

Notice of Proposed Agency Action

SUBJECT: MassHealth: Payment for Chronic Disease and Rehabilitation Hospital Services effective October 1, 2017

AGENCY: Massachusetts Executive Office of Health and Human Services (EOHHS)

Summary of Proposed Action

Pursuant to the provisions of M.G.L. c. 118E, §13A, rates 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 proposed methods and standards for the establishment of payment methods and rates by contract for rate year (RY) 2018 which begins October 1, 2017 between the Executive Office of Health and Human Services (EOHHS) and participating chronic disease and rehabilitation (CDR) hospitals.

Description of Proposed Methods and Standards

EOHHS proposes to establish a comprehensive inpatient per diem rate for each participating hospital, covering both routine and ancillary services provided to inpatients. EOHHS proposes to derive the inpatient per diem rate from the 2014 operating and capital cost information for each hospital. An efficiency standard is applied to inpatient capital costs; the efficiency standard is the median base year unit cost, determined and applied separately for a chronic disease hospital group and a rehabilitation hospital group. The operating and capital costs will be updated from fiscal year 2014 (base year) 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 Inpatient Rehabilitation Facilities (IRF). The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the non-labor cost category will be the non-labor portion of the CMS IRF-specific market basket. The 2018 update factor covering the period from the base year to the rate year beginning October 1, 2018, will be 6.95%.

The MassHealth program proposes to establish a facility-specific rate for short-stay administrative days (AD) (short-stay AD rate) and a statewide standard rate for long-stay administrative days (long-stay AD rate), each derived from a common AD base rate. The AD base rate will be comprised of a routine per diem and an ancillary add-on. The routine per diem will be 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 will be derived from hospital ancillary claims data for AD patients in hospital fiscal year (HFY) 2003. The sum of the routine per diem and ancillary add-on amount equals \$513.05 which is then inflated by 6.95%, resulting in an AD base rate of \$548.71.

For each participating hospital, the short-stay AD rate will be the AD base rate increased by 64% of the difference between each hospital's rate year inpatient per diem rate and the AD base rate of \$548.71.

The long-stay AD rate will be the AD base rate of \$ 548.71, increased by 35%, for a single statewide rate of \$740.75.

The MassHealth program proposes to establish a quality performance payment paid in three installments for CDR Hospitals that serve Medicaid members on an inpatient basis and meet performance benchmarks that are based on two CMS 2017 Inpatient Rehab Facility Compare and Long Term Care Hospital Compare measures designated by EOHHS.

The MassHealth program also proposes to utilize a hospital-specific cost-to-charge ratio for outpatient services that is derived from historical cost and charge information. The cost-to charge ratio will be applied to the hospital's usual and customary charges on file with the Center for Health Information and Analysis (CHIA), as of July 1, 2017 for outpatient services.

The methods and standards described herein are being proposed in order to establish rates by contract that accurately reflect the efficient and economic provision of chronic disease services and/or comprehensive rehabilitation services. The proposed methods and standards described herein are projected to result in a 56% increase in annual aggregate expenditures in RY 2018. The actual change in aggregate expenditures is estimated to be \$15.3 million but may vary depending on actual utilization of services.

Included with this notice are the proposed rates of payment, effective October 1, 2017. Please contact Pavel Terpelets, MassHealth Office of Long Term Services and Supports, One Ashburton Place, 5th Floor, Boston, MA 02108, to send any written comments regarding this notice. **EOHHS specifically invites comments as to how the amendments may impact beneficiary access to care.**

STATUTORY AUTHORITY:

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

Related Regulations:

42 CFR Part 447

**Executive Office of Health and Human Services
Chronic Disease and Rehabilitation Hospitals
Proposed Methods and Standards
For Rates Effective October 1, 2017**

The following sections describe the proposed methods and standards to be utilized by the Executive Office of Health & Human Services (HHS) to establish rates of payment by contract, to be effective October 1, 2017, for services rendered by chronic disease and rehabilitation hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.*

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 3). The Inpatient Per Diem Rate is derived using the following method: (a) the sum of a hospital's base year inpatient operating costs (Section 1, paragraph B) and the allowable capital costs (Section 1, paragraph C) divided by a hospital's base year patient days, inflated by the Adjustment to Base Year Costs (Section 1, paragraph D).

