Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter CDR-30
April 2015

TO: Chronic Disease and Rehabilitation Inpatient Hospitals Participating in MassHealth

FROM: Daniel Tsai, Assistant Secretary and Director of MassHealth

RE: *Chronic Disease and Rehabilitation Inpatient Hospital Manual* (Elimination of Payment for Administrative Days)

Currently, under certain circumstances, MassHealth provides payment to Chronic Disease and Rehabilitation Inpatient Hospitals (CDR hospitals) for inpatient days provided to a member whose care needs can be met in a setting other than a CDR hospital and the member no longer meets criteria for "Hospital Level of Care." The proposed changes to the CDR hospital regulations provide that MassHealth payment for administrative days is not available for members that are 21 years of age or older (adult members) during an adult member's first 45 administrative days. However, if within the first 45 administrative days the CDR hospital is unable to locate an appropriate setting to which an adult member may be discharged, MassHealth payment is available for subsequent administrative days for the adult member, provided that the CDR hospital is able to demonstrate that it has experienced extraordinary difficulty in placing the member and that it continues to make regular efforts to locate an appropriate alternative setting for the member as described in the CDR hospital regulations at 130 CMR 435.412.

These regulations are effective April 17, 2015.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Chronic Disease and Rehabilitation Inpatient Hospital Manual

Pages 4-5, 4-6, 4-9, and 4-10

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Chronic Disease and Rehabilitation Inpatient Hospital Manual

Pages 4-5 and 4-6 — transmitted by Transmittal Letter CDR-27

Pages 4-9 and 4-10 — transmitted by Transmittal Letter CDR-19

(D) Managed-Care Program. To participate in the chronic-disease and rehabilitation hospital managed-care program, a hospital must comply with 130 CMR 435.404(B) and must agree, by contract with the MassHealth agency, to provide or arrange and pay for all services covered by MassHealth, except acute-hospital services, for all MassHealth members who are inpatients of the chronic-disease or rehabilitation hospital and who participate in the hospital's managed-care program.

435.405: Rates of Payment

(A) Payments to in-state hospitals for services furnished to MassHealth members are equal to the rate established in the signed provider agreement with the MassHealth agency.

(B) Payments to out-of-state hospitals are made in accordance with 130 CMR 450.233. The Medicaid program rate methodology of that state applies when such methodology is compatible with the MassHealth agency's claims-processing system. Otherwise, the MassHealth agency and the out-of-state facility negotiate a rate comparable to the median or weighted average in-state rate for similar facilities.

(C) The hospital must accept the amount of payment established by 130 CMR 435.405 as payment in full for all care and services provided by the hospital for which payment is available under MassHealth.

435.406: Billing Exceptions

(A) The hospital may bill separately only for those drugs and durable medical equipment prescribed for take-home use that a member is unable to obtain directly from a pharmacy or durable medical equipment supplier. The charges for such drugs and durable medical equipment must be submitted on the claim form specified in the billing instructions.

(B) A hospital under contract to provide a managed-care program may not bill separately for take-home drugs and durable medical equipment.

435.407: Nonreimbursable Services

(A) The cost of any treatment or testing provided outside the hospital is allowed for in the rate-determination process and is not separately reimbursable.

(B) All administrative and processing costs associated with the provision of blood and its derivatives are allowed for in the rate-determination process and are not separately reimbursable.

(C) Private hospital rooms are not reimbursable except where medically necessary. Payment for medically necessary private hospital rooms is included in the rates of payment set forth under 130 CMR 435.405(A).

(D) Research and the provision of experimental procedures are not reimbursable.

(E) Leave-of-absence days taken by a member are not reimbursable. For billing purposes, leave-of-absence days are to be treated in the same way as discharge and admission days. Thus, the day on which the member leaves the chronic-disease or rehabilitation hospital to start a leave of absence is not reimbursable, regardless of the hour of discharge, while the day on which the member returns is reimbursable.

(F) Rest-home (level IV) services are not reimbursable.

(G) The first 45 administrative days of a member's admission or continued stay are not reimbursable.

435.408: Screening Program for Chronic-Disease and Rehabilitation Hospitals

(A) Introduction. The screening program applies to all in-state and out-of-state chronic-disease and rehabilitation hospitals, except those participating in a managed-care program for all inpatients (see 130 CMR 435.402). The screening program described in 130 CMR 435.408 is intended to ensure that medical and nursing services are medically necessary. The MassHealth agency pays for chronic-disease and rehabilitation hospital services only when the MassHealth agency or its agent determines, pursuant to a screening, that such services are medically necessary and authorizes such services prior to admission or conversion.

(B) Screening.

(1) To initiate admission or conversion screening, the hospital must telephone the MassHealth agency or its agent prior to the proposed admission or anticipated conversion and must:

(a) describe the medical condition that necessitates a chronic-disease or rehabilitation hospital admission or continued stay; and

(b) state the anticipated length of stay.

(2) The MassHealth agency or its agent applies the level-of-care criteria stated in 130 CMR 435.409 or 435.410, whichever is applicable, to determine the medical necessity of the proposed admission or continued stay, as well as the anticipated length of stay.

