOs), and One Care plans; and "non-Emergency services" means services that correspond to the types of Inpatient and Outpatient Services for which Hospitals are paid on a fee-for-service basis under **Sections 5.B.1** through **5.B.3**, **5.B.6**, **5.B.7**, **5.C.1** and **5.D.7** of this RFA (subject to **Sections 8.2** and **8.3**, as applicable), with the exception of (1) Emergency and Post-Stabilization Services (which are governed by **Section 4.A.2.b**, above) and (2) Behavioral Health Services.

If a Hospital (whether network or non-network) provides non-Emergency services to the MCO's MassHealth enrollees, and the MCO offers to pay the Hospital a rate that is equivalent to the Hospital's applicable fee-for-service RFA rate for such non-Emergency services, that Hospital must accept the MCO's rate offer as payment in full. This requirement does not prohibit an MCO from negotiating to pay a Hospital at rates other than the Hospital's MassHealth-equivalent fee-for-service RFA rate for non-Emergency services to the MCO's MassHealth enrollees, pursuant to the MCO's contract with EOHHS.

d. Hospitals are not entitled to any payment from EOHHS, and may not claim such reimbursement for any services that are MCO-covered services or are otherwise reimbursable by the MCO. Any such payment by EOHHS shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

3. Injectable Materials or Biologicals Provided by the Massachusetts Department of Public Health at No Charge

EOHHS will not pay for the cost of injectable materials or biologicals that a Hospital received from the Massachusetts Department of Public Health free of charge. Hospitals administering such injectable materials or biologicals must bill the code for the injectable material or biological itself, with the modifier SL, as well as the code for the administration of the injectable material or biological.

4. Reserved

5. One Care Plan Services

Hospitals that provide medically necessary One Care plan-covered services, including Emergency and Post-Stabilization Services, qualify for payment solely by the One Care plan for services to Members enrolled with the One Care plan pursuant to contracts between the One Care plan and each contracting Hospital.

If a One Care plan offers to pay a non-network Hospital a rate equal to the amount

allowed under original Medicare less any amount for graduate medical education for all Emergency and Post-Stabilization Services for all of the One Care plan's enrollees, that non-network Hospital must accept the One Care plan's rate offer as payment in full. This requirement does not prohibit a One Care plan from negotiating to pay any non-network Hospital at rates lower than original Medicare less any amount for graduate medical education for Emergency and Post-Stabilization Services.

Hospitals are not entitled to any payment from EOHHS, and may not claim such reimbursement for any services that are One Care plan-covered services or are otherwise reimbursable by the One Care plan. Any such payment by EOHHS shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

6. Air Ambulance Services

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

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

Unless otherwise specified in this RFA, EOHHS shall not reimburse Acute Hospitals through this RFA and the accompanying contract for services provided to Members in Non-Acute Units, other than Rehabilitation Units, and any units which have a separate license, such as a skilled nursing unit, or any unit which is licensed to provide services other than Acute Hospital services as described in **Section 3.A.4**.

8. Behavioral Health Diversionary Services

In order to receive reimbursement for Behavioral Health Diversionary Services, Hospitals must have a separate contract with EOHHS for such services.

B. Program Initiatives

1. Hospital Services Reimbursed through Other Contracts or Regulations

The Commonwealth may institute special program initiatives, other than those in this RFA, which provide, through contract or regulation, alternative reimbursement methodologies for Hospital services or certain Hospital services. In such cases, payment for such services is made pursuant to the contract or regulations governing the special program initiative, and not through this RFA and resulting Contract.

2. Demonstration Projects

It is an EOHHS priority to ensure that MassHealth Members receive quality medical care at sites of service that promote delivery of such medical care in a cost-effective and efficient manner. In furtherance of this objective, and subject to state and federal approval requirements, if any, EOHHS may, through separate contracts or through this

RFA, institute demonstration projects with Hospitals to develop innovative approaches to delivery of services and payment for services. Such demonstration projects will be designed to focus on ensuring that Hospitals provide or facilitate the provision of quality services to MassHealth Members in a manner that is efficient and cost-effective and that may include alternative reimbursement methodologies for Hospital services or certain Hospital services.

3. MassHealth Drug List

To help ensure consistency in medication regimens and services, prescribers need to conform to the MassHealth Drug List (see www.mass.gov/druglist) whenever medically appropriate for inpatients, outpatients, and upon discharge.

Hospitals are required to obtain prior authorization from the MassHealth Drug Utilization Review (DUR) Program for certain Drugs that will be administered to Members in an inpatient or outpatient Hospital setting. Drugs for which MassHealth requires Hospitals to obtain prior authorization will be specified on the MassHealth Acute Hospital Carve-Out Drugs List of the MassHealth Drug List (and any other section of the MassHealth Drug List applicable to Acute Hospitals that may be developed); Subchapter 6 of the Acute Outpatient Hospital Provider Manual (in the case of Acute Outpatient Hospitals); or other written statements of policy issued by EOHHS. The prior authorization requirements will be set forth in the MassHealth Drug List or in other written statements of policy issued by EOHHS. See also **Sections 5.B.8.b, 5.C.9**, and **6.A** of this RFA.

4. MCO Offer of Contract

For purposes of this **Section 4.B.4**, "MCO" refers to all MCOs as defined in **Section 2**, except Senior Care Organizations (SCOs) and One Care plans.

Effective as of October 1, 2026, all Hospitals that are parties to a Hospital Contract under this RFA must have a written contract with at least one MCO to participate as a network Hospital provider under the MCO's provider network (and continue to maintain at least one such MCO network provider contract), if offered a network Hospital provider contract by the MCO(s).

5. MassHealth Behavioral Health, Substance Use Disorder, Autism Spectrum Disorder, and Intellectual and Developmental Disability Initiatives

a. Hospitals with DMH-Licensed Beds must comply with all applicable Department of Mental Health regulations and subregulatory guidance, including, but not limited to, the Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards that follow, as they appear in DMH Licensing Division Bulletin #19-01 (or any amended or successor bulletin), when delivering Inpatient Psychiatric Services in those DMH-Licensed Beds:

(1) Clinical Competencies/ Operational Standards Related to Co-occurring Medical

Conditions: Psychiatric Units within General Hospitals

(2) Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

(3) Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)

(4) Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

For reference, excerpts of DMH Licensing Division Bulletin #19-01, including the relevant Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards, are reprinted in **Appendix G**. In the event that the Department of Mental Health amends or supersedes DMH Licensing Division Bulletin #19-01, the amended or superseding bulletin shall be controlling.

b. All Hospitals, including those that do not have DMH-Licensed Beds, must have the capability to treat, in accordance with professionally recognized standards of medical care, all individuals admitted to any unit or bed within the Hospital who present with co-occurring behavioral conditions, including, but not limited to, individuals with co-occurring Substance Use Disorders (SUD), Autism Spectrum Disorder and Intellectual and Developmental Disabilities (ASD/ID/DD), and/or individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk. Consistent with DMH guidance, EOHHS recognizes that patients with significant maladaptive behavior, inability to maintain Activities of Daily Living (ADLs), as well as those with significant self-injurious or violent behavior due to their ASD/ID/DD, may have needs that exceed the expected capability of a general inpatient psychiatric unit.

C. Ambulatory Services Not Covered by the RFA

The following services provided by Hospitals to MassHealth Members on an outpatient basis are not paid pursuant to the Acute Hospital RFA and Contract: ambulance services, psychiatric day treatment, early intervention, home health, adult day health and adult foster care, and outpatient covered drugs processed through the Pharmacy On-Line Processing System (POPS). Hospitals must continue to conform to the separate provider participation and reimbursement requirements for those MassHealth programs.

D. Requirements for Hospital Notifications and Discharge Planning Coordination

1. Notification of Emergency Department (ED) Services

For Members enrolled in the PCC Plan or a Primary Care ACO, the Hospital must notify the Member's PCC or Participating PCP within one business day of the commencement of ED services for the Member. For Members that are identified in EVS as Community

Partner (CP) Assigned Members, the Hospital must notify the Member's CP(s) within one business day of the commencement of ED services for the Member. Notification may include a secure electronic notification of the visit. For the avoidance of doubt, Hospitals shall ensure that any such notification is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance. EOHHS reserves the right to specify the form and format for such notification.

2. Notification of Inpatient Admission and Discharge Planning Activities

a. For Members enrolled in the PCC Plan or a Primary Care ACO (PCACO), the Hospital must notify the Member's PCC Plan or PCACO, as applicable, or the Member's Participating PCP within one business day of the Member's: (1) Inpatient Admission and (2) subsequent discharge (which includes, for purposes of this **Section 4.D.2**, a transfer to another Acute Inpatient Hospital or to a 24-hour facility that provides Behavioral Health Diversionary Services). For members that are identified in EVS as Community Partner Assigned Members, the Hospital must also notify the Member's CP(s) within one business day of the Member's: (1) Inpatient Admission and (2) subsequent discharge (which includes, for purposes of this **Section 4.D.2**, a transfer to another Acute Inpatient Hospital or to a 24-hour facility that provides Behavioral Health Diversionary Services). Notification may include a secure electronic notification of the visit. For the avoidance of doubt, Hospitals shall ensure that any such notification is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance. EOHHS reserves the right to specify the form and format for such notification.

b. The Hospital, when possible, must begin formulating a discharge plan on the first day of a Member's Inpatient Admission.

c. In addition to satisfying all other requirements for discharge planning set forth in MassHealth regulations or other formal written statements of policy:

(1) For Members enrolled in the PCC Plan or a PCACO, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's PCC Plan or PCACO, as applicable or the Member's Participating PCP within two business days of the discharge. For Members identified in EVS as Community Partner Assigned Members, the Hospital shall ensure that the Hospital's discharge summary is sent to the Member's CP(s) within two business days of the discharge. The discharge summary must include a copy of the Hospital's discharge instructions that were provided to the Member, and include details on the Member's diagnosis and treatment. For the avoidance of doubt, Hospitals shall ensure that any such transmission is made in compliance with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance.

(2) For all Members receiving Inpatient Services, the Hospital shall communicate

with, as applicable, the Member's primary care provider, health plan, PCC Plan or PCACO (as applicable), and CP(s) to ensure that, consistent with all applicable federal and state laws, regulations, and sub-regulatory guidance, all appropriate parties are included in the Member's discharge planning process. Such appropriate parties may include CPs, case managers, caregivers, and other critical supports for the Member. Examples of these activities may include setting up appropriate consent and communication protocols, including a designated key contact for parties to liaise with, and protocols to allow staff from these parties onto hospital units to participate in discharge planning and care coordination. For the avoidance of doubt, Hospitals shall ensure that any such communications comply with all applicable federal and state privacy laws, regulations, and sub-regulatory guidance.

(3) For Members admitted for childbirth and newborn care, the hospital's discharge planning process shall include, at a minimum, the following activities to help ensure appropriate follow-up care for the birthing parent and newborn:

(a) Completing and submitting MassHealth's Notification of Birth form in accordance with MassHealth's instructions on that form;

(b) Advising the family to select a pediatrician if one has not yet been selected and, if requested by the family, assisting the parent in the selection of a pediatrician by, at a minimum, providing the parent with:

1) A paper copy of and/or web access to the MassHealth Enrollment Guide and MassHealthChoices.com website;

2) The telephone number by which Members contact MassHealth's Customer Service;

(c) Advising the family to schedule an appointment with the pediatrician for the initial well baby visit and aftercare services as clinically appropriate and, if requested by the family, assisting in securing such an appointment. For any appointment that is critical to the patient's health and safety, the hospital shall strongly encourage and offer to assist the Member in securing an appointment; and

(d) Advising the birthing parent to schedule an appointment for a postpartum visit and any aftercare services (e.g., staple removal post cesarean section) as clinically appropriate and, if requested by the parent, assisting in securing such an appointment. For any appointment that is critical to the patient's health and safety, the hospital shall strongly encourage and offer to assist the Member in securing an appointment.

(4) For all Members receiving Inpatient Services, Hospitals must comply with the

Discharge Planning Procedures for Members Experiencing or at Risk of Homelessness set forth in **Appendix H**.

d. The Hospital must document in the Member's medical record all actions taken to satisfy the notification and discharge planning requirements set forth in this **Section 4.D.2**.

e. For the avoidance of doubt, Hospitals shall ensure that any such notification or discharge planning-related activities are made in compliance with applicable federal and state privacy laws and regulations.

3. Electronic Submission Requirements and Review for Pre-Admission Screening

Except as provided explicitly to the contrary in this **Section 4.D.3**, EOHHS conducts admission screening on elective admissions in accordance with 130 CMR 450.208(A). Notwithstanding that portion of 130 CMR 450.208(A)(1) that requires admitting providers to submit requests for admission screening for elective admissions via telephone or fax, the admitting provider must submit requests for admission screening via the Provider Online Service Center (POSC) at least seven calendar days before the proposed elective admission. For more information about the POSC or to register as a user, see MassHealth Provider Online Service Center (POSC). In all other respects, the admitting provider shall submit requests for admission screening in accordance with 130 CMR 450.208(A).

Section 5 Reimbursement System

A. General Provisions

Acute Hospitals that participate in the MassHealth program under the terms of the Hospital Contract and its accompanying payment methodology shall accept payment at the rates established in this RFA as payment in full for services reimbursable by EOHHS that are rendered to MassHealth Members admitted as inpatients or treated as outpatients on or after October 1, 2026.

Non-acute units, other than Rehabilitation Units, and units within Hospitals that operate under separate licenses, such as skilled nursing units, will not be affected by this methodology.

Pursuant to M.G.L. c. 118E, § 9, which describes pre-admission counseling for long-term care, Hospitals will undertake the following activities in connection with instructions that may be issued from time to time by EOHHS: (i) inform patients of the availability of EOHHS-approved counseling services; (ii) identify patients who might benefit from counseling; (iii) distribute informational materials to patients; and (iv) participate in training events organized by EOHHS.

A Hospital with a DMH-licensed inpatient psychiatric unit must accept into its DMH-licensed inpatient psychiatric unit all referrals of MassHealth Members that meet the established admission criteria of the inpatient unit. Such Hospitals shall report all available DMH-Licensed Beds into the Massachusetts Behavioral Health Access website at a minimum three times per day, seven days per week. Such updates shall occur, at a minimum, between 8:00 a.m.-10:00 a.m., 12:00 p.m.-2:00 p.m., and 6:00 p.m.-8:00 p.m. EOHHS may designate an alternative frequency for such updates.

The Hospital is responsible for providing to EOHHS a report of fee-for-service Members admitted for inpatient psychiatric services, regardless of the inpatient location, in a format and frequency to be determined by EOHHS, for the purposes of supporting clinical management and care coordination of complex cases

B. Payment for Inpatient Services

A Hospital will be paid in accordance with **Section 5.B** for Inpatient Services.

Except as otherwise provided in **Sections 5.B.2** through **5.B.13,** and **Section 5.D.7**, fee-for-service payments to Hospitals for Inpatient Services provided to MassHealth Members not enrolled in an MCO will be an Adjudicated Payment Amount Per Discharge (APAD), calculated as described more fully in **Sections 5.B.1**.a through **5.B.1.**e, 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, **Section 5.B.2**.

Payment to Hospitals for LARC Devices and APAD Carve-Out Drugs, respectively, is as set forth in **Section 5.B.8.a** and **5.B.8.b**, respectively, and not pursuant to the APAD and Outlier Payment methodologies.

For Critical Access Hospitals, payment for Inpatient Services is in accordance with **Section 5.D.7**.

Payment for Behavioral Health Services provided in DMH-Licensed Beds to MassHealth Members who are not served either through a contract between EOHHS and its BH Contractor or an MCO shall be made through an all-inclusive Psychiatric Per Diem (see **Section 5.B.4**).

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.

Payment for physician services rendered by Hospital-Based Physicians will be made as described in **Section 5.B.5**.

1. Adjudicated Payment Amount per Discharge (APAD)

a. 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 5.B.8**, below). 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. These components and the calculation of the APAD are described further below in **Sections 5.B.1.b** through **5.B.1.e**. For components calculated based on data from all Hospitals, the calculation included data for all Hospitals that were operating as of January 1, 2023.

b. Calculation of the Statewide Operating Standard per Discharge

Primary sources of data: In the development of the Statewide Operating Standard per Discharge, EOHHS used APAD Base Year all-payer costs and discharges and FY21 HDD as the primary sources of data to develop operating costs per discharge.

Calculating the average cost per discharge for each Hospital: The Statewide Operating Standard per Discharge is based on the statewide average cost per discharge, which is derived from the actual statewide costs of providing Inpatient Services as reflected in the APAD Base Year cost report. The average cost per discharge for each Hospital was derived by dividing total inpatient Hospital costs by total inpatient Hospital discharges, omitting those costs and discharges from Excluded Units and costs associated with postpartum LARC Devices. Routine outpatient costs associated with admissions from the Emergency Department and routine and ancillary outpatient costs resulting from admissions from observation status were included. The cost centers which are identified as the supervision

component of physician compensation and other direct physician costs were included; professional services were excluded. All other medical and non-medical patient care-related staff expenses were included.

Capital costs and direct medical education costs were excluded from the calculation of the statewide average cost per discharge. Malpractice and organ acquisition costs were included.

Wage area and Casemix adjustments to calculate each hospital's standardized costs per discharge:

The calculation of each hospital standardized cost per discharge, which is unchanged from the methodology used in the RY24 – RY26 RFAs, is calculated as follows.

The labor portion of the average cost per discharge for each Hospital was adjusted by the Hospital's RY24 Massachusetts-specific wage area index, and the labor and non-labor portions were then adjusted by the Hospital-specific FY21 all-payer APR-DRG Version 40 Casemix Index that was determined by using FY21 discharges, APR-DRG version 40 of the Solventum grouper, and MassHealth DRG Weights. Massachusetts Hospitals' wages and hours were determined based on CMS's FY 2024-April-28-2023-Wage-Index-PUF zip file, downloaded May 18, 2023, from the CMS web site at www.cms.hhs.gov. Each Hospital was assigned to a wage area according to CMS's FY 2023 IPPS FR and CA Impact File from the CMS web site at https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page (*FY 2023 IPPS FR and CA Impact File*), except that:

- Brigham and Women's Hospital and Beth Israel Deaconess Hospital-Milton were assigned to the Boston wage area and their wages and hours included in the Boston area;
- Baystate Franklin Medical Center was assigned to the Springfield wage area and their wages and hours included in the Springfield area;
- The following hospitals were redesignated, for the purpose of wage areas, as follows:
    - Baystate Medical Center and Cooley Dickinson Hospital from Springfield to Worcester;
    - Anna Jaques Hospital, Beverly Hospital, Cambridge Health Alliance, Emerson Hospital, Merrimack Health Methuen Hospital, Lahey Hospital, Merrimack Health General Hospital, Lowell General Hospital, Melrose Wakefield Healthcare, MetroWest Medical Center, Mount Auburn Hospital, Newton-Wellesley Hospital, North Shore Medical Center and Winchester Hospital from Cambridge-Newton-Framingham to Boston;
    - Harrington Hospital, HealthAlliance-Clinton Hospital, Heywood Hospital,

Milford Medical Center, St. Vincent Hospital and UMass Memorial Medical Center from Worcester to Boston;

- Southcoast Hospitals Group from Providence-Warwick to Boston; and
- Saint Anne's Hospital from Providence-Warwick to Worcester

- Prospective Payment System (PPS)-exempt hospitals were assigned to the wage area in which their main campus is located, as determined by EOHHS from the hospital's license (PPS-exempt hospitals are not included in the FY2023 Impact File).

Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. 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 redesignated to a different wage area in a written decision from CMS to the Hospital provided to EOHHS by March 28, 2023. 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.

These steps result in the calculation of each Hospital's standardized costs per discharge.

Determining the efficiency standard: All Hospitals were then ranked from lowest to highest with respect to their standardized costs per discharge; a cumulative frequency of FY22 MassHealth discharges for the Hospitals was produced from MMIS claims data on file as of June 12, 2023, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges from Excluded Units were omitted. The efficiency standard was established at the cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 60% of the total number of statewide discharges in the MMIS. The efficiency standard applicable to RY27 is unchanged as compared to RY24 at $15,211.43.

Final calculation of Statewide Operating Standard per Discharge: The Statewide Operating Standard per Discharge was then determined by multiplying (a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by (b) the outlier adjustment factor of 91.85%; by (c) the Inflation Factors for Operating Costs between RY21 and RY24; and then by dividing the result by (d) a conversion factor of 1.1722. The resulting Statewide Operating Standard per Discharge is $11,423.66.

c. Calculation of the Statewide Capital Standard per Discharge

Primary sources of data: In the development of the Statewide Capital Standard per

Discharge, EOHHS used APAD Base Year all-payer costs and discharges and FY21 HDD as the primary sources of data to develop capital costs per discharge.

Calculating each hospital's capital cost per discharge: For each Hospital, the total inpatient capital costs include the Building and Fixtures and Movable Equipment categories reported in the FY21 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 FY21 Massachusetts Hospital Cost Report. Capital costs for Excluded Units were omitted to derive net inpatient capital costs. For each Hospital, the capital cost per discharge was calculated by dividing the Hospital's total net inpatient capital costs by the Hospital's FY22 total inpatient hospital discharges net of Excluded Unit discharges.

Determining the Casemix-adjusted efficiency standard: The Casemix-adjusted capital cost per discharge was determined by (a) dividing the cost per discharge by the Hospital-specific FY21 All-Payer APR-DRG Version 40 Casemix Index; (b) sorting these adjusted costs in ascending order; and (c) producing a cumulative frequency of FY22 MassHealth discharges from MMIS claims data on file as of June 12, 2023, with a status of adjudicated and paid and for which MassHealth was the primary payer. Discharges from Excluded Units were omitted. The Casemix-adjusted efficiency standard was established at the capital cost per discharge corresponding to the position on the cumulative frequency of discharges that represents 60% of the total number of discharges. The efficiency standard applicable to RY27 is unchanged from RY24 at $1080.10.

Calculation of statewide weighted average capital cost per discharge: Each Hospital's capital cost per discharge was then held to the lower of its capital cost per discharge or the Casemix-adjusted efficiency standard, to arrive at a capped capital cost per discharge. Each Hospital's capped capital cost per discharge was then multiplied by the Hospital's FY22 number of MassHealth discharges. The product of the capped capital cost per discharge and the number of MassHealth discharges for each Hospital was then summed and divided by the total number of MassHealth discharges statewide, to arrive at a statewide weighted average capital cost per discharge.

Calculation of final Statewide Capital Standard per Discharge: The statewide weighted average capital cost per discharge was then updated by the Inflation Factors for Capital Costs between RY21 and RY24, and then divided by 1.1722. The resulting Statewide Capital Standard per Discharge is $792.37.

d. Determination of MassHealth DRG Weight

The MassHealth DRG Weight is the MassHealth relative weight developed 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 Solventum APR-DRG grouper Version 43 and Massachusetts weights (see **Chart C** to **Appendix C** for the MassHealth DRG Weights that apply to RY27).

e. Calculation of the APAD

Each APAD is determined by the following steps: (1) multiplying the labor portion of the Statewide Operating Standard per Discharge, determined as described in **Section 5.B.1.b**, by the Hospital's RY27 Massachusetts-specific wage area index, determined as described in this **Section 5.B.1.e**, (2) adding this amount to the non-labor portion of said Statewide Operating Standard per Discharge, determined as described in this **Section 5.B.1.e**, to determine the Hospital's Wage Adjusted Operating Standard per Discharge, (3) adding said Wage Adjusted Operating Standard per Discharge to the Statewide Capital Standard per Discharge, determined as described in **Section 5.B.1.c**, to determine what 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), above, the Hospital's RY27 Massachusetts-specific wage area index, which is multiplied by the labor portion of the Statewide Operating Standard per Discharge derived as specified in **Section 5.B.1.b**., is determined as follows:

Massachusetts Hospitals' wages and hours were determined based on CMS's FY27_April_PUF.20260429.S3andOccMixPUF zip file, downloaded May 18, 2026, from the CMS web site at www.cms.hhs.gov. Each Hospital was assigned to a wage area according to CMS's FY 2026 IPPS Final Rule Impact File from the CMS web site at https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2026-ipps-final-rule-home-page (*FY 2026 Impact File*) except that:

- Brigham and Women's Hospital and Beth Israel Deaconess Hospital-Milton were assigned to the Boston wage area and their wages and hours included in the Boston area;
- The following hospitals were redesignated, for the purpose of wage areas, as follows:
    - Baystate Medical Center and from Springfield to Worcester;
    - Anna Jaques Hospital, Beverly Hospital, Cambridge Health Alliance, Emerson Hospital, Merrimack Health Methuen Hospital, Lahey

Hospital, Merrimack Health General Hospital, Lowell General Hospital, Melrose Wakefield Healthcare, MetroWest Medical Center, Mount Auburn Hospital, Newton-Wellesley Hospital, North Shore Medical Center and Winchester Hospital from Cambridge-Newton-Framingham to Boston;

- Harrington Hospital, HealthAlliance-Clinton Hospital, Heywood Hospital, Milford Medical Center, St. Vincent Hospital and UMass Memorial Medical Center from Worcester to Boston;
- Southcoast Hospitals Group and Sturdy Memorial Hospital from Providence-Warwick to Boston; and
- Saint Anne's Hospital from Providence-Warwick to Worcester
- Cooley Dickinson Hospital from Amherst Town-Northampton to Worcester

- PPS-exempt hospitals were assigned to the wage area in which their main campus is located, as determined by EOHHS from the hospital's license (PPS-exempt hospitals are not included in the FY2026 Impact File).

Each area's average hourly wage was then divided by the statewide average hourly wage to determine the area's wage index. 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 redesignated to a different wage area in a written decision from CMS to the Hospital provided to EOHHS by March 30, 2026. 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.

For purposes of step (4), above, in the calculation of the APAD, for qualifying discharges, the APAD Base Payment will be adjusted as follows:

(1) For Freestanding Pediatric Acute Hospitals for which the MassHealth DRG Weight assigned to the discharge is 3.0 or greater, the APAD Base Payment will be adjusted to include an additional 67%.

(2) For Massachusetts Acute Hospitals, that (i) are not Freestanding Pediatric Acute Hospitals and (ii) maintain between 1 and 15 pediatric beds as determined by EOHHS, the APAD Base Payment will be adjusted to include an additional 25% for discharges of patients who are under 21 years of age.

(3) For Massachusetts Acute Hospitals, that (i) are not Freestanding Pediatric Acute Hospitals, and (ii) do not maintain between 1 and 15 pediatric beds as determined by EOHHS, the APAD Base payment will be adjusted to include an additional 6%

for discharges of patients who are under 21 years of age.

Table 1, below, illustrates the calculation of the Total Case Payment for a standard APAD claim that does not qualify for an Outlier Payment under **Section 5.B.2**. Values are for demonstration purposes only and illustrate the calculation from statewide operating and capital standards to the final APAD payment amount. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 1: Standard APAD Claim

Line	Description	Value	Calculation or Source
1	Statewide Operating Standard per Discharge	$11,423.66	RY27 RFA
2	Hospital's Massachusetts-specific wage area index	1.03657	Varies by hospital
3	Labor Factor	0.67615	RY27 RFA
4	Hospital's Wage Adjusted Operating Standard per Discharge	$11,706.13	$(Line\ 1 \times Line\ 2 \times Line\ 3) + (Line\ 1 \times (1 - Line\ 3))$
5	Statewide Capital Standard per Discharge	$792.37	RY27 RFA
6	APAD Base Payment	$12,498.50	$Line\ 4 + Line\ 5$
7	MassHealth DRG Weight	0.3300	**Appendix C**, Chart C
8	**Total Case Payment = Adjudicated Payment Amount per Discharge (APAD)**	**$4,124.51**	$Line\ 6 \times Line\ 7$

2. Outlier Payments

A Hospital qualifies for a discharge-specific Outlier Payment in addition to the APAD if all of the following conditions are met:

a. The amount of the APAD for the discharge, as calculated as set forth in **Section 5.B.1** exceeds $0;

b. The Hospital's Discharge-Specific Case Cost exceeds the Discharge-Specific Outlier Threshold for that discharge;

c. The patient is not a patient in a DMH-Licensed Bed for any part of the discharge; and

d. The patient is not a patient in an Excluded Unit within an Acute Hospital.

If a Hospital qualifies for an Outlier Payment, 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.

EOHHS reserves the right, as part of an audit, prepayment utilization review or similar process, to deny payment to the Hospital for an Outlier Payment(s), or initiate overpayment proceedings on a post-payment basis to recover an Outlier Payment(s) from the Hospital, if the Hospital fails to fulfill its discharge planning duties as required in MassHealth regulations, the RFA or other written statements of policy issued by EOHHS,

or fails to meet generally accepted medical standards applicable to discharge planning.

Tables 2 is an illustrative example of the calculation of the Total Case Payment for claims involving an Outlier Payment. Values shown are for demonstration purposes only. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 2: Claim with Outlier Payment

Line	Description	Value	Calculation or Source
1	APAD (must be >$0)	$4,124.51	Table 1, Line 8
2	Allowed Charges	$80,000.00	Determined from claim
3	Hospital's Inpatient Cost-to-Charge Ratio	65%	FY22 Massachusetts Hospital Cost Report
4	Discharge-Specific Case Cost	$52,000	Line 2×Line 3
5	Fixed Outlier Threshold	$42,430	RY27 RFA
6	Discharge-Specific Outlier Threshold	$ 46,554.51	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	60%	RY27 RFA
9	Outlier Payment	$3,267.29	(Line 4 − *Line* 6) × *Line* 8
10	**Total Case Payment = APAD plus Outlier Payment**	**$7,391.80**	*Line* 1 + *Line* 9

3. Transfer Per Diem Payments

a. Transfer Between Hospitals

A Hospital that transfers a patient to another Acute Hospital will be paid on a per diem basis (the "Transfer Per Diem"), capped at the Hospital's Total Transfer Payment Cap.

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 **Section 5.B.1** and **5.B.2**, 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 shall equal the Transferring Hospital's Total Case Payment amount, as determined by EOHHS, divided by the applicable DRG-specific mean all-payer length of stay from the APR-DRG Version 43 Massachusetts-specific weight file (**Chart C** to **Appendix C**). 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 **Sections 5.B.1** and **5.B.2** for the period for which the Transferring Hospital is being paid on a Transfer Per Diem basis pursuant to this

Section 5.B.3. In all cases, payment on a Transfer Per Diem basis will be capped at the Transferring Hospital's Total Transfer Payment Cap. This methodology applies to all subsections of **Section 5.B.3**, for admissions in RY27 that are paid on a Transfer Per Diem basis.

Table 3 is an illustrative example of calculation of the Transfer Per Diem, Total Transfer Payment Cap, and Total Transfer Case Payment under **Section 5.B.3** for a claim with transfer, with (APAD only (i.e., without outlier). Values are for demonstration purposes only. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 3: Claim with Transfer (APAD Only)

Line	Description	Value	Calculation or Source
1	APAD (Total Case Payment Amount)	$4,124.51	Table 1, line 8
2	Patient length of stay (# of days)	2.00	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.19	**Appendix C**, Chart C
4	Transfer per diem	$1,883.34	$\frac{Line\ 1}{Line\ 3}$
5	Transfer per diem x Patient length of stay (# of days)	$3,766.68	$Line\ 4 \times Line\ 2$
6	Total Transfer Payment Cap	$4,124.51	Line 1
7	**Total Transfer Case Payment**	**$3,766.68**	**Lower of Line 5 or Line 6**

Table 4. Illustrates the calculation of the Transfer Per Diem, Total Transfer Payment Cap, and Total Transfer Case Payment under **Section 5.B.3** for a claim with a transfer, using the APAD with Outlier. Values are for demonstration purposes only. This illustrative example calculation uses a Boston AWI, with a DRG of 203 (chest pain) and an SOI of 2.

Table 4: Claim with Transfer (APAD and Outlier)

Line	Description	Value	Calculation or Source
1	Total Case Payment Amount (Claim with Outlier Payment)	$7,391.80	Table 2, line 10
2	Patient length of stay (# of days)	2.00	Determined from claim
3	Mean all-payer length of stay for DRG 203	2.19	**Appendix C**, Chart C
4	Transfer per diem	$3,375.25	$\frac{Line\ 1}{Line\ 3}$
5	Transfer per diem x Patient length of stay (# of days)	$6,750.50	$Line\ 4 \times Line\ 2$
6	Total Transfer Payment Cap	$7,391.80	Line 1
7	**Total Transfer Case Payment**	**$6,750.50**	**Lower of Line 5 or Line 6**

b. Transfers within a Hospital

Except as described below, a transfer within a Hospital is not considered a discharge. Consequently, in most cases a transfer between units within a Hospital will be

reimbursed on a Transfer Per Diem basis capped at the Hospital's Total Transfer Payment Cap. This section outlines reimbursement under some specific transfer circumstances.

(1) 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.

(2) MassHealth Payments for Newly Eligible Members, Members Who Change Enrollment from the PCC Plan, a Primary Care ACO, or Non-Managed Care to an MCO during a Hospital Stay (or vice versa); 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 non-managed care 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, up to the Hospital's Total Transfer Payment Cap, or, if the patient is at the Administrative Day level of care, at the AD per diem rate, in accordance with **Section 5.B.6**.

(3) 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 up to the Hospital's Total Transfer Payment Cap.

(4) Transfer between a DMH-Licensed Bed and Any Other Bed within the Same Hospital

Reimbursement 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, BH network or non-network Hospital, or the type of service provided. See also **Section 5.B.3.b.(5)**.

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 at the Psychiatric Per Diem rate for the DMH-Licensed Bed portion of the stay (see **Section 5.B.4**).

When a Member who is 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 for the non-DMH-Licensed Bed portion of the stay at the Transfer Per Diem rate capped at the Hospital's Total Transfer Payment Cap.

(5) Change of BH Managed Care Status during a Behavioral Health Hospitalization

(a) Payments to Hospitals without Network Provider Agreements with EOHHS' BH Contractor

Except as otherwise provided in **Section 4.A.1**, Hospitals that are not in the BH Contractor's network do not qualify for payment from either MassHealth or the BH Contractor for BH Contractor-covered services rendered to a Member during a period in which the Member was enrolled with 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 at the Psychiatric Per Diem rate for Behavioral Health Services in a DMH-Licensed Bed or at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-Licensed Bed.

(b) Payments to Hospitals that are in the BH Contractor's Provider Network

When a Member is enrolled with the BH Contractor during a Behavioral Health Hospital admission, the portion of the Hospital stay during which the Member was enrolled with the BH Contractor shall be paid by the BH Contractor at the rates agreed upon by the Hospital and the BH Contractor provided that the Hospital complies with the BH Contractor's service authorization and billing policies and procedures.

The portion of the Hospital stay during which the Member was not enrolled with the BH Contractor will be paid by EOHHS at the Psychiatric Per Diem rate for Behavioral Health Services in a DMH-Licensed Bed; or at the Transfer Per Diem rate, capped at the Total Transfer Payment Cap, for Behavioral Health Services in a non-DMH-Licensed Bed.

4. Payments for Behavioral Health Services

Services provided to MassHealth Members in DMH-Licensed Beds during an inpatient BH admission who are not enrolled with the BH Contractor or an MCO shall be paid through a combination of a Psychiatric Per Diem and a per inpatient admission behavioral health rate, as described below. This payment mechanism does not apply to

cases in which Behavioral Health Services are provided to Members enrolled with the BH Contractor or an MCO.

a. Statewide Standard Psychiatric Per Diem

The Statewide Standard Psychiatric Per Diem Rate is derived using the sum of the following: the Acute Hospital Standard for Inpatient Psychiatric Overhead Costs, the Acute Hospital Standard for Inpatient Psychiatric Direct Routine Costs, the Acute Hospital Standard for Inpatient Psychiatric Direct Ancillary Costs, the Acute Hospital Standard for Inpatient Psychiatric Capital Costs, plus the Adjustment to Base Year Costs.

b. Data Sources

The Psychiatric Per Diem Base Year is FY04. MassHealth utilizes the costs, statistics, and revenue reported in the FY04 -403 cost reports, as screened and updated as of March 10, 2006, in determining Base Year Operating Standards and the Base Year Capital Standards described in **Section 5.B.4.c** and **d**, below.

c. Determination of Base Year Operating Standards

(1) 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.

(2) 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.

(3) 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.

d. Determination of Base Year Capital Standard

(1) Each hospital's base year capital costs consist of the hospital's actual 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.

(2) 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.

(3) 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.

e. Adjustment to Base Year Costs:

The Standards for Inpatient Psychiatric Overhead Costs, Direct Routine Costs, and Direct Ancillary Costs were updated by the Inflation Factors for Operating Costs between the Psychiatric Per Diem Base Year and RY07. The Standard for Inpatient Psychiatric Capital Costs was updated by the Inflation Factors for Capital Costs between the Psychiatric Per Diem Base Year and RY07.

The Inflation Factors for Operating Costs between RY08 and RY10, between RY12 and RY19, and between RY21 and RY22 were applied to the rate calculated above to determine the RY27 Statewide Standard Psychiatric Per Diem rate.

f. Inpatient Admission Rates Payments:

For inpatient BH admissions in DMH-Licensed Beds for members who are not enrolled with the BH Contractor or an MCO, an inpatient admission rate will be paid in addition to the inpatient per diem rate. The inpatient admission rate is determined based on criteria met upon admission, as set forth below. Each admission may meet only one category below:

Table 4.1: Inpatient Admission Category

	(1) **Category 1 Per Admission Inpatient Rate; OR**	**(2)** **Category 2 Per Admission Inpatient Rate; OR**	**(3)** **Category 3 Per Admission Inpatient Rate**
(A) Weekday Admission - Patient admission occurs Monday to Friday; OR	The Member admission does not meet eligibility criteria for either Category 2 or Category 3 Per Inpatient Admission Rates.	The Member admission meets at least one of the following criteria: 1. The Member is aged 14 years old to 17 years old (inclusive); or 2. The Member has a diagnosis of Autism Spectrum Disorder or Intellection Disability	The Member admission meets at least one of the following criteria: 1. The Member is aged 13 years old or below; or 2. The Member is aged 65 years old or above; or

	(1) **Category 1 Per Admission Inpatient Rate; OR**	(2) **Category 2 Per Admission Inpatient Rate; OR**	(3) **Category 3 Per Admission Inpatient Rate**
		(ASD/ID); or 3. The Member has a diagnosis of an eating disorder; or 4. The Member is homeless as indicated by diagnosis code Z59.0x, or housing unstable as indicated by diagnosis code Z59.1 or Z59.819; or 5. The member is admitted to a hospital identified by CHIA as a teaching hospital (HFY 2024 Massachusetts Hospital Profiles-January 2026); AND The Member admission does not meet eligibility criteria for the Category 3 Per Inpatient Admission Rate.	3. The Member is affiliated (as indicated in MMIS) with one or more of the following Massachusetts human service agencies: DDS, DCF, DMH, or DYS.

	(1) **Category 1 Per Admission Inpatient Rate; OR**	(2) **Category 2 Per Admission Inpatient Rate; OR**	(3) **Category 3 Per Admission Inpatient Rate**
(B) Weekend Admission - Patient admission occurs Saturday or Sunday	The Member admission does not meet eligibility criteria for either Category 2 or Category 3 Per Inpatient Admission Rates.	The Member admission meets at least one of the following criteria: 1. The Member is aged 14 years old to 17 years old (inclusive); or 2. The Member has a diagnosis of ASD/ID; or 3. The Member has a diagnosis of an eating disorder; or 4. The Member is homeless as indicated by diagnosis code 759.0x, or housing unstable as indicated by diagnosis code Z59.1 or Z59.819; or 5. The member is admitted to a hospital identified by CHIA as a teaching hospital (HFY 2024 Massachusetts Hospital Profiles- January 2026); AND The Member admission does not meet eligibility criteria for the Category 3 Per Inpatient Admission Rate.	The Member admission meets at least one of the following criteria: 1. The Member is aged 13 years old or below; or 2. The Member is aged 65 years old or above; or 3. The Member is affiliated (as indicated in MMIS) with one or more of the following Massachusetts human service agencies: DDS, DCF, DMH, or DYS.

