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**State/Territory Name: MA**

**State Plan Amendment (SPA) #: 10-008**

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)**

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

MAR 22 2011

RE: TN 10-008


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) 10-008. This amendment makes technical adjustments pertaining to the effective days and other specific dates.

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 10-008 is approved effective October 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,

 Cindy Mann  
Director  
Center for Medicaid CHIP and Survey & Certification  
(CMSC)

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>010-008</b>	2. STATE:  <b>MA</b>
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
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		4. PROPOSED EFFECTIVE DATE:  <b>October 1, 2010</b>	
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:  <b>a. FFY 2011    \$ 00.00</b> <b>b. FFY 2012    \$ 00.00</b>		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Attachment 4.19-A (2a), pages 1-13</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Attachment 4.19-A (2a), pages 1-13</b>		
10. SUBJECT OF AMENDMENT:  <b>Chronic Disease and Rehabilitation Hospital Services.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>Not required under</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <b>42 CMR 430.12(b)(2)(ii)</b>			
12. SIGNATURE: _____  13. TYPED NAME: <b>Judy Ann Bigby, M.D.</b>	16. RETURN TO:  <b>Michael P. Coleman</b> <b>State Plan Coordinator</b> <b>Office of Medicaid</b> <b>Executive Office of Health and Human Services</b> <b>One Ashburton Place, 11<sup>th</sup> Floor</b> <b>Boston, MA 02108</b>		
14. TITLE: <b>Secretary</b>			
15. DATE SUBMITTED: <b>12/23/10</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:	18. DATE APPROVED: <b>03-22-11</b>		
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>OCT - 1 2010</b>	20. _____ OFFICIAL:		
21. TYPED NAME: <b>William Lasowski</b>	22. TITLE: <b>Deputy Director, CMCS</b>		
23. REMARKS:			

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**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 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 the base year 2003. 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

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The inpatient rates for a privately-owned hospital governed by this section are developed collaboratively through an agreement among the Office of Medicaid, the Division of Health Care Finance and Policy (DHCFP), and any such health care facility.

1. Inpatient Per Diem Rates

The Inpatient Per Diem Rates are all-inclusive daily rates paid for any, and all, inpatient care and services. The Inpatient Per Diem Rates are derived using the following methods:

A. Per Diem Rate 1: Per diem rate 1 is derived by using the following method: the sum of total Inpatient Operating Costs (Schedule XVII, Line 21, Column 2) plus total Capital costs (Schedule XVIII, Line 21, Chronic/Rehab, Column 2 minus Schedule XVII, Line 21, Chronic/Rehab, Column 2), plus the Adjustments to Base Year Costs, divided by total base year patient days (Schedule V-A, Line 21, Column 2).

1. Data Sources.

- a. The base year for inpatient costs is the hospital fiscal year (HFY) 2007. The MassHealth program utilizes the costs, statistics and revenue reported in the HFY 2007 HCFP-403 cost report which is the most recent cost report filed with DHCFP. For each subsequent rate year the base year costs shall be derived from the most recent cost report filed with the Division of Health Care Finance and Policy.
- b. Inpatient costs include only costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined in accordance with the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§ 1395 *et seq.* as set forth in 42 CFR 413 *et seq.* and the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles. All references to specific schedules, columns and lines refer to the HCFP-403 report filed with and reviewed by the Division of Health Care Finance and Policy. Except where noted, all references are to the HFY 2007 version of the HCFP-403.
- c. The calculations use costs and statistics, as adjusted as a result of audits or reviews conducted by DHCFP. The MassHealth program may also request additional information, data and documentation from the hospital or DHCFP as necessary to calculate rates.
- d. 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.

