114.1 CMR 39.00: CHRONIC AND REHABILITATION PUBLICLY ASSISTED RATES OF PAYMENT AND THE FEE FOR RESIDENTIAL ALCOHOLISM TREATMENT PROGRAMS

Section

39.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.1 CMR 39.00 governs the rates of payment effective October 1, 1996 for all care and services rendered to publicly-assisted patients by Chronic and Rehabilitation hospitals. 114.1 CMR 39.00 also governs the fee for Residential Alcoholism Treatment Programs.

114.1 CMR 39.00 does not govern establishment of Medicaid and industrial accident rates of payment for psychiatric, substance abuse or state-owned hospitals. 114.1 CMR 39.00 does govern establishment of Medicaid and Industrial accident rates of payment for pediatric specialty hospitals which provide chronic and rehabilitation services to pediatric patients.

114.1 CMR 39.00 does not apply to payments made to a chronic/rehabilitation hospital under a direct contract with the Division of Medical Assistance for managed care services provided to Medicaid recipients who are inpatients of such hospital.

(2) Authority. 114.1 CMR 39.00 is adopted pursuant to M.G.L. c. 118G, St. 1982 c. 393, and M.G.L. c. 30A, § 2.

39.02: Definitions

As used in 114.1 CMR 39.00, unless the context requires otherwise, terms shall have the meanings ascribed in 114.1 CMR 39.02.

Administrative Day. An inpatient day spent in a chronic/rehabilitation hospital by a patient who has been identified by a Peer Review Organization (where applicable) or otherwise by the Division of Medical Assistance or by the Department of Public Health, or any combination of these organizations as a patient not requiring a Hospital Level of Care.

Base Year.

(a) For hospitals licensed and/or operated as chronic/rehabilitation hospitals in Fiscal Year 1993 (FY 1993), the base year is the hospital's FY 1993.

(b) For hospitals licensed and/or operated as chronic/rehabilitation hospitals in FY 1993 but which converted a majority of beds to long term care beds during FY 1993, the base year shall be FY 1994 deflated to FY 1993.

(c) For hospitals licensed and/or operated as chronic/rehabilitation hospitals in FY 1993 but which eliminated a majority of beds and closed the facility and which in subsequent years continued to provide some services in a new location and under a new management, the base year is the first cost reporting period of at least 12 months after the hospital started to provide the service at the new location.

(d) For hospitals which were not licensed and/or operated as chronic/rehabilitation hospitals in

FY 1993, the base year is the first cost reporting period of at least 12 months after the hospital is licensed and/or operated as a chronic/rehabilitation hospital.

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Commission. The Rate Setting Commission established under M.G.L. c. 6A, and currently referred to as the Division of Health Care Finance and Policy.

Direct Cost. The cost of a center as defined by the Hospital Uniform Reporting Manual (HURM) after reclassification and recoveries of expense and prior to the allocation of overhead cost to patient care cost centers through the stepdown.

DHCFP-450 Form. The Division of Health Care Finance and Policy's DHCFP-450 Form is a report which documents a facilities charges and volume, utilized for the purpose of adjusting the cost-to-charge ratio or the payment on account factor should the facility increase their charges.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G, formerly the Rate Setting Commission.

FTEs. FTE is an acronym for full-time equivalent staff. To compute full-time equivalents (FTEs), divide the total annual paid hours (including vacation, sick leave, and overtime) for all employees in each cost center by a 40 hour standard work week, annualized to a norm of 2080 hours.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, division, or political subdivision of the Commonwealth.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual, promulgated by the Division under 114.1 CMR 4.00.

New Hospital. A hospital which was not licensed and/or operated as a chronic/rehabilitation hospital in FY 1993, or which did not report a full year of actual costs in FY 1993.

Non-Acute Hospital. A hospital which is defined and licensed under M.G.L. c. 111, § 51, with less than majority of medical-surgical, pediatrics, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, § 29, or any public health care facility.

Overhead. Overhead includes expenses for depreciation, long term interest, fringe benefits, administration, plant maintenance and repairs, plant operations, laundry, housekeeping, cafeteria, dietary, maintenance personnel, nursing administration and inservice education, RN & LPN education, medical staff teaching and administration, post graduate medical education, medical records, medical care review, and social services.

Payment on Account Factor. The percentage of charge which was most recently approved by the Commission pursuant to 114.1 CMR 28.00 or 114.1 CMR 37.00 for eligible services rendered to publicly-assisted patients.

Public Health Care Facility. A facility operated by the Department of Public Health, the Department of Mental Health, a County of the Commonwealth, or a Soldiers' Home which provides inpatient medical, skilled nursing, or mental retardation care and services and which may provide outpatient medical, mental health, or mental retardation care and services.

Publicly Aided Patient. A person who receives health care and services for which a governmental unit is in whole or part liable under a statutory program of public assistance.

Rate Year. The rate year is the 12 month period, October 1, through September 30.

39.03: Reporting Requirements

(1) Required Reports.

(a) Each hospital shall file with the Division , for each fiscal year, the following documents, within 120 of the close of its fiscal year. The RSC-403 report is to be completed in accordance with the instructions set forth therein and pursuant to requirements of 114.1 CMR 4.00 and any pertinent

administrative bulletins issued by the Division.

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1. two paper copies of its Hospital Statement of Costs, Revenues, and Statistics, RSC-403,
2. one electronic copy of its Hospital Statement of Costs, Revenues, and Statistics, RSC-403, and
3. two copies of a hospital's audited financial statements.

(b) Each hospital shall file with the Division the following documents at the beginning of each fiscal year and following each quarter that changes occur.

1. two copies of a hospital's charge book, and
2. two copies of the Hospital DHCFP-450 Form.

(c) Each hospital, when required, shall file full cost information as requested by the Division.

(d) Each hospital shall make available all books and records relating to its operation for audit, if requested by the Division.

(e) All reports, schedules, reporting forms, budget information, books and records which are filed with or made available to the Division shall be certified under pains and penalties of perjury as true, correct and accurate by the chief executive officer or financial officer of the hospital.