A. Data Sources.

1. The base year for inpatient costs is (HFY) 2014. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2014 CHIA D403 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 CHIA D403 report filed with and reviewed by the Center for Health Information and Analysis (CHIA). Except where noted, all references are to the HFY 2014 version of the CHIA D403.
3. The calculations use each hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by CHIA. The MassHealth program may also request additional information, data and documentation from a hospital or CHIA 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 CHIA D403.
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.

3. Total Inpatient Overhead.

Total Inpatient Overhead Costs are calculated as follows:

- a. Inpatient Routine Overhead cost is calculated by subtracting Inpatient Direct Routine Cost from Inpatient Routine Cost after step-down of overhead.
- b. 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 CHIA D403.
- c. The Allowable Chronic Disease and Rehab Inpatient Overhead Expense is then determined by adding together the amounts in a. and b. (above).

C. Allowance for Inpatient Capital.

1. Each hospital's base year capital costs consist of the hospital's actual HFY 2014 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 actual base year routine patient days.
4. The Inpatient Unit Capital amounts of all chronic hospitals in the chronic hospital group (below) are calculated and the median is set as the efficiency standard, which serves as the Chronic Disease Hospital Allowance for Inpatient Capital. Each chronic hospital in the Chronic Disease Hospital Group will be paid the lower of their actual costs or the Chronic Disease Hospital Allowance for Inpatient Capital.

The Chronic Disease Hospital Group consists of Curahealth Hospital Stoughton, New England Sinai Hospital, Vibra Hospital of Western Mass and Spaulding Hospital-Cambridge.

5. The Inpatient Unit Capital amounts of all rehabilitation hospitals in the rehabilitation hospital group (below) are calculated and the median is set as the efficiency standard, which serves as the Rehabilitation Hospital Allowance for Inpatient Capital. Each rehabilitation hospital in the Rehabilitation Hospital Group will be paid the lower of their actual costs or the Rehabilitation Hospital Allowance for Inpatient Capital.

The Rehabilitation Hospital Group consists of Braintree Rehabilitation, HealthSouth Fairlawn Hospital, New Bedford Rehabilitation Hospital, New England Rehabilitation Hospital, Spaulding Hospital-Cape Cod, HealthSouth Hospital of Western Massachusetts, Spaulding Rehabilitation Hospital-Boston, Whittier Rehabilitation Hospital-Bradford and Whittier Rehabilitation Hospital-Westborough.

D. Adjustment to Base Year Operating and Capital Costs.

Total Base Year Inpatient Operating Costs and Capital 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 Inpatient Rehabilitation Facilities (IRF) 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 IRF-specific market basket. The update factor, covering the period from the base year to the rate year beginning October 1, 2018, will be 6.95%.

Section 2: Determination of Inpatient Rate for New Hospitals (i.e., Newly Licensed as Chronic Disease or Rehabilitation Hospitals after October 1, 2018).

1. The allowable overhead, routine and ancillary per diem costs will be established at the median of HFY 2014 per diem costs reported by chronic and rehabilitation hospitals, updated by the inflation factor calculated pursuant to Section 1, paragraph D.
2. The allowable capital per diem costs will be established at the efficiency standards as calculated pursuant to Section 1, paragraph C.

Section 3: Determination of Rate for Administrative Day Patients.

A hospital will be paid for Administrative Days using either a facility-specific short-stay or statewide standard long-stay Administrative Day Per Diem Rate (AD Rate). AD Rates are all-inclusive daily rates.

The short-stay and long-stay AD Rates are based on an AD Base Per Diem Rate comprised of the statewide AD routine per diem amount and the statewide AD ancillary 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 routine per diem and ancillary add-on amount equals \$513.05 which is then inflated by 6.95%, resulting in a RY 2018 AD base per diem rate of \$548.71.

For RY 2018, the short-stay AD per diem rate will be the AD base per diem rate of \$548.71 increased by 64% of the difference between each hospital's Inpatient Per Diem Rate and the AD base per diem rate.

For RY 2018, the long-stay AD per diem rate will be the AD base per diem rate of \$548.71 increased by 35%, for a single statewide per diem rate of \$740.75.

Section 4: Determination of Outpatient Rate.

1. The base year for outpatient costs is (HFY) 2014. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2014 CHIA D403 cost report.
2. 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 CHIA as of July 1, 2017. 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, 2017. Any such payment shall not exceed the hospital's Usual and Customary Charge.

3. The Cost-to-Charge Ratio for a specific hospital is calculated by dividing its outpatient costs (Schedule XVIII) by its outpatient service revenue (Schedule VI), as derived from the CHIA D403.