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2. Determination of Base Year Inpatient Operating Costs. Base Year Inpatient Operating Costs are the sum of total Inpatient Direct Routine Costs, Inpatient Direct Ancillary Costs, and Inpatient Overhead Costs as described below.
  - a. Inpatient Direct Routine Costs. Inpatient Direct Routine Costs are the Total Inpatient Routine Costs derived from the HCFP-403.
  - b. Inpatient Direct Ancillary Costs. Inpatient Direct Ancillary Costs are the Total Inpatient Ancillary Costs derived from the HCFP-403.
  - c. Inpatient Overhead Costs. Inpatient Overhead Costs are the Total Inpatient Overhead Costs derived from the HCFP-403.
3. Calculation of the Base Year Inpatient Operating Per Diem. The Inpatient Operating Per Diem is calculated by dividing the sum of the Total Inpatient Operating Costs (Schedule XVII Line 21 Column 2) by the total inpatient days (Schedule V-A Line 21 Column 2).
4. Inpatient Capital Costs: Base year capital costs consist of the hospital's actual HFY 2007 patient care capital requirement for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities (Schedule XVIII Line 21 Column 2 minus Schedule XVII Line 21 Column 2)
5. Inpatient Capital Cost Per Diem. The Inpatient Capital Cost Per Diem is derived by dividing the total Inpatient Capital Costs by the total inpatient days (Schedule V-A Line 21 Column 2).
6. Adjustments to Base Year Costs.
  - a. Total inpatient operating costs will be updated using the CMS Excluded Hospital Market Basket. Total inpatient capital costs will be updated using the Medicare Market Basket Capital Input Price Index. These adjustment factors will be calculated as follows:
    - i. The base year price level will be the average of the four quarters of the applicable base year. The base year 2007 will be the fiscal year October 1, 2006 to September 30, 2007.
    - ii. The rate year price level will be the average of the four quarters of the applicable rate year. The rate year 2008 will be April 1, 2008 to March 31, 2009.
    - iii. The adjustment factor is the percent change between the base year period (i) and the rate year period (ii).
  - b. The limitations applicable to base year capital costs are:
    - i. 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.

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- ii. 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.
  - 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:** 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.

Hospitals subject to a potential decrease in their Inpatient Per Diem Rate would continue to be paid at the Inpatient Per Diem Rate in effect during the prior hospital fiscal year.

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**II. Definitions**

**Administrative Day (AD).** An inpatient day spent in a hospital by a patient who has been identified by a Peer Review Organization (where applicable) or otherwise by the Executive Office of Health and Human Services (EOHHS) or by the Department of Public Health (DPH), or any combination of these organizations as a patient not requiring hospital level of care.

**Administrative Day Per-diem Rate (AD Rate).** An all-inclusive daily rate of payment paid to hospitals for Administrative Days.

**Base Year.** The base year is the hospital's FY 2003.

**Chronic Disease and Rehabilitation Hospital (Hospital).** A hospital facility licensed by the Massachusetts Department of Public Health under M.G.L. c. 111, §51, with a majority of its beds providing chronic disease services and/or comprehensive rehabilitation services to patients with appropriate medical needs. This definition includes such a facility licensed with a pediatric specialty. Hospitals with 50 percent or more of their beds licensed as medical/surgical, intensive care, coronary care, burn, maternal (obstetrics) and neonatal intensive care beds (Level III) possess acute hospital licensure and do not meet the definition of a chronic Disease and Rehabilitation Hospital.

**Department of Public Health (DPH).** An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 17, §1.

**Direct Cost.** The patient care costs of a cost center exclusive of overhead and capital.

**Division of Health Care Finance and Policy (DHCFP).** An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 118G.

**Executive Office of Health and Human Services (EOHHS).** The single state agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.

**Hospital Fiscal Year (HFY):** The fiscal year used by an individual hospital.

**HURM Manual.** The Commonwealth of Massachusetts Hospital Uniform Reporting Manual promulgated by DHCFP under 114.1 CMR 4.00.

**Inpatient Services.** Routine and ancillary services that are provided to Recipients admitted as patients to a Chronic Disease and Rehabilitation Hospital.

**Inpatient Per-diem Rate.** An all-inclusive daily rate of payment for any and all Inpatient Services provided to a Recipient by a hospital.

**MassHealth (also Medicaid).** The Medical Assistance Program administered by EOHHS to furnish and pay for medical services pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, and any approved waivers of such provisions



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**Member.** A person determined by EOHHS to be eligible for medical assistance under the MassHealth Program.

**Overhead.** Overhead consists of expenses for fringe benefits, administration, plant maintenance and repairs, plant operations, laundry, housekeeping, cafeteria, dietary, maintenance personnel, nursing administration, and in-service education, RN and LPN education, medical staff teaching and administration, post-graduate medical education, central service and supplies, pharmacy, medical records, medical care review, and social services.