(f) The Division may, for cause documented in writing, extend the filing date for the submission of reports, schedules, reporting forms, budget information, books and records.

(2) Penalties.

(a) All non-acute hospitals are required to submit to the Division of Health Care Finance and Policy (formerly the Rate Setting Commission) documents needed for the calculation of Medicaid rates of payment. These documents include but are not limited to the aforementioned RSC-403 cost reports and the audited financial statements. If a hospital does not submit this information in a timely fashion, as described above, such hospital may have a reduction applied to their per-diem payment rate on the day following the date the submission is due. Furthermore, this reduction shall continue to accrue in a cumulative manner of 5% for each month of non-compliance. For example, the first adjustment would equal 5%; if the requested documentation is not received for another month, the adjustment shall equal 10%. The adjustment shall not, in any case, exceed 50% of the per-diem rate. If a hospital is not in full compliance with the submission of the aforementioned information at such a time as the hospital's rate is subject to change (i.e., at the start of the new rate year, or upon commencement of an amendment that affects the per-diem rate), at no time can the new rate exceed the adjusted current rate. If, however, the new per-diem rate is less than the rate currently in effect, then the new rate will become effective and potentially subject to further adjustment.

(b) If a hospital fails to file any data, statistics or other information required under 114.1 CMR 39.03, the Division may request the Attorney General of the Commonwealth to seek additional penalties under M.G.L. c. 118G.

39.04: Rates of Payment to Publicly Assisted Patients

(1) Payment Rates. Payment for Inpatient Services to Publicly Assisted Patients will be made at the Inpatient Rate determined pursuant to 114.1 CMR 39.05. Payment for Outpatient Services to Publicly Assisted Patients will be made at the Outpatient Rate determined pursuant to 114.1 CMR 39.06.

(2) Applicability. Rates of payment determined under the rules of 114.1 CMR 39.04 include:

(a) Payment for all inpatient and outpatient hospital care and services which are provided by a chronic/rehabilitation hospital to publicly-assisted patients.

(b) Payment for Administrative Days which are provided by a hospital to publicly-assisted patients under Title XIX of the Social Security Act.

(3) General Payment Provisions.

(a) Reimbursement as Full Payment. Each chronic/rehabilitation hospital which provides services to publicly-aided patients shall, as a condition of receipt of payment, accept reimbursement at rates established by the Division, subject to appellate rights set forth in M.G.L. c. 118G, as full payment and discharge of all obligations of such individuals. There

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shall be no duplication or supplementation of payment for services provided to publicly-assisted patients.

(b) Reimbursement Limitation. Reimbursement determined under 114.1 CMR 39.00 for publicly assisted patients shall not exceed that reimbursement which would result from application of the Principles of Reimbursement of Provider costs established under 42 U.S.C. §§ 1395 et seq., the Medicare Act.

1. For each fiscal year the Division shall calculate the percentage, if any, by which hospitals' Medicaid payment rates must be adjusted in order for the Division of Medical Assistance to comply with the upper limit requirements on Medicaid inpatient and outpatient hospital payments as specified in 42 CFR 447.272 and 42 CFR 447.321. The Division shall calculate the upper limit separately for inpatient services and outpatient services.
2. The Division shall determine whether reimbursement determined under 114.1 CMR 39.00 exceeds the upper limit by comparing the aggregate amount that the Medicare program would pay for Medicaid patients using Medicare principles to the aggregate amount that would be paid using the Medicaid Inpatient Rates determined pursuant to 114.1 CMR 39.05 and the Medicaid Outpatient Rates calculated pursuant to 114.1 CMR 39.06 applied to projected rate year utilization. If the aggregate payment amount pursuant to 114.1 CMR 39.00 is greater than the aggregate payment amount using Medicare principles, an upper limit adjustment is necessary.
3. If an upper limit adjustment is necessary, the Division shall issue an administrative bulletin setting forth the methodology for calculating such adjustment.

39.05: Determination of Inpatient Rate

(1) General. The Division will determine an Inpatient Rate for each chronic/rehabilitation hospital. Except for new hospitals and hospitals which have closed the facility and now provide some services at a new location under new management, the methodology for determining the Inpatient Rate for non-Administrative Day Patients is set forth in 114.1 CMR 39.05(2). The methodology for determination of Inpatient Rate for new hospitals and hospitals which have closed the facility and now provide some services at a new location under new management is set forth in 114.1 CMR 39.05(3). The rates for Administrative Day Patients are set forth in 114.1 CMR 39.05(4).

(2) Determination of the Inpatient Rate.

(a) Data Sources.

1. The base year for Allowable Inpatient Costs will be FY 1993, and the Division will utilize the costs reported in the FY 1993 RSC-403 cost report. For hospitals which converted a majority of beds to long-term care beds during FY 1993, the base year for Allowable Inpatient Costs will be FY 1994 deflated to FY 1993, and the Division will utilize the costs reported in the FY 1994 RSC-403, deflated to FY 1993 using a FY 1993 - FY 1994 inflation factor calculated pursuant to the methodology set forth in 114.1 CMR 39.05(2)(c)2.
2. Allowable Inpatient Costs include only costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§ 1395 *et seq*. as set forth in 42 CFR 413 *et seq*. and the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles. Except where noted, all references to specific Schedules, Columns and Lines of the RSC-403 are to the FY 1993 version of the RSC-403.
3. The Division may adjust reported costs used to determine Allowable Inpatient Costs upon audit of the hospital's RSC-403. The Division may also request additional information, data and documentation from the hospital as necessary to calculate rates. Failure to submit the requested information in a timely manner will result in the application of penalties as determined by 114.1 CMR 39.03(2).
4. If the specified data source is unavailable or inadequate, the Division will determine and use the best alternative data source and/or shall perform a statistical analysis to ensure comparability of data.

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(b) Determination of Allowable Base Year Inpatient Operating Costs. Allowable Base Year Inpatient Operating Costs are the sum of Allowable Total Inpatient Direct Routine Costs, Allowable Total Inpatient Direct Ancillary Costs, Allowable Total Inpatient Overhead Costs as defined below.