Section 5. Quality Performance Supplemental Payments to CDR Hospitals other than Pediatric CDR Hospitals

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 2018 EOHHS will make a total aggregate amount of \$5 Million available for Quality Performance Supplemental Payments to qualifying CDR Hospitals, and as described below:

1. Qualification. In order to qualify for a Quality Performance Supplemental Payment for RY 2018, a CDR hospital must meet the following criteria:
 - a. Be a CDR Hospital (other than a Pediatric CDR Hospital) located in Massachusetts and serve MassHealth members; and
 - b. Have recorded performance, as of February 2, 2017, on the following two Centers for Medicare and Medicaid Services (CMS) 2017 Inpatient Rehabilitation Facility Compare and Long Term Care Hospital Compare measures, as reported by CMS:
 - i. Quality Measure 1: Percent of Residents or Patients with Pressure Ulcers That Are New or Worsened; and
 - ii. Quality Measure 2: All-Cause Unplanned Readmission Measure for 30 Days Post Discharge from Inpatient Rehabilitation Facilities or Long Term Care Hospitals.
2. Performance Measurement. Performance for qualifying CDR hospitals is measured based on a point based scoring system with a maximum score of 4 points.
 - a. CDR hospitals that are located in Massachusetts and serve MassHealth Members earn 1 point.
 - b. Quality Measure 1: CDR hospitals that performed:
 - i. above the national average earn 1 point;
 - ii. consistent with the national average earn 0 points; and
 - iii. below the national average earn -1 point
 - c. Quality Measure 2: CDR hospitals that performed:
 - i. above the national average earn 2 points;
 - ii. consistent with the national average earn 0 points; and
 - iii. below the national average earn -2 point

3. Calculation of the Quality Performance Supplemental Payment.

EOHHS will calculate the amount of each qualifying CDR Hospital's Quality Performance Supplemental Payment as follows:

- a. EOHHS will determine each qualifying CDR Hospital's total performance measurement point value.
- b. The total performance measurement points earned by each qualifying CDR Hospitals will be multiplied by the qualifying CDR Hospital's total number of Massachusetts non-managed care days, excluding those days related to administrative days, paid to the qualifying CDR hospital in state fiscal year (SFY) 2016 as determined by EOHHS. This step yields the total adjusted performance measurement point value for each qualifying CDR Hospital.
- c. EOHHS will divide each qualifying CDR hospital's total adjusted performance measurement point value from 3.b. above by the statewide sum of the adjusted point performance measurement point values for all qualified CDR hospitals identified in 3.b. above.
- d. Each qualifying CDR Hospital's Quality Performance Supplemental Payment equals the ratio determined in 3.c. above times \$5 million.

4. Payment

EOHHS will issue the RY2018 Quality Performance Supplemental Payment to qualifying CDR Hospitals in three installments during RY2018 as follows: October 2017, first payment; January 2018, second payment; April 2018, third payment.

Chronic Disease and Rehabilitation Hospital
Proposed Medicaid Inpatient and Outpatient Per Diem Rates and Outpatient Cost/Charge Ratios
October 1, 2017 - September 30, 2018

Facility	Inpatient Per Diem	Inpatient Short-Stay AD Per Diem	Outpatient Cost/Charge Ratio
Braintree Rehabilitation Hospital	\$ 910.80	\$ 780.44	66.58 %
HealthSouth Fairlawn Hospital	\$ 983.41	\$ 826.91	78.11 %
New Bedford Rehab Hospital	\$ 1071.04	\$ 883.00	51.92 %
New England Rehabilitation	\$ 1091.28	\$895.95	80.48%
New England Sinai Hospital	\$ 1244.97	\$994.32	65.39 %
Curahealth Hospital Stoughton	\$ 1692.85	\$1280.96	39.48 %
Vibra Hospital of Western MA	\$ 944.75	\$ 802.18	N/A
Spaulding Hospital-Cape Cod	\$ 1552.99	\$ 1191.45	38.96 %
HealthSouth Rehab Hospital West MA	\$ 932.51	\$ 794.34	83.13 %
Spaulding Rehab Hospital-Boston	\$ 1707.37	\$ 1290.25	44.08 %
Whittier Rehab-Bradford	\$ 1218.58	\$ 977.42	46.51 %
Whittier Rehab-Westborough	\$ 1178.98	\$ 952.08	36.95 %
Spaulding Hospital-Cambridge	\$ 1664.16	\$ 1262.60	90.63 %