**Rate Year (RY).** The period beginning October 1 and ending September 30. For hospitals covered under Section I.C.1.A. of this state plan, the Rate Year is the period beginning on April 1 and ending on March 31.

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**III. Medicaid Payment Methodology for Privately-Owned Chronic Disease and Rehabilitation Hospitals**

**A. Determination of 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 Medicaid Recipient, except for any and all Administrative Days (see Section III.C). The Inpatient Per-diem Rate is derived using the following method: (a) the sum of a hospital's base year inpatient Operating Cost (Section III.A.2) plus the Adjustments to Base Year Costs (Section III.A.4) is divided by a hospital's base year patient days; plus (b) the Allowance for Inpatient Capital.

**1. Data Sources**

- a) The base year for inpatient costs is the Hospital Fiscal Year (HFY) 2003. The Division utilized the inpatient costs reported in the HFY 2003 RSC-403 cost report.
- b) Inpatient costs include only costs incurred or to be incurred in the provisions of hospital care and service, supplies and accommodations and determined according to the Principles of Reimbursement for Provider Costs under 42 U.S.C. §§1395 *et seq.* as set forth in 42 CFR 413 *et seq.*, the Provider Reimbursement Manual, the HURM Manual, and Generally Accepted Accounting Principles.
- c) The calculations use each hospital's costs and statistics, as adjusted as a result of prior audits or reviews conducted by DHCFP. The Division may also request additional information, data and documentation from a hospital or DHCFP as necessary to calculate rates.
- d) If the specified data source is unavailable or inadequate, the Division will determine and use the best alternative data source and/or it may perform a statistical analysis to ensure comparability of data.

**2. Base Year Inpatient Operating Costs.**

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

- a) **Inpatient Direct Routine Costs.** Inpatient Direct Routine Costs are a hospital's Total Inpatient Routine Costs as adjusted by audit.
- b) **Inpatient Direct Ancillary Costs.** Inpatient Direct Ancillary Costs are calculated as follows:

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- (1) Inpatient Direct Ancillary Costs are calculated for each ancillary cost center by multiplying the cost for each cost center times the ratio of Inpatient Patient Service Statistics to Total Patient Service Statistics. The sum of the allowed costs for ancillary cost center constitutes the Total Inpatient Direct Ancillary Cost. The inpatient direct ancillary costs for the Drug and Medical Supplies cost centers are calculated as follows:
  - (a) The cost for the Drug cost center is the sum of the Drug cost plus the Total Direct Overhead Cost related to Pharmacy. The Inpatient Direct Ancillary Drug cost is calculated by multiplying the above sum times the ratio of the inpatient drug patient service statistics to the total drug patient service statistics.
  - (b) The cost for the Medical Supplies cost center is the sum of Medical Supplies cost plus the Total Direct Overhead cost related to Central Service/Supplies. The Inpatient Direct Ancillary Medical Supplies cost is calculated by multiplying the above sum times the ratio of the inpatient medical supplies patient service statistics to the total medical supplies patient service statistics.
- c) **Total Inpatient Overhead.** Total Inpatient Overhead is calculated by comparing Total Inpatient Overhead to efficiency standard as described below.
  - (1) A HFY 2003 Inpatient Overhead per-diem amount is computed for each hospital as follows:
    - (a) Inpatient Routine Overhead cost is calculated by subtracting Direct Inpatient Routine Cost from Inpatient Routine cost after step-down of overhead.
    - (b) Inpatient Ancillary Overhead Cost is calculated by:
      - i. Determining the total overhead cost allocated to each ancillary department,
      - ii. Extracting the inpatient portion of the ancillary overhead cost by multiplying the overhead cost allocated to each ancillary department by the ratio of Inpatient Patient Service Statistics to Total Patient Service Statistics, and
      - iii. Summing the inpatient portions of the total ancillary overhead cost in each department to obtain the Inpatient Ancillary Overhead Cost.