1. Allowable Inpatient Direct Routine Costs. Allowable Total Inpatient Direct Routine Costs are the hospital's Total Inpatient Routine Costs (Sch. XIV, Col. 2, L. 78).

2. Allowable Inpatient Direct Ancillary Costs. The Division will calculate Allowable Total Inpatient Direct Ancillary Costs as follows:

a. Determine the Inpatient Direct Ancillary Cost for each ancillary cost center by multiplying the total cost for each cost center (Sch. XIV, Col. 2) times the ratio of Inpatient Patient Service Statistics (Sch. XVI, L. 22) to Total Patient Service Statistics (Sch. XVI, L. 42). The otherwise total inpatient direct ancillary costs for the Drug and Medical Supplies cost centers shall be calculated using the following methodology.

i. The total cost for the Drug cost center shall be the reported Drug cost (Sch. XIV, Col. 2, L. 28) plus the Total Direct Overhead Cost (Sch. XIV. Col. 2, L. 16) related to Pharmacy. Determine the Inpatient Direct Ancillary Drug cost by multiplying the total cost for the drug cost center times the ratio of the inpatient drug patient service statistics (Sch. XVI, Col. 11, L. 22) to the total drug patient service statistics (Sch. XVI, Col. 11, L. 42).

ii. The total cost for the Medical Supplies cost center shall be the reported Medical Supplies cost (Sch. XIV, Col. 2, L. 27) plus the Total Direct Overhead cost related to Central Service/Supplies (Sch. XIV, Col. 2, L. 15). Determine the Inpatient Direct Ancillary Medical Supplies cost by multipying the total cost for the medical supplies cost center times the ratio of the inpatient medical supplies patient service statistics (Sch. XVI, Col. 10, L. 22) to the total medical supplies patient service statistics (Sch. XVI, Col, 10, L. 42).

b. Base year costs for the Laboratory, Radiology, Physical Therapy, Speech Therapy, Respiratory Therapy and Occupational Therapy cost centers will be adjusted to incorporate efficiency standards.

c. Separate efficiency standards will be determined for chronic hospitals and rehabilitation hospitals. Hospitals will be classified as chronic or rehabilitation based on whether they provide primarily chronic (longer stay) or rehabilitation as described in their FY 1994 RSC-420 submissions and in the 1989 American Hospital Association Guide, and based on their average length of stay. In classifying hospitals for the efficiency standards, respiratory and other longer-stay specialty services shall be considered chronic rather than rehabilitation, and lengths of stay over 30 days shall indicate longer-stay services. The efficiency standards shall be calculated using the following classifications:

i. The chronic hospital group shall consist of Boston Specialty Hospital, Cranberry Specialty Hospital, Franciscan Children’s Hospital, Jewish Memorial Hospital, Massachusetts Respiratory Hospital, Middlesex County Hospital, New England Sinai Hospital, Shaughnessy Chronic Disease and Rehabilitation Hospital, Springfield Municipal Hospital, St. John of God Hospital, and Youville Hospital.

ii. The rehabilitation hospital group shall consist of Braintree Hospital, Fairlawn Hospital, Mediplex Hospital of Bristol, New England Rehabilitation Hospital, Rehab West, Spaulding Rehabilitation Hospital, and Whittier Rehabilitation Hospital.

d. The efficiency standards will be determined as follows:

i. Calculate each hospital's FY 1994 unit cost for each cost center by dividing the Inpatient Direct Ancillary Cost as calculated pursuant to 114.1 CMR 39.05(2)(b)2.a. by the corresponding statistics for each cost center (Sch. XVI, Cols. 12, 17, 21, 25, 26 and 27).

ii. The Division will rank the unit cost for each hospital in the chronic group and determine the median. The median will be the efficiency standard for the chronic hospital group.

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iii. The Division will rank the unit cost for each hospital in the rehabilitation group and determine the median. The median will be the efficiency standard for the rehabilitation hospital group.

iv. If a hospital's FY 1994 unit cost does not exceed the applicable efficiency standard, its FY 1993 Inpatient Direct Ancillary Costs as calculated pursuant to 114.1 CMR 39.05 (2)(b)2.a will be its allowable cost for that cost center.

v. If a hospital's FY 1994 unit cost exceeds the applicable efficiency standard, the Division will adjust the FY 1993 Inpatient Direct Ancillary Cost for that cost center, as follows:

a. Divide the difference between the FY 1994 unit cost and the efficiency standard by the FY 1994 unit cost.

b. Reduce the FY 1993 Direct Ancillary Costs for that cost center by the resulting percentage.

e. For all other ancillary cost centers, the allowable cost will be the FY 1993 Inpatient Direct Ancillary Cost for that cost center as calculated pursuant to 114.1 CMR 39.05(2)(b)2.a.

f. The sum of the allowed costs for each cost center will be the Allowable Total Inpatient Direct Ancillary Costs.

3. Allowable Total Inpatient Overhead. The Division will calculate Allowable Total Inpatient Overhead by comparing Actual Total Inpatient Overhead to an efficiency standard as defined below.

a. The Division will determine the FY 1993 Actual Inpatient Overhead Per Diem Rate for each hospital as follows:

i. Calculate Inpatient Routine Overhead cost by subtracting Direct Inpatient Routine Cost (Sch. XIV, Col. 2, L. 78) from Inpatient Routine Cost after stepdown of overhead (Sch. XIV, Col. 25, L. 78).

ii. Calculate Inpatient Ancillary Overhead Cost by:

a. determining the total overhead cost allocated to each ancillary department (Sch. XIV, Col. 25 minus Sch. XIV, Col. 2),

b. extracting the inpatient portion of the total ancillary overhead cost by multiplying the total overhead cost allocated to each ancillary department by the ratio of Inpatient Patient Service Statistics (Sch. XVI, L. 22) to Total Patient Service Statistics (Sch. XVI, L.42), and

c. summing the inpatient portions of the total ancillary overhead cost in each department to obtain the Inpatient Ancillary Overhead Cost.

iii. Divide the sum of Inpatient Routine Overhead and Inpatient Ancillary Overhead by FY 1993 Patient Days. For hospitals that reported costs in Schedule XIV, Column 2, Line 15 (Central Service/Supplies) and/or Column 2, Line 16 (Pharmacy), those costs will be removed from the overhead costs and reclassified to Ancillary costs pursuant to 114.1 CMR 39.05 (2)(b)2.a..

b. Separate efficiency standards will be determined for chronic hospitals and rehabilitation hospitals, as defined in 114.1 CMR 39.05(2)(b)2.c.

c. The Division will rank the Inpatient Overhead Per Diem Cost for each chronic hospital and determine the median. The median will be the efficiency standard for chronic hospitals.

d. The Division will rank the Inpatient Overhead Per Diem Cost for each rehabilitation hospital and determine the median. The median will be the efficiency standard for rehabilitation hospitals.

