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Office of Medicaid
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NOTICE OF FINAL AGENCY ACTION

SUBJECT: MassHealth: Payment for Pediatric Chronic Disease and Rehabilitation Hospitals effective October 1, 2019

AGENCY: Massachusetts Executive Office of Health and Human Services

SUMMARY OF PROPOSED ACTION

Pursuant to the provisions of M.G.L. c. 118E, § 13A, methods and terms of payment for services rendered by chronic disease and rehabilitation hospitals to patients entitled to medical assistance under M.G.L. c. 118E, § 1 *et seq.* are established by contract between the MassHealth program and participating hospitals. This notice describes the final methods and standards for the establishment of rates and payments by contract for rate year (RY) 2020 which begins October 1, 2019, between the Executive Office of Health and Human Services (EOHHS) and participating chronic disease and rehabilitation hospitals (CDR hospitals) that serve solely children and adolescents with complex acute rehabilitation and chronic needs (Pediatric CDR Hospitals). There is currently one CDR hospital that meets this criterion, Franciscan Children's (Franciscan).

DESCRIPTION OF FINAL METHODS AND STANDARDS

EOHHS has established a comprehensive inpatient per diem rate for each participating Pediatric CDR Hospital, covering both routine and ancillary services provided to inpatients. EOHHS derived the inpatient per diem rate from the 2003 operating and capital cost information for each hospital. The operating costs were updated from fiscal year 2003 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 Center for Medicare and Medicaid Services (CMS) for Prospective Payment System (PPS)-excluded 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 CMS market basket for hospitals. The CMS Capital Input Price Index is used in computing an allowance for inpatient capital, which is derived from fiscal year 2003 patient care capital expenditure data. An individual efficiency standard is applied to inpatient overhead costs. The efficiency standard is the median base year unit cost.

In accordance with Section 271 of Chapter 224 of the Acts of 2012, Franciscan's rate as determined pursuant to the above methodology for RY 2012 is increased by 160% and further updated by the update factors for RY14-RY15.

The MassHealth program also established a rate for administrative days (AD). The AD rate is comprised of a routine per diem and an ancillary add-on. The routine per diem is derived from the weighted average Medicaid rate in calendar year 2003 for nursing facility case mix category T (10). The weighted average ancillary add-on is

derived from hospital ancillary claims data for AD patients in hospital fiscal year (HFY) 2003. For each participating hospital, the AD rate is supplemented by an adjustment that will increase the AD rate to equal 80% of the difference between each hospital's rate year inpatient per diem rate and the statewide AD routine and ancillary per diem amount of \$513.05.

The MassHealth program utilizes a hospital-specific cost-to-charge ratio for outpatient services that is derived from historical cost and charge information. The cost-to charge ratio is applied to the hospital's usual and customary charges on file with the Center for Health Information and Analysis (CHIA) as of July 1, 2014 for outpatient services.

The MassHealth program established two quality performance incentive payments for Pediatric CDR Hospitals that serve Medicaid members on an inpatient basis and meet performance benchmarks that are based on Children's Hospitals' Solutions for Patient Safety National Children's Network measures and other measures designated by EOHHS.

The methods and standards described herein establish rates and payments by contract that accurately reflect the efficient and economic provision of chronic disease services and/or comprehensive rehabilitation services. The methods and standards described herein are therefore projected to result in a roughly 25% increase in annual aggregate expenditures in RY 2020. The actual change in aggregate expenditures is estimated to be \$3 million but may vary depending on actual utilization of services.

Included with this notice are the proposed rates and methods of payment, effective October 1, 2019. To request copies of any written comments received in connection with RY 2020 methods and terms of payment to pediatric CDR hospitals, please contact:

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STATUTORY AUTHORITY:

M.G.L. c.118E; 42 USC 1396

Related Regulations:

42 CFR Part 447

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
PEDIATRIC CHRONIC DISEASE AND REHABILITATION HOSPITALS
FINAL METHODS AND STANDARDS
FOR RATES EFFECTIVE OCTOBER 1, 2019**

The following sections describe the methods and standards utilized by the Executive Office of Health & Human Services (EOHHS) to establish methods and rates of payment by contract, effective October 1, 2019, for services rendered by chronic disease and rehabilitation (CDR hospitals) that serve solely children and adolescents with complex acute rehabilitation and chronic needs (Pediatric CDR Hospitals). There is currently one CDR hospital that meets this criterion, Franciscan Children's (Franciscan).