The payment rates for inpatient Behavioral Health Services described in the chart

above are as follows:

(1) Psychiatric Per Diem rate - $954.59 per day

(2) Category A1 rate - $350 per admission

(3) Category B1 rate - $1,000 per admission

(4) Category A2 rate - $1,850 per admission

(5) Category B2 rate - $2,500 per admission

(6) Category A3 rate - $2,975 per admission

(7) Category B3 rate - $3,625 per admission

g. Long-Acting Injectable (LAI) Antipsychotics:

(1) LAI Antipsychotics Prior Approval Requirements:

Drug-specific prior authorization requirements must be met, as described on the *Long-Acting Injectable Antipsychotic Medications Administered in Inpatient Psychiatry Units* document, published on the MDHL.

(2) Payment for LAI Antipsychotics:

(a) MassHealth will only pay for LAI Antipsychotics that are administered to Members during an in-state hospital behavioral health (BH) inpatient admission, and such LAI Antipsychotics shall be paid for in addition to the appropriate inpatient psychiatric per diem rate. Hospitals will be paid for LAI Antipsychotics at the fee schedule rates in 101 CMR 317.00: *Rates for medicine services*, which incorporate by reference the rates for LAI Antipsychotics listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File. For LAI Antipsychotics not listed in the fee schedule, payment is set by Individual Consideration (IC).

(b) The Hospital must claim separate payment for LAI Antipsychotics in accordance with applicable MassHealth billing instructions, including, without limitation, as set forth herein, in MassHealth billing instructions and in any special billing instructions for LAI Antipsychotics administered during an in-state hospital BH inpatient admission that may be published under "Billing Tips" on the MassHealth website at https://www.mass.gov/service-details/billing-tips. EOHHS may update the billing instructions from time to time.

5. Physician Payment

For physician services provided by Hospital-Based Physicians to MassHealth patients, the Hospital will be reimbursed for the professional component of physician services in accordance with, and subject to, the Physician regulations at 130 CMR 433.000 et seq.

Such reimbursement shall be at the lower of (1) the fee established in 101 CMR 317.00 (Medicine), 101 CMR 316.00 (Surgery and Anesthesia), and 101 CMR 318.00 (Radiology) 101 CMR 320.00 (Clinical Laboratory Services), or successor regulations as applicable (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge; or (3) 100% of the Hospital's actual Charge submitted.

Hospitals will be reimbursed for such 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. Physician services provided by residents and interns are not reimbursable separately. Hospitals will only be reimbursed separately for professional fees for practitioners who are Hospital-Based Physicians as defined in **Section 2**. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

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

Physician fee schedules are available at the State House Bookstore and at http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html.

6. Payments for Administrative Days

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 Care Hospitals.

The AD rate is a base per diem payment and an ancillary add-on.

The base per diem payment is $281.78, which represents the median nursing facility rate that was effective October 1, 2023, for all nursing home rate categories, as determined by EOHHS.

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. These ratios are 0.278 and 0.382, respectively.

The resulting AD rates are $384.97 for Medicaid/Medicare Part B-eligible patients and $416.29 for Medicaid-only eligible patients.

MassHealth rules and regulations do not allow a patient to be admitted at an AD status, except in limited circumstances outlined in EOHHS regulations and/or subregulatory guidance. Therefore, except as permitted in such regulations or subregulatory guidance, Administrative Days will follow an acute stay in the Hospital. Furthermore, the Hospital may not bill for more than one APAD even if the patient fluctuates between acute status

and AD status in a single hospitalization.

7. Rehabilitation Unit Services in Acute Hospitals

A DPH-licensed Acute Hospital with a Rehabilitation Unit may bill a per diem rate for Rehabilitation Services provided in the Acute Hospital's Rehabilitation Unit.

The Rehabilitation Unit per diem rate for such Rehabilitation Services equals the median MassHealth RY27 Rehabilitation Hospital group per diem rate under the Chronic Disease and Rehabilitation (CDR) Hospital RFA and program, as determined by EOHHS. Acute Hospital Administrative Day rates will be paid in accordance with **Section 5.B.6** for all days that a patient remains in the Rehabilitation Unit while not at Hospital level of care. Such units shall be subject to EOHHS' screening program for chronic and rehabilitation hospitals as detailed in 130 CMR 435.408 and requirements detailed in 130 CMR 435.410 – 411.

8. Payment for APAD Carve-Out Items

a. Payment for LARC Devices

A Hospital may be paid for a LARC Device separate from the APAD, if all of the following conditions are met:

(1) The member requests the LARC Device while admitted as an inpatient for a labor and delivery stay and, at the time of the procedure, is a clinically appropriate candidate for immediate post-labor and delivery LARC Device insertion;

(2) The practitioner has been properly trained for immediate post-partum LARC Device insertion, and performs the procedure immediately after labor and delivery during the same inpatient hospital stay; and

(3) The Hospital submits a separate claim for payment in accordance with applicable MassHealth billing instructions, including any special billing instructions for Acute Inpatient Hospital claims for LARC Devices that MassHealth may publish under "Billing Tips" on the MassHealth website at https://www.mass.gov/service-details/billing-tips, or in other written statements of policy issued by EOHHS (See also **Section 5.G.**). EOHHS may update the billing instructions, from time to time.

If the Hospital qualifies for separate payment of a LARC Device, the Hospital will be reimbursed for the LARC Device according to the fee schedule rates for such devices set forth in EOHHS regulations at 101 CMR 317.00 (Medicine).

b. APAD Carve-Out Drugs

(1) APAD Carve-Out Drugs and Prior Approval Requirements

(a) The EOHHS-designated APAD Carve-Out Drugs are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" within the MassHealth

Drug List. The MassHealth Drug List is published on the MassHealth website at https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do. This list of APAD Carve-Out Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at the above website location.

(b) The APAD Carve-Out Drugs listed on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization through the MassHealth Drug Utilization Review (DUR) Program. The related inpatient stay(s) are also subject to separate MassHealth preadmission screening (PAS) requirements and approval through the MassHealth Acute Hospital Utilization Review vendor (See also **Sections 4.B.3** and **6.A**).

(2) Payment for APAD Carve-Out Drugs

(a) Payment to Hospitals for APAD Carve-Out Drugs administered to Members during an inpatient admission will be the Hospital's "actual acquisition cost" of the Drug. For this purpose, 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 guarantees (or similar arrangements), whether received pre- or post-payment.

(b) Payment to the Hospital for an APAD Carve-Out Drug is conditioned on and subject to all of the following:

1) The Hospital must have satisfied all applicable MassHealth prior authorization and other applicable prior approval requirements, and all other MassHealth conditions of payment (See also **Section 6.A**).

2) The Hospital must provide timely reports to EOHHS on Member progress as a result of being treated with the APAD Carve-Out Drug as required in the prior authorization approval criteria and billing instructions (or other written statements of policy issued by EOHHS).

3) The Hospital must claim separate payment for APAD Carve-Out Drugs in accordance with applicable MassHealth billing instructions, including, without limitation, as set forth herein, in MassHealth billing instructions for 837P via DDE claims (unless otherwise indicated), and in any special billing instructions for Acute Inpatient Hospital claims for APAD Carve-Out Drugs that may be published under "Billing Tips" on the MassHealth website at https://www.mass.gov/service-details/billing-tips, EOHHS may update the billing instructions from time to time. (See also **Section 5.G**.)

4) The Hospital's claim must be accompanied by a copy of the invoice (or invoices) for the APAD Carve-Out Drug from the drug manufacturer, supplier, distributor, or other similar party or agent, as well as any other documentation that is necessary for the Hospital to evidence that the amount listed on the claim is the Hospital's actual acquisition cost for the Drug (as defined in **Section 5.B.8.b.(2)(a)**. Hospitals must provide EOHHS with any additional documentation deemed necessary by EOHHS to establish or verify that the amount included on the claim is the Hospital's actual acquisition cost as defined in **Section 5.B.8.b.(2)(a)**, upon request.

5) In the event the drug manufacturer (or other party) offers any providers an efficacy-, outcome-, or performance-based guarantee (or similar arrangement) related to the APAD Carve-Out Drug in question, the Hospital shall make every effort to enter such an arrangement with the manufacturer (or other party), at least with respect to the Hospital's treatment of MassHealth Members, and shall make every effort to negotiate terms most favorable to the Hospital and MassHealth. Subject to the requirements of 130 CMR 450.309, in the event the terms of the arrangement allow the Hospital to pay in full or in part for the Drug only if certain conditions are met (e.g., Hospital only pays for the Drug if the Member goes into remission), the Hospital shall not submit a claim to MassHealth for the Drug until the Hospital actually remits the payment it will be required to make for the Drug (and shall not submit any claim for the Drug to MassHealth in the event it is not ultimately required to pay for the Drug). Subject to the above, in the event any other performance-based guarantee (or similar arrangement) is triggered to the benefit of the Hospital with respect to the Member's treatment with the Drug after the Hospital has submitted a claim for the Drug, the Hospital shall immediately notify EOHHS in writing and shall adjust or modify its claim for the Drug to account for the benefit, or otherwise pass the benefit back to MassHealth in the manner specified by EOHHS.

6) EOHHS may designate particular APAD Carve-Out Drugs as requiring the Hospitals to obtain a performance-based guarantee (or similar arrangement). In the event EOHHS designates an APAD Carve-Out Drug as requiring such an arrangement, it will so indicate on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List, and may require documentation or attestation that the Hospital has entered such an arrangement as part of the prior authorization process for the Drug.

(c) Any MassHealth payment made to the Hospital for an APAD Carve-Out Drug based on a claim or invoice submitted by a Hospital for an amount that exceeds the Hospital's actual acquisition cost of the Drug, as defined in **Section 5.B.8.b.(2)(a)**, or under circumstances in which EOHHS determines there was noncompliance with the requirements set forth in **Section 5.B.8.b.(2)(b)**, shall constitute an overpayment as defined by 130 CMR 450.235 and will be subject to recoupment. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing.

9. 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.

The Infant Outlier Payment is calculated using the data and methodology as follows:

(1) **Data Source**: The prior year's claims data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.

(2) **Eligibility**: Eligibility for the adjustment is determined as follows:

(a) **Exceptionally Long Lengths of Stay**: First, the statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated. The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

(b) **Exceptionally High Cost**: Exceptionally high cost is calculated for Hospitals providing services to infants less than one year of age as follows:

1) The average cost per Medicaid inpatient discharge for each Hospital is calculated;

2) The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated; and

3) The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two, and that amount is added to the Hospital's

average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.

(c) **Eligibility for an Infant Outlier Payment**: First, for each Hospital providing services to infants less than one year of age, the average Medicaid inpatient length of stay involving individuals less than one year of age is determined. If this Hospital-specific average Medicaid inpatient length of stay for infants less than one year of age equals or exceeds the threshold defined in **Section 5.B.9.a.(2)(a)**, then the Hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants less than one year of age is calculated. If a Hospital has a Medicaid inpatient case with a cost that equals or exceeds the Hospital's own threshold defined in **Section 5.B.9.a.(2)(b)** above, then the Hospital is eligible for an infant outlier payment.

(d) **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 more than one year of age and less than six years of age involving exceptionally high costs or exceptionally long lengths of stay.

The Pediatric Outlier Payment is calculated using the data and methodology as follows:

(1) **Data Source**: The prior year's discharge data residing on EOHHS' MMIS is used to determine exceptionally high costs and exceptionally long lengths of stay.

(2) **Eligibility**: Eligibility for the adjustment is determined as follows:

(a) **Exceptionally Long Lengths of Stay**: First, a statewide weighted average Medicaid inpatient length of stay is calculated. This is determined by dividing the sum of Medicaid days for all Acute Hospitals in the state by the sum of Medicaid discharges for all Acute Hospitals in the state. Second, the statewide weighted standard deviation for Medicaid inpatient length of stay is calculated. Third, the statewide weighted standard deviation for Medicaid inpatient length of stay is multiplied by two and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

(b) **Exceptionally High Cost**: Exceptionally high cost is calculated for Hospitals

providing services to children greater than one year of age and less than six years of age as follows:

1) The average cost per Medicaid inpatient discharge for each Hospital is calculated.

2) The standard deviation for the cost per Medicaid inpatient discharge for each Hospital is calculated.

3) The Hospital's standard deviation for the cost per Medicaid inpatient discharge is multiplied by two and added to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each Hospital's threshold Medicaid exceptionally high cost.

(c) **Eligibility for a Pediatric Outlier Payment**: For Acute Hospitals providing services to children greater than one year of age and less than six years of age, eligibility for a pediatric outlier payment is calculated as follows:

1) The average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this Hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in **Section 5.B.9.b.(2)(a)**, then the hospital is eligible for a Pediatric Outlier Payment.

2) The cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this Hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in **Section 5.B.9.b.(2)(b)**, then the Hospital is eligible for a Pediatric Outlier Payment.

3) **Payment to Hospitals**: Annually, each Acute Hospital qualifying for a pediatric outlier adjustment will receive $1,000.

10. Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders Per Diem Payments

The Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders per diem rate is a daily rate of $1,936.21, payable instead of the standard Psychiatric Per Diem rate under **Section 5.B.4.f.(1)**, and payable once per day per Member under 21 years of age with a diagnosis of ASD/ID for whom the Hospital renders one or more services meeting the definition of Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders, in accordance with **Appendix L**. The Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders per diem rate is not payable on days meeting the definition of Administrative Day, and such days shall be paid at the Administrative Day rate under **Section 5.B.6**.

11. Behavioral Health Crises Evaluations in Medical/Surgical Units

Hospitals providing Behavioral Health Crisis Evaluations to Members experiencing Behavioral Health Crises in medical/surgical beds, in accordance with **Appendix I**, shall be paid at the same rate established in **Section 5.C.11** up to once per day per member receiving such services, in accordance with **Appendix I**.

12. Behavioral Health Crises Management Services in Medical/Surgical Units

Hospitals providing Behavioral Health Crisis Management Services to Members experiencing behavioral health crises in medical/surgical beds, in accordance with **Appendix K**, shall be paid at the same rate established in **Section 5.C.16** up to once per day per member receiving such services, in accordance with **Appendix K**.

13. Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members in Medical/Surgical Units

Hospitals providing recovery support navigator services and recovery support navigator services for pregnant and postpartum Members to Members in medical/surgical beds, in accordance with **Appendix N**, shall be paid at the same rates established in **Section 5.C.17** up to once per day per member receiving such services, in accordance with **Appendix N**.

14. Reserved

15. Specialty Inpatient Psychiatric Service for Eating Disorder Per Diem Payments

The Specialty Inpatient Psychiatric Service for Eating Disorder per diem rate is a daily rate of $1,500, payable instead of the standard Psychiatric Per Diem rate under **Section 5.B.4.f.(1)**, and payable once per day per Member with a diagnosis of Eating Disorder for whom the Hospital renders one or more services meeting the definition of Specialty Inpatient Psychiatric Service for Eating Disorder, in accordance with **Appendix O**. The Specialty Inpatient Psychiatric Service for Eating Disorder per diem rate is not payable on days meeting the definition of Administrative Day, and such days shall be paid at the Administrative Day rate under **Section 5.B.6**

C. Outpatient Hospital Services

Note: *Rates for all Outpatient Hospital Services (including Emergency Department services) that are covered under a contract between the Acute Hospital and EOHHS' BH Contractor, or a contract between the Acute Hospital and an MCO, as applicable, and that are provided to MassHealth Members enrolled with EOHHS' BH Contractor or with the MCO, as applicable, shall be governed by terms agreed upon between the Acute Hospital and the BH Contractor, or between the Acute Hospital and the MCO (as applicable), as set forth in* ***Section 4.A.1, 4.A.2 or 4.A.5*** *(as applicable) of this RFA.*

A Hospital will be paid in accordance with **Section 5.C** for Outpatient Services provided by Hospital Outpatient Departments and Satellite Clinics.

Except as otherwise provided for Outpatient Services specified in **Section 4.C** and **Sections 5.C.3** through **5.C.18**, Hospitals that are not Critical Access Hospitals will receive a Hospital-specific, Episode-specific payment for each payable Episode, known as the Adjudicated Payment per Episode of Care (APEC), calculated as set forth in **Section 5.C.1**, below.

For Critical Access Hospitals, payment for Outpatient Services is set forth in **Section 5.D.7**.

Hospitals will not be reimbursed for Hospital services specified as non-payable in Subchapter 6 of the MassHealth Acute Outpatient Hospital Manual, unless such services are medically necessary services provided to a MassHealth Standard or CommonHealth Member under 21 years. Providers should refer to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) regulations at 130 CMR 450.140 et seq., regarding provision of EPSDT services to MassHealth Standard or CommonHealth Members under 21 years.

1. Adjudicated Payment per Episode of Care

a. Rate Year 2027 APEC

For dates of service in RY27, Hospitals will receive a Hospital-specific, Episode-specific all-inclusive facility payment for all APEC-Covered Services delivered to a Member on an outpatient basis in one Episode known as the Adjudicated Payment per Episode of Care (APEC). The APEC is calculated as set forth in **Section 5.C.1.b**, below.

b. Description of APEC payment method

The APEC will equal the sum of (1) the Episode-Specific Total EAPG Payment, plus, (2) if applicable, an APEC Outlier Component, each as described in more detail, below. For proper payment, Hospitals must include on a single claim all of the APEC-Covered Services that correspond to the Episode, and must otherwise submit properly completed outpatient hospital claims. For components of the APEC calculated based on data from all Hospitals, the calculation included data for all Hospitals that were operating as of January 1, 2023.

(1) Episode-Specific Total EAPG Payment

For each claim detail line containing APEC-Covered Services in the Episode, the Hospital's Wage Adjusted APEC Outpatient Standard (described below) is multiplied by the claim detail line's Adjusted EAPG Weight (described below) to result in the claim detail line's EAPG payment amount. The sum of all of the Episode's claim detail line EAPG payment amounts is the Episode-Specific Total EAPG Payment.

(a) Wage Adjusted APEC Outpatient Standard.

The Wage Adjusted APEC Outpatient Standard is the APEC Outpatient

Statewide Standard, adjusted by the Hospital's Massachusetts-specific wage area index, determined as follows.

1) APEC Outpatient Statewide Standard

   The APEC Outpatient Statewide Standard is based on the average outpatient cost per Episode for all Hospitals' Episodes in the APEC Base Year, adjusted for the Massachusetts wage area index, Casemix, an efficiency standard, an outlier adjustment factor, inflation, and a conversion factor, as further described below.

   Calculating the average outpatient cost per Episode for each Hospital*:* For each Hospital, an average outpatient cost per Episode for the APEC Base Year was calculated by multiplying the Hospital's outpatient cost-to-charge ratio (CCR) by the Hospital's MassHealth allowed outpatient Charges for all FY21 APEC-paid Episodes (which product is the Hospital's total costs), and then dividing this product by the Hospital's total Episodes. Each Hospital's CCR was calculated by EOHHS using the Hospital's FY22 cost report. The Hospital-specific Episodes and related Charges were determined by EOHHS based on paid claims for Episodes residing in MMIS as of May 21, 2023, for the APEC Base Year, for which MassHealth was primary payer.

   Wage area and Casemix adjustments to calculate each hospital's standardized costs per episode*:*

   The calculation of each hospital standardized cost per episode, which is unchanged from the methodology used in the RY24 – RY26 RFAs, is calculated as follows:

   The labor portion of the average outpatient cost per Episode for each Hospital was adjusted by the Hospital's RY24 Massachusetts-specific wage area index, which was derived as specified in **Section 5.B.1.b**, and the labor and non-labor portions were then adjusted by the Hospital-Specific FY21 Outpatient Casemix Index (Outpatient CMI) to determine the Hospital's standardized cost per Episode. The Hospital-specific FY21 Outpatient CMI was determined based on FY21 paid claims data residing in MMIS as of May 21, 2023, for which MassHealth was primary payer. EOHHS calculated each Hospital's FY21 Outpatient CMI by summing the Hospital's FY21 grouper-adjusted EAPG weights for each of its APEC-paid Episodes during FY21, as determined by EOHHS, and then dividing that sum by the Hospital's total number of APEC-paid Episodes in FY21, also as determined by EOHHS.

   Determining the efficiency standard*:* All Hospitals were then ranked

from lowest to highest with respect to their standardized costs per Episode. A cumulative frequency of FY21 MassHealth Episodes for the Hospitals was produced from MMIS paid claims on file as of May 21, 2023, for which MassHealth was the primary payer, and an efficiency standard established at the cost per Episode corresponding to the position on the cumulative frequency that represents 60% of the total number of statewide Episodes in MMIS. The APEC efficiency standard applicable to RY27 is unchanged as compared to RY24 at $854.95.

Final calculation of the APEC Outpatient Statewide Standard*:* The APEC Outpatient Statewide Standard was determined by multiplying (a) the weighted mean of the standardized costs per Episode, as limited by the efficiency standard; by (b) the outlier adjustment factor of 93%; and by (c) the Inflation Factors for Operating Costs between RY21 and RY24, and then dividing that result by a conversion factor of 1.2303. The APEC Outpatient Statewide Standard is $645.96. For Episodes that extend past midnight in the case of Emergency Department Services, or Observation Services, the APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode.

2) Wage Adjusted APEC Outpatient Standard

Except as otherwise provided in this section, the Hospital's Wage Adjusted APEC Outpatient Standard is determined by: (1) multiplying the labor portion of the APEC Outpatient Statewide Standard, determined as described in **Section 5.C.1.b(1)(a)1**, by the Hospital's RY27 Massachusetts-specific wage area index, determined as described in **Section 5.B.1.e**, and (2) adding this amount to the non-labor portion of the APEC Outpatient Statewide Standard, determined as described in said **Section 5.C.1.b(1)(a)1**.

For the Hospital that is a PPS-exempt cancer hospital under 42 CFR 412.23(f), the Hospital's Wage Adjusted APEC Outpatient Standard will be $823.67. For Episodes that extend past midnight in the case of Emergency Department Services, or Observation Services, the Wage Adjusted APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode.

The chart below lists the Wage Adjusted APEC Outpatient Standard for Acute Hospitals identified as Group 1 safety net hospitals in **Appendix N** to the MassHealth 1115 waiver.

Table 4.2: Group 1 Safety Net Hospital Wage Adjusted APEC Outpatient Standard

HOSPITAL	WAGE ADJUSTED APEC OUTPATIENT STANDARD
Group 1 Hospitals that are High Medicaid Volume Safety Net Hospitals	$702.77
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Boston	$731.77
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Springfield	$674.64
Group 1 Hospitals that are not High Medicaid Volume Safety Net Hospitals and whose wage area is Boston-reclass	$715.53

For Episodes that extend past midnight in the case of Emergency Department Services, or Observation Services, the Wage Adjusted APEC Outpatient Statewide Standard that applied to the first date of service shall apply to the entire Episode.

(b) **Claim Detail Line's "Adjusted EAPG Weight"**

EAPG(s) are assigned to the Episode's APEC-Covered Services based on information contained within a properly submitted outpatient Hospital claim, utilizing the Solventum EAPG Grouper. EAPGs are assigned at the claim detail line level. The MassHealth EAPG Weight is the MassHealth relative weight developed by EOHHS for each unique EAPG (see **Chart D** to **Appendix D**). The Solventum EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce that claim detail line's "Adjusted EAPG Weight" for purposes of calculating the Episode-Specific Total EAPG Payment. This Solventum EAPG Grouper logic recognizes the efficiencies and value created when multiple procedures or services are provided to the Member in the same Episode.

(2) **APEC Outlier Component**

The APEC Outlier Component is equal to the difference between the Episode-Specific Case Cost and the Episode-Specific Outlier Threshold, which is then

multiplied by the Marginal Cost Factor of 60%.

The Episode-Specific Case Cost is determined by multiplying the Episode's Total Allowed Charges by the Hospital's FY22 Outpatient CCR, calculated by EOHHS using the Hospital's FY22 Massachusetts Hospital Cost Report. The Episode-Specific Case Cost is compared to the Episode-Specific Outlier Threshold, which is the sum of the Episode-Specific Total EAPG Payment (calculated as described in **Section 5.C.1.b.(1)**, above) and the Fixed Outpatient Outlier Threshold of $4,460. If the Episode-Specific Case Cost exceeds the Episode-Specific Outlier Threshold, then an APEC Outlier Component is computed equal to the Marginal Cost Factor set at 60%, multiplied by the difference between the computed Episode-Specific Case Cost and the Episode-Specific Outlier Threshold. If the Episode-Specific Case Cost does not exceed the Episode-Specific Outlier Threshold, then the APEC Outlier Component is $0.

In no case is an APEC Outlier Component payable if the Episode-Specific Total EAPG Payment is $0.

(3) **Calculation of the APEC**

The Hospital's APEC for the Episode is equal to the sum of the Episode-Specific Total EAPG Payment (calculated as set forth in **Section 5.C.1.b.(1)**, above) and the APEC Outlier Component (calculated as set forth in **Section 5.C.1.b.(2)**, above).

Tables 5 through 5.6 together provide an illustrative example of calculating an APEC for an episode claim containing multiple EAPGs. The relevant example EAPGs for Tables 5.2 through 5.6, respectively are 290 for PET Scans, 220 for Level II Nervous System Injections including Cranial Tap, 220 for Level II Nervous System Injections including Cranial Tap, 299 for Level I Computed Tomography, and 305 for Level I Surgical Pathology Tests. Values shown are for demonstration purposes only.

Table 5: Example of Hospital's RY27 APEC Calculation for a Single Episode

Line	Description	Value	Calculation or Source
1	Episode-Specific Total EAPG Payment	$2,835.53	Sum of episode's claim detail line EAPG payment amounts (sum of Line 5 from claim detail lines #s 1 through 5 from Table 5.2)
2	Episode's Total Allowed Charges	$32,300.00	Sum of episode's claim detail line MassHealth allowed charges (sum of Line 2 from claim detail lines #s 1 through 5 from Table 5.2)
3	Hospital's Outpatient Cost-to-Charge	60.00%	Hospital's FY22 Massachusetts

	Ratio		Hospital Cost Report
4	Episode-Specific Case Cost	$19,380.00	$Line\ 2 \times Line\ 3$
5	Fixed Outpatient Outlier Threshold	$4,460.00	RY27 RFA
6	Episode-Specific Outlier Threshold	$7,295.53	$Line\ 1 + Line\ 5$
7	Does Episode-Specific Cost exceed Episode-Specific Outlier Threshold?	TRUE	Is line 4 > Line 6? If TRUE, then APEC Outlier component is due
8	Marginal Cost Factor	60%	RY27 RFA
9	**APEC Outlier Component (only calculated if Line 1>$0)**	$7,250.68	$(Line\ 4 - Line\ 6) \times Line\ 8$
10	**APEC for the Episode**	$10,086.21	$Line\ 1 + Line\ 9$

Table 5.1: Example of Hospital's Wage Adjusted APEC Outpatient Standard

Line	Description	Value	Calculation or Source
1	APEC Outpatient Statewide Standard	$645.96	RY27 RFA
2	Hospital's Massachusetts-specific wage area index	1.03657	Varies by hospital, determined annually
3	Labor factor	60%	RY27 RFA
4	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	$(Line\ 1 \times Line\ 2 \times Line\ 3) + (Line\ 1 \times (1 - Line\ 3))$

Table 5.2: Example of First Claim Detail Line EAPG Payment Amounts (EAPG of 290)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	2.2567	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	2.2567	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$1,489.72	$Line\ 1 \times Line\ 4$

Table 5.3: Example of Second Claim Detail Line EAPG Payment Amounts (EAPG of 220)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$20,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.9652	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG	1.9652	Determined by EAPG Grouper logic

	weight		
5	Claim detail line EAPG payment amount	$1,297.29	$Line\ 1 \times Line\ 4$

Table 5.4: Example of Third Claim Detail Line EAPG Payment Amounts (EAPG of 220)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$5,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	1.9652	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	-	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	$Line\ 1 \times Line\ 4$

Table 5.5: Example of Fourth Claim Detail Line EAPG Payment Amounts (EAPG of 299)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$2,000.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.1471	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	0.0735	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$48.52	$Line\ 1 \times Line\ 4$

Table 5.6: Example of Fifth Claim Detail Line EAPG Payment Amounts (EAPG of 305)

Line	Description	Value	Calculation or Source
1	Hospital's Wage Adjusted APEC Outpatient Standard	$660.13	Table 5.1, Line 4
2	Claim detail line allowed charges	$300.00	Determined from claim
3	Claim detail line MassHealth EAPG weight	0.0591	**Appendix D**, Chart D
4	Claim detail line Adjusted EAPG weight	-	Determined by EAPG Grouper logic
5	Claim detail line EAPG payment amount	$0.00	$Line\ 1 \times Line\ 4$

c. Payment System

MassHealth processes and pays clean outpatient claims in accordance with 130 CMR 450.000, et seq.

2. Emergency Department Services

a. Required Screening

(1) All Members presenting in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24 must be screened and stabilized in accordance with applicable requirements at 42 U.S.C. 1395dd, et seq., M.G.L. c. 118E, section 17A, and all applicable regulations.

(2) The Hospital shall offer Behavioral Health Crisis Evaluations as described in **Appendix I** to all Members presenting with a mental health and/or substance use disorder crisis in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24. Furthermore, the Hospital is responsible for disposition planning, including assisting in placement for fee-for-service Members requiring inpatient psychiatric treatment or Behavioral Health Diversionary Services, in conjunction with the referring provider and MassHealth.

(3) The Hospital shall offer substance use evaluations, treatment, and notification in the Emergency Department or dedicated emergency department as defined in 42 CFR 489.24 in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.

b. Payment for Emergency Services

Hospitals will be reimbursed for Emergency Services provided in the Emergency Department in the same manner as other Outpatient Services.

3. Outpatient Hospital Services Payment Limitations

a. Payment Limitations on Outpatient Hospital Services Preceding an Admission

Hospitals will not be separately reimbursed for Outpatient Hospital Services when an Inpatient Admission to the same Hospital, on the same date of service, occurs following the provision of Outpatient Hospital Services. See **Section 5.B.3.b.(3)**.

b. Payment Limitations on Outpatient Hospital Services to Inpatients

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

4. Physician Payments

a. A Hospital may only receive reimbursement for physician services provided by Hospital-Based Physicians to MassHealth Members. The Hospital must claim payment for the professional component of physician services in accordance with, and subject to: (1) the Physician regulations at 130 CMR 433.000 et seq.; (2) the Acute Outpatient Hospital regulations at 130 CMR 410.000 et seq.; and (3) other

rules regarding physician payment as set forth in this RFA.

b. Such reimbursement shall be the lower of (1) the fee established in 101 CMR 317.00 (Medicine), 101 CMR 316.00 (Surgery and Anesthesia), 101 CMR 318.00 (Radiology), and 101 CMR 320.00 (Clinical Laboratory Services), or successor regulations as applicable (including the applicable facility fee for all services where such facility fee has been established); (2) the Hospital's Usual and Customary Charge for physician fees; or (3) the Hospital's actual Charge submitted. Hospitals will not be reimbursed separately for professional fees for practitioners other than Hospital-Based Physicians as defined in **Section 2**.

c. Hospitals will be reimbursed for physician services only if the Hospital-Based Physician took an active patient care role, as opposed to a supervisory role, in providing the Outpatient Service(s) on the billed date(s) of service. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

d. Physician Services provided by residents and interns are not separately reimbursable.

e. Hospitals will not be reimbursed for physician services if those services are (1) provided by a Community-Based Physician; or (2) as further described in **Section 5.C**.

f. In order to qualify for reimbursement for physician services provided during the provision of Observation Services or Remote Patient Monitoring, the reasons for the Observation Services or Remote Patient Monitoring, the start and stop time of the Observation Services or Remote Patient Monitoring, and the name of the physician ordering the Observation Services or Remote Patient Monitoring, must be documented in the Member's medical record.

Physician fee schedules are available at the State House Bookstore and at http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html.

5. Laboratory Services

a. Payment for Laboratory Services

Hospitals will be reimbursed for laboratory services according to the Outpatient Hospital regulations at 130 CMR 410.455 through 410.459, subject to all restrictions and limitations described in regulations at 130 CMR 401.000.

The maximum allowable payment for a laboratory service shall be at the lowest of the following:

(1) The amount listed in the most current applicable Clinical Laboratory Services fee schedule at 101 CMR 320.00 and the Surgery & Anesthesia fee schedule at 101

CMR 316.00, or successor regulations as applicable (available at the State House Bookstore and at http://www.mass.gov/eohhs/gov/laws-regs/hhs/community-health-care-providers-ambulatory-care.html).

(2) The Hospital's Usual and Customary Charge, which, for the purposes of this **Section 5.C.5.a**, shall not exceed the amount the hospital charges any contracted laboratory to conduct laboratory services on behalf of the Hospital; or

(3) The amount that would be recognized under 42 U.S.C. §1395*l*(h) for tests performed for a person with Medicare Part B benefits.

b. Physician Services

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

6. Audiology Dispensing

a. Payment for Audiology Dispensing Services

Hospitals will be reimbursed for services designated as hearing aid services in Subchapter 6 of the MassHealth *Audiologist Manual* for providers under 130 CMR 426.000. These services will be performed only by a Hospital-based audiologist according to the Audiologist regulations at 130 CMR 426.00 et seq., and according to the fees established in 101 CMR 323.00 (Hearing Services).

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of audiology dispensing services.

7. Dispensing of Ophthalmic Materials

a. Payment for Ophthalmic Materials Dispensing

Hospitals will be reimbursed for the dispensing of ophthalmic materials only by a Hospital-Based optometrist, ophthalmologist or other practitioner licensed and authorized to write prescriptions for ophthalmic materials and services according to the Vision Care regulations at 130 CMR 402.000 et seq., and according to the fees established in 101 CMR 315.00 (Vision Care Services and Ophthalmic Materials).

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the provision of ophthalmic materials dispensing services.

8. Dental Services

a. Payment for Dental Services

Hospitals will be reimbursed for covered dental services according to the Dental regulations at 130 CMR 420.000 et seq. according to the fees established in 101 CMR 314.00 et seq., or successor regulations, except when the conditions in 130 CMR 420.430(A)(2) or (D) apply. When these conditions apply, EOHHS will reimburse the Hospital according to **Section 5.C.1**. The Hospital-based Dentist may not bill for any professional component of the service that is billed by the Hospital.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician (which, as defined in **Section 2**, includes dentists) services related to the provision of dental services, except when the conditions in 130 CMR 420.430(A)(2) or (D) apply. Under those circumstances, in addition to the APEC payment under **Section 5.C.1**, when a Hospital-Based Physician provides physician services, the Hospital may be reimbursed for such physician services in accordance with **Section 5.C.4**. The Hospital-Based Physician may not bill for any professional component of the service that is billed by the Hospital.

9. APEC Carve-Out Drugs

a. APEC Carve-Out Drugs and Prior Approval Requirements

(1) The EOHHS-designated APEC Carve-Out Drugs are identified on the "MassHealth Acute Hospital Carve-Out Drugs List" within the MassHealth Drug List. The MassHealth Drug list is published on the MassHealth website at: https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do. The list of APEC Carve-Out Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at this website location.

(2) The APEC Carve-Out Drugs listed on the MassHealth Acute Hospital Carve-Out Drugs List require prior authorization through the MassHealth Drug Utilization Review (DUR) Program. See also **Sections 4.B.3** and **6.A**.

b. Payment for APEC Carve-Out Drugs

(1) Payment to Hospitals for APEC Carve-Out Drugs administered to Members during an acute outpatient hospital visit will be the Hospital's "actual acquisition cost" of the Drug. For this purpose, 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 during an Acute Outpatient Hospital visit, including any efficacy-, outcome-, or performance-based guarantees (or similar arrangements), whether received pre- or post-payment.

(2) Payment to the Hospital for an APEC Carve-Out Drug is conditioned on and subject to all of the following:

(a) The Hospital must have satisfied all applicable MassHealth prior authorization and other applicable prior approval requirements (if any), and all other conditions of payment (see also **Section 6.A**).

(b) The Hospital must provide timely reports to EOHHS on Member progress as a result of being treated with the APEC Carve-Out Drug as required in the prior authorization approval criteria and billing instructions (or other written statements of policy issued by EOHHS).

(c) The Hospital must claim payment for APEC Carve-Out Drugs in accordance with applicable MassHealth billing instructions, including without limitation, as set forth herein, in MassHealth billing instructions for 837I via DDE claims (unless otherwise indicated) and in any special billing instructions for Acute Outpatient Hospital claims for APEC Carve-Out Drugs that may be published under "Billing Tips" on the MassHealth website at https://www.mass.gov/service-details/billing-tips. EOHHS may update the billing instructions from time to time.

(d) The Hospital's claim must be accompanied by a copy of the invoice (or invoices) for the APEC Carve-Out Drug from the drug manufacturer, supplier, distributor, or other similar party or agent, as well as any other documentation that is necessary for the Hospital to evidence that the amount listed on the claim is the Hospital's actual acquisition cost for the Drug (as defined in **Section 5.C.9.b.(1)**). Hospitals must provide EOHHS with any additional documentation deemed necessary by EOHHS to establish or verify that the amount included on the claim is the Hospital's actual acquisition cost as defined in **Section 5.C.9.b.(1)**, upon request.

(e) In the event the drug manufacturer (or other party) offers any providers an efficacy-based, outcome-based, or performance-based guarantee (or similar arrangement) related to the APEC Carve-Out Drug in question, the Hospital shall make every effort to enter such an arrangement with manufacturer (or other party), at least with respect to the Hospital's treatment of MassHealth Members, and shall make every effort to negotiate terms most favorable to the Hospital and MassHealth. Subject to the requirements of 130 CMR 450.309, in the event the terms of the arrangement allow the Hospital to pay for the Drug in full or in part only if certain conditions are met (e.g., Hospital only pays for the Drug if the Member goes into remission), the Hospital shall not submit a claim to MassHealth for the Drug until the Hospital actually remits the payment it will be required to make for the Drug (and shall not submit any claim for the Drug to MassHealth in the event it is not ultimately required to

pay for the Drug). Subject to the above, in the event any other performance-based guarantee (or similar arrangement) is otherwise triggered to the benefit of the Hospital with respect to the Member's treatment with the Drug after the Hospital has submitted a claim for the Drug, the Hospital shall immediately notify EOHHS in writing and shall adjust or modify its claim for the Drug to account for the benefit, or otherwise pass the benefit back to MassHealth in the manner specified by EOHHS.

(f) EOHHS may designate particular APEC Carve-Out Drugs as requiring the Hospitals to obtain a performance-based guarantee (or similar arrangement). In the event EOHHS designates an APEC Carve-Out Drug as requiring such an arrangement, it will so indicate on the MassHealth Acute Hospital Carve-Out Drugs List within the MassHealth Drug List, and may require documentation or attestation that the Hospital has entered such an arrangement as part of the prior authorization process for the Drug.

(3) Any MassHealth payment made to the Hospital for an APEC Carve-Out Drug based on a claim or invoice submitted by a Hospital for an amount that exceeds the Hospital's actual acquisition cost of the Drug, as defined in **Section 5.C.9.b.(1)**, or under circumstances in which EOHHS determines there was noncompliance with the requirements set forth in **Section 5.C.9.b.(2)**, shall constitute an overpayment as defined by 130 CMR 450.235 and will be subject to recoupment. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions for improper billing

10. Emergency Department-Dispensed Nasal Naloxone Packages

a. Payment for Emergency Department-Dispensed Nasal Naloxone Packages

Hospitals will be reimbursed for the dispensing of nasal naloxone packages through their emergency departments at the rate of $125 per nasal naloxone package. A single nasal naloxone package consists of two nasal spray inhalers, with each inhaler containing 4 mg of naloxone. This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the member.

b. Physician Payment

Hospitals may not bill for Hospital-Based Physician services related to the dispensing of nasal naloxone packages through their Emergency Departments.

11. Behavioral Health Crises Evaluations in the Emergency Department

Hospitals providing Behavioral Health Crisis Evaluations in accordance with **Appendix I** to Members experiencing Behavioral Health Crises will be paid at a rate of $695.29 per day per Member receiving such services. This payment is only for the first calendar day in which a Member receives a Behavioral Health Crisis Evaluation; any subsequent days

of required Behavioral Health Crisis supports in the ED may be paid under **Section 5.C.16**. Payments under this **Section 5.C.11** are in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the Member as part of the Emergency Department visit.

12. Reserved

13. Reserved

14. Reimbursement for Outpatient Administration of Certain Physician Administered Drugs

Hospitals will be reimbursed for the outpatient administration of certain physician administered Drugs identified on the "Certain MassHealth Outpatient Physician Administered Drugs to be Paid by Fee Schedule" section of the MassHealth Drug List (Fee Schedule Drugs) in accordance with this **Section 5.C.14**. The MassHealth Drug list is published on the MassHealth website at: https://masshealthdruglist.ehs.state.ma.us/MHDL/welcome.do. The list of Fee Schedule Drugs may be updated from time-to-time. Hospitals may sign up to receive email notifications of any updates to this list by enrolling at this website location.