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e. If a hospital's Inpatient Total Overhead Per Diem Cost does not exceed the appropriate efficiency standard, its Allowable Total Inpatient Overhead Costs will be its Actual Total Inpatient Overhead Cost as calculated pursuant to 114.1 CMR 39.05(2)(b)3.a.

f. If a hospital's Inpatient Overhead Per Diem Cost exceeds the appropriate efficiency standard, the hospital's Allowable Inpatient Overhead Costs will be the efficiency standard multiplied by FY 1993 Patient Days.

(c) Adjustments to Base Year Costs.

1. Substantial Program Change. For hospitals which converted beds to long term care use or discontinued major services between the base year and the rate year, the Division shall adjust base year costs to remove the costs of the services no longer provided.

2. Inflation. The Division will adjust Total Inpatient Routine Direct Costs, Allowable Total Inpatient Ancillary Direct Costs, and Allowable Total Inpatient Overhead Costs for inflation prospectively. The Division will adjust these costs from 1993 through fiscal year 1997 using a composite index comprised of two cost categories: labor and non-labor. These categories shall be weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category shall be the non-labor portion of the HCFA market basket for hospitals.

a. The composite inflation index as calculated in accordance with the preceding paragraph will be increased by .02 pursuant.

b. The Commission will recover the additional costs for which hospitals were reimbursed according to the provisions of 114.1 CMR 39.06(2)(c)2.a., but were not expended on the compensation of technicians, nurses, nursing aides, orderlies and attendants, and occupational, speech, recreational, physical, and respiratory therapists.

(d) Capital.

1. The following limitations apply in the determination of the allowable capital cost:

a. The Division shall not allow interest expense attributable to balloon payments on financed debt. Balloon payments are those in which the final payment on a partially amortized debt is scheduled to be larger than all preceding payments. Requests for interest associated with balloon-type payments must be adjusted to conform to the time period for conventional regular installment loans.

b. Where there has been a change of ownership after July 18, 1984, the allowable basis of the fixed assets to be used in the determination of the depreciation and interest expense shall be the lower of the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The allowed depreciation expense shall be calculated using the full useful lives of the assets.

c. All costs (including legal fees, accounting, and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset after July 18, 1984 (by acquisition or merger), for which payment has previously been made by any payer, and which have been included in any portion of prior years' rates, shall be subtracted from allowable capital costs.

2. The hospital's allowable base year capital costs consist of the hospital's actual FY 1993 patient care capital requirement for historical depreciation for building and fixed equipment, for reasonable interest expenses, for amortization, and for leases and rental of facilities. For hospitals which converted a majority of their beds to long-term care beds during FY 1993, allowable base year capital costs consist of the hospital's actual FY 1994 patient care capital requirement deflated to FY 1993 using a FY 1993 - FY 1994 inflation factor calculated pursuant to the methodology set forth in 114.1 CMR 39.05(2)(c)2.

3. The Division will calculate each hospital's FY 1996 Allowed Inpatient Unit Capital Cost according to the following formula:

a. Base Year Recognized Capital Cost is the hospital's actual capital costs (Sch. IX) subject to the limitations set forth in 114.1 CMR 39.05(2)(d)1.

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b. Base Year Inpatient Capital Cost is the base year actual total inpatient cost including capital (Sch. XVIII, Col. 2, L. 22) less the base year actual total inpatient cost excluding capital (Sch. XVII, Col. 2, L. 22).

c. Base Year Routine Patient Days (Sch. III)

d. Base Year Inpatient Unit Capital Cost is the Base Year Inpatient Unit Capital Cost divided by the Base Year Routine Patient Days.

e. FY 1996 Inpatient Unit Capital Cost is the Base Year Inpatient Unit Capital Cost multiplied by a FY 1993 to FY 1996 inflation factor using a composite index comprised of two cost categories: labor and non-labor. These categories are weighted according to the weights used by the Health Care Financing Administration for PPS-exempt hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category is the non-labor portion of the HCFA market basket for hospitals..

f. The FY 1996 Inpatient Unit Capital Cost shall be ranked and an efficiency standard, the median, shall be determined.

g. If the hospital's FY 1996 Inpatient Unit Capital Cost exceeds the efficiency standard, the Allowed Inpatient Unit Capital Cost shall be the sum of the efficiency standard plus 40% of the amount that exceeds the efficiency standard.

h. If the hospital's FY 1996 Inpatient Unit Capital Cost is below the efficiency standard, the Allowed Inpatient Unit Capital Cost will be the sum of its Inpatient Unit Capital Cost and 60% of the amount that is below the efficiency standard.

4. The Division will calculate each hospital's FY 1997 Allowed Inpatient unit Capital Cost according to the following formula:

a. The FY 1997 Inpatient Unit Capital Cost is the FY 1996 Hospital Unit Capital Cost multiplied by the HCFA capital update factor for FY 1996 to FY 1997.

b. The FY 1997 Inpatient Unit Capital Cost shall be ranked and an efficiency standard, the median, shall be determined.

c. If the hospital's FY 1997 Inpatient Unit Capital Cost exceeds the efficiency standard, the Allowed Inpatient Unit Capital Cost shall be the sum of the efficiency standard plus 20% of the amount that exceeds the efficiency standard.

d. If the hospital's FY 1997 Inpatient Unit Capital Cost is below the efficiency standard, the Allowed Inpatient Unit Capital Cost will be the sum of its Inpatient Unit Capital Cost and 80% of the amount that is below the efficiency standard.

