114.1 CMR 40.00: NON-ACUTE HOSPITAL PUBLICLY ASSISTED RATES OF PAYMENT AND THE FEE FOR RESIDENTIAL ALCOHOLISM TREATMENT PROGRAMS

Section

40.01: General Provisions

(1) Scope, Purpose and Effective Date. The purpose of 114.1 CMR 40.00 is to set forth regulations for the establishment of certain non-acute hospital publicly assisted rates of payment, and the fee for residential alcoholism treatment programs. 114.1 CMR 40.00 shall be effective on October 1, 1996. 114.1 CMR 40.00 shall not apply to chronic/rehabilitation hospitals governed by 114.1 CMR 39.00. 114.1 CMR 40.00 shall not apply to managed care services provided to Medicaid recipients who are inpatients of a non-acute hospital under a direct contract with the Division of Medical Assistance.

(2) Authority. 114.1 CMR 40.00 is adopted pursuant to M.G.L. c. 118G; and M.G.L. c. 30A, § 2.

40.02: Definitions

As used in 114.1 CMR 40.00, unless the context requires otherwise, terms shall have the meanings ascribed in 114.1 CMR 40.02.

Adjusted Base Year Volume. The actual base year volume adjusted to include the volume associated with recurring CBCs, new services and transfers on of cost and exclude volume associated with discontinued services and transfers off of cost.

Administrative Day. An inpatient day spent in a non-acute hospital or public health care facility, other than a hospital operated by the Department of Mental Health (except facilities which are certified to provide services under Title XIX of the Social Security Act), by a patient who has been identified by a Professional Standards 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 which does not require a hospital level of care.

Base Year. For DMH and DPH hospitals only licensed and/or operated as non-acute hospitals during FY 1993, the base year is the hospital's FY 1993. For hospitals that were not licensed and/or operated as non-acute hospitals during fiscal year 1993, the base year shall be determined pursuant to 114.1 CMR 40.09. For all other hospitals licensed and/or operated as non-acute hospitals during FY 1984, the base year is the hospital's FY 1984, For hospitals that were not licensed and/or operated as non-acute hospitals during fiscal year 1984, the base year shall be determined pursuant to 114.1 CMR 40.09.

CBC. Cost beyond control.

40.02: continued

Commission. The Rate Setting Commission was established under M.G.L. c. 6A, § 32. On July 1, 1996, all functions were transferred to the Division of Health Care Finance and Policy under M.G.L. c. 118G.

Department of Public Health. The Department of Public Health established under M.G.L. c. 17, § 1.

DHCFP-450. DHCFP-450, Report of Charges and Volume, is a report which documents a hospital's 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 beyond the allowable increase specified in 114.1 CMR 40.04(4)(b).

Discontinued Service. A health service, supply or accommodation which conforms in scope to a cost center as defined in Chapter III of the Reporting Manual which:

(a) is included in the adjusted base year cost and which will not be offered during the budget year, or

(b) is being offered and terminated during the budget year.

Direct Cost. The cost of a center as defined by the Reporting Manual after reclassification and recoveries of expense and prior to the allocation of overhead cost to patient care cost centers through the step-down.

Division. The Division of Health Care Finance and Policy, established under M.G.L. c. 118G.

Free Care. The amount, net of free care income or community fund grants, which is charged off by a hospital for hospital care and services, supplies and accommodations provided to indigent persons, pursuant to a plan adopted by the hospital's governing board and filed with the Division. Free care will not include accounting provisions for free care, free care provided to employees or courtesy allowances.

FTEs: Full-time equivalent staff. To compute 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, or political subdivision of the Commonwealth.

GPSR. Gross patient service revenue is the total dollar amount of a hospital's charges for services rendered during the reporting period, generally within a fiscal year

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

Intermediate Year. The hospital fiscal year just before the current rate year.

Inpatient Day. HURM standard unit of measure to report care of patients admitted to a hospital including the day of admission, but not the day of discharge. If both admission and discharge occurs on the same day, the day is considered a day of admission and counts as one inpatient day.

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

PAF. Payment on account factor is a percentage applied to charges to calculate a purchaser's discounted reimbursement level.

40.02: continued

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 Individual. 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. For all non-acute hospitals, as defined in 114.1 CMR 40.01, the rate year will be defined as follows:

(a) For facilities classified as a "Public Health Care Facility" as defined in 114.1 CMR 40.02, the rate year will be from 7/1 to 6/30.

(b) For all other non-acute facilities, the rate year will be 10/1 to 9/30.

Residential Alcoholism Treatment Program. A residential care program for second-time driving while intoxicated offenders approved by the Division of Alcoholism, Massachusetts Department of Public Health pursuant to 105 CMR 166.00.

RFR. Reasonable Financial Requirements.

Transfer of Cost. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities which provide hospital care or services which changes 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.