Payment to hospitals for the outpatient administration of any Fee Schedule Drug shall be the amount as listed by the quarterly Medicare Part B Drug Average Sales Price for the Fee Schedule Drug, as set forth on CMS's website at https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/asp-pricing-files (2026 ASP Drug Pricing).

This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the member.

15. Reimbursement for CARES for Kids Program Services

The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support for Kids Program (CARES) is a Targeted Case Management (TCM) service rendered by MassHealth providers participating in CARES in accordance with 130 CMR 405.477, 130 CMR 410.482, or 130 CMR 433.485 to members under the age of 21 who satisfy the eligibility criteria set forth in such regulations. Effective for dates of service on or after July 7, 2023, Hospitals providing outpatient CARES services in accordance with 130 CMR 410.482 will be reimbursed as the rate listed in 101 CMR 317.00, et seq.

16. Behavioral Health Crises Management Services in the Emergency Department

Hospitals providing Behavioral Health Crisis Management Services in accordance with **Appendix K** to Members experiencing Behavioral Health Crises will be paid per day per Member receiving such services, at a rate of either $325.64 for Level 1 Behavioral Health Crisis Management Services or $653.64 for Level 2 Behavioral Health Crisis Management Services, dependent on clinical presentation and intensity of services, as

described in **Section III.B** of **Appendix K**. Payments under this **Section 5.C.16** are in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the member as part of the Emergency Department visit, provided however that for any date of service for which the Hospital submits a claim for a Behavioral Health Crisis Evaluation for the same Member under **Section 5.C.11**, the hospital may not bill for Behavioral Health Crisis Management Services under this **Section 5.C.16**.

17. Payment for Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members Provided in the Emergency Department and Outpatient Department

a. Hospitals providing Recovery Support Navigator Services in accordance with **Appendix N** to Members in the ED will be paid for such services at the rate established for code H2015-HF in 101 CMR 444.00, *et seq*. This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the Member as part of the Emergency Department visit.

b. Hospitals providing Recovery Support Navigator Services for Pregnant and Postpartum Members in accordance with **Appendix N** to Members in the ED and /or Outpatient Department may bill for such services using code H2015-HF-HD and will be paid at individual consideration for the service, in accordance with 101 CMR 444.01(4), until such time that an appropriate rate is established for this service in regulation at 101 CMR 444.04. This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the Member as part of the Emergency Department visit.

c. Hospitals may not bill for Hospital-Based Physician services related to the provision of Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members in the Emergency Department or Outpatient Department.

18. Payment for Initiation of Medication for the Treatment of OUD in the ED

Hospitals providing Initiation of Medication for the Treatment of OUD to Members in the ED (ED MOUD), in accordance with **Appendix M**, shall be paid for such ED MOUD services at a non-facility fee rate of $52.90 and a facility fee rate of $49.41. This payment is in addition to any payment that the Hospital may receive pursuant to **Section 5.C** for services rendered to the Member as part of the Emergency Department visit.

D. Reimbursement for Unique Circumstances

1. High Public Payer Hospital Supplemental Payment

a. Qualification

In order to qualify for the High Public Payer Hospital Supplemental Payment, a

Hospital's FY25 public payer percentage, which is the ratio of the Hospital's FY25 Gross Patient Service Revenue from government payers and free care to the Hospital's FY25 Gross Patient Service Revenue ("FY25 Public Payer Percentage"), must exceed 63% ("High Public Payer Threshold"), as determined by EOHHS based on the Hospital's FY25 Massachusetts Hospital Cost Report.

b. Payment Methodology

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make $13 million in total aggregate supplemental payments to High Public Payer Hospitals satisfying the eligibility criteria set forth in **Section 5.D.1.a** (each an "Eligible Hospital" for purposes of this **Section 5.D.1**), allocated $6.5 million to inpatient and $6.5 million to outpatient.

For purposes of this **Section 5.D.1**, references to "MCOs" include only "traditional" MCOs, and exclude ACPPs, SCOs, and One Care plans.

The inpatient portion of the supplemental payment amount for each Eligible Hospital will be determined by apportioning a total of $6.5 million to Eligible Hospitals on a pro-rata basis, as follows:

- First, EOHHS will calculate each Eligible Hospital's Weighted Discharge Volume by summing 60% of the Hospital's FY27 Accountable Care Partnership Plan (ACPP) and Primary Care ACO discharge volume, 20% of the Hospital's FY27 MCO discharge volume, and 20% of the Hospital's FY27 PCC Plan discharge volume;
- Second, EOHHS will calculate each Eligible Hospital's Pro-Rata Discharge Volume by dividing its Weighted Discharge Volume by the sum of all Eligible Hospitals' Weighted Discharge Volumes;
- Third, EOHHS will calculate each Eligible Hospital's HPP Ratio by:
    - Subtracting the 63% High Public Payer Threshold from that Hospital's FY25 Public Payer Percentage;
    - Multiplying that difference by 12%; and
    - Adding 2% to that product.
- Fourth, EOHHS will calculate each Eligible Hospital's Inpatient HPP Distribution Percentage by multiplying its Pro-Rata Discharge Volume by its HPP Ratio;
- Fifth, EOHHS will calculate each Eligible Hospital's Inpatient HPP Payment Factor by dividing its Inpatient HPP Distribution Percentage by the sum of all Inpatient HPP Distribution Percentages for all Eligible Hospitals; and

- Sixth, EOHHS will calculate the inpatient portion of each Eligible Hospital's supplemental payment by multiplying its Inpatient HPP Payment Factor by $6.5 million.

The outpatient portion of the supplemental payment amount for each Eligible Hospital will be determined by apportioning a total of $6.5 million to Eligible Hospitals on a pro-rata basis, as follows:

- First, EOHHS will calculate each Eligible Hospital's Weighted Episode Volume by summing 60% of the Hospital's FY27 ACPP and Primary Care ACO episode volume, 20% of the Hospital's FY27 MCO episode volume, and 20% of the Hospital's FY27 PCC Plan episode volume;
- Second, EOHHS will calculate each Eligible Hospital's Pro-Rata Episode Volume by dividing its Weighted Episode Volume by all Eligible Hospitals' Weighted Episode Volume;
- Third, EOHHS will calculate each Eligible Hospital's HPP Ratio in the same fashion as it did for the inpatient portion of the supplemental payment – namely, by:
    - Subtracting the 63% High Public Payer Threshold from that Hospital's FY25 Public Payer Percentage;
    - Multiplying that difference by 12%; and
    - Adding 2% to that product.
- Fourth, EOHHS will calculate each Eligible Hospital's Outpatient HPP Distribution Percentage by multiplying its Pro-Rata Episode Volume by its HPP Ratio;
- Fifth, EOHHS will calculate each Eligible Hospital's Outpatient HPP Payment Factor by dividing its Outpatient HPP Distribution Percentage by the sum of all Outpatient HPP Distribution Percentages for all Eligible Hospitals; and
- Sixth, EOHHS will calculate the outpatient portion of each Eligible Hospital's supplemental payment by multiplying its Outpatient HPP Payment Factor by $6.5 million.

For purposes of this calculation, FY27 ACPP, Primary Care ACO, MCO, and PCC Plan discharge volume refers to paid inpatient discharges from the qualifying Hospital for MassHealth Members enrolled in an ACPP, a Primary Care ACO, an MCO, or the PCC Plan, and FY27 ACPP, Primary Care ACO, MCO, and PCC Plan episode volume refers to paid outpatient episodes of care delivered by the qualifying Hospital to MassHealth Members enrolled in an ACPP, a Primary Care ACO, an

MCO, or the PCC Plan, each as determined by EOHHS. EOHHS will make these determinations utilizing, for the ACPP and MCO discharges and episodes, ACPP and MCO encounter data submitted by each ACPP or MCO for FY27, respectively, and residing in the MassHealth Data Warehouse as of March 31, 2028, and for the PCC Plan and Primary Care ACO discharges and episodes, Medicaid paid claims data for FY27 residing in MMIS as of March 31, 2028, for which MassHealth is primary payer. Only MCO and ACPP encounter data and MMIS paid claims data pertaining to qualifying High Public Payer Hospitals (as specified in **Section 5.D.1.a**) are considered in determining the pro rata share. Payments to qualifying Hospitals under this **Section 5.D.1** may be made in installments.

2. Essential MassHealth Hospitals

a. Qualification

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 that 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.

b. Reimbursement Methodology

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Essential MassHealth Hospitals. The payment amount will be (i) determined by EOHHS using data filed by each qualifying Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to Essential MassHealth Hospitals in such amounts and pursuant to such methods and using such funding sources as may

be approved by CMS.

Acute Hospitals that receive payment as Essential MassHealth Hospitals shall be determined by EOHHS.

3. Acute Hospitals with High Medicaid Discharges

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Acute Hospitals with High Medicaid Discharges when compared with other participating MassHealth Hospitals. To be eligible for a payment pursuant to this section, a Hospital must have more than 2.7% of the statewide share of Medicaid discharges, as 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, as determined by EOHHS.

The payment amount for inpatient services is the lower of (1) the variance between the Hospital's inpatient Medicaid payments and costs, or (2) the Hospital's Health Safety Net Trust Fund-funded payment amount.

The payment amount for outpatient services is the lower of (1) the variance between the Hospital's outpatient Medicaid payments and costs, or (2) the Hospital's Health Safety Net Trust Fund-funded payment amount.

EOHHS reserves the right to make payments to Acute Hospitals with High Medicaid Discharges in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as Acute Hospitals with High Medicaid Discharges shall be determined by EOHHS.

4. Supplemental Payment for High Medicaid Volume Freestanding Pediatric Acute Hospitals

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment equal to $3.85 million to High Medicaid Volume Freestanding Pediatric Acute Hospitals, to account for high Medicaid volume. Such payment amount is determined by EOHHS based on data filed by each qualifying Hospital in its financial and cost reports, and projected Medicaid volume for the Hospital Rate Year.

EOHHS reserves the right to make payments to High Medicaid Volume Freestanding Pediatric Hospitals in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as High Medicaid Volume Freestanding Pediatric Acute Hospitals shall be determined by EOHHS.

5. High Public Payer Behavioral Health Service Supplemental Payment

a. Qualifications

In order to qualify for the High Public Payer Hospital Behavioral Health Supplemental Payment, an Acute Care Hospital must (1) qualify for a RY27 High Public Payer Supplemental Payment pursuant to **Section 5.D.1** of this RFA, (2) operate at least one DMH-Licensed Bed throughout RY27, and (3) have provided Inpatient Behavioral Health Services to MassHealth members in FY25. Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

b. Reimbursement Methodology

(1) Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to Hospitals that meet the qualifications described in **Section 5.D.5.a**, in the aggregate amount of $9,000,000, to support access to Inpatient Behavioral Health Services for MassHealth Members, with particular emphasis on supporting access to such services for child and adolescent Members, using the APAD payment methodology to develop a proxy that takes into account the various acuity levels such Members present. EOHHS will pay qualifying hospitals in accordance with the formula set forth in **Section 5.D.5.b.2,** below.

(2) Each qualifying Hospital receives an amount as calculated by the following methodology:

Step A. Calculate Hospital Specific Payment Amount based on Share of IP BH Days, weighted toward pediatric/adolescent days.

$$\left[\left[\left[\left[\frac{\text{Hospital Specific IP Pedi Adol BH Days}}{\text{Total IP Pedi Adol BH Days for all Hospitals}} * 0.6\right] + \left[\frac{\text{Hospital Specific IP Adult BH Days}}{\text{Total IP Adult BH Days for all Hospitals}} * 0.4\right]\right] * \$9{,}000{,}000\right] = A$$

Step B. Calculate Hospital Specific Relative Acuity Adjusted Proxy Payment Amount, determined by APAD grouper methodology.

$$\left[\left[\frac{\text{Hospital specific relative acuity adjusted payment proxy}}{\text{Total relative acuity adjusted proxy payments}}\right] * \$9{,}000{,}000\right] = B$$

Step C. Blend Hospital Specific Payment Amount based on Share of IP BH Days and Hospital Specific Payment Amount based on Relative Acuity Complexity

$$\left[\left[\frac{\text{A}}{\$9{,}000{,}000} * 0.5\right] + \left[\frac{\text{B}}{\$9{,}000{,}000} * 0.5\right]\right] * \$9{,}000{,}000 = \text{Hospital Specific Supplemental Payment}$$

Glossary: As used in this **Section 5.D.5**, the following terms shall have the meanings that follow:

"BH days" refers to the total number of days in which MassHealth Members (whether fee for service or enrolled in managed care or MBHP) received Inpatient Behavioral Health Services in FY25, using data residing in MMIS and/or the Data Warehouse as of March 31, 2026.

"Hospitals" refers to qualifying Hospitals that meet the requirements of **Section 5.D.5.a**, above.

"Pedi Adol" is short for "pediatric and adolescent" and refers to MassHealth members under age 18.

"Adult" refers to MassHealth members aged 18 and older.

"Relative Acuity Adjusted Proxy Payment" refers to a relative acuity adjusted proxy payment calculated as follows. To develop a relative acuity adjusted proxy payment, EOHHS processed all Hospital IP BH claims (whether for fee for service members or members enrolled in managed care or MBHP) residing in MMIS and/or the Data Warehouse as of March 31, 2026, using the APAD methodology (used to price medical IP claims). The APAD methodology assigns relative acuity to each discharge and then multiplies the acuity by a base rate to establish an acuity adjusted proxy payment. EOHHS will then take the ratio of each qualifying hospital's total average relative acuity adjusted proxy payment to the sum of all qualifying hospitals' acuity adjusted proxy payments to establish each hospital's pro rata share of such total payments.

"IP" refers to inpatient.

6. Specialized Pediatric Service Hospital Supplemental Payment

a. Qualification

In order to qualify for the Specialized Pediatric Service Hospital Supplemental Payment, a Hospital must be a Specialized Pediatric Service Hospital, as defined in **Section 2**. Acute Hospitals that receive payment pursuant to this section shall be determined by EOHHS.

b. Reimbursement Methodology

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make $5.5 million in total aggregate

supplemental payments to Specialized Pediatric Service Hospitals, with payment to each hospital based on its pro rata share of all Specialized Pediatric Service Hospitals' acute inpatient discharges of Members meeting certain criteria, according to the methodology that follows.

EOHHS will first calculate each Specialized Pediatric Service Hospital's pro rata share of all Specialized Pediatric Service Hospitals' acute inpatient discharges of members under the age of 21 and enrolled in either an ACPP or a Primary Care ACO during the period from October 1, 2025, through September 30, 2026. EOHHS will then multiply that ratio by $5.5 million to determine that Specialized Pediatric Service Hospital's supplemental payment.

7. Critical Access Hospitals

The payment methods set forth in this **Section 5.D.7** apply to Critical Access Hospitals. EOHHS will pay Critical Access Hospitals an amount equal to 101 percent of the Hospital's allowable costs, as determined by EOHHS utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services, as more fully described below. Interim payments will be made to Critical Access Hospitals based on the rates and methods set forth herein, which payments are provisional in nature and subject to the completion of a cost review and settlement for the time period October 1, 2026, through September 30, 2027, as described in **Section 5.D.7.c**. Subject to this **Section 5.D.7**, all sections of this RY27 RFA otherwise apply to Critical Access Hospitals. If the Hospital loses its designation as a Critical Access Hospital during this period, the payments for inpatient and outpatient services shall revert to the standard inpatient and outpatient rate methodologies set forth in **Sections 5.B** and **5.C**, as determined by EOHHS, and payments may be adjusted accordingly. In no event shall the reversion to any such rate methodologies affect the payment rates to other participating acute hospitals for the applicable rate year.

a. Payment for Inpatient Services

For Inpatient Admissions occurring in RY27, Critical Access Hospitals (CAHs) will be paid for Inpatient Services in accordance with **Section 5.B** with the following changes.

Critical Access Hospitals (CAH) 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 5.B.1**, for Inpatient Admissions occurring in RY27, the APAD for each Critical Access Hospital is calculated as follows:

(1) EOHHS calculated a cost per discharge for Inpatient Services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII,

column 1, line 21 of the Hospital's FY22 CMS-2552-10 cost report, by the Hospital's number of FY22 Medicaid (MassHealth) discharges. The Hospital's Medicaid (MassHealth) discharge volume was derived from FY22 paid claims data residing in MMIS as of May 4, 2023, for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per discharge amount by the Inflation Factors for Operating Costs between RY22 and RY24, resulting in the inflation-adjusted cost per discharge for each Critical Access Hospital.

(3) EOHHS then divided each Critical Access Hospital's inflation-adjusted cost per discharge by each Hospital's FY22 inpatient Casemix index (CMI), as determined by EOHHS.

(4) EOHHS then multiplied the result by 0.964.

(5) That result is the 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 RY27.

(6) The Critical Access Hospital's APAD for a specific discharge is then determined by multiplying the CAH-Specific Total Standard Rate per Discharge by the discharge-specific MassHealth DRG Weight from **Chart C to Appendix C**.

Table 6. Illustrates the calculation of the Total Case Payment for a CAH standard APAD claim that does not qualify for an Outlier Payment. Values shown are for demonstration purposes only. This illustrative example calculation uses a DRG of 203 (chest pain) and an SOI of 2.

Table 6: DRG Model Example - Critical Access Hospital Interim APAD Claim

Line	Description	Value	Calculation or Source
1	RY26 CAH-Specific Total Standard Rate per Discharge	$15,000.00	RY26 RFA
2	MassHealth DRG Weight	0.3300	**Appendix C**, Chart C
3	**Adjudicated Payment Amount per Discharge (Interim APAD)**	**$4,950.00**	$Line\ 1 \times Line\ 2$

Outlier Payments and Transfer Per Diem rates for Critical Access Hospitals are calculated and paid as described in **Sections 5.B.2** and **Section 5.B.3**, respectively, except that the APAD used for purposes of those calculations is the CAH's APAD calculated as set forth **Section 5.D.7.a**, above.

b. Payment for Outpatient Services

Critical Access Hospitals (CAHs) will be paid for Outpatient Services in accordance with **Section 5.C** with the following changes.

For dates of service in RY27, Critical Access Hospitals will be paid a Hospital-specific, Episode-Specific Adjudicated Payment per Episode of Care (APEC) for those Outpatient Services for which all other in-state hospitals are paid an APEC.

Notwithstanding **Section 5.C.1**, for dates of service in RY27, the Hospital-specific, Episode-specific APEC for each Critical Access Hospital was calculated as follows:

(1) EOHHS calculated a cost per Episode for Outpatient Services for each Critical Access Hospital by dividing the amount reported on worksheet E-3, part VII, column 2, line 21 of the Hospital's FY22 CMS-2552-10 cost report by the Hospital's number of FY22 Medicaid (MassHealth) Episodes. The Hospital's Medicaid (MassHealth) Episode volume was derived from FY22 paid claims data residing in MMIS as of May 4, 2023, for which MassHealth is the primary payer.

(2) EOHHS then multiplied the cost per Episode amount for each Critical Access Hospital by the Inflation Factors for Operating Costs between RY22 and RY24, resulting in the Critical Access Hospital's inflation-adjusted cost per Episode.

(3) EOHHS then divided each Critical Access Hospital's inflation-adjusted cost per Episode by each Hospital's FY22 outpatient Casemix index (CMI), as determined by EOHHS.

(4) EOHHS then multiplied the result by 0.964.

(5) That result is the CAH-Specific Outpatient Standard Rate per Episode. For Episodes that extend past midnight in the case of Emergency Department Services, or Observation Services, the CAH-Specific Outpatient Standard Rate per Episode that applied to the first date of service shall apply to the entire Episode.

(6) The Critical Access Hospital's APEC for a specific Episode is then determined by substituting the CAH-Specific Outpatient Standard Rate per Episode in place of the Wage Adjusted APEC Outpatient Standard, and calculating a CAH APEC payment as otherwise described in **Section 5.C.1.b**.

c. Post-RY27 Cost Review and Settlement

Each Critical Access Hospital must timely complete all Medicaid (Title XIX) data worksheets on CMS-2552 cost reports for FY27 in accordance with the CMS Provider Reimbursement Manual - Part 2 (CMS publication 15-2) ("CMS-2552-10 cost reports"), and any additional instructions provided by MassHealth, and submit copies of such completed reports to EOHHS no later than February 28, 2027, or such date as otherwise determined necessary by EOHHS. Critical Access Hospitals shall also complete and provide to EOHHS upon request all such other information, and in such format, as EOHHS determines necessary to perform the review described below.

EOHHS will perform a post-RY27 review to determine whether the Critical Access

Hospital received aggregate interim payments in an amount equal to 101% of allowable costs utilizing the Medicare cost-based reimbursement methodology for both inpatient and outpatient services for FY27, as such amount is determined by EOHHS ("101% of allowable costs"). EOHHS will utilize the Critical Access Hospital's FY27 CMS-2552-10 cost reports and such other information that EOHHS determines is necessary, to perform this post RY27 review. "Aggregate interim payments" for this purpose shall include all hospital payments made under the RY27 RFA as determined by EOHHS, but excluding any supplemental payments under **Section 5**, **Section 7B**, or **Section 8.A** of the RY27 RFA.

If EOHHS determines that the Critical Access Hospital was paid less than 101% of allowable costs, EOHHS will pay the Critical Access Hospital the difference between the amount that EOHHS determines is 101% of allowable costs and the aggregate interim payments. If EOHHS determines that 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 the amount that EOHHS determines is 101% of allowable costs.

This post RY27 review and settlement will take place within approximately twelve (12) months after the close of RY27, subject to the availability of data, or, if later, at such other time as EOHHS determines the necessary documentation is available.

In the case of a Critical Access Hospital that does not comply with the reporting requirements set forth in **Section 6.E** and this **Section 5.D.7.C.**, the amount of any reduction(s) to such hospital's APAD and inpatient Outlier Payments pursuant to **Section 6.E** will also be deducted from such hospital's allowable costs, as calculated by EOHHS pursuant to this **Section 5.D.7.C**, for purposes of the post-RY27 review and settlement described in this **Section 5.D.7.C**.

8. High Medicaid Volume Safety Net Hospital Supplemental Payment

a. Qualification

In order to qualify for a High Medicaid Volume Safety Net Hospital supplemental payment, a Hospital must be a High Medicaid Volume Safety Net Hospital as defined in **Section 2**, and must enter into a separate payment agreement with EOHHS relating to payment as a High Medicaid Volume Safety Net Hospital.

b. Reimbursement Methodology

Subject to legislative appropriation or authorization, compliance with all applicable federal statutes, regulations, state plan and waiver provisions, payment limits, and full federal financial participation, EOHHS will make a supplemental payment to a High Medicaid Volume Safety Net Hospital. The payment amount will be (i) determined

by EOHHS using data filed by the qualifying Hospital in financial reports as required by EOHHS, and (ii) specified in an agreement between EOHHS and the qualifying Hospital.

EOHHS reserves the right to make payments to a qualifying High Medicaid Volume Safety Net Hospital in such amounts and pursuant to such methods and using such funding sources as may be approved by CMS.

Acute Hospitals that receive payment as a High Medicaid Volume Safety Net Hospital shall be determined by EOHHS.

9. Reserved

10. Reserved

11. Reserved

12. Medicaid Rate Add-on Payments

EOHHS will make uniform dollar add-on payments per inpatient discharge and outpatient episode to in-state acute care hospitals.

a. Inpatient Discharge Add-on

(1) The inpatient add-on is paid from two pools:

(a) Pool 1 is $225.6 million, calculated by multiplying $480 million by 47%.

(b) Pool 2 is $41.36 million, calculated by multiplying $88 million by 47%

(2) To determine each in-state acute care hospital's Pool 1 adjusted inpatient discharge add-on amount, EOHHS will:

(a) First, divide the inpatient add-on Pool 1 by the total number of RY27 in-state acute care hospital inpatient discharges, inclusive of both MassHealth fee-for-service and managed care discharges, as determined by EOHHS based on paid claims and encounters on file as of March 31, 2028, to determine the Pool 1 inpatient add-on amount per discharge.

(b) Second, multiply the total number of RY27 inpatient discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 1 inpatient add-on amount per discharge, to determine the hospital-specific Pool 1 inpatient add-on payment amounts.

(3) To determine each in-state acute care hospital's Pool 2 adjusted inpatient discharge add-on amount, EOHHS will:

(a) First, divide the inpatient add-on Pool 2 amount by the total number of RY27 in-state acute care hospital inpatient fee-for-service discharges, as

determined by EOHHS based on paid claims on file as of March 31, 2028, to determine the Pool 2 inpatient add-on amount per discharge.

(b) Second, multiply the total number of RY27 fee-for-service discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 2 inpatient add-on amount per discharge, to determine the hospital-specific Pool 2 inpatient add-on payment amounts

(4) To determine each in-state acute care hospital's total final hospital-specific inpatient add-on amounts, EOHHS will add the hospital-specific Pool 1 inpatient add-on payment amounts described in **Section 5.D.12.a(2)** and the hospital-specific Pool 2 inpatient add-on payment amounts described in **Section 5.D.12.a(3)**.

(5) For each hospital, subtract the total hospital-specific interim inpatient add-on payments received in RY27, calculated as described in **Section 5.D.12.a(6)**, from hospital-specific final inpatient add-on payment amounts, calculated as described in **Section 5.D.12.a(4)** and, (i) if the amount is less than $0.00, make a final true-up payment equal to the difference; or (ii) if the amount is more than $0.00, complete a recoupment equal to the difference. The total final amount after true-up or recoupment, as applicable, is the final adjusted inpatient discharge add-on amount for each hospital calculated pursuant to this **Section 5.D.12.a**.

(6) EOHHS will make interim inpatient add-on payments in RY27. For each interim inpatient add-on payment, a new inpatient add-on amount per discharge will be calculated by dividing Pool 1 and Pool 1 funding available for that payment, as determined by EOHHS, by the total number of in-state acute care hospital inpatient discharges in a historical period as determined by EOHHS ("interim dataset"). To determine interim inpatient add-on payment amounts pursuant to this **Section 5.D.12.a(6)**, EOHHS will multiply each in-state acute care hospital inpatient discharge from the interim dataset by the interim payment inpatient add-on amount per discharge.

b. Outpatient Episode Add-on

(1) The outpatient add-on is paid from two pools:

(a) Pool 1 is $254.4 million, calculated by multiplying $480 million by 53%.

(b) Pool 2 is $46.64 million, calculated by multiplying $88 million by 53%.

(2) To determine each in-state acute hospital's Pool 1 adjusted outpatient episode add-on payment amount, EOHHS will:

(a) First, divide the outpatient add-on Pool 1 by the total number of RY27 in-state acute care hospital outpatient episodes, inclusive of both MassHealth fee-for-

service and managed care episodes, as determined by EOHHS based on paid claims and encounters on file as of March 31, 2028, to calculate the Pool 1 outpatient add-on payment amount per episode.

(b) Second, multiply the total number of RY27 outpatient episodes for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 1 outpatient add-on payment amount per episode, to calculate the Pool 1 outpatient add-on payment amount.

(3) To determine each in-state acute care hospital's Pool 2 adjusted inpatient discharge add-on amount, EOHHS will:

(a) First, divide the outpatient add-on Pool 2 amount by the total number of RY27 in-state acute care hospital outpatient fee-for-service discharges, as determined by EOHHS based on paid claims on file as of March 31, 2028, to determine the Pool 2 outpatient add-on amount per discharge.

(b) Second, multiply the total number of RY27 fee-for-service discharges for each in-state acute care hospital, as determined by EOHHS based on paid claims on file as of March 31, 2028, by the Pool 2 outpatient add-on amount per discharge, to determine the hospital-specific Pool 2 outpatient add-on payment amounts.

(4) To determine each in-state acute care hospital's total final hospital-specific outpatient add-on amounts, EOHHS will add the hospital-specific Pool 1 outpatient add-on payment amounts described in **Section 5.D.12.b(2)** and the hospital-specific Pool 2 outpatient add-on payment amounts described in **Section 5.D.12.b(3)**.

(5) For each hospital, subtract the total hospital-specific interim outpatient add-on payments received in RY27, as calculated as described in **Section 5.D.12.b(6)**, from hospital-specific final outpatient add-on payment amounts, calculated in **Section 5.D.12.b(4)**, and (i) if the amount is less than $0.00, make a final true-up payment equal to the difference; or (ii) if the amount is more than $0.00, complete a recoupment equal to the difference. The total final amount after true-up or recoupment, as applicable is the final adjusted outpatient episode add-on amount for each hospital, calculated pursuant to this **Section 5.D.12.b**.

(6) EOHHS will make interim outpatient episode add-on payments in RY27. For each interim outpatient episode add-on payment, a new outpatient add-on amount per episode will be calculated by dividing the pool of funding available for that payment, as determined by EOHHS, by the total number of in-state acute care hospital outpatient episodes in a historical period, as determined by EOHHS ("interim dataset"). To determine interim outpatient add-on payment amounts pursuant to this **Section 5.D.12.b(6)**, EOHHS will multiply each in-state acute

care hospital outpatient episode from the interim dataset by the interim payment outpatient episode add-on amount.

13. Requirements and Payments for Telehealth

MassHealth will pay for telehealth services rendered through the hospital in accordance with MassHealth telehealth policies and billing guidance established through MassHealth provider bulletins or other MassHealth publications. This includes, but is not limited to, any limitations on facility payments to hospitals for telehealth services that may be included in MassHealth provider bulletins or other MassHealth publications.

14. Reserved

15. Reserved

16. Reserved

17. Reserved

18. Reserved

19. Reserved

20. Reserved

21. MassHealth Targeted Hospital Supplemental Payments

a. Eligibility Criteria

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

(a) Reserved;

(b) Reserved;

(c) Reserved;

(d) Reserved; or

(e) Reserved.

(2) In addition, to qualify for a targeted hospital supplemental payment, a Hospital meeting the eligibility criteria set forth above must:

(a) enter into a separate payment agreement or agreements with EOHHS relating to receipt of such payment; and

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

b. Payment Methodology

(1) EOHHS will make a supplemental payment or payments to Hospitals satisfying the eligibility criteria set forth in **Section 5.D.21.a**. according to the methodology that follows.

(a) Reserved.

(b) Reserved.

(c) Reserved.

(d) Reserved.

(e) Reserved.

22. Reserved

23. Reserved

24. Reserved

25. Reserved

26. Inpatient Psychiatric Supplemental Payment

In addition to other payments set forth in **Section 5.D**, EOHHS will make a supplemental payment in Rate Year 2027 to eligible hospitals for a one-time Psychiatric Inpatient Supplemental Payment, as set forth in this **Section 5.D.26**.

a. Definitions

For the purpose of this **Section 5.D.26**, the following definitions apply:

(1) "Claims Period" shall mean the twelve-month period of July 1, 2025, through June 30, 2026.

(2) "Aggregate Psychiatric Admission" shall mean the total number of paid claims for all MassHealth members for the Claims Period as of January 1, 2027, across the eligible Hospitals inpatient psychiatric admissions, including applicable subsets of such claims, as designated in the Payment Methodology described in **Section 5.D.26.c**.

(3) "Inpatient Psychiatric Admissions" shall mean the Hospital's total number of paid claims for all MassHealth members for the Claims Period as of January 1, 2027, for inpatient psychiatric admissions, including applicable subsets of such claims, as designated in the Payment Methodology described in **Section 5.D.26.c.**

b. Eligibility

To be eligible for an Inpatient Psychiatric Supplemental Payment under this **Section 5.D.26**, a Hospital must:

(1) Operate at least one service location providing psychiatric Inpatient Services; and

(2) Maintain at least one inpatient bed that is licensed by DMH as a psychiatric bed as of October 1, 2026.

c. Payment Methodology

Inpatient Psychiatric Supplemental Payments under this **Section 5.D.26** will equal a total aggregate amount of $33 million, apportioned to eligible Hospitals as follows:

(1) The supplemental payment for each eligible Hospital will be determined based on the Claims Period. Each eligible Hospital will receive one supplemental payment amount reflecting three component calculations, as follows:

(a) Percentage of Inpatient Psychiatric Admissions by Hospital. $15 million will be distributed proportionally to eligible Hospitals based on inpatient psychiatric admissions as follows:

$$\frac{(Hospital - Specific\ Psychiatric\ Admissions\ )}{Aggregate\ Psychiatric\ Admissions)} \times \$15{,}000{,}000$$

(b) Percentage of Claims with Certain Secondary Diagnoses. $15 million will be distributed proportionally to each eligible Hospital based on inpatient psychiatric admissions with at least one secondary diagnosis on the claim related to one or more of the following: renal, endocrinology, circulatory, substance use disorder, and/or gastroenterology, as follows:

$$\frac{(Hospital - Specific\ Psychiatric\ Admissions\ with\ applicable\ secondary\ diagnoses\ )}{(Aggregate\ Psychiatric\ Admissions\ with\ applicable\ secondary\ diagnoses)} \times \$15{,}000{,}000$$

(c) Percentage of Members Admitted following the EPIA Protocol. $3 million will be distributed proportionally to each eligible Hospital based on inpatient psychiatric admissions following the EPIA protocol as follows:

$$\frac{(Hospital - Specific\ Psychiatric\ Admissions\ following\ EPIA\ protocols}{(Aggregate\ Psychiatric\ Admissions\ following\ EPIA\ protocols)} \times \$3{,}000{,}000$$

(2) EOHHS will combine the Hospital's resulting payment amounts from each component as outlined in **Sections 5.D.26.B.1.a** through **c.** to calculate the total supplemental payment amount for each eligible Hospital.

E. Safety Net Care Acute Hospital Payments

In accordance with the terms and conditions of the Commonwealth's 1115 waiver governing the Safety Net Care Pool (SNCP), and subject to compliance with all applicable federal requirements, the Commonwealth will make additional payments above the amounts specified in **Sections 5.B**, **5.C**, and **5.D** to Hospitals which qualify for payments under the SNCP. SNCP payments are authorized by the Centers for Medicare and Medicaid Services (CMS) on a state fiscal year basis for each applicable waiver year.

Only Hospitals that have an executed Contract with EOHHS, pursuant to this RFA, are

eligible for SNCP payments.

All SNCP payments are subject to federal approval and the availability of federal financial participation.

F. Federal Financial Participation (FFP)

1. FFP Denials

If any portion of the RFA payment methodology or any amount paid pursuant to this RFA is not approved or is the basis of a disallowance by CMS, such payments made to the Hospital by EOHHS in excess of the federally approved methodology or amounts will be deemed an overpayment and EOHHS may recoup, or offset such overpayments against future payments.

2. Exceeding Limits

a. Hospital-Specific Limits

If any payments made pursuant to this RFA exceed any applicable federal Hospital-specific payment limits, including, but not limited to, charge limits, upper payment limits, and limits based on federally approved payment methods, such amounts will be deemed an overpayment and EOHHS may recoup, or offset against future payments, any such overpayments.

b. Aggregate Limits

If any payments made pursuant to this RFA exceed applicable federal aggregate payment limits, including, but not limited to, upper payment limits provided for in federal law, regulations, and the Commonwealth's 1115 waiver, EOHHS may exercise its discretion to apportion disallowed amounts among the affected Hospitals and to recoup from, or offset against future payments to such Hospitals, or to otherwise restructure payments in accordance with approved payment methods.

G. Billing

Hospitals shall submit claims for non-professional services through an 837I and for the professional component of Hospital–Based Physician (Inpatient and Outpatient) Services through an 837P, except where otherwise indicated by MassHealth regulations, billing instructions, Provider bulletins, or other written statements of policy, and in compliance with all applicable regulations, billing instructions, Provider bulletins, and other written statements of policy, as they may be amended periodically. Until further notice, inpatient Hospital claims for LARC Devices pursuant to **Section 5.B.8.a** and APAD Carve-Out Drugs pursuant to **Section 5.B.8.b** must be separately submitted through an 837P via DDE and in compliance with applicable MassHealth regulations, billing instructions, Provider bulletins, and other written statements of policy, as they may be amended periodically.

In the event that a provider's only means of submission is paper, the provider must meet the

MassHealth requirements of a paper submission waiver request.

H. Treatment of Reimbursement for Members in the Hospital on the Effective Date of the Hospital Contract

Except as described in the next paragraph, EOHHS shall reimburse participating Hospitals for services provided to MassHealth Members who are at acute inpatient status prior to October 1, 2026, and who remain at acute inpatient status on or after October 1, 2026, at the Hospital's MassHealth rates and payment methods established prior to this RY27 RFA, and at the Hospital's MassHealth rates and payment methods established in this RY27 RFA for inpatient services provided to MassHealth members who are admitted on or after October 1, 2026.

For services that qualify for the Rehabilitation Unit per diem, the Psychiatric Per Diem, the Administrative Day per diem, or the Adjudicated Payment Per Episode of Care (APEC), the Hospital's MassHealth rates and payment methods established prior to this RY27 RFA apply to dates of service prior to October 1, 2026, and the Hospital's RY27 RFA rates and payment methods apply to dates of service on or after October 1, 2026. As an exception, for Episodes that extend past midnight in the case of Emergency Department or Observation Services, if the Episode's first date of service occurs in RY26, then the APEC methodology under the RY26 RFA applies to the entire Episode.

I. Future Rate Years

Adjustments may be made each Rate Year to update rates and shall be made in accordance with the Hospital Contract in effect on that date. All provisions of the RFA requiring continuing performance shall survive the termination of such RFA.

J. Compliance with Legal Requirements

The parties agree to comply with, and are subject to, all state and federal statutes, rules, and regulations governing the MassHealth Program, and reimbursement and delivery of Acute Hospital services, including but not limited to Acute Inpatient Hospital regulations at 130 CMR 415.000 et seq., Outpatient Hospital regulations at 130 CMR 410.000 et seq., and Administrative and Billing regulations at 130 CMR 450.00 et seq.; provided, however, that in the event of any conflict between the documents that are part of the Hospital's Contract with EOHHS and any MassHealth regulation now existing or hereinafter adopted, the terms of the Contract shall prevail. All references to statutes and regulations refer to such statutes and regulations as they may be amended from time to time. In addition, the parties must comply with all applicable billing instructions and Provider bulletins, and other written statements of policy issued by EOHHS and its divisions, as they may be amended from time to time.

K. Eligibility Verification

EOHHS will pay the Hospital only for a covered service delivered to a Member who, on the date of service, is (1) eligible under MassHealth to receive that service, and (2) not enrolled

with a MassHealth MCO or EOHHS' Behavioral Health contractor that covers the service. Each day of an inpatient Hospital stay constitutes a discrete "date of service". A Member who meets the foregoing conditions on a given date of service may not meet such conditions on all dates of service comprising a Hospital stay. The Hospital is responsible for determining, through the MassHealth Eligibility Verification System (EVS), that the Member meets the conditions stated herein on each discrete date of service.

L. Updating Groupers

When groupers 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. EOHHS may make adjustments to assure budget neutrality for such grouper changes. EOHHS reserves the right to update to a new grouper.

M. Data Sources

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

N. 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 this RFA, EOHHS, in its sole discretion, shall determine on a case-by-case basis: (1) whether the Hospital qualifies for reimbursement under this RFA; and, if so, (2) the appropriate rates of reimbursement. Such rates of reimbursement shall be determined in accordance with the provisions of this RFA to the extent that EOHHS deems possible. EOHHS' determination shall be based on the totality of the circumstances. Any such rate may, in EOHHS' sole discretion, affect computation of any statewide average or statewide standard and/or any cost standard or component of such standard. MassHealth provider numbers are not assignable to new entities.

See **Sections II.5.a** and **II.5.d of Appendix A**, and **Appendix B**, item 11, for requirements in the event of Hospital change of ownership.

O. Headings

The headings and subheadings used in this RFA are for convenience of reference only, and shall not define or limit any of the terms or provisions hereof.

Section 6 Payment and Reporting Provisions

All payments under this RFA are subject to the following provisions, as well as all other rules and regulations governing service limitations, claims payment, billing and claims processing procedures, utilization control requirements and all other MassHealth conditions of payment.

A. Services Requiring Prior Approval

1. Services Requiring Practitioner Prior Approval

EOHHS will not reimburse a Hospital for services provided when the practitioner is required to, but fails to obtain prior authorization, referrals or other approval for the service. It is the Hospital's responsibility to ensure that a practitioner providing services in the Hospital has obtained the necessary approvals.