(e) Calculation of Inpatient Per Diem Rate. The Inpatient Rate shall be determined by dividing the sum of Allowable Base year Inpatient Operating Cost, as determined pursuant to 114.1 CMR 39.05(2)(b), as adjusted pursuant to 114.1 CMR 39.05(2)(c), plus the Allowable Inpatient Capital Cost determined pursuant to 114.1 CMR 39.05(2)(d), by the base year patient days. The Inpatient Rate shall not exceed the hospital's average charge per day.

(3) Inpatient Rate for New Hospitals and Hospitals which Closed a Majority of Beds and Now Provide Some Services in a New Location under New Management.

(a) Base Year. For new hospitals which were not licensed and/or operated as chronic/rehabilitation hospitals in FY 1993, or which did not report a full year of actual costs in FY 1993, the base year for operating and capital costs shall be the first cost reporting period of at least 12 months after the hospital is licensed and/or operated as a chronic/ rehabilitation hospital. For hospitals licensed and/or operated as chronic/rehabilitation hospitals in FY 1993 but which eliminated a majority of beds and closed the facility and which in subsequent years continued to provide some services in a new location and under a new management, the base year is the first cost reporting period of at least (12) twelve months after the hospital started to provide the services at the new location. If the Division determines that the data source is inadequate or not representative of the hospital's ongoing costs, the Division may consider alternative data sources to determine Base Year costs.

(b) The Division will determine the Inpatient Rate using the methodology set forth in 114.1 CMR 39.05(2), substituting the hospital's base year for FY 1993.

1. Each efficiency standard defined in 114.1 CMR 39.05(2)(b) will be inflated to the hospital's base year using an inflation factor calculated pursuant to the methodology in 114.1 CMR 39.05(2)(c)2..

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2. Base year operating costs which are not subject to efficiency standards will be evaluated for reasonableness. Criteria for such review will include, but will not be limited to, peer group analysis of costs incurred by comparable facilities.

(c) For each new hospital, or hospital which has closed a majority of beds and now provides some services in a new location under new management, for which no base year has yet been determined pursuant to 114.1 CMR 39.05(3)(a), the Division shall evaluate the hospital's projected operating and capital costs for reasonableness. Criteria for such review will include, but will not be limited to, peer group analysis of costs incurred by and the determination of approved rates for comparable facilities.

(4) Rates for Administrative Day Patients. The rate for inpatient services provided to Administrative Day Patients shall be the lesser of the following or the Inpatient Rate.

(a) For FY 1996, the rate for Administrative Day Patients shall not exceed $111 per patient day.

(b) For FY 1997, the rate for Administrative Day Patients shall not exceed $113.27 per patient day (FY 1996 Administrative Day Patient Rate adjusted by a inflation factor for FY 1997 calculated pursuant to methodology in 114.1 CMR 39.05(2)(c)2.

(5) Inpatient Rate for Publicly Assisted Patients. For all eligible services provided to publicly assisted patients, other than those cited in 114.1 CMR 39.05(4), the initial rate of payment shall be equal to the Inpatient Rate. In addition to the initial rate of payment, a supplementary payment shall be made for all eligible services supplied by chronic/rehabilitation hospitals to publicly assisted patients who are not given Administrative Day status. This supplementary payment shall equal the Inpatient Per Diem minus the Rate for Administrative Day Patients pursuant to 114.1 CMR 39.05(4).

39.06: Determination of Publicly Assisted Outpatient Rate

(1) The Outpatient Rate for services provided to publicly-aided patients will be an approved Cost-to-Charge Ratio which will be determined for each hospital as follows:

(a) The Division will determine the actual FY 1993 operating and capital costs of providing Outpatient services as reported in the RSC-403. The Division may adjust this amount upon audit.

(b) The Division will determine the actual FY 1993 charges for providing Outpatient services as reported in the RSC-403. The Division may adjust this amount upon audit.

(c) The FY 1996 approved Cost-to-Charge Ratio will be hospital's actual FY 1993 outpatient cost divided by the hospital's actual FY 1993 outpatient charges.

(d) For Hospitals that have a FY 1996 approved Cost-to-Charge Ratio, the FY 1997 approved Cost-to-Charge Ratio will be the FY 1996 approved Cost-to-Charge Ratio unless adjusted as described below or until it is superseded by new regulation or contract with the Division of Medical Assistance.

1. Determination of the Medicaid Cost-to-Charge shall be made in accordance with the information filed on the Hospital DHCFP-450 Form.

2. The Cost-to-Charge Ratio shall be adjusted downward prospectively, pro-rated for months remaining in the rate year, if the charge per visit as reported in the Hospital DHCFP-450 Form increases beyond the FY 1996 to FY 1997 inflation factor as calculated pursuant to the methodology in 114.1 CMR 39.05(2)(c)2.

a. The adjustment factor shall equal the inflation factor divided by the sum of one plus the percent increase in charges.

b. The pro-rated adjustment shall be determined as follows:

i. Step One: a) the adjustment factor multiplied by the total number of months in the year that the increased charges are in effect less b) the number of months that the increased charges are in effect before the adjusted CCR will take effect.

ii. The pro-rated adjustment shall equal Step One of the adjustment as calculated pursuant to 114.1 CMR 39.06(1)(d)2.b.i. divided by the number of months remaining in the year after the adjusted CCR will take effect.

c. The Adjusted Cost-to-Charge Ratio shall be the FY 1996 approved Cost-to-Charge Ratio multiplied by the pro-rated adjustment factor as calculated pursuant to 39.06(1)(d)2.b.ii.

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d. The Adjusted Cost-to-Charge Ratio shall take effect the first day of the month following the Division's approval.

(e) For Hospitals that do not have a FY 1996 approved Cost-to-Charge Ratio, the FY 1997 approved cost-to-Charge Ratio will be the ratio of allowed outpatient costs, as determined by the Division, to projected outpatient revenue.