40.03: Reporting Requirements

(1) Reporting Requirements.

(a) Each non-acute hospital shall file with the Division one electronic copy and two paper copies of its Hospital Statement of Costs, Revenues, and Statistics, RSC-403, for each fiscal year within 120 of the close of its fiscal year. Two copies of a hospital's audited financial statements must also be submitted within 120 days of the close of its fiscal year. This 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. A copy of the RSC-403 and instructions is incorporated in 114.1 CMR 4.00 and any pertinent administrative bulletins.

(b) Each non-acute hospital shall file with the Division two copies of the DHCFP-450, the Report of Charges and Volume, for the period 7/1/95 through 6/30/96 and the period 7/1/96 through 9/30/96 by January 1, 1997.

(c) Beginning 10/1/96, each non-acute hospital shall file with the Division two copies of the DHCFP-450 within 30 days of the close of the rate year quarter.

(d) Each non-acute hospital shall file with the Division two copies of the hospital's charge book at the beginning of each rate year and at the end of each quarter during which the hospital makes changes.

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

(f) 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.

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

40.03: continued

(2) Penalties.

(a) All non-acute hospitals are required to submit to the Division documents needed for the calculation of Medicaid rates of payment. These documents include but are not limited to the aforementioned RSC-403 cost reports, the audited financial statements and the DHCFP-450. If the hospital does not submit this complete information in a timely fashion as described above, such hospital may have a reduction applied to their PAF as of the week of Division vote of 5% for every overdue month. Furthermore, this reduction shall continue to accrue in a cumulative manner of 5% for each month of non-compliance. For example, the first adjustment might equal 5%, if requested documentation is not received for an additional month, the adjustment shall equal 10%. The adjustment shall not, in any case, exceed a 50% reduction to the PAF. The PAF will be increased to the hospital's FY 1997 PAF level calculated pursuant to 114.1 CMR 40.04(4) as of the Division receipt date of hospital compliance.

(b) If a hospital fails to file any data, statistics or other information required under 114.1 CMR 40.03, the Division may request the Attorney General of the Commonwealth to seek additional penalties under M.G.L. c. 118G.

40.04: Rates of Payment for Services Provided to Publicly-Aided Individuals

(1) Applicability. Rates of payment determined under the rules of 114.1 CMR 40.04 shall include:

(a) Payment for all inpatient, outpatient, and well-newborn hospital care and services which are provided by a non-acute hospital to publicly-aided patients.

(b) Payment for administrative days which are provided by a non-acute hospital to publicly aided individuals under Title XIX of the Social Security Act.

(2) General Payment Provisions.

(a) Reimbursement as Full Payment. Each non-acute hospital which provides hospital care and service to publicly-aided individuals shall, as a condition to 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 shall be no supplementation or duplication of payment.

(b) Reimbursement Limitation. Reimbursement determined under 114.1 CMR 40.04 shall not exceed the 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 non-acute hospitals' Medicaid payment on account factors (PAFs) 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 40.00 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 payment on account factors calculated pursuant to 114.1 CMR 40.04 applied to rate year Medicaid charges. If the aggregate payment amount pursuant to 114.1 CMR 40.00 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.

(3) Rates for Administrative Day Patients. The rate for inpatient services provided to Administrative Day Patients shall be calculated as follows:

(a) For eligible routine services furnished to administrative day patients, the FY 1996 rate of payment will be the lesser of $111 per patient day or the PAF determined pursuant to 114.1 CMR 40.04(4) times the hospital's approved routine charge.

40.04: continued

(b) For eligible routine services furnished to administrative day patients, the FY 1997 rate of payment will be the lesser of $113.27 per patient day or the PAF determined pursuant to 114.1 CMR 40.04(4) times the hospital's approved routine charge.

(c) For eligible ancillary services furnished to administrative day patients, the rate of payment shall be equal to the PAF determined pursuant to 114.1 CMR 40.04(4) times the approved charge for the service.

(4) Payment on Account Factor. For all eligible services supplied to publicly assisted patients, other than those cited in 114.1 CMR 40.04(3), the rate of payment shall be equal to the product of the PAF and the approved charge for the service.

(a) The FY 1996 PAF shall be computed by dividing the RFR determined pursuant to 114.1 CMR 40.06 by the Approved GPSR for the corresponding rate year, as approved under 114.1 CMR 38.00.

If a hospital's approved GPSR is revised pursuant to 114.1 CMR 38.00, the PAF shall be revised to reflect the new approved GPSR. The PAF shall not be revised to reflect changes in RFR made pursuant to 114.1 CMR 38.00.

In no event shall the PAF exceed 100%.