2. Services Requiring Hospital Prior Approval

Services for which MassHealth requires Hospitals to obtain prior approval or prior authorization may be set forth in MassHealth regulations, Subchapter 6 of the Acute Outpatient Hospital Provider Manual (in the case of Acute Outpatient Hospitals), the MassHealth Acute Hospital Carve-Out Drug List of the MassHealth Drug List (and any other Acute Hospital section of the MassHealth Drug List that may be developed), Provider bulletins, or other written statements of policy issued by EOHHS. EOHHS will not reimburse a Hospital for services provided when the Hospital is required to, but fails to obtain prior authorization, referrals or other required approvals for the service.

3. Effect of Prior Authorization

MassHealth reviews requests for prior authorization on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including member eligibility, other insurance, program restrictions, other MassHealth utilization management or control requirements and approvals, and all other MassHealth conditions of payment.

B. Hospital Payments in the Event of Third-Party Coverage

1. Except to the extent prohibited by 42 U.S.C. § 1396a(a)(25)(E) or (F), the Hospital must make diligent efforts, as defined under 130 CMR 450.316(A), to identify and obtain Insurance Payments before billing MassHealth.

2. For Inpatient Admissions, Outpatient Services, and Emergency Department Services where the Member has Third-Party Insurance coverage, EOHHS will pay the Hospital according to Third-Party Liability provisions at 130 CMR 450.316 through 450.321.

3. Subject to compliance with all conditions of payment, for members who have other health insurance in addition to MassHealth, the MassHealth agency's liability is the lesser of:

a. the member's liability, including Coinsurance, Deductibles, and Copayments, as

reported on the explanation of benefits or remittance advice from the insurer; or

b. the maximum allowable amount payable under the MassHealth agency's payment methodology, minus the insurance payments.

C. Notification of Hospital Election to Offer Reduced Medicare Coinsurance Amounts

Acute Hospitals have an option to elect to reduce a Medicare beneficiary's Coinsurance amount under the Medicare outpatient prospective payment system. Such election must be made in writing to the Hospital's fiscal intermediary (FI), specifying the services to which it applies. The first such election must have been made by June 1, 2000, and for future years by December 1 of the year preceding the Calendar Year for which the election is being made. See 42 CFR 419.42.

Hospitals electing to take such an option must forward a copy of their notification to:

Executive Office of Health and Human Services
Office of Medicaid
Attention: Claims Coordination Unit
UMass Chan Medical School
P.O. Box 2816
Worcester, MA 01613

D. Sterilization

EOHHS will pay for an inpatient stay for a sterilization or for outpatient sterilization services only when the Hospital meets all requirements regarding Member consent and service delivery as set forth in MassHealth regulations and subregulatory guidance. For any sterilization for which the Hospital does not demonstrate compliance with Member consent requirements, including submission of all required documentation according to all applicable regulations, MassHealth will deduct an amount equal to the Hospital's APEC in effect October 1, 2026, from the applicable Hospital payment amount. Furthermore, the performance of a sterilization without meeting all such requirements may result in sanctions against the Hospital in accordance with 130 CMR 450.238 et seq. as well as the applicable provisions of this RFA.

E. Reporting Requirements

All Acute Hospitals must furnish ownership, licensure, financial, and statistical documents relating to MassHealth participation, services, and payment, as required by EOHHS and other governmental entities. This shall include, but is not limited to, state and federal cost reports, charge books, merged billing and discharge filings, audited financial statements, and provider enrollment information. In addition, Critical Access Hospitals must timely complete and furnish all Medicaid (Title XIX) data worksheets on CMS-2552-10 cost reports in accordance with the CMS Provider Reimbursement Manual - Part 2 (CMS publication 15-2) (see **Section 5.D.7**). If any Acute Hospital does not furnish required information within the applicable time period, or within a reasonable extension of time approved in writing by

EOHHS, such Hospital may have a 5% reduction applied to its APAD and inpatient Outlier Payments beginning 45 days after the required submission date. This reduction shall accrue in a cumulative manner of 5% for each month of non-compliance.

For example, the downward adjustment to the Hospital's APAD and Outlier Payments for the first month would equal 5%; if the requested documentation is not received for another month, the downward adjustment to the Hospital's APAD and Outlier Payments for the second month shall equal 10%. The adjustment shall not, in any case, exceed 50% of the APAD and Outlier Payments. If a Hospital is not in full compliance with the submission of the aforementioned information at such time as the Hospital's rates are subject to change (i.e., at the start of a new Rate Year, or upon commencement of an amendment that affects the rates), at no time can the new rates exceed the adjusted current rates. If, however, the new rates are less than the rates currently in effect, then the new rates will become effective and potentially subject to further adjustment.

Hospitals must separately identify in the state cost report any costs associated with Rehabilitation Units, in accordance with all applicable instructions.

All Acute Hospitals must report their costs and payments using the Uniform Medicaid & Uncompensated Care Cost & Charge Report (UCCR), in accordance with the requirements of the federally approved cost limit protocol and instructions by EOHHS. Such cost reporting will be based on the provider's CMS-2552-10 cost report and will result in reconciliation and recovery of any overpayments.

F. Accident Reporting

Hospitals shall use reasonable efforts to determine whether a Member's injury is due to an accident or trauma (e.g., automobile accident, accident at work). In the event that a MassHealth Member is treated at a Hospital for injuries resulting from an accident or trauma, the Hospital shall notify EOHHS in writing of the following information, at the address below:

1. Patient's name, MassHealth number (SSN or RID), address, and date of birth;
2. Date(s) of service (from-to);
3. Date of injury;
4. Type of accident (e.g., auto accident, accident at work, slip and fall);
5. Insured's name and address;
6. Insurance company's name;
7. Insured's attorney's name, address and telephone number.

Such written notification shall be sent to the following address:

Executive Office of Health and Human Services
Office of Medicaid

Casualty Recovery Unit
P.O. Box 15205
Worcester, MA 01615-0205
Phone: (800) 754-1864

Alternatively, the written notification may be emailed to the Casualty Recovery unit at casualtyrecoveryunit@umassmed.edu.

G. Reporting on Greenhouse Gas Emissions

To identify industry-specific goals to reduce greenhouse gas emissions and advance statewide goals, MassHealth requires each Hospital to report on its greenhouse gas emissions, and verify its reporting through partnership with an approved third party, as described below.

1. By January 31, 2027, or such other later date as directed by EOHHS, each Hospital must submit to MassHealth, in the form and manner directed by MassHealth, the following information:
   a. The Hospital's designated staff member responsible for greenhouse gas emissions reporting under this **Section 6.G**, including the staff member's name, title, and contact information; and
   b. The third party entity the Hospital intends to work with, upon MassHealth's approval, to validate the Hospital's greenhouse gas emissions reporting under this **Section 6.G**.
2. By June 30, 2027, or such other later date as directed by EOHHS, each Hospital must submit to MassHealth, in the form and manner directed by MassHealth, which may include reporting through the approved third party, and for the time period to be defined by MassHealth, the following information:
   a. The Hospital's total Scope 1 emissions, defined as all emissions under the direct control of the Hospital, including but not necessarily limited to on-site fuel combustion, anesthetic gas, and fleet vehicle gas or diesel use;
   b. The Hospital's total Scope 2 emissions, defined as the Hospital's purchased energy; and
   c. An attestation that such information is true, accurate, and in accordance with the data standards identified or determined by MassHealth.

H. MassHealth Co-payments

For any Hospital service for which a Member co-payment is applied pursuant to 130 CMR 450.130, EOHHS shall deduct the co-payment amount from the applicable Hospital payment amount specified in this RFA. Hospitals may not refuse services to any Member who is unable to pay the co-payment at the time the service is provided, and must otherwise comply with all applicable state and federal requirements regarding co-payments.

Section 7 Reserved

Section 7B Clinical Quality Incentive Program

This **Section 7B**, as further detailed in **Appendix J**, sets forth the MassHealth Clinical Quality Incentive (CQI) Program, including its quality measurement and reporting requirements, performance assessment methodology, and payment methodology for RY27. The CQI Program provides opportunities for Hospitals to earn incentive payments for quality reporting and performance on quality measures.

RY27 incentive payments described in **Section 7B** are contingent upon the Hospital's performance of all applicable requirements specified in **Section 7B**, as well as all requirements in **Appendix J**.

1. **Clinical Quality Incentive (CQI) Program Requirements**

   The MassHealth CQI Program shall operate under the following principles:

   a. Incentivize Hospitals to meet, excel or improve quality of care delivered to MassHealth members, and reward Hospitals for doing so.

   b. Evaluate Hospital performance for CQI Program incentive payments using the quality performance measures in **Appendix J** and the performance assessment methodology (PAM) in **Section 7B.4 and Appendix J**.

   c. Calculate CQI Program incentive payments in accordance with the payment methodology set forth in **Section 7B.5**.

   d. To be eligible for CQI Program incentive payments, Hospitals must adhere to each of the following standards:

      (1) Data requirements:

         (a) Data Accuracy and Completeness: Hospitals shall ensure that all submitted data is complete and accurate, as described in **Appendix J**.

         (b) Measure Specifications: Hospitals shall comply with all data collection and submission guidelines, for all measures listed in **Exhibit 1** of **Appendix J**, as published in the applicable EOHHS Technical Specifications Manual version, to ensure completeness and accuracy of data submitted;

         (c) Reporting Deadlines: Hospitals shall meet data submission deadlines set forth in the applicable EOHHS Technical Specifications Manual version. Failure to timely submit all data and reporting in the formats required by EOHHS may render the Hospital ineligible for some or all CQI Program incentive payments under this **Section 7B**; and

         (d) Portal Transactions: Hospitals shall identify and designate individuals to conduct electronic data transactions via the EOHHS designated secure portal per **Section 7B.2** on the Hospital's behalf.

      (2) Data Validation: Hospitals shall meet the minimum data reliability standards and

pass data validation as defined in **Section 2.C** of **Appendix J**.

(3) Performance: Hospitals shall achieve quality standards and performance benchmarks, as defined in **Appendix J**, on all quality measures data.

e. All Hospitals participating in the MassHealth program and contracting with EOHHS are required to participate in CQI Program quality reporting for all eligible or applicable measures. A Hospital's performance with respect to the requirements in this **Section 7B** and **Appendix J**, may affect its present and future participation in the MassHealth program and its rate of reimbursement, including the CQI Program incentive payments.

2. Hospital Key Quality Representative Requirements

Each Hospital must identify and designate two key quality representatives, with the appropriate expertise to inform, coordinate and communicate with EOHHS on all aspects of the CQI Program requirements and associated amendments during RY27. The two key quality representatives shall be identified and act in accordance with, but not be limited to, the following responsibilities:

a. Serve as the primary contact for all correspondence pertinent to the Hospital's quality performance reports and incentive payment annual reports, including responding to all inquiries and requests made by EOHHS, in accordance with the timeframes and format specified by EOHHS.

b. Identify the key staff responsible for obtaining and responding to quarterly medical record requests list and for accessing annual report results pertaining to all necessary measures listed on **Exhibit 1** of **Appendix J**, via the EOHHS designated secure portal, on the hospitals behalf.

c. Designate the Hospital's MassHealth Quality Exchange (MassQEX) Portal users.

d. Notify EOHHS of any changes in the key quality representatives and MassQEX Portal users that occur during the Contract period as soon as the information becomes available, using the Hospital Quality Contacts Form.

e. Use the EOHHS email address, MassHealthhospitalquality@mass.gov (Hospital Quality Inbox), to expedite communication between EOHHS and the Hospital on **Section 7B** requirements and comply with the following conditions that apply to use of the Hospital Quality Inbox:

(1) Only the two key quality representatives are automatically entered into the Hospital Quality Inbox distribution list. Requests to add other staff not listed on the Hospital Quality Contact Form to Hospital Quality Inbox distribution list must be submitted via email to the Hospital Quality Inbox.

(2) Key quality representatives will receive ongoing updates from the Hospital Quality Inbox on quality reporting requirements and other quality-related

initiatives during the Contract period.

(3) Key quality representatives are responsible for disseminating updates received from the Hospital Quality Inbox and communicating to all Hospital staff and/or third-party vendors involved in quality performance reporting.

f. Complete and submit program participation forms that include information on all staff involved in quality reporting using the Hospital Quality Contacts Form per instructions in **Section 4.F** of **Appendix J.**

3. Hospital CQI Program Performance Measures

For RY27, EOHHS has adopted Hospital quality performance measures for the CQI Program that incentivize safe and high-quality care. Measures included in the CQI Program are drawn from standard measures stewarded by nationally recognized quality measure developers. Further CQI Program Measure Detail is included in **Section 2** of **Appendix J.**

a. CQI Program Measure Domains

(1) CQI Program measures are grouped into four core quality measure domains (referred to as "Core Quality Measure Domain(s)") and two specialty quality measure domains (referred to as "Specialty Quality Measure Domain(s)").

(2) Measures are specified according to the standard specification, with few exceptions necessary for implementation in the context of the CQI Program. Any differences to the standard measures shall be identified and noted in the annual technical specifications and any relevant release notes, as such specifications and release notes may be amended and updated from time to time. The most current EOHHS Technical Specifications Manual may be accessed through the following link: http://www.mass.gov/masshealth-quality-exchange-massqex.

(3) Hospitals are required to report data for individual quality measures that are chart-based or data-entry-based. Claims-based measures will be calculated by EOHHS. Registry data (e.g., safety measures), and Patient Experience (adult only) will be obtained by EOHHS through the National Health Safety Network and CMS, respectively.

b. Hospital Accountability

Hospitals are accountable for performance on measures for which they are eligible, where the Hospital meets the measure specifications outlined in the EOHHS Technical Specifications Manual.

c. Core Quality Measure Domains

(1) All Hospitals must participate in four Core Quality Measure Domains: Care Coordination/Integration of Care; Care for Acute and Chronic Conditions; Patient Safety and Patient Experience.

(2) Pediatric measures are also included in the Core Quality Measure Domains. Hospitals are required to report pediatric measures for which they are eligible, where the Hospital meets the measure specifications outlined in the EOHHS Technical Specifications Manual.

d. Specialty Quality Measure Domains

In addition to being accountable to performance for all measures in Core Quality Measure Domains, Hospitals may also be determined by EOHHS to be accountable to all measures for which the Hospital is eligible in one or more Specialty Quality Measure Domains. Specialty Quality Measure Domain participation and accountability will be determined by EOHHS based on type of Hospital and domain service lines provided.

e. Other Specialty Hospital Measures

In limited cases, a Hospital may provide primarily specialty care or limited services which limits measure eligibility and participation in the Core or Specialty Quality Measure Domains. (e.g., orthopedic, enterology, cancer or other care). In such cases, EOHHS or a Hospital providing specialty care not identified in the current domains may request further consultation to determine an option to incorporate additional measures that may be incorporated into the Core Quality Measure Domain for which they would be eligible. EOHHS shall make the final determination of this option on a case-by-case basis and measures mutually agreed upon may be incorporated into future amendments, or Agreements.

4. Performance Assessment Methodology (PAM)

This **Section 7B.4**, in addition to **Section 3** of **Appendix J**, sets forth the Performance Assessment Methodology (PAM) for the CQI Program. EOHHS considers the following components and principles for its PAM.

a. Standard Calculation Practices

Standard practices will be used wherever possible to calculate measure performance calculations and to validate submitted data.

b. Opportunity to Achieve Incentive Amount

Each Hospital will have the opportunity to achieve its full eligible CQI Program incentive payment for excellent quality performance. This is achieved through design approaches, such as:

(1) Establishing clear threshold and goal benchmarks for measures over a multi-year time period (e.g., five years) rather than for a single performance year only;

(2) Opportunity to earn incentive for year-over-year self-improvement (e.g., gap to goal targets); and

(3) Opportunity to earn CQI Program incentive payments through each measure

based on attainment (e.g., meeting threshold, goal or in-between threshold and goal performance), and, as applicable, meeting targets for improvement.

c. Simple Scoring and Payment

Design approaches, including the following, will ensure simple scoring and payment processes:

(1) Utilizing measures that roll up to a domain score (e.g., sum of the Hospital points earned for each measure/the maximum number of points in a domain)

(2) Weighting domain scores to calculate a single overall quality score that:

(a) Includes 100% weighting of measure domains available to Hospitals.

(b) Does not exclude Hospitals from payments if they are not eligible for a measure domain. Instead, if a Hospital is not eligible for a measure domain, the weighting is redistributed.

(3) Applying a single Hospital overall quality score (calculated as a ratio between 0-1) to the Hospital's CQI Program incentive payment (described in **Section 7B.5**).

d. Alignment of PAM with Other EOHHS Programs

EOHHS will align PAM components and approach with other programs where possible and as appropriate (e.g., ACO, other Hospital programs, CMS), such as aligning practices for introducing new measures or payments.

e. Flexibility for Extenuating Circumstances

EOHHS will monitor the PAM and may amend the RFA to adjust the PAM to extenuating circumstances. Examples of significant extenuating circumstances that may reasonably necessitate adjustments to the PAM, through an RFA amendment, include:

(1) EOHHS' determination that benchmarks are set too low or too high, through EOHHS' application of rules or safeguards to re-evaluate such benchmarks.

(2) PHE or other unforeseen events impacting performance. (e.g., COVID allowances).

5. CQI Program Incentive Payment Methodology

As set forth in this **Section 7B**, a Hospital may qualify to earn a CQI Program incentive payment, through its overall quality score calculated based on its quality measure performance.

The maximum CQI Program incentive payment that each Hospital is eligible to earn will be determined by its pro-rata share of $250,000,000, across both MassHealth fee-for-service and managed care, using Calendar Year 2027 data, as follows:

a. The maximum eligible CQI Program incentive payment for each Hospital is

determined, by dividing each Hospital's Hospital-reported Medicaid gross patient service revenues (Charges) by all Hospital-reported Medicaid Gross Patient Service Revenues (Charges).

b. Each Hospital's maximum eligible CQI Program incentive payment will then be multiplied by the Hospital's overall quality score or ratio (0-1) assessed through the PAM to determine the Hospital's actual CQI Program incentive payment.

c. Each Hospital's maximum eligible CQI Program incentive payment component paid directly by MassHealth through this RFA will be in proportion to the inpatient and outpatient fee-for-service utilization.

6. CQI Reporting Requirements

Each Hospital must comply with all data reporting requirements, including without limitation data submission deadlines, performance evaluation periods, data reporting formats, portal registration requirements, and participant form submission requirements as set forth below, with additional detail found in **Section 4** of **Appendix J** and in applicable EOHHS Technical Specifications**.**

Reporting requirements include:

a. Reporting of chart-based measures on all relevant Medicaid payer codes;

b. Timely submission of measures per performance evaluation periods;

c. Data accuracy and completeness requirements;

d. Data reporting formats; and

e. Submission of program participant reporting forms inclusive of:

(1) The MassHealth Hospital Quality Contacts Form, and

(2) The MassHealth Hospital Data Accuracy and Completeness Attestation Form.

Forms are posted on the Mass.gov webpage entitled "MassHealth Quality Exchange" at: https://www.mass.gov/masshealth-quality-exchange-massqex.

Section 8 Other Quality and Performance-Based Payments

A. Hospital Quality and Equity Incentive Program (HQEIP) (formerly referred to as the Health Equity Incentive (HEI) program) Requirements

1. HQEIP Program Requirements

The MassHealth HQEIP shall operate under the following principles:

a. Incentivize Hospitals to meet, excel or improve quality and equity of care delivered to MassHealth members, and reward Hospitals for doing so, in accordance with the (i) this **Section 8.A**; (ii) "Hospital Quality and Equity Initiative Implementation Plan Performance Years 1-5" (HQEI PY1-5 IP), as amended and as approved by CMS and included as Attachment J to the Special Terms and Conditions of the MassHealth Medicaid Section 1115 Demonstration, and (iii) the applicable HQEIP Technical Specifications Manual and measure specifications for the performance year (PY).

(1) To be eligible for HQEIP incentive payments, Hospitals must adhere to the requirements outlined in the HQEI PY1-5 IP and the applicable HQEIP Technical Specifications Manual and measure specifications for the PY. All Hospitals participating in the MassHealth program and contracting with EOHHS are required to participate in the HQEIP, unless otherwise approved for exemption by MassHealth. A Hospital's performance with respect to the requirements in this **Section 8.A** and the HQEI PY1-5 IP will affect its HQEIP incentive payments.

2. Hospital Key Quality and Equity Representative Requirements

Each Hospital must identify and designate two key HQEIP representatives, with the appropriate expertise to inform, coordinate and communicate with EOHHS on all aspects of the HQEIP requirements described in this **Section 8.A**, the HQEI PY1-5 IP. The two key HQEIP representatives shall be identified and act in accordance with, but not be limited to, the following responsibilities:

a. Serve as the primary contact for all correspondence pertinent to the Hospital's HQEIP reports and incentive payment annual reports, including responding to all inquiries and request made by EOHHS, in accordance with the timeframes and format specified by EOHHS.

b. Identify the key staff responsible for providing, on the Hospital's behalf, reporting results pertaining to all necessary measures identified in the HQEIP Technical Specifications Manual.

c. Use the EOHHS email address, health.equity@mass.gov (Health Equity Inbox), to expedite communication between EOHHS and the Hospital relating to the HQEIP and comply with the following conditions that apply to use of the Health Equity Inbox:

(1) Only the two key HQEIP representatives are automatically entered into the email distribution list of the Health Equity Inbox. Requests to add other staff to this email distribution list must be submitted via email to the Health Equity Inbox.

(2) Key HQIEP representatives will receive ongoing updates from the Health Equity Inbox on reporting requirements and other programmatic updates during the Contract period.

(3) Key HQEIP representatives are responsible for disseminating updates received from the Health Equity Inbox to relevant Hospital staff and/or third-party vendors involved in HQEIP reporting.

3. Health Quality and Equity Committee

The Hospital shall have a Health Quality and Equity Committee (HQEC) designated by, and accountable to, the Hospital and its governing board. Such HQEC may be an existing health equity committee, so long as the committee meets the criteria of this **Section 8.A.3**.

The composition of the HQEC shall, to the extent possible, include individuals that represent the diversity of the MassHealth population. The HQEC shall have representation from various stakeholders of the Hospital, including but not limited to:

a. Hospital representatives;

b. At least two MassHealth Members or family members of MassHealth Members;

c. Hospital clinical staff; and

d. Frontline staff (e.g., community health workers).

Responsibilities of the HQEC include but are not limited to:

a. Developing and steering implementation of the Hospital's HQEIP strategy;

b. Monitoring progress towards addressing disparities;

c. Developing HQEIP reporting; and

d. Sharing all relevant information with the Hospital's Patient and Family Advisory Counsel (PFAC).

4. Hospital HQEIP Performance Measures

For CY26 and CY27, EOHHS has adopted HQEIP performance measures that incentivize high-quality and equitable care. HQEIP performance measures are described in the HQEI PY1-5 IP.

5. Performance Assessment Methodology (PAM)

Applicable HQEIP measure specifications accompanying the HQEI PY1-5 IP are set forth in the Performance Assessment Methodology (PAM) Manual for HQEIP, in Section5.D of the HQEI PY1-5 IP, and the Technical Specifications Manual for the PY,

as applicable.

6. HQEIP Incentive Payment Methodology

Hospitals participating in the HQEIP are eligible to receive payments pursuant to this **Section 8.A.6**, in accordance with Section 4 of the HQEI PY1-5 IP. To be eligible to participate in the HQEIP and receive HQEIP payments, a Hospital must be an Acute Hospital that is not publicly owned and is affiliated with an ACO, and must meet minimum participation requirements established in the HQEI PY1-5.

a. Each eligible Acute Hospital will be assigned to one of three HQEIP tiers (sometimes also referred to as the "Health Equity Pools"), as follows and as described in Section 4.A of the HQEI PY1-5 IP:

(1) Tier 1: HQEIP tier 1 will consist of Hospitals identified as Group 1 Safety Net Hospitals, as described in Attachment N of Massachusetts' 1115 Demonstration;

(2) Tier 2: HQEIP tier 2 will consist of Hospitals identified as Group 2 Safety Net Hospitals as described in Attachment N of Massachusetts' 1115 Demonstration; and

(3) Tier 3: HQEIP tier 3 will consist of all Hospitals eligible to participate in the HQEIP that do not fall into HQEIP tiers 1 or 2.

b. Total tier funding is set forth in Table 6 of Section 4.A of the HQEI PY1-5 IP.

c. As set forth in Section 4.A of the HQEI PY1-5 IP:

(1) For Hospitals in HQEIP tier 1, each Hospital's maximum incentive payment will be equal to $1,000,000, plus their pro-rata share of remaining HQEIP tier funding, determined by dividing each Hospital's FY19 Medicaid Gross Patient Service Revenues by all FY19 Medicaid Gross Patient Service Revenues within the HQEIP tier.

(2) For Hospitals in HQEIP tiers 2 and 3, each Hospital's maximum incentive payment will be equal to their pro-rata share of its respective HQIEP tier funding, determined by dividing each Hospital's FY19 Medicaid Gross Patient Service Revenues by all FY19 Medicaid Gross Patient Service Revenues within the respective HQEIP tier.

d. An individual Hospital's final incentive payment will be equal to their maximum incentive payment multiplied by their Hospital health quality and equity score, of which 25% will be determined based on performance related to Domain 1, 50% related to Domain 2, and 25% related to Domain 3, as described in Section 5.C and Section 5.D, as applicable, of the HQEI PY1-5 IP.

e. Hospitals participating in and meeting relevant requirements for the HQEIP will receive quarterly interim payments as described in Section 4.A of the HQEI PY1-5 IP. Across the interim payments for CY26 and CY27, MassHealth will withhold 25%

each year of each hospital's maximum annual payment. As appropriate, the remaining 25% will be paid out as a reconciliation payment, as described in the HQEI PY1-5.

7. HQEIP Reporting Requirements

Each Hospital must comply with all data reporting requirements, including without limitation data submission deadlines, performance evaluation periods, data reporting formats, portal registration requirements, and participant forms submission requirements as described in the HQEI PY1-5 IP, ***with additional detail found in applicable Technical Specifications for MassHealth Acute Hospital Health Quality and Equity Measures.***

a. Hospitals must adhere to each of the following data requirement standards:

(1) Data Accuracy and Completeness: Hospitals shall ensure that all submitted data is complete and accurate;

(2) Measure Specifications: Hospitals shall comply with all data collection and submission guidelines, for all applicable measures listed in Section 3.C. of the HQEI PY1-5 IP, to ensure completeness and accuracy of data submitted; and

(3) Reporting Deadlines: Hospitals shall meet applicable data submission deadlines set forth in the Technical Specifications Manual for the PY, as applicable. Failure to timely submit all data and reporting in the formats required by EOHHS may render the Hospital ineligible for some or all HQEIP incentive payments under this **Section 8.A**.

8. Reserved

9. Cambridge Health Alliance Health Quality and Equity Incentive Program

Pursuant to Appendix C of the HQEI PY1-5 IP, Cambridge Health Alliance, as a publicly owned acute hospital participating in the MassHealth program, may receive payments pursuant to the Cambridge Health Alliance Health Quality and Equity Incentive Program (CHA-HQEIP), in accordance with all requirements described in Appendix C of the HQEI PY1-5 IP.

All requirements in **Section 8.A.1** through **Section 8.A.8** are applicable to Cambridge Health Alliance, unless the CHA-HQEIP, included as Appendix C to the HQEI PY1-5 IP, or the CHA-HQEIP technical specifications document specify otherwise.

B. Provider Preventable Conditions

The following provisions regarding Provider Preventable Conditions (PPCs), as well as the provisions regarding Serious Reportable Events (SREs) in **Section 8.C**, reflect and further EOHHS' commitment to value-based purchasing and to help ensure safer and cost-effective care delivery to MassHealth members by encouraging Hospitals to establish measures and actions to actively improve performance in patient care safety, reduce readmissions, and avoid preventable errors.

1. Introduction

Under Section 2702 of the Patient Protection and Affordable Care Act (Pub. L. 111.-148) (the ACA), and corresponding federal regulations at 42 C.F.R. 447.26, Hospitals must report "provider preventable conditions" to Medicaid agencies; and Medicaid agencies are prohibited from paying Hospitals for services resulting from a "provider preventable condition" in violation of the federal requirements. EOHHS has implemented policies that conform to the federal requirements. The following provisions and payment methods governing "provider preventable conditions" apply to the Hospital, and the Hospital must comply with such provisions.

As part of the MassHealth "provider preventable condition" policy, certain of the "serious reportable events" designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332, as they pertain to MassHealth members, shall be excepted from the requirement that the Hospital shall not Charge or seek reimbursement for the event, as described in **Section 8.C**, below. The excepted "serious reportable events" are any "serious reportable events" designated by DPH pursuant to its regulations at 105 CMR 130.332 which are not identified in Appendix U of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals. The Hospital shall bill and report, and related payment adjustments shall be made for, these excepted "serious reportable events" as "provider preventable conditions" in accordance with this **Section 8.B** governing Provider Preventable Conditions. The Hospital also shall continue to perform the documented review process and determination for these events, as further described in **Section 8.B.6**, below, solely for the purposes of reporting to DPH. The remaining "serious reportable events" identified in Appendix U of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals shall be governed entirely by the Serious Reportable Events provisions in **Section 8.C**, below.

2. Definitions

The following definitions apply to this **Section 8.B**:

a. Provider Preventable Condition (PPC) – a condition that meets the definition of a "Health Care Acquired Condition" or an "Other Provider Preventable Condition" as defined by CMS in federal regulations at 42 C.F.R. 447.26(b).

b. Health Care Acquired Conditions (HCACs) – conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886(d)(4)(D)(iv) of the Social Security Act (SSA) (as described in Section 1886(d)(4)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

c. Other Provider Preventable Condition (OPPC) – a condition that meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 C.F.R.

447.26(b). OPPCs may occur in any health care setting and are divided into two sub-categories:

(1) **National Coverage Determinations (NCDs)** – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:

(a) Wrong surgical or other invasive procedure performed on a patient;

(b) Surgical or other invasive procedure performed on the wrong body part; and

(c) Surgical or other invasive procedure performed on the wrong patient.

For each of (a) through (c), above, the term "surgical or other invasive procedure" is as defined in CMS Medicare guidance on NCDs.

(2) **Additional Other Provider Preventable Condition (Additional OPPCs)** – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as Additional OPPCs.

3. Hospital Reporting of PPCs to EOHHS

a. Appendix V of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals identify those PPCs that apply to the Hospital for inpatient and outpatient hospital services and hospital-based physician services, respectively. EOHHS may also provide this information to Hospitals through provider bulletins, or other written statements of policy, and all such documentation, including without limitation Appendix V, may be amended from time to time.

b. Hospitals must report the occurrence of a PPC and PPC-related services through MMIS claims submissions to MassHealth. Hospital reporting of PPCs, and related claims submissions, must be conducted in accordance with applicable MassHealth regulations, provider manuals and billing instructions, including without limitation as set forth in Appendix V of the MassHealth Acute Inpatient Hospital and Acute Outpatient Hospital provider manual, respectively. EOHHS may also provide such instructions through provider bulletins, or other written statements of policy, and all such documentation, including without limitation, Appendix V, may be amended from time to time.

c. In accordance with state and federal statutes, rules, and regulations governing the MassHealth program, including but not limited to 130 CMR 415.000 et seq. (Acute Inpatient Hospitals); 130 CMR 410.000 et seq. (Acute Outpatient Hospitals) and 130 CMR 450.000, et seq. (administrative and billing instructions), EOHHS may request additional information from the Hospital which EOHHS deems necessary to facilitate its review of any PPC or to carry out payment, provider enrollment, quality or other routine functions of the MassHealth program, and the Hospital must comply with the request. EOHHS may use this information, as well as the reports provided pursuant to **Section 8.B.6**, in reviewing any PPC, and in applying any payment adjustment as set

forth in **Section 8.B.4**, below.

4. Payment Adjustments to Hospitals for Provider Preventable Conditions

a. Inpatient Hospital Services – For inpatient hospital services, when a Hospital reports a PPC that the Hospital indicates was not present on admission, EOHHS will reduce payments to the Hospital as follows:

(1) **APAD, Outlier Payment and Transfer per diem payments.** For inpatient services for which the Hospital would otherwise be paid an APAD, Outlier Payment or Transfer per diem payment:

(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/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 Unit, or Administrative Day Per Diem payments.** For inpatient services for which the Hospital would otherwise be paid a Psychiatric, Rehabilitation Unit or Administrative Day per diem:

(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/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.

b. Outpatient Hospital Services – For outpatient hospital services, when a Hospital reports that a PPC occurred during treatment at the Hospital (including its satellite clinics), MassHealth will reduce payments to the Hospital as follows:

(1) **APEC**. For outpatient services for which the Hospital would otherwise be paid the APEC:

(a) MassHealth will not pay the APEC if the Hospital reports that only PPC-related services were delivered during the episode of care, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

(b) MassHealth will pay the APEC, in each case as adjusted to exclude PPC-related costs/services, if the Hospital reports that non-PPC related services were also delivered during the same episode of care, and will exclude all reported PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

(2) **Outpatient Hospital Payments for Hospital-Based Physician Services:** MassHealth will not pay for outpatient Hospital-based physician services reported as PPC-related services.

(3) **Follow-Up Care in Same Hospital:** If a Hospital reports that it provided follow-up outpatient hospital services that were solely the result of a previous PPC (inpatient or outpatient) that occurred while the member was being cared for at a facility covered under the same hospital license, MassHealth will not pay for the reported follow-up services. If the hospital reports that non–PPC-related services were provided during the follow-up episode of care, payment will be made, but adjusted in the case of an APEC payment to exclude PPC-related costs/services, and MassHealth will exclude all PPC-related costs/services when determining future year payment rates that are calculated using a data source that would otherwise include the PPC.

c. For each of **Section 8.B.4.a and Section 8.B.4.b**, above, the PPC non-payment provisions also apply to third-party liability and crossover payments by MassHealth.

d. Hospitals are prohibited from charging members for PPCs and PPC-related services, including without limitation co-payments or Deductibles. Hospitals are also prohibited from seeking reimbursement for identified PPC-related services through

the Health Safety Net (HSN) or otherwise, and from including such services in any unreimbursed cost reporting.

e. In the event that individual cases are identified throughout the MassHealth PPC implementation period, EOHHS may adjust reimbursement according to the methodology above.

5. Additional Requirements

The Hospital agrees to take such action as is necessary in order for EOHHS to comply with all federal and state laws, regulations, and policy guidance relating to the reporting and non-payment of provider preventable conditions, including, without limitation, Section 2702 of the ACA. In addition, should EOHHS, in its sole discretion, deem it necessary to further amend this RFA and Contract to implement any such laws, the Hospital agrees that, notwithstanding any other provision in this RFA and Contract, EOHHS may terminate the Hospital's Contract immediately upon written notice in the event the Hospital fails to agree to any such amendment.

6. Reporting to the Massachusetts Department of Public Health

In addition to complying with **Sections 8.B.1** through **5**, above, for any PPC that is also a "serious reportable event (SRE)" as designated by the Massachusetts Department of Public Health (DPH) pursuant to its regulations at 105 CMR 130.332, the Hospital must also continue to report the occurrence of the PPC as an SRE to DPH, and perform the documented review process as set forth in and in accordance with DPH regulations at 105 CMR 130.332(B) and (C). The Hospital must also provide copies of such reports to EOHHS and any other responsible third-party payer and inform the patient as required by and in accordance with DPH regulations at 105 CMR 130.332(B) and (C). The copies to MassHealth must contain a cover letter that includes the patient's MassHealth ID, the event type, and the date of the event. Copies must be sent via secure e-mail to:

PPC/Serious Reportable Event Coordinator
MassHealth Quality Office
MQO@mass.gov
Subject Line: PPC/SRE Report

Notwithstanding such reporting and documented review process as set forth in 105 CMR 130.332(B) and (C), provider claims to MassHealth and related payment methods for PPCs, including without limitation, those that also constitute a DPH-designated SRE, are governed by this **Section 8.B** and not **Section 8.C**, below.

C. Serious Reportable Events

The following provisions regarding Serious Reportable Events (SREs), as well as the provisions regarding Provider Preventable Conditions (PPCs in **Section 8.B**), reflect and further EOHHS' commitment to value-based purchasing and to help ensure safer and cost-effective care delivery to MassHealth members by encouraging Hospitals to establish measures and actions to actively

improve performance in patient care safety, reduce readmissions, and avoid preventable errors.

1. **Applicability**

   a. "Serious Reportable Events (SREs)" for purposes of this **Section 8.C** shall mean those serious reportable events (SREs) listed in Appendix U of the Hospital's Acute Inpatient Hospital and Acute Outpatient Hospital MassHealth provider manuals. All references to SREs in **Sections 8.C.2** through **8.C.4**, below, are subject to this **Section 8.C.1**.

   From time to time, EOHHS may update the list of SREs that are subject to this **Section 8.C** through issuing provider bulletins or updates to provider manuals, or through other written statements of policy.

   b. For purposes of this section, "preventable" is defined as DPH has defined the term in its regulations at 105 CMR 130.332 and means events that could have been avoided by proper adherence to applicable patient safety guidelines, best practices, and hospital policies and procedures.

2. **Scope of Non-Reimbursable Services**

   a. MassHealth's SRE policy applies to both Hospitals and Hospital-Based Physicians.

   b. Hospitals are prohibited from charging or seeking reimbursement from MassHealth or the member for Hospital and Hospital-Based Physician services that are made necessary by, or are provided as a result of, an SRE occurring on premises covered by the hospital's license that was preventable and unambiguously the result of a system failure, as described in DPH regulations ("preventable SRE"). Non-reimbursable Hospital and Hospital-based physician services include:

      (1) All services provided during the inpatient admission or outpatient visit during which a preventable SRE occurred; and

      (2) All services provided during readmissions and follow-up outpatient visits as a result of a non-billable SRE provided:

         (a) At a facility under the same license as the hospital at which a non-billable SRE occurred; or

         (b) On the premises of a separately licensed hospital or ambulatory surgery center with common ownership or a common corporate parent of the hospital at which a non-billable SRE occurred.

      (3) Charges for services, including co-payments or Deductibles, deemed non-billable to MassHealth are not billable to the member.

      (4) The non-payment provision of this RFA also applies to third-party liability and/or crossover payments by MassHealth.

      (5) A Hospital not involved in the occurrence of a preventable SRE that also does not

meet the criteria in **Section 8.C.2.b.(2)**, 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.

3. Required Reporting and Preventability Determination

a. In accordance with DPH regulations at 105 CMR 130.332(B) and (C), as may be amended, Hospitals must (i) timely report the occurrence of an SRE to DPH and provide copies of the report to required parties, as specified in such regulations, (ii) establish policies for making and documenting preventability determinations following the occurrence of an SRE, (iii) timely make preventability determinations for all SREs occurring on premises covered by the Hospital's license, and (iv) timely submit the preventability determination report to DPH ("updated SRE report"), with copies to all other required parties, as specified in such regulations.

b. A Hospital shall notify the MassHealth program of the occurrence of an SRE by securely emailing a copy of the report as filed with DPH pursuant to **Section 8.C.3.a** to the email below. Copies of reports sent to MassHealth must contain a cover letter that includes the patient's MassHealth ID, the event type, and the date of the event. Copies must be sent to:

PPC/Serious Reportable Event Coordinator
MassHealth Quality Office
MQO@mass.gov
Subject Line: PPC/SRE Report

Hospitals shall also use this address to send MassHealth a copy of the updated SRE report as submitted to DPH containing the information as specified under DPH regulations at 105 CMR 130.332.

c. No later than thirty days after the date of initial reporting of the SRE to DPH and MassHealth, if upon completing a preventability determination following the occurrence of an SRE pursuant to **Section 8.C.3.a**, above, the Hospital seeks payment for Inpatient Services or Outpatient Services to a MassHealth member, the Hospital shall submit the following required documentation to MassHealth, using the email set forth in **Section 8.C.3.b**, above, so it can review the circumstances of the SRE;

(1) A copy of the updated SRE report issued to DPH describing the hospital's preventability determination including, at a minimum, the following:

(a) Narrative description of the SRE;

(b) Analysis and identification of the root cause of the SRE;

(c) Analysis of the preventability criteria required by DPH;

(d) Description of any corrective measures taken by the hospital following

discovery of the SRE; and

(e) Whether the hospital intends to Charge or seek reimbursement from MassHealth for services provided at the hospital as a result of the SRE,

(2) MassHealth may request additional information, such as a copy of the member's medical record for the inpatient Hospital admission or outpatient episode of care during which the SRE occurred.

