

## **Table of Contents**

**State/Territory Name: MA**

**State Plan Amendment (SPA) #: 10-006**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form (with 179-like data)
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, M/S S3-13-15  
Baltimore, MD 21244-1850



**Center for Medicaid, CHIP and Survey & Certification (CMCS)**

---

Dr. Judy Ann Bigby, Secretary  
Executive Office of Health and Human Services  
State of Massachusetts  
One Ashburton Place  
Boston, MA 02108

FEB - 2 2011

RE: TN 10-006

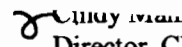
Dear Dr. Bigby:

We have reviewed the proposed amendment to Attachment 4.19-A (2a) of your Medicaid State plan submitted under transmittal number (TN) 10-006. This amendment updates the rate methodology for a Chronic Disease and Rehabilitation hospital that had no fewer than five hundred (500) licensed beds as of June 30, 2007. Specifically, it also allows a 4% rate increase for Per Diem Rate one (1).

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 10-006 is approved effective April 1, 2010. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

  
Director, CMCS

Enclosures:

cc: Terry Dougherty, Medicaid Director, EOHHS

bcc: Richard McGreal, ARA, CMS Region I  
Joseph Barkas, Region I  
Irvin Rich, Region I  
Mark Cooley, CMS NIRT  
Official SPA File

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER: <b>010-006</b>	2. STATE: <b>MA</b>
	3. PROGRAM IDENTIFICATION TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: <b>04/01/10</b>	
5. TYPE OF PLAN MATERIAL. (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)		
6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR 447.250 et seq.</b>	7. FEDERAL BUDGET IMPACT: a. FFY 2010 \$ 1,224,504.50 b. FFY 2011 \$ 1,224,504.50	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-A (2a), page 1 &amp; 4</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if applicable):  <b>Attachment 4.19-A (2a) page 1 &amp; 4</b>	

10. SUBJECT OF AMENDMENT:  
**Chronic Disease and Rehabilitation Hospital Services.**

11. GOVERNOR'S REVIEW (Check One):  
 GOVERNOR'S OFFICE REPORTED NO COMMENT       OTHER, AS SPECIFIED:  
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      **Not required under**  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL      **42 CMR 430.12(b)(2)(ii)**

12. OFFICIAL:	16. RETURN TO: <b>Michael P. Coleman State Plan Coordinator Office of Medicaid Executive Office of Health and Human Services One Ashburton Place, 11<sup>th</sup> Floor Boston, MA 02108</b>
13. TYPED NAME: <b>Judy Ann Bigby</b>	
14. TITLE: <b>Secretary</b>	
15. DATE SUBMITTED: <b>06/25/10</b>	

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:	18. DATE APPROVED: <b>02-02-11</b>
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>APR 1 2010</b>	
21. TYPED NAME: <b>William Lasowski</b>	22. TITLE: <b>Deputy Director, CMCS</b>
23. REMARKS:	

State Plan under Title XIX of the Social Security Act  
State: Massachusetts  
Methods for Establishing Payment Rates – Privately Owned  
Chronic Disease and Rehabilitation Inpatient Hospital Services

---

**I. General Description of Payment Methodology**

The following sections describe the methods and standards utilized by the Executive Office of Health and Human Services (EOHHS) to establish rates of payment by contract, to be effective April 1, 2010, for services rendered by chronic disease and rehabilitation hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.*

- A. Chief Components:** The payment method described in this attachment is a comprehensive per-diem rate for each participating hospital. The daily rate covers both routine and ancillary services provided to inpatients. The base year used for both operating and capital cost information was HFY 2003. A composite inflation index was used to update costs from 2003 to 2010. Individual efficiency standards were applied to Inpatient Overhead Costs and Inpatient Capital Costs.
- B. Patients Transferred from State Facilities:** The following describes the payment method for Privately-Owned Chronic Disease and Rehabilitation Hospital services provided to former patients of Lakeville Hospital, a State-Owned Nonacute Hospital that has been closed.

The rate of payment in connection with this state facility closure has been set based on allowable actual costs under the methodology described herein and expenses that must be incurred by a provider in order to serve the particular patients transferred from this state facility. The Division of Health Care Finance and Policy (DHCFP) reviewed the budget costs of the hospital to which patients were to be transferred and found them to meet the reasonableness standards of the DHCFP rate methodology. Pursuant to such rate setting, the provider must demonstrate that items and services, furnished because of the special needs of the patients transferred, are necessary in the efficient delivery of necessary health care.

- C. Provisions for a Hospital with no fewer than 500 Licensed Beds as of June 30, 2007:** The General Appropriation Act for fiscal year 2008, item 4000-0300 of Chapter 61 of the Acts of 2007, governs the payments for inpatient care to a privately-owned health care facility licensed by the Department of Public Health as a non-acute chronic hospital with no fewer than 500 licensed beds as of June 30, 2007, with no fewer than 150,000 Medicaid patient days in the state fiscal year ended June 30, 2007, and with an established geriatric teaching program for physicians, medical students, and other health professionals.

Chapter 61 of the Acts of 2007 requires two per diem rates for inpatient care. Per Diem Rate 2 is for more complex care patients. In order to bill for payment at Per Diem Rate 2, the hospital must obtain prior authorization of the admission and continuing inpatient stay from the Office of Medicaid or its designated screening entity based on services ordered by a physician and documented in the medical record showing a need for daily physician intervention, 24 hour care or intensive multidisciplinary rehabilitation overseen by a physician board certified in rehabilitation medicine.

**State Plan under Title XIX of the Social Security Act  
State: Massachusetts  
Methods for Establishing Payment Rates – Privately Owned  
Chronic Disease and Rehabilitation Inpatient Hospital Services**

---

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.

iii.. 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.

7. Effective April 1, 2009, Per Diem Rate 1 is updated by a 4.3% increase.

8. Effective April 1, 2010, Per Diem Rate 1 is updated by a 4% increase.

**B. Per Diem Rate 2:** Effective October 1, 2009, Per Diem Rate 2 is determined by averaging the HFY 2010 payment rates under Section III of this attachment for Chronic Disease and Rehabilitation Hospitals identified by the MassHealth program as having similar characteristics of treatment and populations. The Hospitals used to calculate the payment are: Braintree Hospital, Franciscan Children's, Radius Specialty, New Bedford Rehabilitation, New England Sinai, Kindred Hospital Northeast-Stoughton, Kindred Hospital Parkview, Shaughnessy-Kaplan, Spaulding Rehabilitation and Youville Hospital.

**D. Provision for Certain Hospitals Subject to Potential Rate Decreases:**

In accordance with the General Appropriation Act for fiscal year 2007, any hospital whose inpatient rate of payment under the payment methodology described herein for hospital fiscal year 2007, would otherwise be less than the rate in effect during hospital fiscal year 2006, shall continue to be paid at the applicable inpatient rate of payment in effect during hospital fiscal year 2006.

For fiscal year 2010, hospitals subject to a potential rate decrease in their Inpatient Per Diem Rate would continue to be paid at the Inpatient Per Diem Rate in effect during hospital fiscal year 2009.