(2) For new hospitals, and hospitals which have closed a majority of beds and now provide some services in a new location under new management, who have not yet established a base year of outpatient costs and charges, but have an outpatient rate established by the Commission, the Division will calculate the Outpatient Rate using the following methodology

(a) For those hospitals that have an outpatient rate established by the Division (formerly the Commission) the FY 1997 outpatient rate shall be the FY 1996 outpatient rate, unless adjusted pursuant to 114.1 CMR 39.06(1)(d)1. and 2., or superseded by new regulation or contract with the Division of Medical Assistance.

(b) For those hospitals that do not have an outpatient rate previously established by the Division, the FY 1997 outpatient rate shall be the ratio of allowed outpatient costs, as determined by the Division, to projected outpatient revenue.

(3) The Outpatient Rate shall not exceed 100%.

(4) Reimbursement for Outpatient services will be determined by multiplying the hospital's Outpatient Rate by the published charge for each service.

39.07: Medicaid Disproportionate Share Adjustments

The Medicaid program will assist hospitals which carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirement, Medicaid will make an additional payment adjustments to hospitals which qualify for such an adjustment under any one or more of the following classification. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described in 114.1 CMR 39.07.

(1) To qualify for any type of disproportionate payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing Medicaid patient days by total patient days) of not less than 1%.

(2) The total of all disproportionate share payments awarded to a particular hospital under 114.1 CMR 39.07 shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third part coverage, less payments by Medicaid and by uninsured patients.

(3) Data Sources. The Division shall determine for each fiscal year a federally-mandated Medicaid disproportionate share adjustment, for all eligible hospitals, using the data and methodology described below. The Division shall use the following data sources in its disproportionate share adjustment, unless the specified data source is unavailable. If the specified data source is unavailable, the Division shall determine and use the best alternative data source.

(a) The prior year RSC-403 report shall be used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient charges and free care charge-offs. If said RSC-403 report is not available, the Division shall use the most recent available previous RSC-403 report to estimate these variables.

(b) The hospital's audited financial statements for the prior year shall be used to determine the state and/or local government cash subsidy.

(c) The prior year claims data residing on the Division of Medical Assistance's Massachusetts Medicaid Information System shall be used to determine exceptionally high costs and exceptionally long lengths of stay for the outlier adjustment for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay of individuals under six years of age pursuant to 114.1 CMR 39.07(7).

39.07: continued

(4) Determination of Eligibility Under the Medicaid Utilization Method. The Division shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of non-acute care hospitals for the federally-mandated disproportionate share adjustment. The Division shall determine such threshold as follows:

(a) First, calculate the statewide weighted average Medicaid inpatient utilization rate. This shall be determined by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total inpatient days for all non-acute care hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

(c) Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted average Medicaid inpatient utilization rate. The sum of these two numbers shall be the threshold Medicaid inpatient utilization rate.

(d) The Division shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 39.07(4)(c), then the hospital shall be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(5) Determination of Eligibility Under the Low-Income Utilization Rate Method. The Division shall calculate each hospital's low-income utilization rate. The Division shall make such determination as follows:

(a) First, calculate the Medicaid and subsidy share of net revenues by dividing the sum of Medicaid net revenues plus state and local government subsidies by the sum of total net revenues plus state and local government subsidies.

(b) Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of audited free care charge-offs by total inpatient charges.

(c) Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of net revenues calculated pursuant to 114.1 CMR 39.07(5)(a) to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 39.07(5)(b). If the low-income utilization rate exceeds 25%, the hospital shall be eligible for the federally-mandated Medicaid disproportionate share adjustment under the low-income utilization rate method.

(6) Determination of Payment. The payment under the federally-mandated disproportionate share adjustment requirement shall be calculated as follows:

(a) For each hospital determined eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 39.07(4), the Division shall divide the hospital's Medicaid utilization rate calculated pursuant to 114.1 CMR 39.07(4)(d) by the threshold Medicaid utilization rate calculated pursuant to 114.1 CMR 39.07(4)(c). The ratio resulting from such division shall be the federally-mandated Medicaid disproportionate share ratio.

(b) For each hospital determined eligible for the federally-mandated Medicaid disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally-mandated Medicaid disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 39.07(6)(a) and 114.1 CMR 39.07(6)(b).

(d) The Division shall then calculate a minimum payment under the federally-mandated Medicaid disproportionate share adjustment requirement by dividing the amount of funds allocated pursuant to 114.1 CMR 39.07(8) for payments under the federally-mandated Medicaid disproportionate share adjustment requirement by the sum of the federally-mandated Medicaid disproportionate share ratios calculated pursuant to 114.1 CMR 39.07(6)(c).

39.07: continued

(e) The Division shall then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment requirement by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 39.07(6)(a) and (b). The product of such multiplication shall be the payment under the federally-mandated disproportionate share adjustment requirement.

(7) Determination of Eligibility of Disproportionate Share Non-Acute Care Hospitals for an Outlier Adjustment in Payment Amount for Medically Necessary Inpatient Hospital Services Provided to Individuals under Six Years of Age Involving Exceptionally Long Lengths of Stay or exceptionally high Cost. The Division shall make such a determination as follows:

(a) Exceptionally long lengths of stay.

1. First, calculate a statewide weighted average Medicaid inpatient length of stay. This shall be determined by dividing the sum of Medicaid days for all non-acute care hospitals in the state by the sum of total discharges for all non-acute care hospitals in the state.
2. Second, calculate the statewide weighted standard deviation for Medicaid inpatient length of stay statistics.
3. Third, add 1½ time the statewide weighted standard deviation for Medicaid inpatient length of stay to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers shall be the threshold Medicaid exceptionally long length of stay.

(b) Exceptionally high cost. For each disproportionate share hospital providing services to individuals under six years of age, the Division shall:

1. First, calculate the average cost per Medicaid inpatient discharge for each hospital.
2. Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital.
3. Third, add 1½ times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers shall be each hospital's threshold Medicaid exceptionally high cost.