4. Non-Payment for SREs

a. MassHealth will review the circumstances of the SRE and shall make a determination regarding payment based on the criteria set forth in DPH regulations at 105 CMR 130.332 and above, and utilizing **Table 8-1**, below:

Table 8-1. MassHealth Non-Payment Methodology, Acute Hospitals

Payment Component that includes Preventable SRE	Resulting Non-payment
Inpatient acute admission	Non-payment of APAD and Outlier Payments
Inpatient - Transfer Per Diem, Psychiatric Per Diem, Acute Rehabilitation Unit Per Diem, or Administrative Day Per Diem	Non-payment of all per diems associated with the inpatient stay
Outpatient Hospital Services	Non-payment of APEC and any other outpatient services payable under the RFA
Hospital-Based Physician services	Non-payment of physician fees for care associated with the SRE

b. In accordance with state and federal statutes, rules, and regulations governing the MassHealth program, including but not limited to 130 CMR 415.000 et seq. (Acute Inpatient Hospitals); 130 CMR 410.000 et seq. (Acute Outpatient Hospitals) and 130 CMR 450.000, et seq. (administrative and billing instructions), EOHHS may request additional information from the Hospital which EOHHS deems necessary to facilitate its review of any SRE or to carry out payment, quality or other routine functions of the MassHealth program, and the Hospital must comply with the request.

Section 9 Submission Requirements

A. Contents of Submission

Each Hospital's response to the RFA must consist of the following:

1. Cover Letter

The cover letter must be signed by the individual authorized to execute the Hospital Contract for the applicant and shall contain the name, title, address, and telephone number of the individual who should be contacted for the purpose of clarifying the response.

2. Hospital Contract

The MassHealth Hospital Contract (**Appendix A**) will become the Contract between EOHHS and each Hospital and its Satellite Clinics. **Appendix A** must be properly completed and signed without modification to terms. EOHHS will sign a Hospital's Contract upon acceptance of that Hospital's response.

3. Application

One original of **Appendix B**, the application and its attachments, shall be completed and signed in accordance with the instructions in **Appendix B**.

4. Documentation

Each applicant must complete and sign one original of **Appendix B**, and provide certain official documents relating to institutional status and disclosures of the owner, operator and licensee of the Hospital required in **Appendix E**.

5. Certification

Each applicant must certify (in **Appendix B**) as part of its response to this RFA that the information and supporting documentation submitted in response to this RFA (such as licenses, certificates and permits) and all information and supporting documentation contained in its Provider application and the Provider applications of each of its Satellite Clinics that are currently on file with MassHealth are current, correct and complete. If such documentation is not complete, current or correct, or if the Provider has never participated in the MassHealth program before, the missing, new or corrected documentation shall be included in the Hospital's response, and the Hospital must certify that the documents submitted with the application make the file complete, current and correct.

Any Hospital that does not currently have on file with MassHealth a MassHealth Provider application for itself or any of its Hospital-Licensed Health Centers and Satellite Clinics must request an application from Jin Pantano, Executive Office of Health and Human Services, MassHealth Office of Provider Network at AcuteHospitalRFA@mass.gov, and must submit the completed application on behalf of

that entity, along with all required documentation, by the applicable closing date in **Section 9.B**. Any Hospital wishing to review the application(s)/information currently on file with MassHealth may do so by contacting Jin Pantano to make an appointment to personally review the application or request a copy of its file.

6. Data Privacy Certification Form

Each applicant must complete and return the Data Privacy Certification form contained in **Appendix F** as part of its response to this RFA.

B. Submission Instructions/Closing Dates

Each Hospital must submit all required documents **either** electronically (*preferred form of submission*) **or** in hard copy, as such options are described in **Section 9.B.1** and **Section 9.B.2**, below. Hospitals must submit timely, accurate and complete responses to this RFA, including all information specified in the Appendices**,** by the date and time indicated in **Section 13**.

In addition, following this submission, and no later than the deadline for submission indicated in **Section 13**, each Hospital must send an email to Jin Pantano, Deputy Director, Acute Hospital Program, at AcuteHospitalRFA@mass.gov, which recites that all required documents have been submitted in accordance with this **Section 9.B**. Each Hospital must include in its submission an updated Contractor Authorized Signatory Listing form, and must ensure that the individual(s) signing on behalf of the Contractor are listed as authorized signatories on such form.

1. Electronic Submission

If submitting electronically, the Hospital must complete all necessary documentation, including all necessary signatures, compile such documentation, and submit via email to AcuteHospitalRFA@mass.gov.

Only the following forms of signature will be accepted:

- *(Preferred method)* Electronic signature affixed using a digital tool such as Adobe Sign or DocuSign; or
- Electronic signature that is:
  - Hand drawn using a mouse or finger if working from a touch screen device; or
  - An uploaded picture of the signatory's hand drawn signature.
- Traditional "wet signature" (ink on paper); print out one original of the signature page, have an authorized signatory sign it, and scan the signed page.

Please note: If using an electronic signature, the signature must be visible and must be accompanied by the signatory's printed legal name and title, the printed legal name of the acute care hospital represented by the signatory, and the signature date. Typed text of a name not generated by a digital tool such as Adobe Sign or DocuSign, even in computer-

generated cursive script, or an electronic symbol, are not acceptable forms of electronic signature.

2. Hard Copy Submission

If submitting via hard copy, the Hospital must complete all necessary documentation, including all necessary signatures, compile such documentation, and submit via a sealed envelope to:

Executive Office of Health and Human Services
Attention: MassHealth Acute Hospital Program – Jin Pantano
1 Enterprise Drive, 4th Floor
Quincy, MA 02171

Section 10 Response Review and Provider Selection

EOHHS will review all responses submitted in accordance with the terms of this RFA. Each application will be reviewed to determine whether the Program Participation Requirements in **Section 11** have been met. Those applicants that meet all of the Program Participation Requirements may participate as a Hospital provider in the MassHealth program.

Any submission determined to be non-responsive to any requirement of this RFA may be rejected. EOHHS may determine that non-compliance is insubstantial and can be corrected. In such cases, EOHHS may, at its discretion, seek clarification, allow the applicant to make corrections, and/or allow the applicant to submit additional information. All such responses to EOHHS requests for clarification must be in writing, unless otherwise specified by EOHHS. Those applicants who do not meet all of the Program Participation Requirements in **Section 11** may be disqualified from participation in the MassHealth program for the provision of non-Emergency Services.

Section 11 Program Participation Requirements

A Hospital's response may be rejected or its Hospital Contract may be terminated if it fails to meet any one of the following criteria:

A. Proper Submission

Each Hospital must submit a complete response in accordance with all applicable instructions to the designated address by the deadline established in this RFA. (See **Section 9** of this RFA.)

B. Certification

The Hospital must:

1. Be Medicare-certified and participate in Medicare;
2. Be located in Massachusetts;
3. Be licensed by the Department of Public Health under M.G.L. c. 111, §51;
4. Have 50% or more of its beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds as determined by DPH; and
5. Currently utilize more than 50% of its beds exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (obstetrics) or neonatal intensive care (Level III) beds, as may be determined by EOHHS. In determining whether the Hospital satisfies this utilization requirement, EOHHS may evaluate, pursuant to an on-site audit or otherwise, a number of factors, including but not limited to the average length of patient stay by type of bed at the Hospital.

C. Acceptance of Reimbursement Methodology

The applicant must accept as payment in full for services provided as of the Contract commencement date the following reimbursement on behalf of the Hospital, including its Inpatient Department(s), Outpatient Department(s), and Satellite Clinic(s), if any.

1. The reimbursement for Inpatient Services according to **Section 5.B** of this RFA and **Appendix C**;
2. The reimbursement for Outpatient Services, including Emergency Department and Satellite Clinic services, according to **Section 5.C** of this RFA and **Appendix D**;
3. The reimbursement for unique circumstances according to **Section 5.D** of this RFA and **Appendices C** and **D**; and
4. Payments contingent upon Hospital adherence to quality standards and achievement of performance benchmarks, and subject to compliance with **Sections 7** and **8** of this RFA.

D. Acceptance of Agreement

Appendix A, the Hospital Contract, is the Contract that will be awarded pursuant to this RFA. The applicant must accept the provisions of **Appendix A** without revision by signing the last page of **Appendix A**. The Hospital shall not include any statement in any portion of its response to this RFA, including in the cover letter submitted pursuant to **Section 9.A.1,** that conflicts with this acceptance, such as a purported "reservation of rights" or "conditional acceptance" of the terms of the Hospital Contract. EOHHS will construe any such statements as an expression of concern, with no legal significance. Such statements are not part of that Contract, do not operate to modify the terms of that Contract, will not operate as a rejection of that Contract, will not create a counteroffer, and do not create any rights not otherwise explicitly available to the hospital under federal or state law or regulation. EOHHS's subsequent counter-execution of a MassHealth Hospital Contract that accompanied a submission that included any such statements shall not be construed to constitute agreement, express or implied, with any such statement contained in that submission.

E. Documentation

The applicant must provide the required documentation and information regarding institutional status in **Appendix E**.

F. Certification

The applicant must complete **Appendix B** and certify that all information and documentation required to be on file with MassHealth is complete, current and correct.

G. Quality, Equity, and Performance Reporting

The applicant must provide the documentation and information regarding quality reporting as required in **Section 7B** and **Section 8.A**, and must otherwise comply with all requirements related to quality as set forth in **Section 7B** and **Section 8.A**. Failure to comply to the satisfaction of EOHHS may result in fines, sanctions, reduced payment amounts, and/or termination of the Hospital's Contract for provision of non-Emergency Services.

Notwithstanding the termination provision in **Section I.2** of **Appendix A** (Hospital Contract), any such termination shall be effective upon 30 days' prior written notice by EOHHS to the Hospital, and 130 CMR 450.000 et seq. shall not apply.

Section 12 RFA Information

A. Issuing Office

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th floor
Boston, MA 02108

B. Applicants' Conference

An Applicants' Conference will be held via remote audio and video transmission on the dates and times indicated in **Section 13**. Applicants and all interested parties are invited to attend. As noted in the timetable in **Section 13**, registration in advance is encouraged but not required. Representatives of the MassHealth Program will address questions of general interest pertaining to the RFA at that time. Oral answers will be given if the information is then available. Written answers may be prepared for certain questions of general interest and made available to prospective applicants after the date of the conference.

C. Inquiries

Prospective applicants may submit written business and contractual questions concerning this RFA no later than the dates and times indicated in **Section 13**, to the following e-mail address: AcuteHospitalRFA@mass.gov. Applicants should indicate in the subject line that the inquiries are regarding the Hospital RY27 RFA.

The Bid Solicitation Q&A functionality in COMMBUYS will be also used for this RFA; emailing Bidder questions to the email address listed above is preferred.

Inquiries regarding the CQI or HQEI Programs should be separated from other questions, and the subject line should indicate that the inquiry is specific to CQI or HQEIP.

EOHHS shall review inquiries received before the relevant deadline and will identify questions for which written answers will be prepared. Any written answers of general interest will be made available to all prospective applicants, and to other interested parties upon request.

D. Anticipated Date of Contractor Selection

EOHHS anticipates selection of Hospital Contractors by the date listed in **Section 13, Timetable**.

E. Anticipated Date of Contract Commencement

EOHHS anticipates that Hospital Contracts will commence on the date listed in **Section 13, Timetable**.

F. Addendum or Withdrawal of RFA

If it becomes necessary to revise any part of this RFA, or if additional data is necessary to

clarify any of its provisions, a supplement shall be provided to prospective applicants who have received a copy of the RFA. EOHHS reserves the right to amend the RFA at any time and to terminate this procurement in whole or in part at any time.

G. COMMBUYS

COMMBUYS is the official source of information for this RFA and is publicly accessible at no charge at www.commbuys.com. The RFA, and any RFA attachments and amendments, are all components of the RFA, and are incorporated into the RFA and any resulting contract.

Applicants are solely responsible for obtaining and completing required attachments that are identified in this RFA and for obtaining all information distributed for this RFA via COMMBUYS.

It is also each Applicant's responsibility to check COMMBUYS for:

- Any amendments, addenda or modifications to this RFA, and
- Any RFA Q&A records that may be posted related to this RFA.

The Commonwealth accepts no responsibility and will provide no accommodation to Applicants who submit a Response based on an out-of-date RFA or on information received from a source other than COMMBUYS. Applicants may not alter (manually or electronically) the RFA language or any RFA component files. Modifications to the body of the RFA, specifications, terms and conditions, or which change the intent of this RFA are prohibited and may disqualify a response.

COMMBUYS Subscription. Applicants may elect to obtain a free COMMBUYS subscription which provides value-added features, including automated email notification associated with postings and modifications to COMMBUYS records.

The COMMBUYS system utilizes terminology which Applicants must be familiar with in order to conduct business with the Commonwealth. To view this terminology and to learn more about the COMMBUYS system, please visit the COMMBUYS Resource Center.

H. Public Records

All applications and related documents submitted in response to this RFA are public records under the Massachusetts Freedom of Information Law, M.G.L. c. 66, Section 10, and M.G.L. c. 4, Section 7, regarding public access to such documents. Statements inconsistent with public record laws will be disregarded.

I. Subcontracting

If subcontractors are used, the Contractor shall accept full responsibility that the performance of subcontractors meets all provisions of this RFA.

J. Limitations

This Request for Application does not commit EOHHS to award a Contract, to pay any costs incurred in the preparation of the application, or to procure or contract for services or

supplies. EOHHS reserves the right to accept or reject any and all applications received as a result of this request, or to cancel this RFA in any part or in its entirety if it is in the best interest of EOHHS to do so. To the extent that the methodologies require State Plan approval by the Centers for Medicare and Medicaid Services (CMS), Contracts are subject to such approval. EOHHS reserves the right to amend the reimbursement methodology as necessary to meet federal requirements.

K. Cost of Application

No costs or expenses incurred by applicants in submitting a response to this RFA shall be borne by the Commonwealth.

L. Return of Applications

The Commonwealth shall be under no obligation to return any materials submitted by an applicant in response to this RFA.

M. Reasonable Accommodation

Applicants with disabilities or hardships that seek reasonable accommodation, which may include the receipt of RFA information in an alternative format, must submit a written statement to the RFA contact person describing the Applicant's disability and the requested accommodation to the contact person for the RFA. EOHHS reserves the right to reject unreasonable requests.

N. Privacy and Security of Health Information

Applicants shall comply with all state and federal laws and regulations relating to confidentiality, privacy, and security.

Section 13 Timetable

The following Timetable represents EOHHS' best estimate of the schedule that shall be followed. **EOHHS reserves the right, at its sole discretion, to adjust this schedule as it deems necessary.** Notification of any adjustment to the RFA Schedule of Events shall be posted on COMMBUYS.

Event	Date/Time
RFA Issued:	September 15, 2026
Applicants' Conference (registration link below):	September 21, 2026, 1:00 p.m. to 2:00 p.m.
Deadline for E-mailed Questions (except as specified below):	September 23, 2026, at 5:00 p.m.
Contract due by mail/email confirmation to RFA contact due (see Section 9.B):	**September 30, 2026, at 5:00 p.m.**
Contract Start Date:	October 1, 2026

Registration in advance for the Applicants' Conference is encouraged but not required. To register, please use this link: https://www.mass.gov/forms/register-for-the-eohhsmasshealth-rate-year-2027-acute-hospital-rfa-applicants-conference.

Join Zoom Meeting Applicants' Conference

Meeting ID: 935 397 8200

Passcode: 800606

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+13092053325,,9353978200#,,,,*800606# US

Dial by your location

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+1 309 205 3325 US

+1 312 626 6799 US (Chicago)

+1 646 558 8656 US (New York)

+1 646 931 3860 US

+1 253 215 8782 US (Tacoma)

+1 346 248 7799 US (Houston)

+1 386 347 5053 US

+1 564 217 2000 US

+1 669 444 9171 US

+1 669 900 9128 US (San Jose)

+1 719 359 4580 US

Find your local number: https://zoom.us/u/abToXeOO5C

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX A:
MASSHEALTH HOSPITAL CONTRACT

(Applicants are instructed to fill in the blanks and sign)

Agreement between the Commonwealth of Massachusetts, acting by and through its Executive Office of Health and Human Services (hereinafter "EOHHS"), and

_____

(legal name of Contractor)

_____

(hereinafter "the Contractor"), with a principal place of business located at:

_____

_____

(address(es) of Hospital[s])

_____

_____

(address(es) of Hospital-Licensed Health Center[s])

_____

_____

(address(es) of Satellite Clinics[s])

_____

_____

(address(es) of any other off-site services)

EOHHS operates a program of Medical Assistance under 42 U.S.C. § 1396 et seq., and M.G.L. c. 118E, § 1 et seq. (hereinafter the "Medical Assistance Program") and desires to purchase Inpatient and Outpatient Hospital Services for eligible Members in said program from participating Hospitals, including their Inpatient and Outpatient Departments, and Satellite Clinics, and desires to operate said program in a fiscally responsible manner; and

The Contractor desires to furnish services and/or goods to eligible Members in accordance with the legal requirements of the Medical Assistance Program and the terms of this Agreement and to receive reimbursement for them.

Therefore, in consideration of the mutual promises herein, the parties agree as follows:

I. The Contractor and EOHHS mutually agree:

1. The term of this Contract shall be from October 1, 2026, through September 30, 2027, or such other dates as EOHHS may designate in writing to the Contractor. EOHHS has the sole and unilateral discretion to grant a Contractor's request for an alternative commencement date.

Except as otherwise provided in this section, and in **Section 5.H** of the RY27 RFA, all terms and conditions of the MassHealth program which were in effect prior to the Contract commencement date, including rates of payment, utilization review requirements, and billing procedures, shall apply to MassHealth Members who were on acute inpatient status prior to the Contract commencement date and who remain on acute inpatient status after the Contract commencement date until their date of discharge, or until their status changes from acute inpatient status, whichever occurs first. Subject to **Section 5.H** of the RY27 RFA, any provisions of the Contract which are inconsistent with the terms and conditions of the MassHealth program in effect prior to the Contract commencement date shall not apply to such Members prior to their discharge or change from acute inpatient status, whichever occurs first. The terms of this Contract will apply to: a) Members admitted to the Acute Hospital or converted to Administrative Day or Administrative Psychiatric Day status on or after the Contract commencement date; b) Members treated on an outpatient and/or emergency basis beginning on or after the Contract commencement date; and c) Members for whom an Administrative Day, Psychiatric or Rehabilitation Unit per diem payment applies on or after the Contract commencement date, regardless of the date of admission.

2. Either party may terminate this Contract upon written notice given no less than 30 days prior to the termination date.

3. If EOHHS determines that the Contractor has breached this Contract or has otherwise violated the laws, regulations, or rules that govern the MassHealth Program, EOHHS may take any actions set forth in 130 CMR 450.000 et seq., or anywhere in this Contract, including the RFA, including but not limited to sanctions, fines, suspension, and/or termination of this Contract. EOHHS shall give notice to the Contractor

specifying all such breaches or violations and shall inform the Contractor of all applicable appeal rights contained in the Medical Assistance Program regulations. EOHHS shall make all such appeal rights available to the Contractor so long as the Contractor makes a proper and timely request for each appeal right.

No provision in this Contract or RFA shall be construed to limit the generality of this paragraph.

Upon breach of this Contract by EOHHS, the Contractor may terminate this Contract upon 30 days' prior written notice to EOHHS.

4. If EOHHS determines that the continued participation of the Contractor may endanger the health, safety, or welfare of Members, EOHHS, without prior notice or hearing, may immediately suspend the Contractor from participation in the MassHealth Program and take other appropriate administrative actions against the Contractor. In such event EOHHS shall notify the Contractor in writing of the reasons for the immediate suspension and of the appeal rights available to the Contractor in accordance with 130 CMR 450.000 *et seq*.

5. Amendments, Notice to Parties, Compliance with Laws, and Other Important Terms

a. Amendments and revisions determined necessary by EOHHS:

i. EOHHS may revise payment rates, methodology, and/or billing instructions, as it determines necessary. EOHHS may amend any term of this Contract, as it determines necessary. Without limiting the generality of the foregoing, EOHHS may make such amendments as it deems necessary to comply with CMS requirements relating to services provided by or through Hospitals, their Outpatient Departments or Satellites, and Hospital-Based Physicians. Except as provided in **Sections I.5.b** and **I.5.c** below, EOHHS shall provide the Contractor with 30 days' written notice prior to implementing any amendment to the terms of the Contract. In the event that EOHHS provides notice of any such amendment to the Contract, EOHHS, upon the Contractor's request, shall provide such data and calculations, if applicable, as form the basis for the amendment.

ii. Except as provided in **Sections I.5.b** and **I.5.c** below, upon notification by EOHHS of any amendment to the Contract, the Contractor shall respond in one of the following ways: (a) submit to EOHHS an executed original of such amendment within 30 days; or (b) terminate its participation in the MassHealth program upon 30 days' prior written notice to EOHHS, given at any time during the 30-day notice period.

In the event that the Contractor does not act in accordance with the alternatives stated in the preceding paragraph, EOHHS may exercise its discretion either to terminate for cause (upon 30 days' prior written notice) or continue the Contractor's participation in the MassHealth Program.

Where EOHHS opts to continue the Contractor's participation in MassHealth, EOHHS shall notify the Contractor whether pre- or post-amendment methodology, rates, and Contract provisions shall apply.

b. If (1) the Legislature directs MassHealth to make a payment adjustment to any specific Contractor or group of Contractors which would affect payments during the term of this Contract; or (2) the provisions of Title XIX of the Federal Social Security Act would permit adjustments to Safety Net Care Pool payments, or payments to Essential MassHealth Hospitals or High Medicaid Volume Safety Net Hospitals (as otherwise described in **Sections 5.D** and **5.E** of the RY27 RFA); or (3) the provisions of Title XIX, Title XXI or waivers thereof, as interpreted by CMS, would require adjustments to payments or methods of payment; or (4) EOHHS determines that an amendment is necessary to correct rates for any Contractor or group of Contractors so that rates are in conformity with the methodologies specified in the RFA; or (5) EOHHS determines an amendment is necessary to comply with the Governor's exercise of authority under Section 9C of Chapter 29 of M.G.L., EOHHS may make amendments to the Contracts of the specific Contractors affected (which may be all Contractors in EOHHS' discretion) without the advance notice required by **Section I.5.a** above. Any such amendments shall become effective as stated in EOHHS' notice to the Contractor(s) affected. In the case of item (5) of this **Section I.5.b**, above, EOHHS may instead, at its option, take all actions necessary to implement the Governor's exercise of authority under Section 9C of Chapter 29 of the general laws by sending written notice to the Contractors affected (which may be all Contractors in EOHHS' discretion) stating that EOHHS has determined that payments as specified in the notice have been subject to the Governor's exercise of authority under Section 9C of Chapter 29 of M.G.L. Any such notice shall be effective as stated in EOHHS' notice to the Contractor(s).and shall act to amend the Contract(s) without further action of the parties.

c. If EOHHS determines that events beyond the reasonable control of a Contractor adversely affect the Contractor's ability to comply with this Contract, EOHHS may make amendments to the Contracts, including rates of reimbursement hereunder, of those Contractors with regard to which EOHHS has made such determination. EOHHS may make such amendment without the advance notice required by **Section I.5.a** above. Any such amendment shall become effective pursuant to the provisions of **Section I.5.b** above. In determining whether an event is beyond the reasonable control of the Provider, EOHHS shall consider, but shall not be limited to considering, whether such event results from acts of God, strikes, lockouts, fire, civil commotion, casualties or other similar circumstances.

6. EOHHS shall give the Contractor at least 30 days' notice of all general changes in billing specifications and instructions which require Hospital computer enhancement,

unless state or federal law requires implementation sooner than 30 days.

7. **Reserved**

8. This Contract shall be governed by and construed in accordance with the laws of the Commonwealth of Massachusetts. The terms of this Contract shall be construed, to the extent possible, to be consistent with applicable federal and state laws and regulations. If a court finds any provision of this Contract to be illegal or ineffective, the remainder of this Contract shall not be affected thereby.

9. Failure by the Contractor or EOHHS, in any instance or series of instances, either to exercise any of its rights or to insist on the performance of any of the other party's duties under this Agreement, shall not be construed as a waiver by the Contractor or EOHHS of its rights or of the other party's duties under this Agreement.

10. Notwithstanding any other provision of this Contract, EOHHS may, at its option, recover amounts owed by Contractor to EOHHS, or offset any payment obligations under this RFA against amounts owed by the Contractor to EOHHS, as determined by EOHHS.

11. No person not executing this Contract shall be entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

12. All payments hereunder are subject to appropriation and availability of state and federal funds, as determined by the Commonwealth.

II. The Contractor agrees:

1. To furnish services and/or goods that conform to the requirements for such services and/or goods as set forth in MassHealth regulations; to furnish only those services and goods that qualify as medically necessary under MassHealth regulations; and to furnish services and/or goods that conform to the professionally recognized standards of health care within the Commonwealth for the applicable Provider type and/or specialty type, or, if appropriate, that conform to the generally accepted standards within the Commonwealth for the trade.

2. To comply with all federal and state laws, waivers, regulations, rules, billing instructions, Provider bulletins, and other written statements of policy applicable to the Contractor's participation in the MassHealth Program, now existing or adopted during the term of this Agreement.

3. To comply with all applicable provisions of 45 CFR 160, 162 and 164 (the Health Insurance Portability and Accountability Act of 1996, or HIPAA), M.G.L. c. 66A (Massachusetts Fair Information Practices Act), 42 CFR Part 2 (Federal Substance Use Disorder Confidentiality Regulations), and 42 CFR 431, Subpart F (Federal Medicaid Safeguards) and to execute, at EOHHS' direction, a Trading Partner Agreement and any and all other agreements and amendments EOHHS determines are necessary to meet the requirements of HIPAA or other applicable laws or

regulations.

4. That all information submitted to MassHealth that has been incorporated by reference into this Agreement is to the best of the undersigned's knowledge and belief, true, accurate, and complete. Any information submitted to MassHealth concerning future changes in or amendments to the information submitted must, to the best of the undersigned's knowledge and belief, be true, accurate, and complete. The undersigned shall use his/her best efforts to obtain and verify as provided herein, all information that has been or will be submitted to MassHealth.

5. To notify EOHHS in writing:

a. Of any change in the information submitted in response to the RY27 RFA within 30 days of the date on which the Contractor becomes aware of such change;

b. Of any written communication by a regulatory, certifying, or licensing authority that indicates an intention, conditionally or otherwise, to revoke, void, suspend, delay, or deny the issuance, renewal, or extension of any license, certificate, or other statement of qualification that constitutes an eligibility criterion for the Contractor's participation in the MassHealth program, within 10 days of receiving such communication;

c. Of any intention by the Hospital to file for bankruptcy or to otherwise surrender, terminate, or substantially modify any license, certificate, or other statement of qualification, within 10 days; and

d. At least 20 days prior to any closure, merger, sale of assets, or other transaction involving the identity, licensure, ownership, or operation of the Contractor, which notification shall include, but not be limited to, any and all communications between the Department of Public Health and any party to the transaction, and any agreement setting forth the terms of the transaction.

In addition, notwithstanding any other provision herein, the Contractor will provide EOHHS with the following information at least 20 days prior to any closure, merger, sale of assets, or other transaction involving any change to the identity, licensure, ownership, or operation of the Contractor (hereinafter, "merger"):

i. Number, location and current Provider number of each facility to remain open after the merger;

ii. Number of beds licensed for medical/surgical patients to remain in use at each facility after the merger;

iii. Number and description of each type of beds licensed for non-medical/ surgical patients to remain in use at each facility after the merger;

iv. Number, location and current Provider numbers of Outpatient Departments

to remain open after the merger;

v. Number, location and current Provider numbers of Hospital-Licensed Health Centers and other Satellite Clinics to remain open after the merger;

vi. Number, location and current Provider numbers of Emergency Departments to remain open after the merger;

vii. Proposed date of the merger and proposed dates of any and all related transactions;

viii. List and description of any and all changes to proposed service delivery after the date of the merger;

ix. The name of the entity that will own the Hospital after the date of the proposed merger;

x. The name of the entity that will manage the Hospital after the date of the proposed merger; and

xi. Any other merger-related information that EOHHS, at its discretion, may request as necessary for purposes of determining whether the new Hospital entity will qualify for an agreement pursuant to the RFA and this Contract, and, if so, what the appropriate rates for that new entity should be.

In addition, the Contractor must comply with all other related provisions in this Contract and the RFA, including but not limited to the following: **Item 11** of **Appendix B**; **Appendix E**; and **Section II.8** of **Appendix A** regarding information providers must disclose upon a change in ownership and control.

If a Hospital fails to consummate any proposed merger after notifying EOHHS pursuant to the provisions above, it shall notify EOHHS immediately that it does not intend to merge.

6. That, without limiting any of its other rights pursuant to the RFA, this Contract, or at law, if the Contractor fails to comply with the notification and submission requirements of **Section II.5**, EOHHS reserves the right to take any or all of the following actions:

a. Withhold or otherwise adjust payments under this Contract and the RFA;

b. Terminate the Contract;

c. Refrain from executing an Agreement pursuant to the RFA with any successor Hospital entity involved in the merger;

d. Impose sanctions pursuant to 130 CMR 450.238-240 if the new Hospital entity fails to have a completed MassHealth Provider application as of the date of the merger and continues to bill MassHealth for services under the pre-merger Provider number;

e. Impose a penalty according to specific circumstances of the situation for each breach of this Contract.

7. To comply with (1) the requirements of 42 CFR 431.107(b)(4) and 42 CFR Part 489, Subpart I, relating to the maintenance of written policies and procedures regarding advance directives; and (2) the requirements of 130 CMR 450.112.

8. To comply with the disclosure requirements set forth at 42 CFR 455.100 et seq. and 42 CFR 1002.3(a), including, without limitation, submitting within 35 days after the date of a request by the United States Secretary of Health and Human Services or MassHealth, full and complete information related to business transactions as set forth in 42 CFR § 455.105. For purposes of making disclosures to EOHHS as required by 42 CFR 455.100 et seq. and 42 CFR 1002.3, the Contractor agrees to: (a) use any form required by EOHHS for such purpose, unless otherwise directed by EOHHS; (b) fully and accurately complete any such EOHHS-supplied form (or such portions thereof as directed by EOHHS); and (c) sign, date and return the form to EOHHS within the required time period. The Contractor should refer to 42 CFR 455.100 et. seq. and 42 CFR 1002.3, as necessary.

EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section II.8** or due to the information contained in the Contractor's disclosures. In addition, the Contractor shall not be entitled to payment for any MassHealth services for which EOHHS reasonably determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238 et seq. to impose sanctions.

9. To keep such records as are necessary to disclose fully to EOHHS, EOHHS' designees, or any other federal or state agency that has a legal right of access to such records the nature and extent of the services and/or goods furnished to eligible Members for each claim submitted to MassHealth; to maintain in these records all information required both by MassHealth and by generally accepted standards for record keeping within the applicable Provider type; to keep such records for a period of six years from the date the service was furnished or the goods delivered, or longer if so dictated by the generally accepted standards for record keeping within the applicable Provider type, or if required by MassHealth regulations.

10. To furnish on request all information maintained pursuant to **Section II.9**, above, to EOHHS or its designees, or to any other federal and state officials and agencies authorized by law to inspect such information, or their designees, including the United States Secretary of Health and Human Services, the Comptroller General of the United States, the Governor of Massachusetts, the Massachusetts Secretary of Administration and Finance, the Massachusetts State Auditor, and the Massachusetts Medicaid Fraud Division (MFD) of the Office of the Attorney General; and to allow these officials, agencies or their designees to examine and photocopy all information

maintained pursuant to **Section II.9**, above, including medical records, at reasonable times and upon reasonable notice, at the location where these records are normally stored if such location is within the Commonwealth of Massachusetts, or at EOHHS' Central Office in Boston, Massachusetts, if the normal storage location is outside the Commonwealth.

11. To furnish reimbursable services and/or goods of the type furnished by the Contractor to any eligible Member who requests such services, without regard to race, color, religion, national origin, sex, age, disability, or status as a recipient of public assistance, including Medical Assistance, except as required or permitted by governing program regulations, in compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.) and its implementing regulations at 45 CFR part 80; Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794 and its implementing regulations at 45 CFR Part 84; M.G.L. c. 151B, § 4(10)); the Americans with Disabilities Act of 1990 (Pub. L. 101-336) codified at 42 USC § 12101 et. seq.; Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92; and other applicable federal and state laws or regulations.

12. To accept as payment in full the reimbursement methodology, rates of payment and payment rules set forth in the RY27 Acute Hospital RFA, which is attached and incorporated herein by reference. The Contractor further agrees that such methodology and rates are subject to adjustment to: (a) avoid, and only in the amount of, any duplicate payment in the event special program initiatives of the Commonwealth provide alternative reimbursement for Hospital services or certain Hospital services; (b) meet federal requirements; (c) revise the rates for future Rate Years; (d) revise rates in accordance with **Section I.5**, above; and (e) as EOHHS otherwise may deem necessary and to the extent permitted under relevant federal law.

13. Reserved

14. To comply with all information security programs, plans, guidelines, standards and policies that apply to performance under this Contract, that it will communicate these requirements to and enforce them against their subcontractors, and that it will implement and maintain any other reasonable and appropriate security procedures and practices necessary to protect personal information from unauthorized access, destruction, use, modification, disclosure or loss.

15. To notify EOHHS in writing within ten (10) calendar days if the Contractor or, where applicable, any of its subcontractors receives or identifies any information that gives them reason to suspect that a MassHealth Provider or Member has engaged in fraud as defined under 42 CFR 455.2. In the event of suspected fraud, no further contact shall be initiated with the Provider or Member on that specific matter without EOHHS' approval.

The Contractor and, where applicable, its subcontractors shall cooperate fully with the Office of the Attorney General's Medicaid Fraud Division (MFD) and the Office of the State Auditor's Bureau of Special Investigations (BSI). Such cooperation shall include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding Medicaid fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

16. The Contractor is qualified and shall at all times remain qualified to perform this Contract; that performance shall be timely and meet or exceed industry standards, including obtaining requisite licenses, registrations, permits and resources for performance; and that the Contractor shall provide access to records to state officials under Executive Order 195 and M.G.L. c. 11, s.12; and the Contractor certifies that the Contractor and any of its principals, subcontractors or affiliates are not currently debarred or suspended by the federal or state government under any law or regulation including, without limitation, Executive Order 147; M.G.L. c. 29, s. 29F and M.G.L. c. 152, s. 25C.

17. To accept any changes to the Contract deemed necessary by EOHHS resulting from the Governor's exercise of authority under **Section 9C** of Chapter 29 of the general laws, and implemented pursuant to written notice by EOHHS in accordance with **Section I.5.b**.

18. That notwithstanding any other provision of this Contract, MassHealth may, at its option, recover amounts owed by the Contractor to MassHealth, or offset any payments under the RFA and this Contract against amounts owed by the Contractor to MassHealth, as determined by MassHealth.

19. Comply with health information technology requirements, as detailed in **Appendix P**

III. EOHHS agrees:

1. To reimburse the Contractor according to the methodology and at rates of reimbursement set forth in the Acute Hospital RFA attached and incorporated by reference herein, for all reimbursable services and goods actually and properly delivered to eligible Members and properly billed to MassHealth in accordance with the terms of this Agreement and in accordance with and subject to all applicable federal and state laws, waivers, regulations, rules, fee schedules, billing instructions, Provider bulletins, and other written statements of policy as they may be amended from time to time. Such rates are subject to change in accordance with **Section II.12**, above.

2. To maintain, in accordance with applicable MassHealth regulations concerning privacy of Member records, all records furnished to EOHHS pursuant to the

requirements of **Section II.9**, above.

3. To undertake to send to the Contractor, upon request, the Provider manual applicable to each type of service to be furnished by the Contractor as indicated in the eligibility information section of the Provider application, which is incorporated by reference into this Agreement.

IV. The Contractor and EOHHS mutually agree that the entire Agreement of the parties is contained in this Contract taken together with the laws, waivers, regulations, rules, fee schedules, billing instructions, Provider bulletins, and other written statements of policy that govern the MassHealth program; that this Contract supersedes all previous agreements, negotiations, and verbal agreements between the parties concerning the RFA and Contract, including any prior year RFA and Contract; and that the following will be deemed to be part of this Contract:

1. Any special conditions that indicate they are to be incorporated into this Contract and that are signed by both parties to this Contract;
2. The Rate Year 2027 Acute Hospital RFA dated September , 2026, all appendices and attachments thereto;
3. Information and documentation required by EOHHS in response to the Acute Hospital RFA; and
4. The Provider application(s) and supporting documentation of the below-named Contractor, which is required to be on file with MassHealth and supporting documentation and any changes or amendments thereto accepted and agreed to by EOHHS.

In the event of any conflict among the documents that are a part of this Contract and any regulation now existing or hereinafter adopted by MassHealth, the terms of the Contract shall prevail.

The Contractor hereby represents and warrants that it is the licensee of the below-named Hospital facility(ies).

The person signing this Agreement on behalf of the Contractor warrants that he/she has actual authority to bind the Contractor. The person signing this Agreement on behalf of the Contractor must be listed as an authorized signatory on the Hospital's submitted Contractor Authorized Signatory Listing.

Contractor	**Executive Office of Health and Human Services**
(Legal Name of Licensee)	
(Name[s] of Hospital[s], if Different)	
(Signature)	(Signature)
Name	Ryan Schwarz, MD, MBA Name
Title	Assistant Secretary for MassHealth Title
Date	Date

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX B:

APPLICATION FOR PARTICIPATION

Instructions

Complete and sign the attached application and chart (one original for each licensee) and submit them, along with all other required documentation, in accordance with **Sections 9, 10, 11, and 12 of the RFA, by the date and time listed in Section 13 of the RFA**. One application is required for each Hospital licensee which will cover all facilities, locations, and satellite clinics operating under its Hospital license.

1. Name of Licensee: _____

2. Address of Licensee: _____

3. DBA(s) (if different): _____

4. Name of Chief Executive Officer (CEO): _____

Address of CEO: _____

Telephone Number: _____

E-mail: _____

Fax: _____

5. Name of Chief Financial Officer (CFO): _____

Address of CFO: _____

Telephone Number: _____

E-mail:_____

Fax: _____

6. Additional contact person regarding application: _____

Name: _____

Title: _____

Address: _____

Telephone:_____

E-mail:_____

Fax: _____

7. Person authorized to execute Contract:_____

Name: _____

Title: _____

8. Site-Specific Information: Please provide the indicated information for each facility, location and satellite clinic that operates under the licensee's hospital license.

SITE NAME (DBA)	SITE STREET ADDRESS	CITY/TOWN	STATE	ZIP	TAX ID	MASSHEALTH PROVIDER ID/SERVICE LOCATION (PID/SL)	NPI	MEDICARE PROVIDER ID	TAXONOMY CODE	INDICATE TYPE OF SITE (Inpatient, Outpatient Department, HLHC, Other Satellite Clinic, or School-Based Health Center [SBHC])

9. a. For each HLHC and other Satellite Clinic listed in the table above, the Hospital must attach documented evidence of CMS provider-based status. Such documentation may include a written provider-based determination from CMS, copies of voluntary Medicare provider-based attestation forms, or attestation from the Hospital that the Satellite Clinic has

grandfathered status. Please use additional sheets as needed.

b. If any HLHC or Satellite Clinic listed in the table above is also a Federally Qualified Health Center, identify that HLHC or Satellite Clinic here by its Site Name(s):_____. Please use additional sheets as needed.

10. Does the applicant hospital have a Critical Access Hospital designation?

yes _____ no_____

11. Has there been a merger, purchase, or change of ownership affecting the applicant Hospital since the effective date of the RY26 RFA?

yes _____ no_____

If so:

- Please describe the transaction.
- Please attach a sheet showing the name of the previous owner, operator, and licensee, and the MassHealth Provider number issued to that Provider. MassHealth Provider numbers are not transferable.
- Please submit a copy of the applicant Hospital's "Notice of New Employer Identification Number" assigned from the Department of the Treasury, Internal Revenue Service.

12. Please submit with this application an organizational chart for the licensee that includes all Hospital sites and Satellite Clinics, and that clearly indicates the name, title and reporting structure for all key personnel.