Section 1: Inpatient Per Diem Rate

The Inpatient Per Diem Rate is an all-inclusive daily rate paid for any, and all, inpatient care and services provided by a hospital to a MassHealth member, with the exception of any, and all, Administrative Days (see Section 2). The Inpatient Per Diem Rate is derived using the following method: (a) the sum of a hospital's base year inpatient Operating Cost (Section 1, paragraph B) plus the Adjustment to Base Year Costs (Section 1, paragraph C) is divided by a hospital's base year patient days; plus (b) the Allowance for Inpatient Capital are calculated as for RY 2012. Then, in accordance with Section 271 of Chapter 224, MassHealth applies a factor of 1.6 times the hospital's rate year 2012 inpatient per diem rate established in RY 2012. After having applied the factor of 1.6, the update factors described in Section 1, paragraph C and Section 1, paragraph D.3. for RY 14-15 are applied to determine the final per diem.

The administrative day per diem rate is calculated using the methodology described in Section 2 below.

A. Data Sources.

1. The base year for inpatient costs and the outpatient cost-to-charge ratio is the (HFY) 2003. The MassHealth program utilizes the costs, statistics, and revenue reported in the HFY 2003 HCFP-403 cost report.
2. 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. All references to specific schedules, columns, and lines refer to the HCFP-403 report filed with and reviewed by the Division of Health Care Finance and Policy (DHCFP). Except where noted, all references are to the HFY 2003 version of the HCFP-403.
3. The calculations use each hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by DHCFP or successor agency. The MassHealth program may also request additional information, data, and documentation from a hospital or DHCFP or successor agency as necessary to calculate rates.
4. If the specified data source is unavailable or inadequate, the MassHealth program will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data. If required information is not furnished by a hospital within the applicable time period, it may not receive any increase to its rate.

B. Determination of Base Year Inpatient Operating Costs. Base Year Inpatient Operating Costs are the sum of Inpatient Direct Routine Costs, Inpatient Direct Ancillary Costs, and Inpatient Overhead Costs as described below.

1. Inpatient Direct Routine Costs. Inpatient Direct Routine Costs are a hospital's Total Inpatient Routine Costs derived from the HCFP-403.
2. Inpatient Direct Ancillary Costs. Inpatient Direct Ancillary Costs are calculated as follows:
 - a. Inpatient Direct Ancillary Costs are calculated by multiplying each hospital's chronic and rehabilitation inpatient ancillary expenses times the ratio of Total Direct Ancillary Expenses to Total Ancillary Expenses (including overhead). The resulting product constitutes the Total

Inpatient Direct Ancillary Cost. For hospitals that reported costs in Sch. XIV, Column 2, Line 15 (Central Service/Supplies) and/or Column 2, Line 16 (Pharmacy), those costs are removed from Overhead costs and reclassified to Ancillary costs pursuant to Section 1, paragraph B.3.a.

3. Total Inpatient Overhead. Total Inpatient Overhead is calculated by comparing Total Inpatient Overhead to an efficiency standard as described below.

- a. A HFY 2003 Inpatient Overhead per diem amount is computed for each hospital as follows:
 - i. Inpatient Routine Overhead cost is calculated by subtracting Direct Inpatient Routine Cost from Inpatient Routine Cost after step-down of overhead.
 - ii. Inpatient Ancillary Overhead Cost is calculated by subtracting the Total Inpatient Direct Ancillary Cost determined in Section 1, paragraph B.2.a from the Total Chronic and Rehabilitation Inpatient Ancillary Expenses reported on the HCFP-403.
 - iii. The Central Service and Supplies and Pharmacy expenses are then reclassified to Ancillary costs as follows:

The Central Service/Supplies Direct Expense is multiplied by the ratio of the inpatient medical supplies patient service statistics to the total medical supplies patient service statistics, all as derived from the HCFP-403 report.

The Pharmacy Direct Expense is multiplied by the ratio of the inpatient drug patient service statistics to the total drug patient service statistics, all as derived from the HCFP-403 report.

The two products of these calculations are then added together to equal the Total Inpatient CSS and Pharmacy Expense.

- iv. The Allowable Chronic Disease and Rehab Inpatient Overhead Expense is then determined by adding together the amounts in i. and ii (above) and subtracting from this the amount determined in iii (above). The resulting amount is then divided by HFY 2003 Patient Days.
- b. The efficiency standards for pediatric CDR hospitals are determined as follows:

The chronic disease hospital group consists of Kindred Hospital Northeast, Franciscan Hospital for Children, Radius Specialty Hospital, New England Sinai Hospital, Spaulding Hospital-North Shore, Vibra Hospital of Western Mass, and Spaulding Hospital-Cambridge.