(b) The FY 1997 PAF shall be computed by dividing the FY 1997 RFR by the FY 1997 GPSR. For hospitals with a rate year beginning 7/1/96, the FY 1997 GPSR shall be the GPSR calculated using the FY 1997 RSC-440 as reviewed and adjusted by the Division. For hospitals with a rate year beginning 10/1/96, the FY 1997 GPSR shall be the FY 1996 GPSR as approved by the Division. This PAF shall remain in effect unless adjusted as described below or until it is superseded by new regulation or a contract with the Division of Medical Assistance.

1. Determination of the Medicaid PAF shall be made in accordance with the information filed on the DHCFP-450 Form.
2. The PAF shall be adjusted downward prospectively, pro-rated for months remaining in the rate year, if the charge per day as reported in the DHCFP-450 Form increases beyond an allowable increase. The allowable increase shall equal the FY 1996 to FY 1997 inflation factor, as calculated pursuant 114.1 CMR 40.08(2), multiplied by the greater of 1 or the ratio of FY 1997 RFR to FY 1996 RFR.
3. The adjustment factor shall equal the product of:
   a. the inflation factor divided by the sum of one plus the percent increase in charges; and
   b. the greater of one or the ratio of FY 1997 RFR to FY 1996 RFR.
4. The pro-rated adjustment shall be determined as follows:
   a. Step One: i) the adjustment factor multiplied by the total number of months in the year that the increased charges are in effect less ii) the number of months that the increased charges are in effect before the adjusted PAF will take effect.
   b. The pro-rated adjustment shall equal Step One of the adjustment as calculated above divided by the number of months remaining in the year after the adjusted PAF will take effect.
5. The current PAF shall be multiplied by the pro-rated adjustment factor as calculated pursuant to 114.1 CMR 40.04(4)4.
6. The Division will determine the lower of the PAF adjusted in 114.1 CMR 40.04(b)5. or the PAF currently in effect and will approve a change in the PAF, if applicable, to take effect the first day of the month following the Division's approval.

(c) In addition to the initial rate of payment, a supplementary payment shall be made for all eligible services supplied by non-acute hospitals to publicly-assisted patients who are not given administrative day status. This supplementary payment shall equal the following:

Total Supplementary Payment =
Total Routine Charges for Administrative Day Patients x PAF
- $113.27 x Number of Administrative Days

(c) The supplementary payment shall be payable by the Division of Medical Assistance to the hospital.

40.05: Residential Alcoholism Treatment Programs

(1) Fee.

(a) The FY 1996 fee for a residential alcoholism treatment program shall be equal to the approved charge times the ratio of RFR determined pursuant to 114.1 CMR 40.06 to the Approved GPSR for the corresponding rate year, as approved under 114.1 CMR 38.00. If a hospital's approved GPSR is revised pursuant to 114.1 CMR 38.00, the ratio shall be revised to reflect the new approved GPSR. The ratio shall not be revised to reflect changes in RFR made pursuant to 114.1 CMR 38.00.

(b) The FY 1997 fee for a residential alcoholism treatment program shall be equal to the charge times the PAF calculated pursuant to 114.1 CMR 40.04(4).

(c) This fee shall be paid in full by the individual served, 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. 373. The Commonwealth shall pay to the hospital any difference between the payment made by the individual served and the fee determined under 114.1 CMR 40.05.

(2) Reimbursement as Full Payment. Each non-acute hospital which operates a residential alcoholism treatment program shall, as a condition to 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 discharges of all obligations of individuals served by such programs. There shall be no duplication or supplementation of payment.

(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 this regulation. Costs associated with residential alcoholism treatment program operating without such permission shall not be included in allowed operating cost.

40.06: Determination of Reasonable Financial Requirements (RFR)

(1) Purpose. The Division shall determine the Reasonable Financial Requirement (RFR) in accordance with CMR 114.1 40.06 for the purposes defined in 114.1 CMR 40.01.

(2) Method of Determination of RFR. The Division will determine the RFR for each non-acute hospital for a rate year by summing [a] the rate year operating requirements, [b] the rate year capital requirement, [c] the rate year working capital requirement, and then subtracting [d] the labor cost recovery pursuant to 40.08(2)(b). The calculation of these elements of RFR is described below.

(a) The rate year operating requirement is the sum of:

1. The base year allowed operating cost under 114.1 CMR 40.07(2), and
2. The adjusted base year to rate year adjustments calculated pursuant to 114.1 CMR 40.08.

(b) The rate year capital requirement is the sum of:

1. The base year allowed capital cost under 114.1 CMR 40.07(3), and
2. The adjusted base year to rate year adjustments pursuant to 114.1 CMR 40.08(6).

(c) The rate year working capital requirement is calculated by multiplying the sum of the rate year operating and capital requirements by 0.0055.

(3) The FY 1997 RFR.

(a) For hospitals with rate years beginning 7/1/96, the FY 1997 RFR is the RFR derived from the FY 1997 RSC-440 as reviewed and adjusted by the Division.