13. Please submit with this application:

a. A copy of the most recent Executive Summary report issued by The Joint Commission (TJC) or other nationally recognized hospital accreditation organization with deeming authority from CMS acceptable to EOHHS ("Other Acceptable Hospital Accreditation Organization") that outlines evidence of compliance for all standards required for accreditation; and

b. As applicable:

   i. A letter removing requirements for improvement to priority areas mentioned in the report, or

   ii. Documentation of application for renewal of accreditation to TJC or Other Acceptable Hospital Accreditation Organization

14. Applicants must submit with this application a copy of their current unexpired Acute Hospital License as issued by the Department of Public Health, as well as the name and address of each site.

15. Are more than 50% of the Applicant's hospital beds licensed as medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by DPH?

yes _____ no_____

16. Are more than 50% of the Applicant's hospital beds currently utilized exclusively as either medical/surgical, intensive care, coronary care, burn, pediatric (Level I or Level II), pediatric intensive care (Level III), maternal (Obstetrics), or neonatal intensive care beds (Level III), as determined by EOHHS?

yes _____ no_____

ACKNOWLEDGEMENT

This RFA requires that all information required by the most recent MassHealth provider application(s) of the applicant Hospital, as well as all required supporting documentation, be current, complete, and accurate. In response to this item, the applicant must attach all additional information and/or documentation, which is necessary to update, complete or correct such application(s). In addition, MassHealth participating Hospitals have a continuing obligation to submit promptly all additional information and/or documentation to reflect any changes to previously submitted documentation and/or information pursuant to this RFA.

I, _____ , hereby certify that the information submitted in response to the Acute Hospital Request for Applications, including this Application for Participation in **Appendix B,** is current, complete and accurate.

This application is signed under the pains and penalties of perjury.

_____

Signature of Person Authorized to Execute Contract

_____

Date

_____

Name and Title (Please Print)

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX C:

RY27 INPATIENT SERVICE RATES

Appendix C of each Hospital's Contract contains the Hospital's specific Inpatient Service Rates or rate components applicable to RY27. **Appendix C** also incorporates by reference **Chart B**, which lists In-State Acute Hospital Rates, and **Chart C**, which lists the MassHealth DRG Weights and the corresponding DRG-specific Mean All-Payer Length of Stay applicable to RY27.

Charts B and **C** are available on the MassHealth "**Special Notices for Acute Hospitals**" webpage as "**Chart B – In-State Acute Hospital Rates**" and "**Chart C – Acute Hospital RY27 MassHealth DRG Weights and Mean All-Payer Lengths of Stay**", under the heading "Federal Fiscal Year 2027 Notices".

Chart A - Out-of-State Acute Hospital Rates is also available on the same webpage under the heading "Federal Fiscal Year 2027 Notices".

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX D:

RY27 APEC RATES

Appendix D of each Hospital's Contract contains the Hospital's specific APEC rate components applicable for dates of service in RY27. **Appendix D** also incorporates by reference **Chart B**, which lists In-State Acute Hospital Rates, and **Chart D**, which lists the MassHealth EAPG Weights applicable to RY27.

Charts B and **D** are available on the MassHealth "Special Notices for Acute Hospitals" webpage as "**Chart B – In-State Acute Hospital Rates**" and "**Chart D – Acute Hospital RY27 MassHealth EAPG Weights**", under the heading "Federal Fiscal Year 2027 Notices".

Chart A - Out-of-State Acute Hospital Rates is also available on the same webpage under the heading "Federal Fiscal Year 2027 Notices".

Note: The Solventum EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the Episode's claim detail line MassHealth EAPG Weights to produce the claim detail line's Adjusted EAPG Weight that is used in the APEC calculation.

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX E:

ADDITIONAL REQUIRED DOCUMENTATION AND INFORMATION

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1. Is the licensee of the applicant Hospital the operator of the Hospital facility?

   yes _____ no_____

   If not, the following information must be provided:

   Name of Operator: _____

   Address of Operator:_____

   _____

   Telephone Number: _____

2. Is the licensee of the applicant Hospital the owner of the real estate that comprises the Hospital facility?

   yes _____ no_____

   If not, the following information must be provided:

   Name of Landlord: _____

   Address of Landlord: _____

   _____

   Telephone Number: _____

3. If the licensee of the applicant Hospital is a not-for-profit corporation, it must provide the following document:

   A current (i.e., dated August 1, 2026, or later, and still in effect as of October 1, 2026)

scanned original "Short Form Certificate of Legal Existence", which Massachusetts corporations may obtain from:

Secretary of State's Office
Corporate Division
One Ashburton Place - Room 1715
Boston, MA 02108

Note: Foreign (non-Massachusetts) not-for-profit corporations must submit equivalent documentation from the Secretary of State where incorporated, and a copy of the corporation's Massachusetts Foreign Corporation Certificate.

4. If the licensee of the applicant Hospital is a for-profit corporation, it must provide the following document:

   A current (i.e., dated August 1, 2026, or later, and still in effect as of October 1, 2026) scanned original "Short Form Certificate of Legal Existence with Officers", which Massachusetts corporations may obtain from the Secretary of State's Office at the address listed above.

   Note: Foreign (non-Massachusetts) for-profit corporations must submit equivalent documentation from the Secretary of State where incorporated, and a copy of the corporation's Massachusetts Foreign Corporation Certificate.

5. If the licensee of the applicant Hospital is a corporation, it must submit a current scanned original Clerk's Certificate (1) certifying that the individual executing the contract on behalf of the licensee of the applicant Hospital has the authority and is authorized to do so; and (2) listing the names and titles of all current officers.

6. If the licensee of the applicant Hospital is not a corporation (e.g., limited partnership or trust), appropriate evidence of legal existence must be provided.

Signature _____

Print name _____

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX F:

SECURITY STANDARDS CONTRACTOR CERTIFICATION FORM

HOSPITAL LEGAL NAME: _____

For all Contracts involving the Contractor's access to personal information, as defined in M.G.L. c. 93H, personal data, as defined in M.G.L. c. 66A, or protected health information, as defined in 45 C.F.R. Part 160, owned or controlled by Executive Department agencies, or access to agency systems containing such information or data (herein collectively "personal information"), Contractor certifies under the pains and penalties of perjury that the Contractor (1) agrees to protect any and all personal information; and (2) has reviewed and agrees to comply with all of the Commonwealth of Massachusetts EOTSS' Security Policies under Policies and Standards.

The Executive Department agency providing Contractor access to any system containing personal information retains the right, in its own discretion, with or without cause, to terminate the access granted at any time.

Notwithstanding any contractual provision to the contrary, in connection with the Contractor's performance under this Contract, for all state agencies in the Executive Department, including all executive offices, boards, commissions, agencies, departments, divisions, councils, bureaus, and offices, now existing and hereafter established, the Contractor shall:

(1) obtain a copy, review, and comply with the contracting agency's Information Security Program (ISP) and any pertinent security guidelines, standards and policies; (2) comply with all of the Commonwealth of Massachusetts Executive Office of Technology Services and Security (EOTSS) Security Policies ("Security Policies") available at https://www.mass.gov/orgs/executive-office-of-technology-services-and-security under Policies and Standards;

(2) communicate and enforce the contracting agency's ISP and such Security Policies against all employees (whether such employees are direct or contracted) and subcontractors;

(3) implement and maintain reasonable technical and administrative safeguards to protect personal information to which the Contractor is given access by the contracting agency from the unauthorized access, destruction, use, modification, disclosure or loss;

(4) be responsible for the full or partial breach of any of these terms by its employees (whether such employees are direct or contracted) or subcontractors during or after the term of this Contract, and any breach of these terms may be regarded as a material breach of this Contract;

(5) in the event of a security incident, as defined by the HIPAA Security Rule, 45 C.F.R. Part 164 subpart C, or any other unauthorized access, destruction, use, modification, disclosure, or loss of the personal information (collectively referred to as the "unauthorized use"), which shall include, but not be limited to, any breach, as defined by the HIPAA Breach Notification Rule, 45 C.F.R. Part 164 subpart D: (a) immediately take all steps reasonably necessary to secure personal information; (b) mitigate to the extent practical, any actual or potential impacts stemming of the unauthorized use of personal data; (c) immediately notify the contracting agency if the Contractor becomes aware of any unauthorized use of any Executive Department agency system to which access was provided or any security incident that may impact Executive Department agency systems; (d) provide full cooperation and access to information necessary for the contracting agency to determine the scope of the unauthorized use or security incident impacting Executive Department agency systems; and (e) provide full cooperation and access to information necessary for the contracting agency and the Contractor to fulfill any notification requirements;

Breach of these terms may be regarded as a material breach of this Contract, such that the Commonwealth may exercise any and all contractual rights and remedies, including without limitation indemnification under Section 11 of the Commonwealth's Terms and Conditions, withholding of payments, contract suspension, or termination. In addition, the Contractor may be subject to applicable statutory or regulatory penalties, including and without limitation, those imposed pursuant to M.G.L. c. 93H and under M.G.L. c. 214, § 3B for violations under M.G.L. c. 66A.

Contractor/Hospital Name: _____

Contractor/Hospital Authorized Signature: _____

Print Name and Title of Authorized Signatory: _____

Date: _____

This Certification may be signed once and photocopied to be attached to any Commonwealth Contract that does not already contain this Certification Language and shall be interpreted to be incorporated by reference into any applicable contract for this Contractor.

Refreshed 3/27/2024

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX G:

DEPARTMENT OF MENTAL HEALTH, DIVISION OF CLINICAL AND PROFESSIONAL SERVICES LICENSING DIVISION – BULLETIN #19-01

March 1, 2019

Clinical Competencies/Operational Standards for DMH Licensed Inpatient Facilities

This bulletin, and the attachments hereto are issued pursuant to Department of Mental Health (DMH) regulations 104 CMR 27.03(5)&(8), which provide that DMH "may establish clinical competencies and additional operational standards for care and treatment of patients admitted to facilities[1] licensed pursuant to 104 CMR 27.00, including for specialty populations." The purpose of this regulatory provision is to assist the Department in assuring that DMH licensed facilities have the capability to provide the level of care needed by individuals who meet criteria for inpatient hospitalization, thereby increasing access to services required by citizens of the Commonwealth.

The attached clinical competencies/standards were developed by a broad stakeholder group that included DMH clinical and licensing staff, representatives of DMH licensed facilities, public and commercial payers, and professional trade associations. They are intended as guidelines to inform practice and to provide a baseline for DMH licensing reviews of individual facility's compliance with licensing regulations. The competencies/standards cover the following areas:

- Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric units within General Hospitals
- OMITTED
- Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk
- Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ID/DD)
- Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

While it is expected that all facilities will generally be able to meet the clinical competencies/standards (including provision of services and equipment), it is not necessarily

[1] The term "facility" as used in this bulletin includes DMH licensed units within general hospitals.

expected that each facility will have the resources or staff available at all times to meet all competencies and standards at all times, as circumstances within facility at any given time may limit its ability to be in compliance. Facilities must, however, have a plan in place to provide additional staff coverage or equipment as may be needed to facilitate admission of patients who require such coverage or equipment, and should be prepared to engage with public and commercial payers proactively as indicated.

The DMH Licensing Division will begin referring to the attached competencies/standards in its licensing reviews beginning May 1, 2019.

Questions regarding this bulletin should be directed to the DMH Licensing Division at 617-626-8117 or DMH.Licensing@massmail.state.ma.us.

Attachments:

- Clinical Competencies/ Operational Standards Related to Co-occurring Medical Conditions: Psychiatric units within General Hospitals
- OMITTED
- Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk
- Clinical Competencies/ Operational Standards Related to Co-occurring Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ ID/ DD)
- Clinical Competencies/ Operational Standards Related to Co-occurring Substance Use Disorders (SUD)

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Co-Occurring Medical Conditions

Psychiatric Units within General Hospitals

Psychiatric units in general hospitals are expected to have the capability, or the ability to secure the capability within a reasonable period of time (in hours or, for very complex medical care needs, days), to provide necessary medical care to patients requiring inpatient psychiatric hospitalization who also have medical conditions requiring the following services.

Each inpatient psychiatric unit in a general hospital shall have policies to assure that it has the capacity to provide care for persons with the following medical needs or conditions. If resources are not immediately available for patients with certain medical conditions, the facility must have a plan to secure the resources necessary to provide the care (e.g., securing "just in time" training for nurses from a specialty nurse educator, availability of a specialist to consult with the attending psychiatrist, etc.) through training, supplemental staff, etc. within a reasonable period of time:

- Intravenous (IV) hydration
- Continuous Positive Airway Pressure (CPAP)
- Diabetes Care
- Oxygen Therapy
- Alcohol Detoxification (See specific competencies required for treatment of co-occurring Substance Use Disorders)
- Opiate Detoxification (See specific competencies required for treatment of co-occurring Substance Use Disorders)
- Methicillin-resistant Staphylococcus aureus (MRSA) or other antibiotic-resistant infections or communicable infections
- Assistive devices/specialty equipment (e.g., walkers, canes, wheelchairs, hospital beds, specialty mattresses)
- Occupational Therapy (OT)/ Physical Therapy (PT)

- Anticoagulation therapies
- Eating disorders
- Incontinence
- Foley catheter
- Ostomy care
- Seizures – History and/ or risk of
- Respiratory conditions
- Wound care (any stage)
- Patient in need of in-house Lab services
- Patient in need of internal medicine resources on site

Each facility shall ensure that all staff designated to provide the listed services receive education and demonstrate competencies (i.e., upon hire, as needed, and/ or annually) that are consistent with their role in patient care regarding the above competencies. Each facility shall further ensure that medical and nursing care staff are trained in and can demonstrate knowledge of the facility's policy or plan for securing the resources necessary to provide the listed services and to provide just-in-time training to all staff who will provide care to the patient being admitted.

DMH recognizes that some capabilities may be beyond the capacity of certain general inpatient units within general hospitals. It is necessary; however, that these capabilities be present within the Commonwealth's hospital system, even if they may require extra resources, transportation or preparation. Facilities are encouraged to develop these capabilities, either through direct service arrangements, affiliations with outside providers or otherwise. These capabilities include, but are not limited to:

- IV medications
- Bilevel Positive Airway Pressure (BiPAP)
- Dialysis
- Suction
- Nasogastric (NG) Tube
- Eating disorders – severe restrictive or purging
- Pregnancy

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why

mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - *Documentation of Unit Conditions and Facility Denial of Inpatient Care* and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Severe Behavior/ Assault Risk

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization and who present with high level of acuity, including severe behavior and assault risk.

Each general inpatient psychiatric facility shall assure that it has the capacity to:

- Provide treatment to patients with severe behavior/assault risk, including evaluating patients during the intake and admissions process to determine if additional staffing supplementation is required.
- Adjust staffing levels to meet varying levels of unit acuity.
- Evaluate and document care needs during the referral and acceptance process which serves as preparation for direct care staff and others to incorporate risk and individualized crisis prevention planning (ICPP) upon admission. (While safety tools are generally completed within 48 hours of admission, a person admitted with this risk level should have their safety tool or ICPP completed as soon as possible after arrival.)
- Provide a range of intervention approaches to address the needs of patients with higher levels of acuity. Aggressive, assaultive patients may benefit from behavior management plans, anger management, relaxation techniques, occupational therapy, and social skills development. Consideration for consultation with behavior specialists should be given.
- Provide ongoing training and demonstration of competencies in verbal de-escalation, including hands on experience, to reduce likelihood of harm.

  De-escalation and Preventative Skills that can assist direct care staff to safely respond to patient agitation or aggression include but are not limited to:

  - Motivational Interviewing
  - Trauma Informed Care
  - Person-Centered Approaches
  - Stigma/ Countertransference
  - Mindfulness
  - Flexible Rules
  - Strength-based interventions
  - Approachability of staff for providing help

    - Anger Management
    - Leadership Rounds regularly on units
- Security specialists/ guards who may participate in direct interactions with patients experiencing episodes of severe behavior or assault risk should have training (e.g., CPI, Handle With Care, MOAB) that is consistent with training received by the direct care psychiatric inpatient staff, as should any additional staff who may participate in such episodes.
- Ensure robust debriefing processes, including incidents that qualify as "near misses."
- Provide Medication Management with proactive use of PRNs and use of withdrawal protocols as indicated.
- Ensure that staff on all shifts have access to Sensory Tools, and the training required to select and work with patients to use these tools as coping skills and methods for decreasing frustration and aggression.
- Involve community treaters, state agency representatives, and the legal system (if involved) in treatment and discharge planning as soon as possible after admission in order to assess the patient's current continuum of care and foster successful outcomes.
- Ensure that wraparound community services are in place (e.g., get/fill medications, an outpatient medication/injection clinic (if needed), access transportation to appointments, stable housing, and case management).
- Engage patients who are identified as having "personality disorders or traits," utilizing Trauma Informed Care (TIC), Motivational Interviewing (MI), Sensory Tools, attention to diet (e.g., polydipsia, excessive caffeine or sugar intake), and Mindfulness Training.
- Work with court system, families and/ or guardians to expedite the process of commitment if necessary.
- Provide increased security presence, specialized psychopharmacology interventions, and active treatment with the patient to identify and practice greater behavioral control skills.
- Ensure all staff receive consistent education and maintain current trainings and certifications (i.e., upon hire, as needed, and annually) to work with and care for these patients.

Each general inpatient psychiatric facility is recommended to consider:

- When possible, create flexibility in the physical plant for non-restraint and seclusion management of behavior. This can involve providing special observation/single rooms and higher staffing ratios for patients requiring assault precautions to mitigate the risk to roommates and other patients on the unit. It is ideal that a unit be able to provide a distinct, spacious area for the most acute patients with specialized group programming, activity space, and comfort space (if possible). Patients could move to the regular section

of the milieu when able to tolerate more stimulation.

- Consideration should be given to the inclusion of Peer Support Specialists in milieu treatment.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See *DMH Licensing Bulletin #18-01 - Documentation of Unit Conditions and Facility Denial of Inpatient Care* and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/Operational Standards Related to Co-occurring Autism Spectrum Disorder or Other Intellectual and Developmental Disabilities (ASD/ID/DD)

Inpatient psychiatric facilities licensed by the Department of Mental Health are expected to have the capability to provide care to patients who require inpatient psychiatric hospitalization, who present with Autism Spectrum Disorders or Other Intellectual and Developmental Disabilities (ASD/ID/DD), but who do not require specialized treatment due to their ASD/ID/DD beyond the competencies listed below.

Each general inpatient psychiatric facility shall assure that it has the capacity to:

- Provide care to patients with mild to moderate presentations of Autism Spectrum Disorder or other intellectual and/or developmental disabilities whose baseline level of functional impairment is mild to moderate as well. Patients with significant maladaptive behavior, inability to maintain ADLs, as well as those with significant self-injurious or violent behavior, due to their ASD/ID/DD may have needs that exceed the expected capability of a general inpatient psychiatric unit.
- Recognize the clinical needs of common co-occurring physical conditions that are associated with many patients with ASD/ID/DD (e.g., severe constipation, diarrhea, urinary tract infections, food allergies, etc.).
- Provide sensory supports for varying levels of functioning.
- Ensure all staff receive consistent education and maintain current trainings (i.e., upon hire, as needed, and annually) to work with and care for this population.
- Provide ongoing trainings and demonstration of competencies in de-escalating behaviors of patients with ASD/ID/DD, as part of the general de-escalation program.
- Evaluate and document care needs during the referral and acceptance process, and use this information to incorporate the inclusion of behavioral triggers/warning signs, as well as strengths, motivators and any sensory tools that have been successfully employed for direct care staff and the multidisciplinary team.
- Notify and collaborate with the Department of Developmental Services, as appropriate and with the Department of Education (DOE), town or city special education departments to ensure the continuity of special education services for eligible students.
- Engage the Children's Behavioral Health Initiative (CBHI) teams, Department of Education (DOE) teams, DMH, and/or DDS for consultation and discharge planning as needed.

- Minimize the difficulty with transitions, especially by providing discharge information to care managers and outpatient services. Ideally, the same team members (both inpatient and outpatient) would work with these patients as they move across the care continuum.
- Work with families and other caregivers before discharge to enhance successful transition of level of care and reduce recidivism.

Each general inpatient psychiatric facility is recommended to consider:

- Flexible availability of a separate, designated, less stimulating space is best.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - *Documentation of Unit Conditions and Facility Denial of Inpatient Care* and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Department of Mental Health

Inpatient Licensing Division

Clinical Competencies/ Operational Standards Related to Co-Occurring Substance Use Disorders (SUD)

The Department of Public Health Bureau of Substance Addiction Services (BSAS) licenses inpatient psychiatric facilities that also provide a separate, identifiable inpatient SUD treatment program. Such units/ facilities are required to be dually licensed by DMH and BSAS.

A DMH licensed facility that provides SUD treatment or services, such as medication for addiction treatment (MAT) and/or medication for the treatment of opioid use disorders (MOUD), incidental to the evaluation, diagnostic and treatment services for which it is licensed under 104 CMR 27.00, and that does not offer a separate, identifiable inpatient substance use disorder treatment unit or program, or represent themselves to the public as providing substance use disorder treatment or services as a primary or specialty service, must comply with DMH licensing requirements at 104 CMR 27.03(11) but is not subject to BSAS licensure requirements.

As part of its licensure obligations under 104 CMR 27.00, each inpatient psychiatric facility that is not subject to BSAS licensure shall assure that it has the capacity to:

- Identify potential for addictive disorders through evidence-based screening and assessment tools during the admission assessment process.
- Evaluate for, order, assess, and provide medication assisted treatments for alcohol, benzodiazepine, and opioid withdrawal and for addictions to these substances within limitations of licensure. Medication assisted treatment, education, orientation, and initiation is required when clinically indicated. (See SAMHSA Treatment Improvement Protocol 63 –Medications for Opioid Use Disorder)

  This includes:

  - Assessing the patient for the appropriateness of induction on MAT using one of the three FDA-approved medications for the treatment of Opioid use disorder: buprenorphine, methadone, or naltrexone; and
  - Ensuring that once an induction begins, referrals for an outpatient provider (ex. OTP, OBOT) are secured.

  Any physician or other authorized hospital staff in DMH-licensed inpatient facilities can administer or dispense methadone and buprenorphine without additional state or federal oversight or approval, provide the methadone or buprenorphine is administered or dispensed incident to the patient's medical treatment for a condition other than substance use disorder. This includes MAT

induction for a patient with a secondary diagnosis of substance use disorder on either methadone or buprenorphine.

- DEA regulations[2] authorize physicians or other authorized hospital staff to administer or dispense buprenorphine or methadone in the hospital, which includes psychiatric hospitals, in order to maintain or detox a patient "as an incidental adjunct to medical or surgical treatment of conditions other than addiction". In effect, this allows a physician or other authorized hospital provider to administer or dispense MAT to patients at the hospital, without time limitation, where SUD is a secondary diagnosis.

Practitioners who are DATA- waived[3] can prescribe, administer, or dispense buprenorphine to patients in DMH-licensed inpatient facilities.

- Administer opioid antagonist, if needed. All units must have naloxone available on unit and staff trained to order/administer.
- Provide group and/ or individual therapeutic programming and patient education, provided by appropriately trained staff, which addresses recovery and relapse prevention planning related to SUD. Engage, inform, and support parents and guardians of minors with SUD (on adolescent units). Suggested training for staff may include effects of substance use disorders on the family and related topics such as the role of the family in treatment and recovery.
- Provide active discharge planning to next step placements based on the patient's care plan. Placements should address ongoing needs related to mental health, addiction, and other biopsychosocial needs and may include step down to subacute levels of care, 24 hour settings, partial hospitalization, intensive outpatient, ongoing outpatient treatment, access to peer services, and other community and housing supports as appropriate. When appropriate, discharge planning must include access to ongoing medication management, both for psychiatric and addiction medications; for continuity of treatment with the goal of reducing readmissions and the likelihood of relapse. This includes having knowledge of Clinical Stabilization/Stepdown Services (CSS) and Transitional Support Services (TSS), Outpatient Medication Management, Sober Houses, and step down to subacute

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[2] 21 CFR Part 1306.07. Note that these regulations also include the "three day rule", which allows any physician to **administer** methadone or buprenorphine **without additional state or federal oversight or approval**. This includes MAT induction for a patient being treated for acute withdrawal symptoms. The rule allows MAT treatment to relieve acute withdrawal symptoms, provided the treatment is limited to 72 hours where not more than one day's medication is administered to a person at a time. The 72-hour period cannot be renewed. For more information, see 21 CFR Part 1306.07(b).

[3] The Drug Addiction Treatment Act (DATA) of 2000 authorized physicians to dispense or prescribe buprenorphine in settings other than an opioid treatment program (OTP), subject to certain limitations. This has subsequently been expanded to also authorize nurse practitioners and physician assistants to dispense or prescribe buprenorphine, subject to certain limitations. Information on the process for submitting a waiver to SAMHSA and the DEA can be accessed here: https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

level of care.

- Understand deterrents to successful discharges such as housing, financial assistance for medication Copayments, transportation to non-24-hour programs, applying for a prescription for transportation PT-1 form for those with financial issues, etc.
- Ensure a physician dispenses buprenorphine or morphine at discharge or a DATA-waived practitioner provides "bridge" prescriptions for buprenorphine (and other medications) until outpatient appointments can be secured and prescriptions provided for in the outpatient setting.
- Provide direct care staff with a general overview of addictions medicine.

Each inpatient psychiatric facility is recommended to:

- Facilities are strongly encouraged to provide access to all FDA-approved medications for the treatment of opioid use disorder.
- Consider engaging Substance Use Recovery Coaches and/or Peer Specialists within staffing models.
- Include credentialed staff with experience in SUD treatment and resources, ideally, but not necessarily as Licensed Alcohol and Drug Abuse Counselor (LADC) or Certified Alcohol and Drug Abuse Counselor (CDAC) levels.
- Consider referrals to ensure a continuum of care for the client, including arrangements for further substance abuse treatment and post-discharge counseling and other supportive service.
- Consider entering into formal agreements (Qualified Services Organization Agreement - QSOA's) with community-based Substance Use Disorder treatment providers to support continuation of care.

A facility with available beds may deny admission to a patient whose needs have been determined by the facility medical director, or the medical director's physician designee when unavailable* to exceed the facility's capability at the time admission is sought. The medical director's determination must be written, and include the factors justifying the denial and why mitigating efforts, such as utilization of additional staff, would have been inadequate. [See DMH Licensing Bulletin #18-01 - *Documentation of Unit Conditions and Facility Denial of Inpatient Care* and 104 CMR 27.05 (3) (d).]

* The medical director's physician designee must be a physician who is vested with the full range of the medical director's authority and responsibility in the medical director's absence.

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX H:
DISCHARGE PLANNING PROCEDURES FOR MEMBERS EXPERIENCING OR AT RISK OF HOMELESSNESS

MassHealth regulations at 130 CMR 415.419 describe discharge planning requirements for members expected to require post-hospital care and services. This Appendix clarifies that a member experiencing or at risk of homelessness, as those terms are defined below, is a "member expected to require post-hospital care and services" for purposes of those regulations. Building on those regulations, the required discharge planning procedures that follow are designed to enable Acute Inpatient Hospitals (AIHs) to identify these members in a timely fashion after admission and ensure that such members have access to the post-hospital care or services that they need, including an appropriate housing setting.

I. Definitions

A Member Experiencing Homelessness is any member who lacks a fixed, regular, and adequate nighttime residence and who:

- has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group; or
- is living in a supervised publicly or privately operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

A Member at Risk of Homelessness is any member who does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation.

II. Discharge Planning Activities at the Time of Admission

A. At the time of admission, and as part of its general discharge planning processes, each AIH must assess each admitted member's current housing situation. At a minimum, the AIH must assess whether such member is experiencing or at risk of homelessness. To aid in this assessment, AIHs must also ensure that their discharge planning staff screen admission data, including but not limited to age, diagnosis, and housing status, within 24 hours of admission. For any member determined by the AIH to be experiencing or at risk of homelessness, the AIH must commence discharge-planning activities within three days of the member's admission.

B. To assist in the discharge planning process for each member experiencing homelessness or at risk of homelessness, the AIH must, to the extent consistent with all applicable federal and state privacy laws and regulations,[1] invite and encourage the following persons to participate in or otherwise contribute to such member's discharge planning activities: the member; the member's family members, guardians, primary care providers, behavioral health providers, key specialists, Community Partners, case managers or other representatives, emergency shelter outreach or case management staff, or care coordinators; and any other supports identified by the member. For any such member who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Children and Families (DCF), the Department of Youth Services (DYS), or the MassAbility (MBY), the AIH must, to the extent consistent with all applicable federal and state privacy laws and regulations, invite and encourage designated staff from each such agency to participate in such member's discharge planning activities.

C. For any member experiencing or at risk of homelessness enrolled with a MassHealth Managed Care Entity (MCE), the AIH must contact the member's MCE to work together to identify resources to assist the member's housing situation. Each MCE has designated a single Point of Contact for these discharges that is reachable via phone/email between 8:00AM and 6:00PM each day of the week, including weekends.

D. The AIH must determine whether any non-DMH, non-DDS, or non-MBY-involved member experiencing or at risk of homelessness may be eligible to receive services from some or all of those agencies. For any such member, the AIH must, within two business days of admission, and to the extent consistent with all applicable federal and state privacy laws and regulations, offer to assist the member with completing and submitting an application to receive services from DMH, DDS, or MBY, as appropriate.

E. The AIH must determine whether any member experiencing or at risk of homelessness has any substance use disorder. For any such member, the AIH must contact the DPH-sponsored Helpline (800) 327-5050, the statewide, public resource for finding substance use treatment, recovery options, and assistance with problem gambling. The AIH must support the member's interaction with the Helpline's trained specialists to help the member understand the available treatment services and their options.

F. For any member experiencing homelessness who is expected to remain in the AIH

[1] To the extent that any applicable federal or state privacy law or regulation requires member consent as a prerequisite to any activity described in this Appendix H, the AIH must seek such consent.

for fewer than 14 days, the AIH must contact:

a. The emergency shelter in which the member most recently resided, if known, to discuss the member's housing options post discharge; or

b. If the member has not resided in an emergency shelter, or if the emergency shelter in which the member most recently resided is unknown, the local emergency shelter, to discuss the member's housing options post discharge.

c. The names and contact information for emergency shelters is available via https://hedfuel.azurewebsites.net/iShelters.aspx.

III. Assessing Discharge Options

A. AIHs must make all reasonable efforts to prevent discharges to emergency shelters of members who have skilled care needs, members who need assistance with activities of daily living, or members whose behavioral health condition would impact the health and safety of individuals residing in the shelter. For such members, AIHs should seek placement in more appropriate settings, such as DMH community-based programs or skilled nursing facilities. EOHHS has established a website to assist provider hospital discharge staff when helping patients with skilled nursing or other long term care needs. This website, which includes information about EOHHS's new Long Term Care Discharge Support Line, is available via the following URL: https://www.mass.gov/info-details/helping-patients-with-skilled-nursing-or-other-long-term-care-needs.

B. For certain members, discharge to an emergency shelter or the streets may be unavoidable. For example, certain members may choose to return to the streets or go to an emergency shelter despite the best efforts of the AIH. For these members, the AIH shall:

a. Discharge the member only during daytime hours;

b. Provide at least 24 hours advance notice to the shelter prior to discharge;

c. Ensure that the shelter has an available bed for the member. In the event that a shelter bed is unavailable on the planned discharge date, but a bed will be available soon, the AIH should delay discharge until a bed is available. In these cases, the AIH should bill MassHealth at the Administrative Day rate for each such day on which the member remains in the AIH, in accordance with the Acute Hospital Request for Applications and Contract (RFA);

d. Provide the member a meal prior to discharge;

e. Ensure that the member is wearing weather appropriate clothing and footwear;

f. Provide the member a copy of their health insurance information;

g. To the extent clinically appropriate and consistent with all applicable laws and regulations, provide the member with a written copy of all prescriptions and at least one week's worth of filled prescription medications;

i. Note that members experiencing homelessness who are being discharged from AIHs meet the standards of an emergency situation that allows for a written prescription, pursuant to DPH Drug Control Program (DCP) Circular 19-12-108.

ii. For AIHs that do not have outpatient retail pharmacies, prescriptions that are filled for patients during an inpatient hospital stay should be billed as part of the Adjudicated Payment Amount per Discharge (APAD) claim. This includes any prescriptions filled by inpatient pharmacies for patients that are about to be discharged.

h. Provide the member with access to paid transportation to the emergency shelter.

C. AIHs must ensure that their discharge planning staff are aware of and utilize available community resources to assist with discharge planning for Members experiencing homelessness or at risk of homelessness including information available at https://www.mass.gov/info-details/helping-patients-who-are-homeless-or-housing-unstable. Specifically, AIHs are expected to complete the training series on discharge planning with patients experiencing homelessness or housing instability at https://www.mass.gov/info-details/introduction-for-the-course. In addition, AIHs must provide regular training to discharge planning staff on other available resources and/or up-to-date resource guides.

IV. Tracking and Reporting Discharge Planning Activities

A. AIHs must document in each member's medical record all efforts related to the discharge planning activities described above, including options presented to the member and, if applicable, the member's refusal of any alternatives to discharge to the streets or emergency shelters.

B. AIHs must track discharges of members to local emergency shelters or the streets in a form, format, and cadence to be specified by MassHealth.

C. All reports required by 104 CMR 27.09(1)(b) shall be submitted to MassHealth.

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APPENDIX I:
STANDARDS FOR BEHAVIORAL HEALTH CRISIS EVALUATIONS RENDERED BY HOSPITALS

Effective as of 10/1/2023

I. Scope

This Appendix I defines the responsibilities of Acute Hospitals in performing comprehensive Behavioral Health Crisis Evaluations for individuals presenting either in the Emergency Department or Medical/Surgical floors in a Behavioral Health Crisis. These Behavioral Health Crisis Evaluations include the initial comprehensive assessments of risk, diagnosis, and treatment needs, the initial crisis interventions, the initial determination and coordination of appropriate disposition, and the required reporting and community collaboration for members presenting in a Behavioral Health Crisis. These standards apply only to Behavioral Health Crisis Evaluations provided during the first calendar day of an individual's readiness to receive such an evaluation and do not apply to any ongoing Behavioral Health Crisis Management Services provided to individuals in the ED or Medical/Surgical floors on days subsequent to receiving the initial Behavioral Health Crisis Evaluation. These standards apply to all Acute Hospitals providing Behavioral Health Crisis Evaluation Services. See **Appendix K** for a description of the standards for ongoing Behavioral Health Crisis Management Services.

II. Operational Standards for Behavioral Health Crisis Evaluations

A. General Procedures

The Acute Hospital is responsible for the provision of Behavioral Health Crisis Evaluations, including a comprehensive assessment, crisis interventions, disposition planning and coordination, and reporting and community collaboration, 24 hours per day, seven days per week, and 365 days per year for individuals who are presenting in the ED or medical/surgical floors with a behavioral health crisis. These evaluations may be provided in-person or via telehealth as requested by the individual, and as clinically appropriate. Behavioral Health Crisis Evaluations may be provided by hospital staff or by clinicians under contract with the hospital.

B. Staffing Composition and Qualifications

i. Staffing Composition: Behavioral Health Crisis Evaluations shall be provided by members of a multidisciplinary team that shall minimally include the availability of the following:

a. A qualified behavioral health professional. A qualified behavioral health

professional shall conduct the comprehensive behavioral health crisis assessment, provide behavioral health crisis interventions, and perform, or assist with, disposition planning, care coordination, reporting, and community collaboration procedures. Qualified behavioral health professionals, shall include, but not be limited to, a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in the field of psychiatry (vii) advanced practice registered nurses who practice in the field of psychiatry, including but not limited to licensed nurse practitioners and licensed psychiatric clinical nurse specialists; or (viii) healthcare provider qualified within the scope of the individual's license, or advanced education pre-licensure, to conduct an evaluation of a behavioral health condition, including an intern, resident or fellow pursuant to the policies and practices of the hospital and medical staff.

b. A complex behavioral health care clinician. A complex behavioral health care clinician shall be available to provide consultation to the qualified behavioral health professional or multidisciplinary staff regarding issues with assessment or intervention for members with complex clinical presentations, including individuals with significant medical comorbidity, severe behavioral disturbance, or complicated medication regimens. Complex behavioral health care clinicians shall include appropriately experienced psychiatrists or advanced practice providers (Advanced Practice Registered Nurses or Physician Assistants). Complex behavioral health care clinicians may provide consultation to the team by phone/video when in-person consultation is not available or clinically necessary.

c. Multidisciplinary staff. In addition to staff listed in **Section II.B.1.a** and **II.B.1.b** of this **Appendix I**, the behavioral health crisis evaluation team may include other staff, including certified peer specialists and recovery coaches, with appropriate training and experience to provide a welcoming, supportive, responsive, and recovery-oriented encounter.

ii. Staffing Qualifications: Hospitals must ensure that personnel delivering Behavioral Health Crisis Evaluation services possess appropriate education and training to meet the unique clinical needs of persons across the lifespan. In addition, staff must be knowledgeable of condition- and population-specific behavioral health interventions and care delivery models (e.g., substance use disorders, developmental disorders, eating disorders, and behavioral manifestations of dementia).

C. Procedural Components of Behavioral Health Crisis Evaluations

i. Comprehensive Behavioral Health Crisis Assessment

a. Hospitals must have the capacity to provide a comprehensive behavioral health crisis assessment by a qualified behavioral health professional to individuals within 60 minutes of time of the member's readiness to receive such an assessment. Readiness is the point at which the individual is awake and sufficiently cleared from the effects of substances to participate in the assessment. Determination of readiness to receive an assessment should not be based exclusively on the results of a drug or alcohol test.

b. The comprehensive behavioral health crisis assessment, which shall be documented in the hospital medical record, must minimally include the following:

i. Elicitation of a complete psychiatric history, including from relevant collaterals familiar with individual's history (in accordance with HIPAA privacy rules in emergency situations), community treatment plan, and the events and context that led to the individual presenting to the hospital.

ii. Mental status examination

iii. Evaluation of the individual's ability and capacity to respond to treatment

iv. Diagnostic evaluation

v. Assessment of current or past use of substances

vi. Clinical bio-psychological-social formulation

vii. Treatment plan including the recommended least restrictive and appropriate level of care and post-stabilization interventions

viii. Should the individual require any active safety interventions (i.e. arms-length 1:1 safety observation or interventions of equal or higher intensity) on the billing calendar day, the comprehensive behavioral health crisis assessment should capture the hospital's assessment of the individual's safety risks in the hospital, including contextual risks unique to the individual, and the hospital's active interventions to mitigate those risks.

ii. Crisis Interventions

a. The hospital shall provide monitoring, treatment, and support to individuals experiencing a behavioral health crisis to:

i. stabilize the individual's physical and behavioral health status

ii. ensure safety of the individual in the hospital

iii. restore functioning

iv. strengthen the resources and capacities of the individual, family, and other natural supports

v. prepare the individual for a timely and safe disposition to the most appropriate and least-restrictive setting

b. Crisis interventions must be tailored to each individual's unique presentation on the billing calendar day and must be documented accordingly in the hospital medical record.

c. Crisis interventions must be directed by a comprehensive treatment plan, which must be documented in the hospital medical record, and updated to capture any changes in presentation throughout the individual's hospital stay.

d. Guided by the age and treatment preferences of the individual, the hospital shall actively involve family and other natural supports at a frequency based on individual needs- and in accordance with HIPAA privacy rules in emergency situations.

e. The hospital shall coordinate treatment with existing and/or newly established treatment providers and consultants.

iii. Disposition Planning and Care Coordination Procedures

a. Post assessment, the hospital shall develop a disposition plan to an appropriate level of care and goals for that level of care.

b. The discharge disposition must be to a distinct level of care (including home with provider referral information) unless the individual declines.

c. The hospital shall gather information from all relevant collaterals (in accordance with HIPAA privacy rules in emergency situations) to inform appropriate disposition planning.

d. Initial consideration, when clinically appropriate, shall be given to all diversionary levels of care available to MassHealth Members. Diversion is to be explored, discussed, and utilized when safety can be maintained in a level of care lower than hospitalization.

e. For individuals going to a 24-hour level of care, the hospital is responsible for bed finding, and shall obtain any required insurance notifications or authorizations for levels of care included in the discharge plan and shall arrange any necessary transportation. The hospital shall inform all collateral providers of the disposition (in accordance with HIPAA privacy rules in emergency situations) and inform the 24-hour level of care of the contact

information for collaterals. The hospital is also responsible for warm handoff to all 24-hour levels of care, including review of Member's hospital course to date.

f. The hospital is responsible for all disposition planning to community-based services, inclusive of warm hand off to a Community Behavioral Health Center (CBHC), and all included services, or other community-based outpatient provider, in any instance that is clinically appropriate.

g. All individuals who receive crisis evaluation services in the hospital are eligible for community-based post-crisis stabilization services by the Adult and Youth Mobile Crisis Intervention teams (AMCI/YMCI) after leaving the hospital. Where clinically indicated and in consideration of the disposition plan, the hospital shall contact the AMCI/YMCI to conduct a warm hand off for follow up behavioral health crisis intervention services.

h. All individuals shall be provided the contact information for their local Adult and Youth Mobile Crisis Intervention teams (AMCI/YMCI) and Community Behavioral Health Center (CBHC) in the event of a need for future crisis evaluation and support.

i. The discharge plan must address safety planning specific to the presenting problem and inclusive of resources to utilize in crisis, crisis prevention, referral to appropriate community resources, post-stabilization services, and follow-up instructions.

j. All individuals who present with opioid use who are discharged to the community shall be offered nasal Naloxone and given resources for medication-assisted treatment (MAT)/medication for opioid use disorder (MOUD) and other support services.

iv. Reporting and Community Collaboration Expectations

a. As further directed by EOHHS, the hospital shall complete and submit data to be determined by EOHHS, in a form and format specified by EOHHS, for every Behavioral Health Crisis Evaluation provided. EOHHS may issue further instruction on such metrics completion and submission through an Acute Hospital Provider Bulletin or other written issuance.

b. Hospitals must notify MassHealth by using the Massachusetts Behavioral Health Access (MABHA) website, or other process as specified by EOHHS, not later than 24 hours after a MassHealth member identified as requiring inpatient psychiatric hospitalization arrives in the Acute Hospital's ED and has not yet been admitted to an appropriate inpatient psychiatric setting. The hospital shall follow procedures specified by EOHHS for removal of an

individual from the list once the individual is no longer awaiting disposition.

c. The hospital must follow the EPIA protocol for reporting all individuals awaiting psychiatric inpatient placement (EPIA protocol may be accessed here: Mass.gov. https://www.mass.gov/info-details/expedited-psychiatric-inpatient-admissions-epia-policy#epia-protocols-).

d. All hospitals shall establish and maintain referral relationships with their local CBHC(s), and participate in ongoing collaboration, planning, and process implementation to ensure a successful and seamless experience for individuals in crisis, and to ensure continued enhancement to the crisis system.