(c) Eligibility for an outlier adjustment in the payment amount. For each disproportionate share hospital providing services to individuals under six years of age, the Division shall perform the following:

1. Calculate the average Medicaid inpatient length of stay involving individuals under six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold Medicaid exceptionally long length of stay calculated pursuant to 114.1 CMR 39.07(7)(a), then the hospital shall be eligible for an outlier adjustment in the payment amount.
2. Calculate the cost per inpatient discharge involving individuals under six years of age. If this cost per discharge equals or exceeds the hospital's own threshold Medicaid exceptionally high cost calculated pursuant to 114.1 CMR 39.09(7)(b), then the hospital shall be eligible for an outlier adjustment in the payment amount.

(8) Allocation of Funds. The total amount of funds allocated for payment to non-acute care hospitals under the federally-mandated Medicaid disproportionate share adjustment requirement shall be $150,000 annually. These amounts shall be paid by the Division of Medical Assistance and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 39.07(6)(e).

If any hospitals qualify for an Outlier Adjustment to the payment amount pursuant to 114.1 CMR 39.07(7), each hospital shall receive on-half of one percent of the total funds allocated for payment to non-acute hospitals under the federally-mandated Medicaid disproportionate share adjustment. The amounts in each fiscal year to be distributed pursuant to 114.1 CMR 39.07(6)(e) shall be reduced commensurately. That is, if in fiscal year 1997, two hospitals qualify under 114.1 CMR 39.07(7), the $150,000 which would have been other wise allocated shall be reduced by one percent for distribution pursuant to 114.1 CMR 39.07(6)(e).

39.08: Administrative Adjustment to Inpatient Per Diem Rate

(1) A hospital may apply for a discretionary administrative adjustment to its Inpatient Per Diem Rate. Any such application, except for those related to New Governmental Requirements and Disaster Losses, must be based upon the grounds set forth below and must be filed within 90 days of initial rate approval to receive consideration. Applications for New Governmental Requirements and Disaster Losses must be based upon the grounds set forth below and must be filed within 60 days from the date the costs were incurred to receive consideration. Except for adjustments granted for Mechanical Error, adjustments shall be effective on the later of 1) the beginning of the quarter (October 1, January 1, April 1, July 1) in which a complete application is received or 2) the date the costs will be incurred. Adjustments granted for Mechanical Error shall be effective on the date the rate containing the error went into effect Adjustments granted for New Governmental Requirements and Disaster Losses shall be effective on the date the costs were incurred.

(2) In order to qualify for an administrative adjustment, the hospital must demonstrate the following:
(a) the timing and amount of the increase in costs is reasonably certain; and
(b) the category of cost for which an administrative adjustment is sought is not included in the base year cost;
(c) the amount requested is greater than 1% of the hospital's total patient care costs. Multiple unrelated requests for administrative adjustments may be grouped together to meet the materiality limit; however, each individual item must equal or exceed 1/10 of 1% (.10%).
(d) the adjustment is necessary for the appropriate provision of services. The Division will consider a cost "necessary" only if it can be demonstrated to the satisfaction of the Division that such costs cannot be met through efficient management and economic operation at the existing reimbursable cost level.

(3) Requests for an administrative adjustment shall be accompanied by full and complete documentation of the request. The Division may deny any request for an administrative adjustment for which documentation is not submitted.

(4) A hospital must begin to expend the costs for which it has received approval within 60 days of the effective date of the administrative adjustment. An interim financial report demonstrating these expenditures must be submitted within 90 days of the effective date of the administrative adjustment. Failure to submit this will result in the approved amount being deducted from current rate year rates. If the hospital does not begin to expend such costs within 60 days, the hospital must notify the Division that approved amounts were not expended. The approved amount will then be deducted from current rate year rates.

(5) The Division will not allow an administrative adjustment for the following types of costs:
(a) a cost increase which results from or is attributable to a hospital's voluntary business decision;
(b) an increase in the cost of doing business which affects the industry as a whole;
(c) costs incurred to correct Department of Public Health or JCAHO deficiencies; and
(d) costs which fall within a category encompassed by an inflation factor.

(6) The following are grounds for an administrative adjustment provided the criteria set forth in 114.1 CMR 39.05(2) and 39.05(3) are met:
(a) Mechanical Error. There has been a mechanical error in calculating the Inpatient or Outpatient Per Diem Rate approved under 114.1 CMR 39.00.
(b) New Governmental Requirements. Statutory or regulatory requirements of a governmental unit or federal government have generated a substantial increase in allowable costs as adjusted pursuant to 114.1 CMR 39.05. An increase in existing governmental requirements shall not be considered to be a new governmental requirement. Documentation shall include written certification or a copy of an official notice from the governmental unit detailing the new requirements imposed on the hospital and the verification of the costs.

39.08: continued

(c) Disaster Losses. The hospital has incurred disaster losses in excess of insurance or extraordinary costs related to disaster losses not covered by outside sources. Documentation shall include verification of loss or extraordinary cost and the insurance or outside source payment. If, however, the loss or extraordinary cost is caused by a facility being inadequately insured according to the standards of the hospital industry, or through negligence on the part of hospital management, such losses or costs shall not be approved.

(d) DON Operating Costs. A hospital has incurred or expects to incur an increase in operating costs associated with a major capital expenditure or substantial change in services which is subject to and has received a determination of need pursuant to M.G.L. c. 111, §§ 25B through 25G. In its application, the hospital must segregate the increased costs from other allowed operating costs and must demonstrate that the increased costs requested are reasonable. If an approved DON results in increased patient days, those increased patient days will be added to the Inpatient Per Diem Patient Day Divisor.

(e) Wage Parity. The Commission may allow an administrative adjustment for costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation. This administrative adjustment is not to exceed actual rate year expenditures for such increases.

1. Wage relief may be requested for technicians, nurses, nursing aides, orderlies, attendants, occupational therapists, speech therapists, recreational therapists, physical therapists, and respiratory therapists. Any personnel in these categories who are primarily conducting administrative job duties and are not directly involved with providing patient care are not eligible for wage relief under this exception.