(3) If the MassHealth agency or its agent determines that the proposed admission or continued stay is not medically necessary and denies authorization for such admission or continued stay, the hospital may appeal the denial as stated in 130 CMR 435.408(C).

(4) If the MassHealth agency or its agent determines that the proposed admission or continued stay is medically necessary, the admission or continued stay will be authorized with a specified, approved length of stay, and the hospital will be issued a preapproved screening number to be used when billing for the hospital stay. Approval may be given by telephone; however, authorization for payment is contingent upon receipt of written authorization from the MassHealth agency or its agent. The MassHealth agency will not pay the hospital for any costs incurred after the expiration of the specified, approved length-of-stay period.

435.411: Utilization Review

(A) The hospital must determine the medical or administrative necessity of each continued inpatient hospital stay of a member in accordance with the level-of-care criteria in 130 CMR 435.409 and 435.410. For those members requiring a less-than-hospital level of care, the hospital must determine the appropriate care in accordance with the MassHealth agency's medical eligibility criteria in 130 CMR 456.000.

(B) The MassHealth agency may designate an agent to determine the medical or administrative necessity of each inpatient hospital stay.

435.412: Reimbursable Administrative Days

(A) For members younger than 21 years old, the MassHealth agency will pay a hospital for up to 30 administrative days for each admission or each continued stay resulting from a conversion, as defined in 130 CMR 435.402. The MassHealth agency may pay a hospital for administrative days exceeding the 30-day limit for members younger than 21 years old, when the hospital can demonstrate, to the satisfaction of the MassHealth agency or its agent, that the hospital has

(1) experienced extraordinary difficulty in placing the member, including the specific reasons for such extraordinary difficulty; and
(2) exhaustively explored all potential appropriate placements.

(B) For members 21 years of age or older, the MassHealth agency will pay a hospital for administrative days for each admission or each continued stay resulting from a conversion, as defined in 130 CMR 435.402 only if they occur after the 45-day period described in 130 CMR 435.407(G) and where the hospital can demonstrate to the satisfaction of the MassHealth agency or its agent that the hospital has

(1) experienced extraordinary difficulty in placing the member, including the specific reasons for such extraordinary difficulty; and
(2) exhaustively explored all potential appropriate placements.

(C) An administrative day, as defined in 130 CMR 435.402, is reimbursable after the 45-day period described in 130 CMR 435.407(G) only if a hospital is making regular efforts to discharge the member to the appropriate setting. These efforts must be documented according to the procedures described in 130 CMR 450.205. The regulations covering discharge-planning standards described in 130 CMR 435.417 must be followed, but they do not preclude additional, effective discharge-planning activities.

(D) Examples of situations that may require hospital stays at less than a hospital level of care include, but are not limited to, the following.

(1) A member is awaiting transfer to a nursing facility or any other institutional placement, and no appropriate nursing-facility bed is available.
(2) A member is awaiting arrangement of home services (nursing, home health aide, durable medical equipment, personal care attendant, therapies, or other community-based services).
(3) A member is awaiting arrangement of residential, social, psychiatric, or medical services by a public or private agency.
(4) A member is awaiting results of a report of abuse or neglect made to any public agency

charged with the investigation of such reports.

(5) A member in the custody of the Department of Children and Families is awaiting foster care when other temporary living arrangements are unavailable or inappropriate.

(6) A member cannot be treated or maintained at home because the primary caregiver is absent due to a medical or psychiatric crisis, and a substitute caregiver is not available.

(7) A member is awaiting a discharge from the hospital and is receiving skilled nursing or other skilled services. Skilled services include, but are not limited to the following:

(a) maintenance of tube feedings;
(b) ventilator management;
(c) dressings, irrigations, packing, and other wound treatments;
(d) routine administration of medications;
(e) provision of therapies, such as respiratory, speech, physical, and occupational;
(f) insertion, irrigation, and replacement of catheters; and
(g) intravenous, intramuscular, or subcutaneous injections, or intravenous feedings (for example, total parenteral nutrition).

435.413: Nonreimbursable Administrative Days

Administrative days after the 45-day period described in 130 CMR 435.407(G) are not reimbursable when:

(A) a hospitalized member is awaiting services or an appropriate placement is currently available, but the hospital has not transferred or discharged the member because of the hospital's administrative or operational delays;

(B) the MassHealth agency or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the member's noninstitutional (customary) residence and the member, the member's family, or any person legally responsible for the member refuses the placement or services; or

(C) the MassHealth agency or its agent determines that appropriate noninstitutional or institutional placement or services are available within a reasonable distance of the member's noninstitutional (customary) residence and advises the hospital of the determination, and the hospital or the physician refuses or neglects to discharge the member.

435.414: Readmission after Medical Absence

When a member who was transferred for treatment to an acute inpatient hospital no longer needs acute inpatient hospital care but does meet the level-of-care criteria in 130 CMR 435.409(B) or 435.410(B), the chronic disease or rehabilitation hospital from which the member was transferred must readmit the member to the first available bed, in accordance with admission screening requirements (see 130 CMR 435.408).