III. Billing Requirements

A. Billing requirements for Behavioral Health Crisis Evaluations apply to individuals experiencing a behavioral health crisis, either in the ED or while admitted to a medical/surgical bed.

B. The following billing option will be reimbursed outside of the APEC for members in an ED and will be reimbursed outside of the APAD for members in a medical/surgical bed.

i. Hospitals may bill S9485, without a modifier, for Behavioral Health Crisis Evaluation.

ii. S9485, without a modifier, may be billed no more than one unit per day, no more than once per hospital stay.

iii. As described in **Section 5.C.11** of the RFA, S9485, without a modifier, cannot be billed on the same date of service as Behavioral Health Crisis Management Services (S9485, with modifier V1 or V2).

iv. As described in **Section 5.C.11** of the RFA, any clinical service outside of the scope of Behavioral Health Crisis Evaluation other than Behavioral Health Crisis Management Services can continue to be billed separately according to the requirements and billing instructions of each such service. Services outside the scope of Behavioral Health Crisis Evaluation may include, but are not limited to:

a. Direct psychiatric evaluation of the member by a psychiatrist or advanced practice provider (Advanced Practice Registered Nurses or Physician Assistants) requested by the primary hospital medical team for diagnostic clarification and treatment recommendations (90791, 90792, 99201-99205, 99211-99215, 99241-99245, 99251-99255).

b. Intensive, specialized therapies or therapeutic consultations requested by the primary hospital team to support the stabilization efforts of members in the hospital with complex needs, including Applied Behavioral Analysis for members with Autism Spectrum Disorder.

c. Initiation of medication for the treatment of opioid use disorder in the Emergency Department setting and connection to recovery support navigation in the Emergency Department (G2213 and H2015-TF respectively).

d. Community-Based Mobile Crisis Intervention services provided to the member on their day of discharge as a warm handoff to facilitate a smooth disposition to the community.

e. Children's Behavioral Health Initiative services provided to family members/caregivers of youth members throughout the member's stay in the hospital to help strengthen the resources and capacities of the family to support the member in the community upon discharge.

v. Any MassHealth payment made to the Hospital for a Behavioral Health Crisis Evaluation, based on a claim or invoice submitted by a Hospital, on the same calendar day as a similar service provided and billed by a non-hospital provider shall constitute an overpayment as defined by 130 CMR 450.235 and will be subject to recoupment.

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APPENDIX J:

EOHHS ACUTE HOSPITAL CLINICAL QUALITY INCENTIVE (CQI) PROGRAM

This **Appendix J** details the performance assessment methodology for the CQI Program inclusive of the CQI quality measures, how the quality measures will be calculated, scoring of the measures, calculation of measure scores that are grouped into domain scores, and calculation of domain scores into an overall quality score described in **Section 7B** of the RFA.

EOHHS reserves the right to modify the measures and performance assessment methodology set forth herein through written amendment to the RFA and may modify the methodology set forth herein after the execution of the Contract by written amendment. EOHHS anticipates ongoing monitoring and evaluation of the methodology and performance, including, but not limited to, the list of CQI Program quality measures and performance assessment methodology (PAM), for the duration of the CQI Program.

This **Appendix J** includes the following components:

1. CQI Program: Overview

2. CQI Program Measures

3. CQI Program - Performance Assessment Methodology (PAM)

- A. PAM - Scoring Approach
- B. PAM - Measure Benchmarks
- C. PAM - Measure Level Scoring
- D. PAM - Domain Level Scoring
- E. PAM - Quality Scoring and Earned Incentive Calculation

4. CQI Program Reporting Requirements

5. Other Considerations

6. Bonus Opportunity

1. CQI Program: Overview

The Clinical Quality Incentive (CQI) program includes and is not limited to the following responsibilities and expectations:

a. The Hospital shall make all appropriate efforts to meet a set of performance benchmarks and, as applicable, improvement targets for individual quality measures established by EOHHS and set forth in **Section 7B** of the RFA and this **Appendix J**. Hospitals must collect data and report on the measures within the measure domains per guidance from the EOHHS Technical Specifications Manual.

   i. EOHHS publishes a Technical Specifications Manual, a comprehensive manual as a supplement to this RFA, to which Hospitals must adhere for data collection and reporting, and which applies to all CQI Program quality measures listed in this **Appendix J**.

   ii. The Technical Specifications Manual contains detailed instructions on clinical and administrative data element specifications, sampling guidelines, data abstraction tools, XML schema tools, data dictionary, portal user system requirements, and more.

   iii. The Technical Specifications Manual is regularly updated and Hospitals are responsible for downloading and using the appropriate versions of the EOHHS Technical Specifications Manual that apply to each reporting data period. EOHHS Technical Specifications Manual versions, updates and additional release notes are posted on the Mass.Gov website at https://www.mass.gov/masshealth-quality-exchange-massqex.

b. EOHHS shall calculate under **Section 7B** of the RFA, a Hospital's CQI Program overall quality score based on the Hospital's performance with respect to CQI quality measures and a performance assessment methodology (PAM) set forth in this **Appendix J**. For the quality score calculation:

   i. EOHHS shall use data reported by the Hospital, other measure data as further specified herein and obtained from other sources (e.g., through the CDC NHSN registry, CMS Provider Data Catalog), or calculated by EOHHS.

   ii. Individual measure performance is scored based on attainment of threshold or goal benchmarks and, as applicable, an improvement target.

   iii. Individual measure scores are further grouped and calculated into several domain scores.

   iv. Domain scores are further weighted and calculated into a single Hospital overall quality score.

   v. The Hospital quality score shall be a number between zero (0) and one (1) which represents a ratio or percentage that may be applied against incentive

dollars that are available for the Hospital to earn as part of the CQI Program.

c. The Hospital's quality measure performance under the CQI Program shall be measured for specified reporting and performance periods, set forth in this **Appendix J**. EOHHS will perform all calculations after the conclusion of the Rate Year.

d. Hospitals shall earn a quality incentive payment based on the Hospital's overall quality score multiplied by the eligible incentive dollars that are available for a Hospital to earn.

e. CQI Program measure performance will be monitored such that CQI Program measures and associated performance assessment methodology (PAM) shall be maintained and modified only in extenuating circumstances, at the discretion of EOHHS. This and other considerations are further detailed in this **Appendix J**.

2. CQI Program Measures

As set forth in **Section 7B.3 of the RFA** EOHHS is introducing Hospital CQI Program quality measures aimed at ensuring members receive safe and high-quality care. CQI Program quality measures are categorized into four Core Quality Measure Domains and two Specialty Quality Measure Domains, which will be used to assess performance and incentives.

a. Hospital requirements to be eligible to earn CQI Program incentive dollars include:

   i. Participation in Measure Domains, as follows:

      1) Participation in Core Quality Measure Domains: All Acute Hospitals are required to participate in four Core Quality Measure Domains which include: Care Coordination/Integration of Care, Care for Acute and Chronic Conditions, Patient Safety and Patient Experience.

      2) Participation in the Specialty Quality Measure Domains: Birthing Hospitals with deliveries are required to participate in the Perinatal Domain

      3) Participation in the Specialty Quality Measure Domains: Hospitals that have an inpatient psychiatric unit and participate in the current CMS IPFQR program are required to participate in the Behavioral Health Care Domain.

   ii. Collection and reporting of measure data: Hospitals must collect data and report on the measures within the applicable measure domains per guidance from the EOHHS Technical Specifications Manual (https://www.mass.gov/masshealth-quality-exchange-massqex).

b. CQI Measures by Domain

Exhibit 1 below displays each measure domain and the quality measure(s), identified by a unique measure ID and measure name which correspond to each

quality measure domain, the data source and measure type, and the population included in the measure.

Pediatric measures are included in the Core Quality Measure Domains. Hospitals are responsible for pediatric measures if they meet measure requirements per the Technical Specifications Manual.

Exhibit 1: CQI Program – Core and Specialty Quality Domain Measures

Row Number	Quality Domain	Measure ID	Measure Steward: Measure Name	Data Source and Measure Type	Population
1	Reserved				
2	Care Coordination / Integration	PED-1	Center of Excellence for Pediatric Quality Measurement: Pediatric All-Condition Readmission Measure (CBE ID 2393)	Claims-Based (Outcome Measure)	All Medicaid
3	Care Coordination / Integration	CCI-2	NCQA FUM: Follow-up After ED Visit for Mental Illness (CBE ID 3489) (7-Day and 30-Day) - *Treated as 1 measure which includes 2 sub-measures*	Claims-based (Process Measure)	All Medicaid
4	Care Coordination / Integration	CCI-3	NCQA FUA: Follow-up After ED Visit for Substance Use (CBE ID 3488) (7-Day and 30-Day)- *Treated as 1 measure which includes 2 sub-measures*	Claims-based (Process Measure)	All Medicaid
5	Care Coordination/ Integration	CCI-4	NCQA FUH: Follow-up After Hospitalization for Mental Illness (CBE ID 0576) (7 and 30 day) - *Treated as 1 measure which includes 2 sub-measures*	Claims-based (Process Measure)	All Medicaid
6	Care for Acute and Chronic Conditions	SUB-2	TJC SUB-2: Alcohol Use – Brief Intervention Provided or Offered (CBE ID 1664)	Chart Abstracted (Process Measure)	All Medicaid
7	Care for Acute and Chronic Conditions	SUB-3	TJC SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge (CBE ID 1663)	Chart-Abstracted (Process Measure)	All Medicaid
8	Care for Acute and Chronic Conditions	OP-1e	CMS 506v5: Safe Use of Opioids – Concurrent Prescribing (CBE ID 3316e)	Data Entry (Process Measure)	All-Payer
9	Care for Acute and Chronic Conditions	PED-2	NCQA: Avoidance of Antibiotic Treatment for Acute	Claims-Based Measure	All Medicaid

Row Number	Quality Domain	Measure ID	Measure Steward: Measure Name	Data Source and Measure Type	Population
			Bronchitis/Bronchiolitis (CBE ID 0058)	(Process Measure)	
10	Patient Safety	HAI-1	CDC: Central Line-Associated Bloodstream Infection (CLABSI)	National Registry-Based Measures (Outcome Measure)	All-Payer
11	Patient Safety	HAI-2	CDC: Catheter-Associated Urinary Tract Infection (CAUTI)	National Registry-Based Measures (Outcome Measure)	All-Payer
12	Patient Safety	HAI-3	CDC: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)	National Registry-Based Measures (Outcome Measure)	All-Payer
13	Patient Safety	HAI-4	CDC: Clostridium Difficile Infection (CDI)	National Registry-Based Measures (Outcome Measure)	All-Payer
14	Patient Safety	HAI-5	CDC: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)	National Registry-Based Measures (Outcome Measure)	All-Payer
15	Patient Experience	HCAHPS	AHRQ: Hospital Consumer Assessment of Healthcare Provider Systems Survey (HCAHPS) This measure includes 5 survey dimensions: 1) nurse communication, 2) doctor communication, 3) communication about medicines, 4) discharge information, and 5) overall rating.	National Survey-Based Measure (Outcome Measure)	All-Payer
16	Perinatal Care	MAT-4	TJC PC-02: Cesarean Birth, NTSV (CBE ID 0471)	Chart-abstracted (Outcome Measure)	All Medicaid
17	Perinatal Care	NEWB-3	TJC PC-06: Unexpected Newborn Complications in Term Infants (CBE ID 0716)	Chart-abstracted (Outcome Measure)	All Medicaid
18	Perinatal Care	SOC	TJC PC-07: Severe Obstetric Complications	Data Entry (Outcome Measure)	All-Payer
19	Behavioral Health Care	BHC-2	CMS IPFQR: Medication Continuation Following Inpatient Psychiatric Discharge (CBE ID	Claims-based (Process Measure)	All Medicaid

Row Number	Quality Domain	Measure ID	Measure Steward: Measure Name	Data Source and Measure Type	Population
			3205)		
20	Behavioral Health Care	BHC-3	CMS IPFQR: Screening for Metabolic Disorders	Data Entry (Process Measure)	All Payer

c. Measure Reporting and Data Validation

As set forth in **Section 7B.2 of the RFA**, each Hospital must comply with all measure reporting and meet validation requirements as described below and further detailed in the applicable Technical Specifications Manual and release notes.

i. **Measure reporting:** Hospitals are required to report data or make data available through other sources for individual quality measures for which they are eligible that are chart-based, registry-based, data-entry, or national survey-based.

1) Eligible measures are measures where the Hospital meets the measure specifications outlined in the Technical Specifications Manual (e.g., eligible denominator populations, sufficient cases etc.).

2) Measure data must be reported on all relevant Medicaid payer codes and other data elements.

ii. **Data Validation:** All reported chart-based measures are subject to data validation that requires meeting the minimum reliability standard of 80 percent for data elements. Hospitals are considered to have "passed" validation if the overall agreement rate of 80 percent has been met, based on the data collected for the first three quarters of CY2027 (Q1-2027, Q2-2027 and Q3-2027) that the Hospital must collect and report per the reporting schedule in the applicable version of the EOHHS Technical Specifications Manual. Passing data validation is required prior to computing a Hospital's performance scores on each chart-based measure.

d. Measure Types and Data Sources

Measure types and their respective data sources are summarized below. Specific CQI Program measures, their measure type and population may be found in **Exhibit 1**. The source of the payer data for each measure type is described below and further detailed in the EOHHS Technical Specifications Manual and applicable release notes.

i. **Chart-Abstracted Measures Data.** The individual process measures are chart-abstracted and must be collected and reported by Hospitals on populations identified (e.g., All-Medicaid payer). Detailed instructions, including all relevant payer codes, are included in the applicable version of

the EOHHS Technical Specifications Manual.

ii. **Claims-Based Measures Data.** The data for the claims-based measures will be collected on all Medicaid payer data by EOHHS from the Medicaid Management Information System (MMIS) fee-for-service claims and from encounter data in the MassHealth Data Warehouse, using the criteria and methods outlined in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required for these measures.

iii. **Reserved**

iv. **Data Entry Measures Data.** The data entry measures are reported in an aggregate format for an all-payer population using the criteria outlined in the EOHHS Technical Specifications Manual.

v. **National Registry-Based Measures Data.** The data for the HAI measures are national registry-based and are reported by Hospitals on all payer data to the CDC's NHSN registry surveillance tracking system, and the relevant data will be accessed by EOHHS via the MassHealth NHSN Group reflecting all payer data obtained directly from the CDC's NHSN registry surveillance tracking system database to which Hospitals previously conferred rights to EOHHS during the RY2019 MassHealth NHSN Group one-time enrollment process. Further details on data collection methods are outlined in the EOHHS Technical Specifications Manual. No direct electronic data file reporting to EOHHS is required.

vi. **National Survey-Based Measures Data.** The data for the 5 survey dimensions of the HCAHPS measure are national survey-based and are reported by Hospitals on all payer data to CMS, and relevant all-payer archived data will be obtained by EOHHS from the CMS Provider Data Catalog website (https://data.cms.gov/provider-data/)**.** No direct electronic data file reporting to EOHHS is required.

e. Measure Calculations and Case Minimums

Each measure will be calculated using the following methods described below. For measures to be included in EOHHS's performance assessment, Hospital's reported data for each measure must meet minimum case requirements. Hospitals that do not meet the case minimum for the measurement periods are not eligible for quality measure performance scoring on that measure. Minimum case requirements, measurement periods, and any applicable reporting method requirements, for each measure are outlined in the Technical Specifications Manual.

i. **Chart-Based Measure Rate Result:** A measure rate is calculated by dividing the numerator by the denominator, to obtain the result for each individual chart-based measure. All measure rate results are rounded to the nearest integer (e.g., 3.3 is rounded to 3.0; 3.5 is rounded to 4.0).

ii. **Claims-Based Measure Rate Result**: A measure rate is calculated by dividing the numerator by the denominator, to obtain a percentage for each individual claims-based measure.

iii. **Healthcare-Associated Infection Measures Results**: EOHHS will obtain each Hospital's standardized infection ratio (SIR) output value and supporting data elements for each HAI measure listed in **Exhibit 1**, as calculated by the CDC, from the CDC's NHSN registry surveillance tracking system via the MassHealth NHSN Group.

iv. **Patient Experience and Engagement Measure Result**: EOHHS will obtain the archived HCAHPS measure "top box" raw results directly from the CMS Provider Data Catalog website that are posted in rounded integer format. The "top-box" raw score for each of the 5 survey dimensions represents the percentage of a Hospital's patients who chose the most positive, or "top-box," response to a survey item. The "top box" raw result calculation includes a AHRQ patient-mix adjustment and survey-mode adjustment.

v. **Other measure results**: The OP-1e, SOC, and BHC-3 measure results will be calculated using Hospital submission of aggregated numerator and denominator values and other related elements based on all-payer data submissions to CMS.

3. Performance Assessment Methodology (PAM)

As set forth in **Section 7B.4 of the RFA**, a Hospital may qualify to earn incentive payments if it meets data completeness requirements, data validation and reliability requirements, case minimum requirements, and achieves performance benchmarks or, as applicable, improvement targets for measures listed in **Section 2, Exhibit 1,** of this **Appendix J**.

The opportunity to earn incentive payments using a performance assessment methodology (PAM) includes:

- Scoring individual measures through a point system applied to pay-for-reporting (P4R) or pay-for-performance (P4P) CQI Program measures.
- Calculating domain scores based on points earned for the group of measures within each domain.
- Weighting the domain scores to calculate an overall quality score, and
- Applying the quality score to a Hospital's individual amount of eligible CQI incentive dollars.

This **Section 3** of this **Appendix J** details the performance assessment methodology (PAM).

A. PAM: Scoring Individual Measures – Point Scoring Approach

Incentive payments will be based on a point scoring approach for the following

performance measure types. The maximum number of points that a Hospital may attain for each measure is 10 points. Additional improvement points, however, may also be allocated for pay-for-performance measures.

a. **CQI Program measure status**: P4R, P4P and Reporting-Only status for the RY2027 CQI Program is indicated in **Exhibit 2**. Measure status beyond RY2027 is subject to change.

b. **Pay-for-reporting (P4R) measures**: Each Hospital will receive 10 points per measure depending upon whether it met timely reporting and data validation requirements. P4R measures will be based solely on Pass/Fail criteria for meeting the data reliability standard (.80) for clinical measures. Hospitals that pass validation for P4R measures will receive 10 points for each measure.

c. **Pay-for-performance (P4P) measures**: Each Hospital may receive 0-10 points depending on each measure's performance compared to performance benchmarks for the individual measures.

d. **Reporting-Only measures**: Hospitals are not eligible to receive points as they are measures that are calculated by EOHHS or measures being collected for informational purposes to inform performance baselines and/or benchmarking in future years. Reporting-only measures do not factor into Hospital quality measure score calculations.

Exhibit 2: Hospital CQI Measure Slate – RY2027 Measures

Row Number	Quality Domain	Measure ID	Measure Name	2023	2024	2025	2026	2027
1	Reserved							
2	Care Coordination / Integration	PED-1	Pediatric All-Condition Readmission	R	R	P4P	P4P	P4P
3	Care Coordination / Integration	CCI-2	Follow-up After ED Visit for Mental Illness	R	P4P	P4P	P4P	P4P
4	Care Coordination / Integration	CCI-3	Follow-up after ED Visit for Substance Use	R	P4P	P4P	P4P	P4P
5	Care Coordination / Integration	CCI-4	Follow-up After Hospitalization for Mental Illness	R	R	P4P	P4P	P4P
6	Care for Acute and Chronic Conditions	SUB-2	Alcohol Use – Brief Intervention Provided or Offered	P4R	P4R	P4P	P4P	P4P
7	Care for Acute and Chronic Conditions	SUB-3	Alcohol & Other Drug Use Disorder – Treatment Provided/Offered at Discharge	P4R	P4R	P4P	P4P	P4P
8	Care for Acute and Chronic Conditions	OP-1e	Safe Use of Opioids – Concurrent Prescribing	P4R	P4R	P4P	P4P	P4P
9	Care for Acute and Chronic Conditions	PED-2	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	R	R	P4P	P4P	P4P
10	Patient Safety	HAI 1-5	CLABSI, CAUTI, MRSA, CDI, SSI	P4P	P4P	P4P	P4P	P4P
11	Patient Experience	HCAHPS	Hospital Consumer Assessment of Healthcare Provider System Survey	P4P	P4P	P4P	P4P	P4P
12	Perinatal Care	MAT-4	Cesarean Birth, Nulliparous, Singleton, Vertex	P4P	P4P	P4P	P4P	P4P
13	Perinatal Care	NEWB-3	Unexpected Newborn Complications in Term Infants	P4R	P4R	P4P	P4P	P4P
14	Perinatal Care	SOC	Severe Obstetric Complications	N/A	P4R	R	P4P	P4P
15	Behavioral Health Care	BHC-2	Medication Continuation Following Inpatient Psychiatric Discharge	R	P4P	P4P	P4P	P4P

Row Number	Quality Domain	Measure ID	Measure Name	2023	2024	2025	2026	2027
16	Behavioral Health Care	BHC-3	Screening for Metabolic Disorders	P4R	P4P	P4P	P4P	P4P

B. PAM: Quality Measure Benchmarks

This **Section 3.B** of this **Appendix J** identifies the methodology for establishing performance benchmarks for CQI Program measures to determine eligibility for incentives per measure and scoring of the measures based on performance.

Each Hospital's performance on measures will be assessed for reaching a minimum threshold benchmark to determine achievement points for meeting performance toward goal or a goal benchmark for high performance. Improvement points may also be earned, as applicable, by reaching improvement targets which may be earned whether the Hospital reaches threshold or exceeds the goal benchmarks. The improvement target represents a specified improvement for each applicable measure where a Hospital may earn improvement points. For improvement targets that rely on improvement over self, improvement is assessed by comparing the Hospital's performance to their baseline or, if applicable, the most recent year performance where a Hospital reached targeted improvement.

a. **The following benchmarks are established for each measure:**

   i. ***Threshold:*** The threshold benchmark represents the minimum level of performance that must be attained on each individual measure to earn achievement points (Between 1-9 points).

   ii. ***Goal:*** The goal benchmark represents a high level of performance on each individual measure where a Hospital may score a maximum number of achievement points (10 points).

Exhibit 3 summarizes threshold, goal and improvement targets for RY27 CQI Program P4P measures.

Exhibit 3: CQI Benchmarks for each RY2027 P4P measure

Row Number	Quality Domain	Measure ID	Measure Name	Performance Threshold	Performance Goal	Improvement Target
1	**Reserved**					
2	Care Coordination / Integration	PED-1	Pediatric All-Condition Readmission	Better or no different than the state average (based on hospital's adjusted rate)	Better or no different than the state average (based on hospital's adjusted rate)	1% point decrease (based on hospital's unadjusted rate)
3	Care Coordination / Integration	CCI-2	Follow-up After ED Visit for Mental Illness	7 day: 40% 30 day: 50%	7 day: 85% 30 day: 90%	7 day: 5% points increase 30 day: 5% points increase
4	Care Coordination / Integration	CCI-3	Follow-up after ED Visit for Substance Use	7 day: 25% 30 day: 30%	7 day: 45% 30 day: 55%	7 day: 4% points increase 30 day: 5% points increase
5	Care Coordination / Integration	CCI-4	Follow-up After Hospitalization for Mental Illness	7 day: 20% 30 day: 40%	7 day: 40% 30 day: 60%	7 day: 4% points increase 30 day: 4% points increase
6	Care for Acute and Chronic Conditions	SUB-2	Alcohol Use – Brief Intervention Provided or Offered	15%	60%	5% points increase
7	Care for Acute and Chronic Conditions	SUB-3	Alcohol & Other Drug Use Disorder – Treatment Provided/Offered at Discharge	40%	75%	5% points increase
8	Care for Acute and Chronic Conditions	OP-1e	Safe Use of Opioids – Concurrent Prescribing	24%	14%	2% points decrease
9	Care for Acute and Chronic Conditions	PED-2	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	85%	97%	2% points increase
10	Patient Safety	HAI 1-5	CLABSI, CAUTI,	Standard Infection Ratio	Standard Infection	For each measure: The Standard

Row Number	Quality Domain	Measure ID	Measure Name	Performance Threshold	Performance Goal	Improvement Target
			MRSA, CDI, SSI	(SIR) value <= to 1 or no different than other hospitals (nationally) *Confidence intervals will be calculated for the MassHealth aggregate SIR, through available NHSN software to identify Hospitals that may have an SIR greater than 1.0, but not significantly greater than the MassHealth aggregate SIR, thus meeting the measure threshold/goal benchmark.	Ratio (SIR) value <= to 1 or no different than other hospitals (nationally) *Confidence intervals will be calculated for the MassHealth aggregate SIR, through available NHSN software to identify Hospitals that may have an SIR greater than 1.0, but not significantly greater than the MassHealth aggregate SIR, thus meeting the measure threshold/goal benchmark.	Infection Ratio (SIR) value is < 1, **and** where confidence intervals will be calculated for the MassHealth aggregate SIR, to identify Hospitals that are better than the MassHealth aggregate, thus performing above the threshold/goal benchmark.
11	Patient Experience	HCAHPS	Hospital Consumer Assessment of Healthcare Provider System Survey	Composite score of .50 Composite Score = Average of the top box scores	Composite score of .80 Composite Score = Average of the top box scores	.01 - .05 improvement in a Hospital's composite score over the prior year
12	Perinatal Care	MAT-4	Cesarean Birth, Nulliparous, Singleton, Vertex	32%	22%	2% points decrease
13	Perinatal Care	NEWB-3	Unexpected Newborn Complications in Term	>50 and <=70	<=50 per	N/A

Row Number	Quality Domain	Measure ID	Measure Name	Performance Threshold	Performance Goal	Improvement Target
			Infants	per 1000	1000	
14	Perinatal Care	SOC	Severe Obstetric Complications	Better or no different than the average state rate	Better or no different than the average state rate	N/A
15	Behavioral Health Care	BHC-2	Medication Continuation Following Inpatient Psychiatric Discharge	30%	65%	5% points increase
16	Behavioral Health Care	BHC-3	Screening for Metabolic Disorders	70%	93%	5% points increase

b. **Principles to how benchmarks were determined:**

i. Review of historic Hospital performance and NCQA national percentiles.

ii. If the 90th percentile was 97% or above, the goal benchmark was capped at 97%.

iii. Annual improvement targets were based on review of historical and recent rates of improvement and utilizing with modification, a gap-to-goal approach, to recognize incremental but reasonable improvement.

iv. Allowing for step-wise improvement, or maintenance of excellent performance over a five-year horizon with stable attainment and improvement values.

C. Performance Assessment Methodology: Individual Quality Measure Scoring

The method for CQI Program measure scoring depends on the measure or type of measure. Methods described in this **Section 3.C** of this **Appendix J** are further detailed in **Exhibit 4**.

a. **A quality point system**: Hospitals can earn a range of attainment and, as applicable, improvement quality points based on the Hospital's measure performance rate, relative to achieving attainment (threshold or goal) benchmarks and, as applicable, improvement targets. This system applies to the RY2027 CQI Program pay-for-performance measures, not including Patient Safety Domain, Readmission, Severe Obstetric Complications, and Patient Experience Domain measures described separately in b. and c. below, and unless otherwise further specified.

i. Attainment Points:

1) A Hospital can earn 10 attainment points based on meeting or exceeding the goal benchmark, or

2) A Hospital can receive a range of 1-9 points based on the Hospital's measure performance relative to the goal benchmark.

ii. If a Hospital's rate for the measure is less than the attainment threshold, it will receive zero (0) attainment points, but is eligible for the improvement points opportunity described below for those measures with an improvement target.

iii. Improvement Points Opportunity: A Hospital can earn 5 additional improvement points if the Hospital's measure performance rate meets or exceeds the improvement target for the measure, compared to either the baseline period for initial improvement, or the most recent performance year for which improvement points were earned (whichever is the better rate).

Note: Hospitals may earn 7 (instead of 5) additional improvement points if the Hospital's measure performance did not meet threshold and did not receive attainment points. Once a Hospital reaches threshold performance, the Hospital may only earn 5 additional improvement points. Further:

1) The baseline period for improvement is the first year the measure was in reporting-only or pay-for-reporting status in the Hospital Quality CQI program. Measures that were in P4P status in RY23 use RY2023 Hospital Quality CQI program performance as baseline.

2) If the Hospital failed validation in the previous reporting year, data from that period is considered invalid for use in calculating comparative year performance. Therefore, the Hospital would not be eligible for improvement points. However, the Hospital may be eligible for attainment points on each chart-based measure, based on calculation of Calendar Year 2027 data reported on the measure in RY2027, if it passed validation on these measures.

3) Partial points may not be earned if the improvement target is not met during the performance year, however a stepwise approach is used so that if a target is met (e.g., cumulatively in future performance periods), the full 5 points are earned in that future performance period.

4) If a Hospital's performance improves one year and declines the following year, improvement is based on the most recent highest performing year.

b. **Safety, Readmission, and Severe Obstetric Complications Measure Scoring.** A Hospital can earn 10 attainment points per each safety, readmission, or severe obstetric complications measure based on meeting the threshold or goal benchmark. If a Hospital's measure performance does not meet the attainment threshold, it will receive zero (0) attainment points. For safety measures, Hospitals may receive 5

additional points per measure if their performance statistically exceeds State Hospital performance.

c. **Patient Experience Measure Scoring.** The Patient Experience (HCAHPS) involves the Hospital's measure composite scores and improvement in composite scores over the prior year or the highest of the most recent performance year, to determine an improvement score. Improvement is not awarded based on comparison to the prior year if performance had declined and is lower than in prior years.

d. **Pay-For-Reporting (P4R) Measure Scoring.** A Hospital can earn 10 attainment points for measures that are in P4R status and meet reporting and data validation requirements.

e. **Reporting-Only Measures.** Reporting-only measures are not scored.

Exhibit 4: PAM - Point and Domain Scoring by RY2027 CQI P4P Measures

Row Number	Quality Domain	Measure ID and Name	Attainment: Threshold	Attainment: Goal	Improvement Points	Domain Scoring(Scores may not exceed 1)
1	Reserved					
2	Care Coordination / Integration	PED-1: Pediatric All-Condition Readmission Measure	10 points	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
3	Care Coordination / Integration	CCI-2: Follow-up After ED Visit for Mental Illness (7 and 30-Day) *(2 sub-measures are equally weighted)*	Performance/ Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
4	Care Coordination / Integration	CCI-3: Follow-up After ED Visit for Substance Use (7 and 30-Day) *(2 sub-measures are equally weighted)*	Performance/ Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
5	Care Coordinati	CCI-4: Follow-up After Hospitalization for Mental	Performance/ Goal *10 =	10 points	5 points for meeting target	Total # of Attainment (either

Row Number	Quality Domain	Measure ID and Name	Attainment: Threshold	Attainment: Goal	Improvement Points	Domain Scoring(Scores may not exceed 1)
	on/ Integration	Illness (7 and 30 day) *(2 sub-measures are equally weighted)*	Attainment Points		(no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
6	Care for Acute and Chronic Conditions	SUB-2: Alcohol Use – Brief Intervention Provided or Offered	Performance/ Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
7	Care for Acute and Chronic Conditions	SUB-3: Alcohol & Other Drug Use Disorder – Treatment provided/offered at Discharge	Performance/ Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
8	Care for Acute and Chronic Conditions	OP-1e: Safe Use of Opioids – Concurrent Prescribing	5 + (((Threshold – goal performance) - (hospital performance - goal))/(Threshold – goal	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in

Row Number	Quality Domain	Measure ID and Name	Attainment: Threshold	Attainment: Goal	Improvement Points	Domain Scoring(Scores may not exceed 1)
			performance)) *5		meeting target on measures where the rate is below the threshold rate.	each domain X 10)
9	Care for Acute and Chronic Conditions	PED-2: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	Performance/Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise) 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
10	Patient Safety	HAI-1: Central Line-Associated Bloodstream Infection (CLABSI)	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical significance	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical significance	5 points if SIR is <1 and considered better than other Hospitals in the MassHealth aggregate – Use of standard confidence intervals methodology to determine statistical significance (NHSN software)	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
11	Patient Safety	HAI-2: Catheter-Associated Urinary Tract Infection (CAUTI)	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine	5 points if SIR is <1 and considered better than other Hospitals in the MassHealth aggregate – Use of standard confidence intervals methodology to	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)

Row Number	Quality Domain	Measure ID and Name	Attainment: Threshold	Attainment: Goal	Improvement Points	Domain Scoring(Scores may not exceed 1)
			statistical significance	statistical significance	determine statistical significance (NHSN software)	
12	Patient Safety	HAI-3: Methicillin-Resistant Staphylococcus Aureus bacteremia (MRSA)	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical significance	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical significance	5 points if SIR is <1 and considered better than other Hospitals in the MassHealth aggregate – Use of standard confidence intervals methodology to determine statistical significance (NHSN software)	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
13	Patient Safety	HAI-4: Clostridium Difficile Infection (CDI)	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical significance	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical significance	5 points if SIR is <1 and considered better than other Hospitals in the MassHealth aggregate – Use of standard confidence intervals methodology to determine statistical significance (NHSN software)	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
14	Patient Safety	HAI-5: Surgical Site Infections: Colon and abdominal hysterectomy surgeries (SSI)	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical	10 points if SIR <=1 or considered same as other Hospitals (nationally) – Use of confidence intervals to determine statistical	5 points if SIR is <1 and considered better than other Hospitals in the MassHealth aggregate – Use of standard confidence intervals methodology to determine	Total # of Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)

Row Number	Quality Domain	Measure ID and Name	Attainment: Threshold	Attainment: Goal	Improvement Points	Domain Scoring(Scores may not exceed 1)
			significance	significance	statistical significance (NHSN software)	
15	Patient Experience	HCAHPS: Hospital Consumer Assessment of Healthcare Provider Systems Survey	0.50 HCAHPS Composite Score No points: Composite Score used in calculating domain score	0.80 HCAHPS Composite Score No points: Composite Score used in calculating domain score	Improvement multiplier: 2 multiplied by the increase in Hospital composite score. A range of.01-.05 increase in composite score over the prior year will receive an improvement score. (E.g., .05 composite score increase yields a .1 improvement score used to calculate to domain score)	Domain Score = (Hospital Composite Score/ Goal Composite Score) + .02 Improvement Multiplier per .01 increase in composite score.
16	Perinatal Care	MAT-4: Cesarean Birth, NTSV	5 + (((Threshold – goal performance) - (hospital performance – goal))/(Threshold – goal performance))*5	10 points	5 points for meeting target (no partial credit, but stepwise). 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
17	Perinatal Care	NEWB-3: Unexpected Newborn Complications in Term Infants	Performance is >50 and <=70, 7 points	10 points	N/A	Total Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)

Row Number	Quality Domain	Measure ID and Name	Attainment: Threshold	Attainment: Goal	Improvement Points	Domain Scoring(Scores may not exceed 1)
18	Perinatal Care	SOC: Severe Obstetric Complications	10 points	10 points	N/A	Total Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
19	Behavioral Health Care	BHC-2: Medication Continuation Following Inpatient Psychiatric Discharge	Performance/ Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise). 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)
20	Behavioral Health Care	BHC-3: Screening for Metabolic Disorders	Performance/ Goal *10 = Attainment Points	10 points	5 points for meeting target (no partial credit, but stepwise). 7 points may be earned for meeting target on measures where the rate is below the threshold rate.	Total Attainment (either threshold or goal points) AND Improvement Points/ (Total number of eligible measures in each domain X 10)

D. PAM: Domain Scoring

There are two methods for calculating domain scores:

a. **For all domains except the Patient Experience domain:** The domain score is calculated by taking the number of points associated with measures in a domain that a Hospital earned (attainment + improvement points where applicable) divided by the maximum number of attainment points that the Hospital could have earned per measure (10 points) multiplied by the number of measures the Hospital was eligible for. The domain score that is calculated represents a ratio value between 0-1 (inclusive of 0 and 1). In cases where the domain score is calculated and yields a score greater than 1, the domain score value is capped at 1.

Domain Score Calculation:

$$\frac{(Sum\ of\ attainment\ and\ improvement\ points\ for\ measures\ in\ the\ domain)}{10 \text{ x (number of measures a hospital was eligible for in the domain)}}$$

b. **Patient Experience Domain scoring**: A domain score is calculated by taking a Hospital's measure composite score and dividing it by the goal composite score. If the Hospital also improved over the prior year (or highest prior year), a 2 improvement multiplier will be applied for improvement in the Hospitals composite score (minimum improvement in composite score of .01, maximum of .05). The domain score that is calculated represents a ratio value between 0-1 (inclusive of 0 and 1). In cases where the domain score is calculated and yields a greater than 1 score, the domain score value is capped at 1.

Domain Score Calculation:

(Hospital member experience composite measure Score / Goal member experience composite Score) + (2 x score improvement in the Hospital's composite score over the prior year or highest prior year) *Composite score improvement must be at least .01 and at most .05 to receive an improvement score and will be rounded.*

E. PAM: Hospital Quality Score and Earned Incentive Calculation

EOHHS will calculate a Hospital quality score by multiplying the domain scores for each domain by the domain weights detailed in **Exhibit 5**, and then summing the resulting weighted domain scores together. The Hospital's overall quality score will be a number between zero (0) and one (1), inclusive.

A Hospital's domain weights will be contingent on the Hospital's domain participation. For example, some Hospitals may report on the core and perinatal domains, while other Hospitals may report on only the core domains, etc. Hospital domain weights must equal 1 in calculating a Hospital's overall quality score and include only the domains for which the Hospital is required to participate.