The Inpatient Overhead Per Diem Cost for each chronic disease hospital in the chronic disease hospital group is calculated and the median is set as the efficiency standard for pediatric CDR hospitals.
- c. If a pediatric CDR hospital's Total Inpatient Overhead Per Diem Cost does not exceed the appropriate efficiency standard, its Total Inpatient Overhead Cost is calculated pursuant to Section 1, paragraph B.3.a., without further adjustment.
- d. If a pediatric CDR hospital's Total Inpatient Overhead Per Diem Cost exceeds the appropriate efficiency standard, the hospital's Total Inpatient Overhead Cost is the efficiency standard multiplied by HFY 2003 Patient Days.

C. Adjustment to Base Year Operating Costs. Total Inpatient Routine Direct Costs, Total Inpatient Ancillary Direct Costs, and Total Inpatient Overhead Costs are updated using a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals. The year-to-year update factors used in the rate calculation are as follows: 2003-2004 2.21%; 2004-2005 1.198%; 2005-2006 1.84%; 2006-2007 1.637%; 2007-2008 1.588%; 2008-2009 1.459%; 2009-2010 0.516%; 2012-2013 1.643%; 2013-2014 1.571%; 2014-2015 1.672%; 2015-2016 0.0%; 2016-2017 0.0%.

D. Allowance for Inpatient Capital.

1. Each hospital's base year capital costs consist of the hospital's actual HFY 2003 patient care capital requirement for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities.

2. The limitations applicable to base year capital costs are:
 - a. Interest expense attributable to balloon payments on financed debt is excluded. Balloon payments are those in which the Final payment on a partially amortized debt is scheduled to be larger than all preceding payments.
 - b. Where there was a change of ownership after July 18, 1984, the basis of the fixed assets used in the determination of depreciation and interest expense is the lower of the acquisition cost to the new owner or the basis allowed for reimbursement purposes to the immediate prior owner. The depreciation expense is 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, are subtracted from capital costs.
3. Each hospital's base year inpatient unit capital cost equals the base year inpatient capital cost divided by the greater of: (i) the actual base year routine patient days; or (ii) eighty-five percent (85%) of base year maximum licensed bed capacity, measured in days. The CMS Capital Input Price Index adjusts the base year inpatient unit capital cost to determine the Inpatient Unit Capital amount. The year-to-year update factors used in the rate calculation are as follows: 2003-2004 .7%; 2004-2005 .7%; 2005-2006 .7%; 2006-2007 .8%; 2008-2009 .7%; 2009-2010 1.2%; 2012-2013 1.2%; 2013-2014 1.4%; 2014-2015 1.5%; 2015-2016 0.0%; 2016-2017 0.0%.
4. The Inpatient Unit Capital amounts of all chronic hospitals in the Chronic Disease Hospital Group as set forth at Section 1.B.3.b. is calculated and the median is set as the efficiency standard, which serves as the Pediatric Chronic Disease Hospital Allowance for Inpatient Capital.

Section 2: Determination of Rate for Administrative Day Patients.

A hospital is paid for Administrative Days using an Administrative Day Per Diem Rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each Administrative Day. The AD Rate is comprised of three components: a statewide AD routine per diem amount, a statewide AD ancillary per diem amount and a hospital-specific supplementary per diem amount. The statewide AD routine per diem amount is derived from the weighted average Medicaid payment rate for case mix category T (10) patients in nursing facilities in 2003. The statewide AD ancillary per diem amount is derived from the statewide weighted average Medicaid ancillary payment for AD patients in Chronic Disease and Rehabilitation Hospitals in FY 2003. The sum of the statewide AD routine per diem amount and ancillary per diem amount equals \$513.05.

For RY 2020, the supplementary per diem amount for each hospital is the sum of the statewide AD routine and ancillary per diem amount of \$513.05 increased by 80% of the difference between each hospital's Inpatient Per Diem Rate and the statewide AD routine and ancillary per diem amount of \$513.05.

Section 3: Determination of Outpatient Rate.

A hospital will be paid for Outpatient Services using a hospital-specific Outpatient Cost-to-Charge Ratio. The Outpatient Cost-to-Charge Ratio is a fixed percentage that is applied to a hospital's Usual and Customary Charges for Outpatient Services, based on charges filed with the Division of Health Care Finance and Policy, or successor agency as of July 1, 2014. Payment for a particular Outpatient Service shall be equal to the product of the Cost-to-Charge Ratio times the hospital's Usual and Customary Charge for the Outpatient Service in effect as of July 1, 2014. Any such payment shall not exceed the hospital's Usual and Customary Charge.