(b) For hospitals with rate years beginning 10/1/96, the FY 1997 RFR is the FY 1996 RFR approved by the Division. Therefore, the Division will not make adjustments pursuant to 114.1 CMR 40.07 and/or 40.08 for changes affecting costs in FY 1997.

40.07: Determination of Allowed Base Year Cost

(1) Purpose. Except for new non-acute hospitals which have not yet been assigned a base year, the commission will determine Allowed base year Operating Cost for the purpose of establishing a hospital's RFR pursuant to 114.1 CMR 40.07.

40.07: continued

(2) Calculation of Allowed Base Year Operating Cost.

(a) For DMH and DPH hospitals only the base year for operating costs shall be FY 1993, and the Division shall utilize the costs reported in audited FY 1993 RSC-403 cost report. For all other hospitals, the base year for operating costs shall be the year recognized by the Division as the base year during FY 1996. For hospitals with a later base year assigned pursuant to 114.1 CMR 40.09, the Division shall utilize the costs reported in the audited RSC-403 cost report for that year.

1. Allowable operating 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.

2. Allowable operating costs do not include costs of personnel or consultants where the primary purpose is, either directly or indirectly, to persuade or seek to persuade hospital employees to support or oppose unionization.

(b) The Division will make a one time adjustment to base year costs to reflect the following:

1. Audit adjustments when the audit is complete.

2. Annualization of partial year costs for which the hospital received adjustments in the RFR approved in the base year.

3. Annualization of partial year reductions in costs as a result of transfers off of costs and discontinued services during the base year.

(3) Calculation of Allowed Base Year Capital Cost. The base year for capital cost is the year recognized as the base year for operating costs. The base year capital cost is calculated by adjusting the hospital's actual base year capital cost for historical depreciation for buildings and fixed equipment, for reasonable interest expense, for amortization and for leases and rentals of facilities. The following limitations apply in the determination of allowable capital costs and, in addition, shall apply to any projected capital acquisitions as set forth in 114.1 CMR 40.08(6).

(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 the RFR, shall be subtracted from the capital requirement.

40.08: Determination of Base to Rate Year Adjustment of Costs

(1) Purpose. The Division will make a Base to Rate Year Adjustment of Costs in order to determine RFR pursuant to 114.1 CMR 40.06. The Division will make a year to year adjustment to base year costs for additional costs that are projected to occur in the rate year due to inflation, changes in volume, costs beyond reasonable control , and new services.

(2) Inflation. The Division shall make an adjustment for inflation prospectively. The Division will adjust allowed operating costs from the base year through the rate 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 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 non-acute hospitals. There will be no adjustment upward or downward to account for over or under-projection.

40.08: continued

(a) The composite inflation index as calculated in accordance with the preceding paragraph will be increased by .02 pursuant to M.G.L. c. 118G.

(b) The Division will recover the additional labor costs for which hospitals were reimbursed according to the provisions of 114.1 CMR 40.07(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, as required by M.G.L. c. 118G. The Division will recover these costs according to the following procedure:

1. Hospitals will report upon the request of the Division, the rate year expenditure of staff positions defined above . Any amount not expended will be excluded from the rate year RFR.
2. The Division may further adjust a hospital's RFR upon audit.

(3) Volume. Allowed base year operating costs shall be further adjusted to reflect reasonable volume increases and decreases as follows:

(a) The Division shall require each hospital to report its costs, revenue, and volume data by HURM designated cost centers. The statistics used for volume adjustment shall be the same as those statistics specified in the HURM Manual. For purposes of calculating the volume adjustment, the Allowed Unit Cost for each cost center shall equal the base year direct and indirect costs for that cost center divided by base year units. The volume associated with a Determination of Need (DoN) project, new service, or transfer on of cost shall be part of the volume used in the computation of the volume allowance. Any allowance due to new service, DoN, or transfer-on volume shall be netted out if the costs associated with it are submitted as new services, CBCs or transfers.

(b) For projected volume increases or decreases from the intermediate year to the budget year which are greater or equal to 10%, the hospital must submit a supporting statement of explanation accompanied by the appropriate statistical documentation. No volume increase shall be allowed without such explanation and documentation.

(c) For routine inpatient care services and routine ambulatory services, the allowed marginal cost for a unit increase or decrease in volume shall be 50%. The allowed cost for marginal cost for ancillary services for a unit increase or decrease in volume shall be 60%. There shall be no upside corridors for volume increases.

(d) An increase in costs due to an increase in routine inpatient services or routine ambulatory services volume from the base year to the budget year shall be calculated as the product of the projected increase in units multiplied by 50% of the allowed unit cost as defined in 114.1 CMR 40.08(3)(a) inflated by the base to rate year composite inflation index.