Exhibit 5: Domain Weighting

Row Number	Domains	Core and Perinatal Domain Weights	Core and BH Domains	Core, Perinatal and BH Domains	Core Only Domain Weight	Core Only/no Patient Exp. Weight
1	Coordination/Integration of Care	0.25	0.25	0.20	0.25	0.33
2	Care for Acute and Chronic Conditions	0.15	0.15	0.15	0.20	0.33
3	Safety	0.25	0.25	0.25	0.30	0.34
4	Patient Experience	0.20	0.20	0.20	0.25	n/a
5	Perinatal Care	0.15	n/a	0.10	n/a	n/a
6	Behavioral Health Care	n/a	0.15	0.10	n/a	n/a
7	**Total Weight**	1.00	1.00	1.00	1.00	1.00

Domain weights are assigned employing the following principles:

- Emphasis of weighting on Coordination/Integration of Care and Safety Domain given number of measures, followed by Patient Experience
- Perinatal Care, Behavioral Health Care and Care for Acute and Chronic Conditions assigned similar weighting where possible
- Hospitals reporting on fewer domains have a larger weighting spread over the fewer domains
- Hospital required participation in domains is weighted to equal 1.00

a. **Hospital Quality Score:** The Hospital's quality score is calculated using the following formula:

Sum of each (Domain Score X Domain Weighting) = Ratio between 0-1

Below is an example of how the Hospital quality score is calculated for a Hospital that participates in all measure domains with the following Hospital domain scores.

Exhibit 6: Hospital Quality Score Example

Row Number	Domain	Domain Weighting (a)	Hospital Domain Score (b)	Weighted Domain Score (a X b)
1	Coordination/ Integration of Care	.20	1.0	.20
2	Care for Acute and Chronic Conditions	.15	1.0	.15
3	Patient Safety	.25	.92	.23
4	Member Experience	.20	.92	.184
5	Perinatal Care	.10	.9	.09
6	Behavioral Health Care	.10	1.0	.10
7	Quality Score	1.00	n/a	.954

In the example above, the Hospital quality score is the sum of domain weights multiplied by domain scores:

(.20 x 1) + (.15 X 1) + (.25 X .92) + (.20 X .92) + (.10 X .90) + (.10 X1.0) = .954 = .95

b. **Hospital CQI Program - Earned Incentive Dollars:** A Hospital may earn CQI Program incentive dollars through its Hospital quality score and the eligible CQI incentive dollar amount that the Hospital is eligible to earn per **Section 7B.6** of the RFA.

A Hospital's CQI earned incentive dollars is calculated as follows:

Hospital CQI earned incentive dollars = Hospital Quality Score X Hospital eligible incentive dollars

Example: .95 (Hospital Quality Score) X $1M (Eligible incentive dollars) = $950,000

4. CQI Program Reporting Requirements

a. As set forth in **Section 7B.6** of the RFA, each Hospital must comply with all reporting requirements inclusive of data submission timelines, data reporting formats, portal registration requirements, and participant forms submission requirements further described in the EOHHS Technical Specifications Manual and release notes.
Measure Reporting

i. Chart-based Measure. Chart-based measures must be reported on all relevant Medicaid payer codes further outlined in the applicable EOHHS Technical

Specifications Manual and in accordance with the data submission cycle due dates.

ii. Data-Entry Measure. Data-entry measures must be submitted annually using the web-based data collection tools specified by EOHHS in the applicable Technical Specifications Manual.

b. **Performance Evaluation Periods.** RY2027 performance evaluation periods are detailed in the applicable EOHHS Technical Specifications Manual.

c. **Data Accuracy and Completeness Requirements.** Hospitals must meet data accuracy and completeness requirements, including timeliness requirements, for all CQI quality measures listed in **Exhibit 1** as described below, and as further described in the EOHHS Technical Specifications Manual. Failure to meet requirements will affect the Hospital's eligibility for quality scoring on the measure.

i. **Chart-Abstracted Measures Data.** Hospitals are required to submit complete data on all chart-based measures, including Race and Hispanic Indicator to support the Hospital Quality and Equity Incentive Program outlined in **Section 8.A,** in the form of electronic data files, aggregate ICD patient population data, and proper documentation for chart validation purposes, for each quarterly discharge period being reported. The Hospital data files must include all cases that meet the inclusion criteria for each measure's eligible patient population and conform to the XML file layout format with all required MassHealth patient identifier data. Each Hospital must also enter the ICD patient population data that supplements the upload of electronic data files, for each reporting quarter, via the secure portal.

ii. **National Registry-Based Measures Data.** EOHHS relies on the completeness and accuracy of the HAI data, as collected and reported by Hospitals to the CDC's NHSN registry surveillance tracking system, to ensure reliability and comparability of results across facilities. Hospitals must adhere to all NHSN required collection and reporting protocols for the HAI measures listed on **Exhibit 1,** including and in accordance with all requirements further outlined in the EOHHS Technical Specifications Manual.

iii. **National Survey-Based Measures Data.** EOHHS relies on the completeness and accuracy of nationally reported HCAHPS archived data posted on the CMS Provider Data Catalog website. Hospitals must adhere to the survey data collection and reporting protocols in applicable versions of the quality assurance guidelines posted on the CMS sponsored website http://www.hcahpsonline.org/.

iv. **Data-Entry Measure Data for the all-payer population.** The BHC-3, OP-1e and SOC measures for which data is abstracted for an all-payer population and submitted to CMS are required to be reported via the EOHHS-approved web-

based entry tool method. These measures will ONLY require aggregate numerator and denominator values and other elements outlined in the applicable version of the EOHHS Technical Specifications Manual. Hospitals must attest that the data submitted for these elements yield the same measure result to what is calculated through the CMS submission.

v. Each Hospital is required to sign and submit the MassHealth Hospital Data Accuracy and Completeness Attestation (DACA) Form that acknowledges specific quality reporting exceptions for measures listed in **Exhibit 1** of this **Appendix J** based on a non-existing service line or other federal CMS IPPS granted exemption, per instructions in **Section 4.c** of this **Appendix J**, by the due date set forth in **Section 4.f** of this **Appendix J**.

d. **Data Submission Timelines.** All electronic data files for the Hospital quality performance measures must be submitted by the due dates noted in the applicable EOHHS Technical Specifications Manual.

e. **Data Reporting Format.** All electronic data for the individual chart-based and data-entry measures must be submitted using the following formats:

i. **MassHealth Quality Exchange (MassQEX) Portal.** EOHHS has designated the MassQEX website, available at https://www.mass.gov/service-details/massqex-portal, as the secure portal for the submission of all electronic data files required. The MassQEX portal meets HIPAA requirements to ensure data confidentiality is protected. All Hospitals must identify and designate staff that will conduct data transactions on their behalf, plus meet portal system requirements. All users of the MassQEX portal system are required to complete the on-line registration form via the website, which requires designation from the Hospital's Key Quality Contact and the EOHHS vendor to establish user accounts for uploading data and downloading all medical record request lists, year-end results, and performance reports of the applicable quality measures listed in **Section 2** of this **Appendix J**, per instructions set forth in the EOHHS Technical Specifications Manual.

ii. **ICD On-line Data Entry Form.** All aggregate ICD patient population data for chart-abstracted measures must be reported via the secure web portal using the on-line data entry form. This form is only visible to registered users after they have logged into the MassQEX system. Hospitals must comply with ICD data entry for each quarterly submission cycle even when the Hospital has zero cases to report during a given quarter. Only Hospitals, and not third-party data vendors, are authorized to enter ICD data. Instructions on how to access and enter the ICD data are contained in the applicable EOHHS Technical Specifications Manual.

iii. **Third-Party Data Vendors.** Hospitals can identify third-party vendors to

conduct clinical data file transactions on their behalf via the MassQEX secure portal. Third-party data vendors must follow the registration process and establish user accounts, if previously designated by the Hospital. Hospitals are responsible for communicating directly with their data vendors on all aspects of data reporting requirements set forth in **Section 7B** of the RFA, including adherence to the appropriate versions of the EOHHS Technical Specifications Manual to ensure completeness and accuracy of data files submitted on the Hospital's behalf.

iv. **Web-Based Data Collection Tool.** EOHHS has expanded the secure MassQEX portal to include an online web-based data entry tool approved for Hospitals to report on specific measures of the RFA. Only Hospitals, and not third-party data vendors, can access the web-based data entry tool of the RFA. Measures that require using the web-based entry format cannot be submitted via an XML file or any other electronic format. Detailed instructions to specific web-based measures data reporting requirements are provided in the EOHHS Technical Specifications Manual.

v. **Medical Record Submissions.** Hospitals must use the MassQEX portal website to submit medical records requested for data validation purposes on the specified quarterly reporting cycles set forth in the applicable EOHHS Technical Specifications Manual. All Hospitals must identify and designate staff that will upload copies of medical records requested for validation, via the MassQEX secure file transfer procedures. Detailed instructions on how to prepare records for upload via secure file transfer are provided in the EOHHS Technical Specifications Manual.

f. **Program Participant Reporting Forms.**

Each Hospital is required to submit the MassHealth Hospital CQI Program participation forms **by October 30, 2026**, per the instructions set forth below:

i. **MassHealth Hospital Quality Contacts Form.** Each Hospital must complete and submit information on all staff involved in quality reporting, pursuant to **Section 7.B.5** of the RFA, using the HospContact_2027 form. This form is due at the beginning of the rate year and must be resubmitted when any change in key quality representatives and MassQEX portal users listed occurs.

ii. **MassHealth Hospital Data Accuracy and Completeness Attestation Form.** Each Hospital must submit this form to acknowledge data completeness requirements using the HospDACA_2027 form. This form must be signed by the Hospital's chief executive officer (CEO) and is due at the beginning of each rate year.

iii. **Forms.** Forms are posted on the Mass.gov webpage entitled "MassHealth Quality Exchange" at the following website:

https://www.mass.gov/masshealth-quality-exchange-massqex

5. Other Considerations

Other considerations may result in amendment(s), at EOHHS' discretion, to the RY27 RFA current or future contracts based on ongoing monitoring of the program, and as determined by EOHHS.

Considerations may include, but are not limited to:

- Adjustments in attainment or improvement point methodology
- Adjustments to address substantial differences in Hospital class quality scores
- Extenuating circumstances that may substantially impact quality performance (e.g., public health emergency)
- Opportunities to earn back unearned CQI Program incentive dollars

6. Bonus Opportunity

a. Overview

In RY2027, MassHealth anticipates providing an opportunity for hospitals to earn a bonus payment (e.g. using unearned funds). Details on included measures, data submission, and payment are expected to be released in an amendment to the RY27 RFA.

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APPENDIX K:
STANDARDS FOR BEHAVIORAL HEALTH CRISIS MANAGEMENT SERVICES

Effective as of 10/1/2023

I. Scope

To define the billing option for Acute Hospitals who choose to perform Behavioral Health Crisis Management Services in accordance with standards outlined below, on days subsequent to the initial Behavioral Health Crisis Evaluation (see Appendix I) for individuals in the Emergency Department (ED) or Medical/Surgical floors experiencing a behavioral health crisis in need of ongoing behavioral health crisis supports. Behavioral Health Crisis Management Services include ongoing behavioral health crisis interventions, ongoing determination and coordination of appropriate disposition, and ongoing reporting and community collaboration.

II. Operational Standards for Behavioral Health Crisis Management Services

A. General Procedures

i. Behavioral Health Crisis Management Services may be provided in person or via telehealth as requested by the individual, and as clinically appropriate. Behavioral Health Crisis Management Services may be provided by hospital staff or by clinicians under contract with the hospital.

B. Staffing Composition and Qualifications

i. Staffing Composition:

Behavioral Health Crisis Management Services shall be provided by members of a multidisciplinary team that shall minimally include the availability of the following:

a. A qualified behavioral health professional. A qualified behavioral health professional shall provide behavioral health crisis interventions, and perform, or assist with, disposition planning, care coordination, reporting, and community collaboration procedures. Qualified behavioral health professionals, shall include, but not be limited to, a: (i) licensed physician who specializes in the practice of psychiatry; (ii) licensed psychologist; (iii) licensed independent clinical social worker; (iv) licensed certified social worker; (v) licensed mental health counselor; (vi) licensed physician assistant who practices in the field of psychiatry (vii) advanced practice registered nurses who practice in the field of psychiatry, including but not limited to licensed nurse practitioners and licensed psychiatric clinical nurse specialists; or (viii) healthcare provider qualified within the scope of the individual's license, or advanced education pre-licensure, to conduct an

evaluation of a behavioral health condition, including an intern, resident or fellow pursuant to the policies and practices of the hospital and medical staff.

b. A complex behavioral health care clinician. A complex behavioral health care clinician shall be available to provide consultation to the qualified behavioral health professional or multidisciplinary staff regarding issues with reassessment or intervention for members with complex clinical presentations, including individuals with significant medical comorbidity, severe behavioral disturbance, or complicated medication regimens. Complex behavioral health care clinicians shall include appropriately experienced psychiatrists or advanced practice providers (Advanced Practice Registered Nurses or Physician Assistants). Complex behavioral health care clinicians may provide consultation to the team by phone/video when in-person consultation is not available or clinically necessary.

c. Multidisciplinary staff. In addition to staff listed in **Appendix K**, **Section II.B.i.a** and **II.B.i.b**, the behavioral health crisis management team may include other staff, including certified peer specialists and recovery coaches, with appropriate training and experience to provide a welcoming, supportive, responsive, and recovery-oriented encounter.

ii. Qualifications:

Hospitals must ensure that personnel delivering Behavioral Health Crisis Management Services possess appropriate education and training to meet the unique clinical needs of persons across the lifespan. In addition, staff must be knowledgeable of condition- and population-specific behavioral health interventions and care delivery models (e.g., substance use disorders, developmental disorders, eating disorders, and behavioral manifestations of dementia).

C. Procedural Components of Behavioral Health Crisis Management Services

i. Crisis Interventions

a. The hospital shall provide monitoring, treatment, and support to individuals experiencing a behavioral health crisis to:

i. stabilize the individual's physical and behavioral health status

ii. ensure safety of the individual in the hospital

iii. restore functioning

iv. strengthen the resources and capacities of the individual, family, and other natural supports

v. prepare the individual for a timely and safe disposition to the most appropriate and least-restrictive setting

b. Crisis interventions must be tailored to each individual's unique presentation on

the billing calendar day and must be documented accordingly in the hospital medical record.

c. On each billing calendar day, the hospital shall conduct and document in the hospital medical record a crisis reassessment, which must minimally include the following:

   i. Any updates to the psychiatric history, including from relevant collaterals familiar with individual's history (in accordance with HIPAA privacy rules in emergency situations), community treatment plan, or the events and context that led to the individual presenting to the hospital.

   ii. An updated mental status examination

   iii. Any updates to the individual's ability and capacity to respond to treatment, or any observed response to crisis interventions

   iv. Any updates to the diagnostic evaluation

   v. Any updates to the assessment of current or past use of substances

   vi. Any updates to the clinical bio-psychological-social formulation

   vii. An updated treatment plan, which must capture any changes in presentation throughout the individual's hospital stay, and include the recommended least restrictive and appropriate level of care and post-stabilization interventions

   viii. Should the individual require any active safety interventions (i.e. arms-length 1:1 safety observation or interventions of equal or higher intensity) on the billing calendar day, the crisis reassessment should capture the hospital's assessment of the individual's safety risks in the hospital, including contextual risks unique to the individual, and the hospital's active interventions to mitigate those risks

d. Guided by the age and treatment preferences of the individual, the hospital shall actively involve family and other natural supports at a frequency based on individual needs- and in accordance with HIPAA privacy rules in emergency situations.

e. The hospital shall coordinate treatment with existing and/or newly established treatment providers and consultants.

ii. Disposition Planning and Care Coordination Procedures

a. Post assessment, the hospital shall develop a disposition plan to an appropriate level of care and goals for that level of care.

b. The discharge disposition must be to a distinct level of care (including home with provider referral information) unless the individual declines.

c. The hospital shall gather information from all relevant collaterals (in accordance with HIPAA privacy rules in emergency situations) to inform appropriate disposition planning.

d. Initial consideration, when clinically appropriate, shall be given to all diversionary levels of care available to MassHealth Members. Diversion is to be explored, discussed, and utilized when safety can be maintained in a level of care lower than hospitalization.

e. For individuals going to a 24-hour level of care, the hospital is responsible for bed finding, and shall obtain any required insurance notifications or authorizations for levels of care included in the discharge plan and shall arrange any necessary transportation. The hospital shall inform all collateral providers of the disposition (in accordance with HIPAA privacy rules in emergency situations) and inform the 24-hour level of care of the contact information for collaterals. The hospital is also responsible for warm handoff to all 24-hour levels of care, including review of Member's hospital course to date.

f. The hospital is responsible for all disposition planning to community-based services, inclusive of warm hand off to a Community Behavioral Health Center (CBHC), and all included services, or other community-based outpatient provider, in any instance that is clinically appropriate.

g. All individuals who receive crisis evaluation services in the hospital are eligible for community-based post-crisis stabilization services by the Adult and Youth Mobile Crisis Intervention teams (AMCI/YMCI) after leaving the hospital. Where clinically indicated and in consideration of the disposition plan, the hospital shall contact the AMCI/YMCI to conduct a warm hand off for follow up behavioral health crisis intervention services.

h. All individuals shall be provided the contact information for their local AMCI/YMCI and CBHC in the event of a need for future crisis evaluation and support.

i. The discharge plan must address safety planning specific to the presenting problem and inclusive of resources to utilize in crisis, crisis prevention, referral to appropriate community resources, post-stabilization services, and follow-up instructions.

iii. All individuals who present with opioid use who are discharged to the community shall be offered nasal Naloxone and given resources for medication-assisted treatment (MAT)/medication for opioid use disorder (MOUD) and other support services.
Reporting and Community Collaboration Expectations

a. Hospitals must notify MassHealth by using the Massachusetts Behavioral Health Access (MABHA) website, or other process as specified by EOHHS, not later than 24 hours after a MassHealth member identified as requiring inpatient

psychiatric hospitalization arrives in the Acute Hospital's ED and has not yet been admitted to an appropriate inpatient psychiatric setting. The hospital shall follow procedures specified by EOHHS for removal of an individual from the list once the individual is no longer awaiting disposition.

b. The hospital must follow the EPIA protocol for reporting all individuals awaiting psychiatric inpatient placement (EPIA protocol may be accessed here: Mass.gov. https://www.mass.gov/info-details/expedited-psychiatric-inpatient-admissions-epia-policy#epia-protocols-).

c. All hospitals shall establish and maintain referral relationships with their local CBHC(s), and participate in ongoing collaboration, planning, and process implementation to ensure a successful and seamless experience for individuals in crisis, and to ensure continued enhancement to the crisis system.

III. Billing Requirements

A. Billing requirements for Behavioral Health Crisis Management Services apply to individuals experiencing a behavioral health crisis demonstrating ongoing needs for crisis supports subsequent to the initial Behavioral Health Crisis Evaluation, either in the ED or while admitted to a medical/surgical bed.

B. The following billing option will be reimbursed outside of the APEC for members in an ED and will be reimbursed outside of the APAD for members in a medical/surgical bed.

i. As per scope in **Appendix K, Section I** and operational standards in **Appendix K, Section II**, hospitals may bill one of the following two options on any one calendar day:

a. Level 1 Behavioral Health Crisis Management Services: S9485, V1 modifier, no more than one unit per day. This option should be used for the provision of Behavioral Health Crisis Management Services, in accordance with Operational Standards for Behavioral Health Crisis Management Services (**Appendix K**, **Section II**), for members requiring ongoing safety monitoring but without the need for active safety interventions, as described in **Appendix K**, **Section III.B.i.b**, below, on the billing calendar day.

b. Level 2 Behavioral Health Crisis Management Services: S9485, V2 modifier, no more than one unit per day. This option should be used for the provision of Behavioral Health Crisis Management Services, in accordance with Operational Standards for Behavioral Health Crisis Management Services (**Appendix K**, **Section II**), for members requiring active staff safety monitoring and intervention to prevent, or respond to, attempts of self-injury or aggression in the hospital on the billing calendar day (i.e., arms-length 1:1 safety observation or interventions of equal or

higher intensity).

c. The Hospital's compliance with this **Appendix K**, **Section III** will be subject to auditing and validation by EOHHS.

ii. S9485, with V1 modifier and S9485 with V2 modifier cannot be billed on the same date of service, and neither can be billed for the on the same date of service as Behavioral Health Crisis Evaluation (S9485, without modifiers).

iii. Any clinical service outside of the scope of Behavioral Health Crisis Management Services other than Behavioral Health Crisis Evaluation can continue to be billed separately, as per applicable billing rules, including, but not limited to:

a. Direct psychiatric evaluation of the member by a psychiatrist or advanced practice provider (Advanced Practice Registered Nurses or Physician Assistants) requested by the primary hospital medical team for diagnostic clarification and treatment recommendations (90791, 90792, 99201-99205, 99211-99215, 99241-99245, 99251-99255).

b. Intensive, specialized therapies or therapeutic consultations requested by the primary hospital team to support the stabilization efforts of members in the hospital with complex needs, including Applied Behavioral Analysis for members with Autism Spectrum Disorder.

c. Initiation of medication for the treatment of opioid use disorder in the Emergency Department setting and connection to recovery support navigation in the Emergency Department (G2213 and H2015-TF respectively).

d. Community-Based Mobile Crisis Intervention services provided to the member on their day of discharge as a warm handoff to facilitate a smooth disposition to the community.

e. Children's Behavioral Health Initiative services provided to family members/caregivers of youth members throughout the member's stay in the hospital to help strengthen the resources and capacities of the family to support the member in the community upon discharge.

iv. Any MassHealth payment made to the Hospital for a Behavioral Health Crisis Management Service, based on a claim or invoice submitted by a Hospital, on the same calendar day as a similar service provided and billed by a non-hospital provider shall constitute an overpayment as defined by 130 CMR 450.235 and will be subject to recoupment.

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APPENDIX L:
CLINICAL COMPETENCIES AND OPERATIONAL STANDARDS FOR SPECIALTY INPATIENT PSYCHIATRIC SERVICE FOR CHILDREN/ADOLESCENTS WITH NEURODEVELOPMENTAL DISORDERS

I. Eligibility

A. A Hospital is eligible to provide a Specialty Inpatient Psychiatric Services for Children/Adolescents with Neurodevelopmental Disorders if the Hospital:

i. Agrees to:

1. Admit and provide treatment for Members under 21 with severe behavioral manifestations of Autism Spectrum Disorders (ASD)/Intellectual Disabilities (ID) and co-occurring mental health conditions;

2. Maintain staffing levels and programming components appropriate to ensure the safety of Members and capacity to provide the appropriate treatment intensity to meet the clinical needs of Members receiving Specialty Inpatient Psychiatric Services for Children/Adolescents with Neurodevelopmental Disorders;

3. Meet all requirements described in **Appendix L**, including components of service;

4. Maintain a safety management technique recommended for this Members receiving Specialty Inpatient Psychiatric Services for Children/Adolescents with Neurodevelopmental Disorders;

5. Maintain written treatment protocols for all required service components as described in **Appendix L**, and to make such treatment protocols available to EOHHS by request.

ii. Is a Contractor with DMH-Licensed Beds; and

iii. Complies with all other requirements of this Contract.

II. Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders Staffing Composition and Qualifications

A. The Hospital shall staff the Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders with at least one attending psychiatrist with relevant training, experience, and demonstrated expertise in treating children/adolescents with Neurodevelopmental Disorders and co-occurring mental health conditions. Any psychiatrists supporting Specialty Program services shall maintain current expertise and relevant certification through ongoing training.

B. The Hospital shall ensure the Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders is appropriately supported by multi-disciplinary staff with established skills, training and/or expertise in the treatment of Members with Neurodevelopmental Disorders and mental health conditions. This team must include sufficient staff members to support the following treatment modalities:

   i. Child psychiatry;

   ii. Behavioral psychology;

   iii. Applied behavioral analysis by Board-certified behavioral analyst;

   iv. Speech/language therapy including expertise in using AAC devices;

   v. Occupational therapy;

   vi. Social work;

   vii. Nursing;

   viii. Direct care by Milieu counselors /Behavior technicians;

   ix. Coordination by school liaison; and

   x. Discharge planning coordination

C. The Hospital shall ensure all multi-disciplinary staff members supporting the Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders receive mandatory trainings related to the clinical needs of this specialty population to ensure clinical competency among the treatment team. Trainings must at least include the assessment and treatment of children/adolescents with:

   i. ASD/ID;

   ii. Common comorbid genetic syndromes

   iii. Common comorbid neurological disorders

   iv. Learning disorders;

   v. Motor skills disorders;

   vi. Communication disorders; and

vii. Common comorbid conditions and concerns (e.g., obesity, Post-Traumatic Stress Disorder, etc.).

III. Components of Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders

A. Consultation and Screening: The Hospital shall ensure medical consultation with appropriate clinicians with relevant expertise are provided to assist in assessing the medical conditions and needs of Members with Neurodevelopmental disorders and co-occurring mental health conditions disorders. The Hospital shall regularly screen for Neurodevelopmental disorders and co-occurring mental health conditions disorders, as appropriate.

B. Assessment: The Hospital shall provide assessments to Members receiving Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders. Assessments must be provided at time of admission and updated as clinically indicated include:

i. History of placements outside the home and residential placements for special education for children and adolescents in the care and/or custody of the Commonwealth;

ii. Educational records inclusive of progress reports within the last three years;

iii. Behavioral intervention data;

iv. Individualized Education Programs (IEPs), when applicable;

v. Individual Care Plans (ICPs) for Intensive Care Coordination (ICC)-enrolled youth, when applicable;

vi. Consideration of the impact and special needs related to the Member's Neurodevelopmental Disorder;

vii. Neurological evaluation(s);

viii. Other medical evaluations, as clinically appropriate;

ix. Neuropsychological evaluation(s); and

x. Other consultation reports (i.e., occupational therapy, physical therapy, etc.), as clinically appropriate.

C. Treatment and Treatment Planning: The Hospital shall develop a treatment plan for all Members admitted to the Specialty Inpatient Psychiatric Service for Children/Adolescents with Neurodevelopmental Disorders, in accordance with 130 CMR 425.416. Treatment plans must include specific goals and interventions to meet the Member's needs related to their Neurodevelopmental Disorders. The Hospital shall provide the following required service components by staff who are skilled in treating Members with Neurodevelopmental Disorders:

i. Functional behavioral assessment and functional behavioral treatment planning;

ii. Adaptive functioning assessment and treatment planning

iii. Sensory issue assessment and treatment planning;

iv. Functional communication assessment and treatment planning;

v. Social communication assessment and treatment planning;

vi. Neurological assessment and treatment planning; and

vii. Family support, training, and education.

D. Referrals: The Hospital shall provide or refer the member to the following services, as clinically indicated, within two days of admission:

1. Neurological consultation

2. Assistive technology/Augmentative and alternative communication (AAC) assessment

3. Physical therapy consultation

4. Gastroenterology consultation

5. Endocrinology consultation;

6. Nutritional consultation;

7. Genetic assessment; and

8. Neuropsychological and/or neurodevelopmental testing.

E. Discharge Planning: The Hospital shall ensure that all discharge planning activities address the Members' needs related to their Neurodevelopmental Disorder and co-occurring psychiatric conditions. Discharge planning shall include:

i. Referrals to aftercare services that offer appropriate services to this population and their parents/guardians, including providing parents/guardians with information about, and make appropriate connections to, community-based support for families of individuals with Neurodevelopmental disorders.

ii. Care coordination with state agencies, special education directors and other state agencies, as needed, including facilitation of collaboration between parent/guardian(s), local educational authorities, and involved state agencies including, to coordinate treatment, bolster community-based supports, and facilitate successful discharge planning; and

iii. Provision of Member home visits, as appropriate, with the treatment team

available as a resource to families during home visits.

F. Collateral Engagement: Hospitals shall ensure assessments, treatment planning and discharge planning components of services include parent/guardian(s), as much as clinically appropriate. Including:

   i. Encouraging family participation in treatment as much as possible, preferably in person, including during visits to the unit to see the Member;

   ii. Staffing appropriately to provide behavior training during weekends; and

   iii. Encouraging weekly family meetings with parents/guardians or other family members.

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APPENDIX M:

STANDARDS FOR INITIATION OF MEDICATION FOR THE TREATMENT OF OPIOID USE DISORDER IN THE ED AND MEDICAL/SURGICAL SETTINGS

I. Scope:

This **Appendix M** defines the responsibilities of Acute Hospitals in initiating Medication for the Treatment of Opioid Use Disorder In the ED. Pursuant to Chapter 208 of the Acts of 2018, Emergency Departments are mandated to have the capacity to provide medications to treat opioid use disorders (MOUD). Hospitals may be reimbursed for services that support the long term recovery of members, including the induction of patients onto MOUD in the ED.

1. General Procedures:

When a Member presents in the Emergency Department seeking treatment for any medical or behavioral health need, and is found to have signs or symptoms of an opioid use disorder, an appropriate prescriber may evaluate the patient for medication for the treatment of opioid use disorder and initiate the medication, in addition to treating the presenting health need.

2. Staffing Composition and Qualifications:

a. All health care practitioners with a standard DEA controlled medication registration that includes Schedule III authority will be able to prescribe buprenorphine for opioid use disorder without separate registration or patient limits, subject to state requirements.

b. Any such healthcare provider is eligible to provide the evaluation and initiation of MOUD, as covered by the G2213 code.

3. Procedural Standards for Components of the MOUD service in the ED

a. The MOUD service in the ED is designed for individuals presenting to the hospital for any medical or behavioral health need, who are then identified by the hospital staff as having signs or symptoms of an untreated opioid use disorder.

b. When such a patient is identified, their presenting medical or behavioral health need must be treated as standard of care requires.

c. A qualified prescriber may offer the patient medication to treat opioid use disorder, and if they consent, the prescriber should initiate medication for the treatment of opioid use disorder.

4. Billing and Reimbursement Requirements

a. The induction of Medication for the Treatment of OUD will be reimbursed outside of the APEC for Members receiving induction of medication for the treatment of OUD in the ED.

i. Hospitals may bill G2213, no modifier, for induction of Medication for the Treatment of OUD in the ED.

ii. G2213, no modifier, may be billed no more than one unit per day per Member.

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APPENDIX N:

STANDARDS FOR RECOVERY SUPPORT NAVIGATORS AND RECOVERY SUPPORT NAVIGATOR SERVICES FOR PREGNANT AND POSTPARTUM MEMBERS IN THE ED, OUTPATIENT DEPARTMENT, AND MEDICAL/SURGICAL FLOORS

1. Scope:

   This **Appendix N** defines the responsibilities of Acute Hospitals in the Provision of Recovery Support Navigator Services. Pursuant to Chapter 208 of the Acts of 2018, Emergency Departments are mandated to have the capacity to provide medications to treat opioid use disorders (MOUD). Hospitals may be reimbursed for services that support the long term recovery of members, including for Recovery Support navigator Services that are provided in Emergency Departments or on Medical/Surgical floors and Recovery Support Navigator Services for Pregnant and Postpartum Members that are provided in the Emergency Department, Outpatient Department or on Medical/Surgical floors to support patient warm hand-offs to outpatient care.

2. Operational Standards:

   a. If the patient is initiated onto medication for opioid use disorder in the ED setting (see **Appendix L**), the patient should also be offered Recovery Support Navigator Services or Recovery Support Navigator Services for Pregnant and Postpartum Members, as appropriate, in order support their referral to ongoing care and supportive services, pursuant to **Section 5.B.13** or **5.C.17**.

   b. Staffing Composition and Qualifications:

      i. Recovery support navigators and Recovery Support Navigator Services for Pregnant and Postpartum Members must comply with requirements stated in 130 CMR 418.000.

   c. Procedural Standards for Components of Recovery Support Navigator Services and Recovery Support Navigator Services for Pregnant and Postpartum Members

      i. Recovery Support Navigator services are designed for individuals presenting to the ED or who are admitted to a medical/surgical floor, who are identified as having signs or symptoms of an untreated substance use disorder.

      ii. Recovery Support Navigator Services for Pregnant and Postpartum members are designed for individuals presenting to the ED, Outpatient Department or who are admitted to a medical/surgical floor, who are identified as having signs or symptoms of

an untreated substance use disorder and are pregnant up to 12 months postpartum, inclusive of all pregnancy outcomes.

1. If the patient presents to the ED and their presenting condition has stabilized so that they may be safely discharged from the ED to the community, the patient should be offered recovery support navigator services, so that the patient may be connected to an outpatient level of care that can maintain them in long-term SUD recovery.
2. If the patient's presenting condition requires that they be admitted to the medical/surgery floor or other acute care setting within the hospital, the patient should also be offered recovery support navigator services as part of their discharge plan from the acute care setting so that the patient may be connected to an outpatient level of SUD care that can support them in long-term SUD recovery.
3. If the patients presents or is being treated in the Outpatient Department and the presenting conditions include Substance Use Disorder and pregnancy or a pregnancy in the previous 12 months, inclusive of all pregnancy outcomes, the patient should be offered Recovery Support Navigator Services for Pregnant and Postpartum Members to support their SUD recovery and assist them through care navigation with collateral providers.

3. Billing and Reimbursement Requirements

   a. The following billing options will be reimbursed outside of the APEC for members in an ED and Outpatient Departments and will be reimbursed outside of the APAD for members in a medical/surgical bed.

      i. On any one calendar day, Recovery support navigators and Recovery Support Navigator Services for Pregnant and Postpartum Members services rendered in accordance with this **Appendix N** and the RFA may be billed according to the procedure code and modifier set forth for Recovery support navigators and Recovery Support Navigator Services for Pregnant and Postpartum Members services in 101 CMR 444.00, and paid with the floor rate of the unit rate (per 15 minutes of service) set forth in such regulation.

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APPENDIX O:

SPECIALTY INPATIENT PSYCHIATRIC SERVICES FOR EATING DISORDERS/CLINICAL COMPETENCIES/OPERATIONAL STANDARDS

I. Eligibility

A Hospital is eligible to provide Specialty Inpatient Psychiatric Services for Eating Disorders if the Hospital:

1. Agrees to:

   i. Admit and provide treatment for members with an eating disorder diagnosis and requiring acute psychiatric and medical stabilization;

   ii. Maintain staffing levels and programming components to provide the appropriate treatment intensity and meet the clinical needs of Members receiving Specialty Inpatient Psychiatric Services for Eating Disorders;

   iii. Meet all requirements described in **Appendix O**, including components of service; and

   iv. Maintain written treatment protocols for all required service components as described in **Appendix O**, and to make such treatment protocols available to EOHHS by request.

2. Is a Hospital with DMH-Licensed Beds.

3. Complies with all other requirements of this Contract.

II. Staffing Composition and Requirements:

1. The Hospital shall staff the Specialty Inpatient Psychiatric Services for Eating Disorders programming with at least one attending psychiatrist with relevant training, experience, and demonstrated expertise in treating individuals with severe Eating Disorders and co-occurring behavioral health conditions, and maintains current expertise and relevant certification through ongoing training.

2. The Hospital shall ensure the Specialty Services for Eating Disorders Program is appropriately supported by a multi-disciplinary staff with established skills, training, and/or expertise in the integrated treatment of eating disorders, and include adequate

psychiatric, medical, nursing, social work, credentialed nutritionist and counseling staff, and clinical assistant/nurses' aide staff to ensure that all required components of service are met.

3. The Hospital shall ensure all multi-disciplinary staff members supporting the Specialty Inpatient Psychiatric Services for Eating Disorders receive mandatory training related to the clinical needs of this specialty population are available to ensure clinical competency among the treatment team. Trainings must at least include the following:

   i. The assessment and treatment of eating disorders and co-occurring behavioral health conditions;

   ii. Phases of the recovery process (acute stabilization, engagement, active treatment to maintain stabilization, and wellness and recovery);

   iii. Medical complications of eating disorders;

   iv. Integrated treatment approaches including integration with primary care; and

   v. Family systems issues related to the treatment of eating disorders.

III. Service Components

1. Consultation: The Hospital shall ensure Members are able to obtain appropriate laboratory tests and cardiac monitoring, as clinically indicated, and physicians shall be available for consultation relative to medical complications, if any.

2. Assessment: At the time of admission, the Hospital shall provide assessments to Members receiving Specialty Inpatient Psychiatric Services for Eating Disorders as follows:

   i. A nursing assessment, and

   ii. An assessment of the Member's eating disorder, co-occurring behavioral health disorders, and potential medical complications.

3. Treatment and Treatment Planning: The Hospital shall develop a treatment plan in accordance with 130 CMR 425.416 and engage in ongoing treatment for all Members receiving Specialty Inpatient Psychiatric Services for Eating Disorders as follows:

   i. Treatment plans shall include specific goals and interventions specific to the Member's eating disorder, co-occurring behavioral health disorders, and potential medical complications.

   ii. Treatment shall include a comprehensive, structured treatment program, which, at a minimum, includes three hours or more per day of psycho-educational groups on the psychological and medical effects of eating disorders, related mental health issues, and the complications associated with dual recovery. The Hospital shall assign each Member a primary clinician and/or treatment team that develops a treatment and a rehabilitation and recovery program and coordinates ongoing treatment interventions

for their eating disorder(s). The hospital shall ensure the following required service components are provided by staff who are skilled in treating Members with Eating Disorders:

a. Medical monitoring and management, provided under the supervision of physicians, of medical sequelae of severe eating disorders, including, but not limited to, cardiovascular complications (ex. bradycardia, arrythmias, orthostatic hypotension), electrolyte imbalance (ex. refeeding syndrome), gastrointestinal complications (ex. constipation), hormonal/endocrine imbalance (ex. menstrual irregularities, osteopenia/porosis);

b. Medical interventions to support recovery, including, but not limited to, administration of feeding tubes;

c. Nutrition monitoring, education, counseling, and management overseen by a credentialed nutritionist;

d. Behavioral monitoring to prevent disordered eating behavior;

e. Evidence-based individual, group, milieu, and family psychotherapy treatment protocols specific for members with diagnosed eating disorders; and

f. Peer support and/or other recovery-oriented services.

4. Referrals: If clinically indicated, the Hospital shall provide, or refer, the Member to the following:

i. Dermatology consultation;

ii. Dental consultation;

iii. Endocrinology consultation;

iv. Gastroenterology consultation;

v. Neurology consultation; and

vi. Physical therapy consultation.

5. Discharge Planning: The Hospital shall ensure that all discharge planning activities address the Member's needs related to their eating disorder diagnoses, including:

i. Referrals to aftercare services that offer appropriate services address eating disorder recovery, and make appropriate connections to community-based support for families of individuals with eating disorders.

ii. Involvement of the Member's primary care provider (PCP) in discharge planning and providing a copy of the discharge summary (or other such document(s) that contain the required elements) to the Member's PCP within required timeframes.

iii. Care Coordination with parent/guardian(s), local educational authority, involved state agencies, and others to coordinate treatment, bolster community-based supports, and facilitate successful discharge planning, as clinically appropriate.

Commonwealth of Massachusetts
Executive Office of Health and Human Services

APPENDIX P:

HEALTH INFORMATION TECHNOLOGY AND HIE REQUIREMENTS

1. The Hospital shall establish and implement policies and procedures to:

    a. Enhance interoperability of its health information technology to support the continued evolution of patient clinical data and operational data;

    b. Increase utilization of Health Information Exchange services operated or promoted by the Mass HIway (e.g., direct messaging, Statewide Event Notification Service Framework);

    c. When future Mass HIway services are developed, operated, or promoted (e.g., FHIR-based APIs), and the Contractor is notified as further specified by EOHHS, the Contractor shall establish and implement policies and procedures to increase their connectivity to such services; and

    d. Upon notification by EOHHS of its implementation, participate in the Behavioral Health Treatment and Referral Platform (BHTRP), including the ability to both create and receive updates from providers using the BHTRP to support members.

2. The Hospital shall provide documentation of the policies and procedures described in **Section 1** of this **Appendix P** within 30 calendar days of an EOHHS request;

3. The Hospital shall ensure that all of its providers enable and utilize Query and Retrieve functionality that is natively available in the behavioral health providers' EHRs (e.g., via the Carequality or Commonwell networks) for the purpose of Health Information Exchange;

4. The Hospital shall adopt and integrate an interoperable EHR certified by the Office of the National Coordinator (ONC) using ONC's 2015 certification edition, along with subsequent edits to the 2015 certification edition pursuant to the 21st Century Cures Act;

5. The Hospital must be able to access or receive event notifications from a Certified ENS Vendor participating in the Statewide ENS Framework, and must also establish and implement policies and procedures for PCPs it may have within the hospital system to integrate such event notifications into appropriate care management or population health management workflows; and

6. Upon notification by EOHHS of its implementation, the Hospital shall utilize the BHTRP as the tool to comply with the EPIA protocol, as directed by EOHHS.