2. The adjustment for reasonable increases in direct care staff salaries and wages is defined as the reasonable rate year wage rate less the inflated base year wage rate, times the lesser of the rate year FTE direct care labor force or the base year FTE direct care labor. The reasonable rate year wage shall be the level of increase required to attract sufficient staff to ensure minimum quality of care as determined by the Department of Public Health for current patients. The rate will be determined by the Commission with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

a. Outlier wage rates as defined by the Commission shall be excluded from the computation;

b. Special weight shall be given to rates prevailing at non-acute hospitals located in the hospital's Medicare labor market region; and

c. In no case shall the reasonable rate year wage rate used in this calculation exceed the wage rate actually prevailing at hospitals located in the hospital's Medicare labor market region at the time of application.

d. The determined Medicare Labor Market Regions and their associated counties are as follows:

Medicare Labor Market Region	Counties
Eastern Mass	Bristol
	Essex
	Middlesex
	Norfolk
	Plymouth
	Suffolk
	Worcester
Berkshire	Berkshire
Springfield	Hampden
	Hampshire
Barnstable	Barnstable
	Dukes
	Nantucket
Rural	Franklin

39.08: continued

3. In order to be eligible for this adjustment, a hospital must demonstrate that it is facing extraordinary difficulties in the market for direct care staff, as indicated by one or more of the criteria established in St. 1988, c. 270. These criteria include, but are not limited to:

a. existence of significant vacancy rates for a period of time sufficient to jeopardize the welfare of patients according to Department of Public Health standards, JCAHO standards or other qualifying guidelines utilized in Massachusetts to ensure adequate care; and

b. persistent difficulty in recruitment.

(f) Case Mix Intensity. The Division may allow an administrative adjustment for an increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population.

1. In order to qualify for an administrative adjustment for case mix intensity, the hospital must demonstrate a net increase in Medicaid patient care intensity between the base upon which the rate is calculated.

2. If the Division determines that the hospital has demonstrated a net increase in intensity, the hospital must document the increase in patient care costs resulting from the higher level of intensity.

(g) Transfers of Costs.

1. Where a hospital has reduced or increased costs by the transfer of those costs to or from other persons or entities which provide health care and services, the Division may modify the allowable cost pursuant to 114.1 CMR 39.05(2)(b) to reflect the change in cost. In order to give effect to a transfer of cost each hospital must file information concerning cost, volume and revenue 30 days prior to implementation of a proposed transfer of cost, and must submit any additional information regarding the transfer of cost which the Division may require.

2. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities which provide hospital care or services, and which change compensation arrangements from non-hospital based to hospital-based (transfer on) or from hospital-based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

39.09: Fee for Residential Alcoholism Treatment Programs

(1) Fee. The fee for a residential alcoholism treatment program shall be equal to the actual charge times the Payment on Account Factor most recently approved by the Commission pursuant to 114.1 CMR 28.00 or 114.1 CMR 37.00, unless adjusted as described below, or until it is superseded by a new regulation, or unless a lesser amount is established by any valid order of a court of competent jurisdiction upon a written finding of indigence or inability to pay pursuant to St. 1982, c. 393. The Commonwealth shall pay to the hospital any difference between the payment made by the individual served and the approved charge times the Payment on Account Factor.

(a) The Payment on Account Factor shall be adjusted downward prospectively, pro-rated for months remaining in the rate year, if the charge per visit as reported in the DHCFP-450 Form increases beyond the FY 1996 to FY 1997 inflation factor calculated pursuant to the methodology in 114.1 CMR 39.05(2)(c)2..

(b) Determination of the Medicaid Payment on Account Factor shall be made in accordance with the information filed on the DHCFP-450 Form.

(2) Reimbursement as Full Payment. Each hospital which operates a residential alcoholism treatment program shall, as a condition to receipt of payment, accept reimbursement at rates established by the Commission, subject to appellate rights set forth in M.G.L. c. 118G, as full payment and discharges of all obligations of individuals served by such programs. There shall be no duplication or supplementation of payment.

39.09: continued

(3) Eligible Providers. Only providers receiving specific permission from the Division of Alcoholism, Massachusetts Department of Public Health may receive reimbursement for residential alcoholism treatment programs under 114.1 CMR 39.00. Costs associated with residential alcoholism treatment program operating without such permission shall not be included in allowed operating cost.

39.10: Administrative Review

(1) Purpose of Administrative Review. If the Division receives information from any source that indicates that a provider's rate may be based upon inaccurate or outdated information, it may initiate an administrative review to determine if a rate reduction is warranted. The reasons for which the Division may initiate the review include, but are not limited to: to ensure that costs included in the rate were actually incurred, to ensure that costs were properly reported, or to determine whether a rate should be adjusted to reflect a major change in services which occurred after the base year.

(2) Notice of Administrative Review. The Division may at any time review the rates upon notice to the hospital. the Division shall initiate administrative review by notifying the hospital and the purchasers that it intends to conduct an administrative review. The notification shall be in writing and shall include a statement of reason for the review.

(3) Request for Information. The Division may request that the provider submit books, records and other information necessary for its review.

(4) Results of Administrative Review. After review, the Division will render a written decision and statement of reasons for its decision.

39.11: Appeal

A hospital which is aggrieved by an action or failure to act under 114.1 CMR 39.00 may file an appeal within 30 days to the Division of Administrative Law Appeals pursuant to the requirements of M.G.L. c. 118G and M.G.L. c. 7, § 4H. The pendency of an appeal does not limit the Division's right to undertake administrative review of charges under 114.1 CMR 39.00.

39.12: Severability

The provisions of 114.1 CMR 39.00 are hereby declared to be severable and if such provisions or the application of such provisions to any person or circumstances shall be held to be invalid or unconstitutional, such invalidity or unconstitutionality shall not be construed to affect the validity or constitutionality of any of the remaining provisions of 114.1 CMR 39.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

39.13: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.1 CMR 39.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.1 CMR 39.00 if necessary for informed consideration of charge requests, charge adjustments, and charge review under 114.1 CMR 39.00.

REGULATORY AUTHORITY

114.1 CMR 39.00: M.G.L. c. 118G.