An increase in costs due to an increase in ancillary services volume from the base year to the budget year shall be calculated as the product of the projected increase in units multiplied by 60% of the allowed unit cost as defined in 114.1 CMR 40.08(3)(a) inflated by the base to rate year composite inflation index.

(e) For routine inpatient care services, routine ambulatory services and ancillary services, the allowed marginal cost for a unit decrease in volume shall be as follows:

Unit Decrease	Allowed Marginal Cost
Up to 5%	100%
Over 5% to 25%	50%
Over 25% to 50%	25%
Over 50% to 75%	12.5%
Over 75%	0%

There shall be no downside corridors for volume decreases.

(f) A decrease in cost due to a decrease in routine inpatient care service, routine ambulatory care services or ancillary services volume shall be calculated as the product of the projected decrease in units multiplied by one minus the applicable marginal cost percentage, as provided in 114.1 CMR 40.08(3)(e), multiplied by the Allowed Unit Cost as defined in 114.1 CMR 40.08(3)(a) inflated by the base to rate year composite inflation index.

40.08: continued

(4) Cost Beyond Hospital Control (CBCs). Allowed base year operating costs shall be further adjusted to reflect costs beyond the reasonable control of the hospital which meet the requirements of 114.1 CMR 40.08(4)(a) and the criteria of 114.1 CMR 40.08(4)(b).

(a) A CBC is an unusual and unforeseen increase in reasonable and allowable costs which is solely attributable to unique and exceptional circumstances that are beyond the control of the hospital. The following requirements must be met before certain costs are qualified as CBCs and included in RFR.

1. A cost shall not be determined to be a CBC if in a prior fiscal year the Division approved costs corresponding to the CBC and the events giving rise to the cost did not take place in the year the cost was approved.

2. The timing and amount of the increase in costs must be reasonably certain. If the hospital does not begin to expend costs for which it has received a CBC adjustment within six months, the hospital must notify the Division that approved amounts were not expended, and the Division will deduct such costs from RFR.

3. The hospital shall demonstrate that the category of cost of the requested CBC is not included in the adjusted base year operating cost or in the base to rate year inflation and volume allowances.

4. A cost shall be allowed as a CBC only if the amount requested is greater than one tenth 1/10 of 1% of the hospital's total patient care costs.

5. Multiple unrelated CBC requests for any one cost beyond control category must not be grouped together. Each individual CBC request for a particular item must meet the materiality limit specified in 114.1 CMR 40.08(4)(a)4..

6. Approved costs beyond control shall be only those 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.

(b) The following shall qualify for CBCs provided that the criteria set out in 114.1 CMR 40.08(4)(a) and (b) are met.

1. Costs generated by correcting citations for failure to comply with changes in government requirements related to hospital licensure and participation in programs of hospital care and services under 42 U.S.C. §§ 1395 *et seq*. and 42 U.S.C. §§ 1396 *et seq*. An example of this category of CBC is a cost incurred or expected to be incurred within six months of filing to comply with a change in the manual issued after 1984 by the Joint Division on Accreditation of Healthcare Organizations (JCAHO). Costs of complying with standards contained in the manual before 1985 or costs which merely recommend improvement will not be considered as a cost beyond reasonable hospital control. Hospitals which have not previously been accredited by JCAHO will be allowed reasonable costs of complying with accreditation standards of the JCAHO contained in its manual. An example of cost which would not be considered to be beyond reasonable hospital control is expanded emergency room coverage. Also, increased utilization review costs which are not due to any allowable cost beyond control shall not be recognized as additional cost in a hospital's projected reasonable financial requirement. Documentation shall include a copy of the government requirement, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

2. Costs generated by compliance with changes in government requirements which are set forth in federal or state regulations which mandate non-discretionary hospital expenditures. However, if the costs fall within a category encompassed by an inflation factor, it shall not be allowed as a CBC. Documentation shall include a copy of the government requirement, verification of the costs, and verification that the increase in costs requested is reasonable to meet the government requirement.

3. Costs generated by 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 part of hospital management, such losses or costs shall not be approved.

40.08: continued

4. Allowed 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. These costs must be segregated from other allowed operating costs. Any volume allowance due to a DoN shall be netted out if the costs associated with it are submitted as a CBC. The hospital must demonstrate that the increased costs requested are reasonable.

5. Wage parity adjustments resulting from mergers which are clearly demonstrated to be cost-effective. The term "cost-effective" used in this context shall mean that at the end of three years the merged hospitals are spending less than the combined projections of both hospitals. Documentation shall include a copy of the merger agreement and projections of costs without the merger as well as projection of the cost savings to be achieved through the merger. This adjustment will be considered a non-recurring CBC and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base for future rate years.