The Cost-to-Charge Ratio for a specific hospital is calculated by dividing its outpatient costs (Schedule XVIII) by its outpatient service revenue (schedule XI), as derived from the HCFP-403.

Section 4. Quality Performance Incentive Payments. Subject to legislative authorization, compliance with all applicable federal statutes, regulations, state plan provisions, the availability of funds, and full federal financial participation, in RY 2020 EOHHS will make a total aggregate amount of \$500,000 available for Quality Performance Incentive Payments to qualifying Pediatric CDR Hospitals, and as described below.

A. Qualification. In order to qualify for Quality Performance Incentive Payments, a Pediatric CDR Hospital must meet the following criteria:

1. Be a chronic disease and rehabilitation hospital that serves solely children and adolescents with complex acute rehabilitation and chronic needs that is located in Massachusetts and serving MassHealth members;
2. For Quality Performance Incentive Payment A, have recorded performance, for the second quarter 2019 (April 2019 – June 2019) that meets or exceeds the Performance Measurement A criteria described in **Section B.1.** below, for the following measures, as reported by The Children's Hospitals' Solutions for Patient Safety National Children's Network:
 - a. Pressure Injury Prevention Bundle;
 - b. Rate of Adverse Drug Events (ADE) per 1,000 patient days.
3. For Quality Performance Incentive Payment B, have recorded performance for April 2019 – June 2019 that meets or exceeds the Performance Measurement B criteria described in **Section B.2.**, below, on the following measures, as reported by The Joint Commission:
 - a. Admission Screening For Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed – Children (1 through 12 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1b;
 - b. Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed Adolescent (13 through 17 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1c.

B. Performance Measurements.

1. Performance Measurement A. Performance will be measured based on
 - a. an average of the three months of data for the second quarter 2019 (April 2019 – June 2019) that is submitted to The Children's Hospitals' Solutions for Patient Safety, National Children's Network:

The number of audits completed with the bundle elements (Skin Assessment, Device Rotation, Patient Positioning, Appropriate Bed Surface, Moisture Management) completed, divided by the number of audits completed x 100 must be equal or greater than 75%; and,
 - b. an average of the three months of data for the second quarter 2019 (April 2019 – June 2019) that is submitted to The Children's Hospitals' Solutions for Patient Safety, National Children's Network:

The average rate of Adverse Drug Events (ADE) per 1,000 patient days is at or below 0.125 per 1000 patient days.
2. Performance Measurement B. Performance as reported by the Joint Commission for the second calendar quarter 2019 (April 2019 – June 2019), on the following measures:
 - a. 80% for Admission Screening For Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed - Children (1 through 12 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1b;
 - b. 80% for Admission Screening For Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths - Completed Adolescent (13 through 17 years), as described in the Specifications Manual for Joint Commission National Quality Measures HBIPS-1c.

C. Payment.

1. EOHHS will issue the RY 2020 Quality Performance Incentive Payment A in a total aggregate amount of \$300,000 and apportioned equally across the Pediatric CDR Hospitals that qualify for Payment A. Payment will be issued in one installment during RY 2020 as follows: April 2020.
2. EOHHS will issue the RY 2020 Quality Performance Incentive Payment B in a total aggregate amount of \$200,000 and apportioned equally across the Pediatric CDR Hospitals that qualify for Payment B. Payment B will be issued as part of payment A during April 2020.

Section 5. Supplemental Payment.

Subject to legislative authorization, compliance with all applicable federal statutes, regulations, state plan provisions, the availability of funds, and full federal financial participation, in RY 2020 EOHHS will make a total aggregate amount of \$3 million available for Supplemental Payments for High-Complexity Pediatric Care provided by Pediatric CDR Hospitals to qualifying Pediatric CDR Hospitals, as described below:

In order to qualify, for a Supplemental Payment for High-Complexity Pediatric Care provided by a Pediatric CDR Hospital, a Pediatric CDR Hospital must be a chronic disease and rehabilitation hospital that serves solely children and adolescents with complex acute rehabilitation and chronic needs that is located in Massachusetts and serving MassHealth members.

1. Payment. EOHHS will issue the RY 2020 Supplemental Payment for High-Complexity Pediatric Care in a total aggregate amount of \$3 million and apportioned equally across the Pediatric CDR Hospitals that qualify. Payment will be issued in one installment during RY 2020 as follows: April 2020.

Pediatric Chronic Disease and Rehabilitation Hospital

Proposed Medicaid Inpatient and Outpatient Rates

October 1, 2018 - September 30, 2019

Facility	Inpatient Per Diem	Inpatient AD Per Diem	Outpatient Cost/Charge Ratio
Franciscan Children	1,785.59	1,531.08	70.52%