6. Intra-hospital wage and salary adjustments which are clearly demonstrated to be cost-effective. The term "cost-effective" as used in this context shall mean that at the end of three years the hospital is spending less than it would have without the wage and salary adjustments. The hospital shall submit documentation of the projected cost savings to be achieved as a result of adjustments to wages and salaries. This adjustment will be considered a non-recurring CBC and the costs associated with it will be subtracted from rate year costs for any year in which the rate year becomes the base for future rate years.

7. Costs for reasonable increases in direct care staff salaries and wages in excess of the amount allowed through inflation.

a. 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.

b. The CBC 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 force.

c. The inflation allowance for direct care staff includes the full amounts granted under 114.1 CMR 40.08(2)(a) and (b).

d. 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 Division with reference to average rates prevailing at other hospitals within the same Medicare labor market region, subject to the following conditions:

i. Outlier wage rates as defined by the Division shall be excluded from the computation;

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

iii. If it can be demonstrated that direct care staff at a hospital are transferring in significant numbers to another competing hospital, then the wage rates prevailing at that competing hospital shall be given special weight.

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

40.08: continued

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

e. In order to be eligible for this CBC, 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:

i. 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;

ii. persistent difficulty in recruitment given *bona fide* recruitment efforts to obtain staffing levels referenced in 114.1 CMR 40.08(4)(e)7.e.i.; and

iii. existing dependency upon temporary nursing services in order to maintain staffing levels referenced in 114.1 CMR 40.08(4)(e)7.e.i..

f. This CBC shall not produce reimbursement exceeding actual rate year expenditures for such direct care staff.

8. An increase in inpatient care costs generated by increased care or services required by a more intensely ill patient population. The hospital shall have the burden of demonstrating a net increase in intensity from the base year to the intermediate or rate year. The higher intensity level in the intermediate or rate year shall be used to adjust RFR.

a. To document that an increase in intensity has taken place between the base year and the intermediate year, a non-acute hospital may use any JCAHO-mandated measures of minimum staffing requirements mutually acceptable to itself and to the Division, or the management minutes system, in either case with results subject to verification by the Division or its agents. Alternatively, psychiatric hospitals may demonstrate that hospital-wide increases in certain intensity factors between the first eligible year and the intermediate year (intensity factors include, but are not limited to changes in age mix, average length of stay, number of involuntary lockup patients, patient disability index, and percentage of patients admitted from an acute hospital) have led to increases in hospital-wide service intensity (e.g., FTEs, nursing hours per patient), which in turn have led to quantifiable increases in cost. Note that increases in inputs alone are not enough to qualify for an intensity CBC; some intensity-related change in patient characteristics must also be identified.

b. If the documentation for the increase in intensity is found to be acceptable, then the hospital shall have the burden of documenting the increase in patient care costs resulting from the higher level of intensity.

9. Costs for increases in physician malpractice insurance premiums paid by the hospital for physicians who are employees of the hospital and who do not bill patients or third party reimbursers separately for their professional services. The amount of the approved CBC will be net of all the increases already determined through the inflated adjusted base year costs. The hospital must document the actual malpractice insurance premium expense, as well as show that the physicians covered are employees of the hospital and do not bill separately for their services. The hospital may include in its request the amount of any retroactive premium payments to be made during the rate year.

40.08: continued

(c) No costs other than those meeting the criteria set forth in one or more of the categories enumerated in 114.1 CMR 40.08(4)(b) are allowable CBCs. A cost increase which is affected by or attributable to a hospital's voluntary business decision is not a CBC. An increase in the cost of doing business which affects the industry as a whole is not a CBC.

(5) New Services.

(a) The Division shall recognize as a new service any health services that were not offered by a hospital prior to the intermediate year. In order to be recognized as a new service by the Division, the service to be provided should conform with the cost centers as defined in the HURM Manual. The Division shall not approve any cost allowances for a new service that is not scheduled to start within six months.

(b) For a new service to be implemented after the start of the hospital's rate year, the allowable cost shall be equal to the reasonable operating costs attributed to the new service cost centers. For a new service started in the base year, the allowable cost shall be equal to the reasonable base year cost attributed to the new service inflated by a base to rate year inflation factor plus a base to rate allowance for volume adjustment attributed to the new service.

(6) Capital. The base year capital requirement shall be adjusted to include reasonable projected acquisitions and retirements of fixed equipment and plant, and reasonable projected increases and decreases in amortization, leases and rentals. The limitations to allowed base year capital costs defined in 114.1 CMR 40.07(3) apply to these adjustments as well.

40.09: New Hospitals

(1) For hospitals which were not licensed and/or operated as non-acute hospitals in FY 1993, or did not report a full year of actual costs in FY 1993, the base year for operating and capital costs shall be the year used in the hospital's first RFR calculation.

(2) If the base year RFR was not based on a full year of actual costs, the Division shall determine whether to utilize base year RFR information, establish a different base year in accordance with Medicare regulations at 42 CFR 413.40(f)(1)(i), or to evaluate the hospital's projected operating and capital costs for reasonableness. Criteria for such review will include, but are not limited to, peer group analysis of costs incurred by comparable facilities.

(3) For new hospitals where base year RFR information is not used, the Division shall make any necessary adjustments to the provisions of 114.1 CMR 40.07 and/or 114.1 CMR 40.08 to reflect the use of a different data source.

(4) For new hospitals, which were not licensed and/or operated as non-acute hospitals in FY 1996, or did not have a base year previously established, the base year for operating and capital cost shall be the first full year of hospital cost pursuant to 114.1 CMR 40.06. 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. Criteria for such review will include but will not be limited to peer group analysis of costs incurred and the determination of approved rates for comparable facilities.

(5) For FY 1997, the PAF shall be based upon projected cost determined by 114.1 CMR 40.09(4) and projected GPSR. The projected inpatient GPSR shall be reviewed by the Division for reasonableness against the Charge per Medicaid Inpatient Day for comparable facilities.

40.10: 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 requirements, Medicaid will make an additional payment adjustment to hospitals which qualify for such an adjustment under any one or more of the following classifications. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments

are described in 114.1 CMR 40.12 through 114.1 CMR 40.13.

40.10: continued

(1) To qualify for any type of disproportionate share 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 40.11 through 114.1 CMR 40.13 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 party coverage, less payments by Medicaid and by uninsured patients.

40.11: Federally Mandated Disproportionate Share Adjustments

(1) 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, then 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.

(2) 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 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 40.11(2)(c), then the hospital shall be eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(3) Determination of Eligibility Under the Low-Income Utilization Rate Method. The Division shall then 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 and state and local government subsidies by the sum of total net revenues and 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 40.11(3)(a) to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 40.11(3)(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.

40.11: continued

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

(a) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the Medicaid utilization method established in 114.1 CMR 40.11(2), the Division shall divide the hospital's Medicaid utilization rate calculated pursuant to 114.1 CMR 40.11(2)(d) by the threshold Medicaid utilization rate calculated pursuant to 114.1 CMR 40.11(2)(c). The ratio resulting from such division shall be the federally-mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally-mandated 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 disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally-mandated disproportionate share ratios calculated pursuant to 114.1 CMR 40.11(4)(a) and 114.1 CMR 40.11(4)(b).

(d) The Division shall then calculate a minimum payment under the federally-mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to 114.1 CMR 40.11(5) for payments under the federally-mandated disproportionate share adjustment by the sum of the federally-mandated disproportionate share ratios calculated pursuant to 114.1 CMR 40.11(4)(c).

(e) The Division shall then multiply the minimum payment under the federally-mandated Medicaid disproportionate share adjustment by the federally-mandated Medicaid disproportionate share ratio established for each hospital pursuant to 114.1 CMR 40.11(4)(a) and (b). Except as provided in 114.1 CMR 40.10(2), the product of such multiplication shall be the payment under the federally-mandated disproportionate share adjustment.

(5) 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 one hundred fifty thousand dollars 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 40.11(4)(e).

40.12: Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals

The Division shall determine for FY 1996 and succeeding years an extraordinary disproportionate share adjustment for all eligible psychiatric hospitals, using the data and methodology described in 114.1 CMR 40.12.

(1) Data Sources. The Division shall use the RSC-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said RSC-403 report is not available, the Division shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a psychiatric hospital must:

1. specialize in providing psychiatric/psychological care and treatment;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. consist partly or wholly of locked wards;
5. meet requirements for the receipt of federal matching funds;
6. meet the low-income standard as set forth in 114.1 CMR 40.12(2)(b); and
7. meet the unreimbursed cost standard as set forth in 114.1 CMR 40.12(2)(c).

40.12: continued

(b) Low-income standard.

1. For each psychiatric hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.

b. The Division shall divide each hospital's free care charges by its total charges.

c. The total of these percentages shall equal the hospital's low-income utilization rate.

2. If the hospital-specific low-income utilization rate exceeds 45%, then the psychiatric hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each psychiatric hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.

b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in 114.1 CMR 40.12(2)(c)1.a., to determine the amount of unreimbursed costs.

c. The Division shall divide the amount of unreimbursed costs determined in 114.1 CMR 40.12(2)(c)1.b. by the costs determined in 114.1 CMR 40.12(2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the psychiatric hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Except as provided in 114.1 CMR 40.10(2), for each psychiatric hospital determined eligible for the extraordinary disproportionate share adjustment under 114.1 CMR 40.12(2), the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

a. First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals as set forth in 114.1 CMR 40.12(2)(c)1.a., substituting rate year Reasonable Financial Requirements for source data RFR.

b. Then, multiply this cost by the unreimbursed cost percentage determined pursuant to 114.1 CMR 40.12(2)(c)1.c.

(4) Payments made pursuant to this section are subject to Health Care Financing Administration approval of state plan amendments incorporating this methodology.

40.13: Extraordinary Disproportionate Share Adjustment for State Owned Special Population Hospitals

The Division shall determine for FY 1996 and succeeding years an extraordinary disproportionate share adjustment for all eligible state owned special population hospitals using the data and methodology described below.

(1) Data Sources. The Division shall use the RSC-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said RSC-403 report is not available, the Division shall use the most recent available previous RSC-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a state owned special population hospital must:

1. specialize in providing treatment to people with AIDS, tuberculosis patients, the medically needy homeless, multiply handicapped pediatric patients and patients with combined medical and psychiatric needs;

40.13: continued

2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. meet requirements for the receipt of federal matching funds;
5. meet the low-income standard as set forth in 114.1 CMR 40.13(2)(b); and
6. meet the unreimbursed cost standard as set forth in 114.1 CMR 40.13(2)(c).

(b) Low-income standard.

1. For each state owned special population hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:
   a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.
   b. The Division shall divide each hospital's free care charges by its total charges.
   c. The total of these percentages shall equal the hospital's low-income utilization rate.
2. If the hospital-specific low-income utilization rate exceeds 45%, then the state owned special population hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each state owned special population hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:
   a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying Medicaid RFR by the ratio of Medicaid charges plus self pay charges plus free care charges to total charges.
   b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in 114.1 CMR 40.13(2)(c)1.a., to determine the amount of unreimbursed costs.
   c. The Division shall divide the amount of unreimbursed costs determined in 114.1 CMR 40.13(2)(c)1.b. by the costs determined in 114.1 CMR 40.13(2)(c)1.a. to determine the percentage of unreimbursed costs.
2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the state owned special population hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Except as provided in 114.1 CMR 40.10(2), for each state owned special population hospital determined eligible for the extraordinary disproportionate share adjustment under 114.1 CMR 40.13(2), the payment amount shall be equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

(a) First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals as set forth in 114.1 CMR 40.13(2)(c)1.a., substituting rate year Reasonable Financial Requirements for source data RFR.

(b) Then, multiply this cost by the unreimbursed cost percentage determined pursuant to 114.1 CMR 40.13(2)(c)1.c.

(4) Payments made pursuant to this section are subject to Health Care Financing Administration approval of state plan amendments incorporating this methodology.

40.14: Administrative Adjustment

(1) A hospital may apply at any time during the rate year for an administrative adjustment if there has been an arithmetic error in the calculation of the PAF or residential alcoholism treatment program fee. The Division will not entertain an application for an administrative adjustment, if the applicant hospital is seeking to reverse a substantive determination pursuant to 114.1 CMR 40.00.

(2) A hospital may apply at any time during the first nine months of the rate year for an administrative adjustment based on a request for a CBC pursuant to 114.1 CMR 40.08(4) or a new service pursuant to 114.1 CMR 40.08(5).

40.14: continued

(3) An application for an administrative adjustment shall be made to the Chairman of the Division in writing and shall contain the following:

(a) The name and address of the hospital.

(b) The rate or rates sought to be reviewed.

(c) A clear, concise statement of reasons for the application for administrative adjustment.

(d) A detailed statement of financial, statistical, and related information in support of the application.

(e) If the application concerns a requested CBC or new service, all relevant documentation for that CBC or new service.

(f) Such other books, records and information as the Division may require.

(3) Within 60 days from receipt of a complete and satisfactory application for administrative adjustment, the Division will render a decision. A statement of reasons for the decision will be provided.

40.15: Administrative Review

(1) Purpose of Administrative Review. To assure that a hospital's rates are in continuing compliance with this part, the Division may at any time and upon its own motion, review the rates upon notice to the hospital.

(2) Administrative Review of Transfers of Costs. 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 Reasonable Financial Requirements 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.

(3) Administrative Review and Decision. Upon notice of administrative review, a hospital shall submit such books, records, documentation, and information as the Division may require. After review, the Division will render a written decision and a statement of reasons for its decision.

40.16: Appeal

A non-acute hospital which is aggrieved by an action or failure to act under 114.1 CMR 40.00 may file an appeal within 30 days to the Division of Administrative Law Appeals pursuant to the requirements of M.G.L. c. 118 G. The pendency of an appeal does not limit the Division's right to undertake administrative review under 114.1 CMR 40.00.

40.17: Severability

The provisions of 114.1 CMR 40.00 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 40.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

40.18: 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 40.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.1 CMR 40.00 if necessary for informed consideration of rate determination under 114.1 CMR 40.00.

REGULATORY AUTHORITY

114.1 CMR 40.00: M.G.L. c. 118G; c. 30A, § 2.