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- (c) The sum of Inpatient Routine Overhead and Inpatient Ancillary Overhead is divided by HFY 2003 Patient Days. For hospitals that reported costs in the RSC-403 cost report Sch. XIV, Column 2, Line 15 (Central Service/Supplies) and/or Column 2, Line 16 (Pharmacy), those costs are removed from the overhead costs and reclassified to Ancillary costs pursuant to Section A.2.b.
- (2) Separate efficiency standards are determined for chronic hospitals and rehabilitation hospitals. Hospitals are classified as chronic or rehabilitation using the following classifications:
  - (a) The chronic disease hospital group consists of Kindred Hospital Northeast – Stoughton, Franciscan Children's Hospital, Radius Specialty Hospital, New England Sinai Hospital, Shaughnessy-Kaplan Hospital, Kindred Hospital-Park View and Youville Hospital.
  - (b) The rehabilitation hospital group consists of Braintree Hospital, Fairlawn Hospital, New Bedford Rehabilitation Hospital, New England Rehabilitation Hospital, Rehabilitation Hospital of the Cape and Islands, Rehabilitation Hospital of Western Massachusetts, Spaulding Rehabilitation Hospital and Whittier Rehabilitation Hospital (Bradford) and Whittier Rehabilitation Hospital (Westboro).
- (3) The Inpatient Overhead Per-diem Cost for each chronic hospital is ranked from lowest to highest and the median is determined. The median is the efficiency standard for the chronic hospital group.
- (4) The Inpatient Overhead Per-diem Cost for each rehabilitation hospital is ranked from lowest to highest and the median is determined. The median is the efficiency standard for the rehabilitation hospital group.
- (5) If a hospital's Total Inpatient Overhead Per-diem Cost does not exceed the appropriate efficiency standard, its Total Inpatient Overhead Cost is calculated Pursuant to Section A, paragraph 2(c)(1) without further adjustment.
- (6) If a hospital's Total Inpatient Overhead Per-diem Cost exceeds the appropriate efficiency standard, the hospital's Total Inpatient Overhead Cost is the efficiency standard multiplied by HFY 2003 Patient Days.

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3. **Adjustment to Base Year Costs.** Total Inpatient Direct Costs, Total Inpatient Ancillary Direct Costs, and Total Inpatient Overhead Costs are adjusted for inflation from base year 2003 through the rate year using a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by the Centers for Medicare and Medicaid Services (CMS) for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals. The inflation amounts used in the rate calculations are as follows:

2003 – 2004	Labor 1.581%	Non Labor 0.6287%
2004 – 2005	Labor 0.635%	Non Labor 0.563%
2005 – 2006	Labor 1.28%	Non Labor 0.56%
2006 – 2007	Labor 1.163%	Non Labor 0.474%
2007 – 2008	Labor 1.241%	Non Labor 0.347%
2008 – 2009	Labor 1.140%	Non Labor 0.319%
2009 – 2010	Labor 0.408%	Non Labor 0.108%
2010 – 2011	Labor 0%	Non Labor 0%

4. **Allowance for Inpatient Capital**

- a) Each hospital's base year capital costs consist of the hospital's actual HFY 2003 patient care capital requirement for historical depreciation for: building and fixed equipment; reasonable interest expenses; amortization and leases; and rental of facilities, subject to the limitations described below.
- b) The limitations applicable to base-year capital costs are:
- (1) Interest expense attributable to balloon payments on financed debt is excluded. Balloon payments are those in which the proposed payment on a partially amortized debt is scheduled to be larger than all preceding payments.
  - (2) 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 immediate prior owner. The depreciation expense is calculated using the full useful lives of the assets.
  - (3) All costs (including legal fees, accounting costs, 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

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- c) Each hospital's base-year inpatient unit capital cost equals the base-year inpatient capital cost divided by the greater of: (i) the actual base-year routine patient days; or (ii) eighty-five percent (85%) of base-year maximum licensed bed capacity, measured in days. The CMS Capital Input Price Index adjusts the base-year inpatient unit capital cost from the base year 2003 to the rate year to determine the Inpatient Unit Capital amount.
- d) The Inpatient Unit Capital amounts of all chronic hospitals are ranked from lowest to highest and median is determined. The median is the efficiency standard, which serves as the Chronic Disease Hospital Allowance for Inpatient Capital.
- e) The Inpatient Unit Capital amounts of all rehabilitation hospitals are ranked from lowest to highest and median is determined. The median is the efficiency standard, which serves as the Rehabilitation Hospital Allowance for Inpatient Capital.

**B. Determination of Inpatient Rate for Hospitals Licensed as Chronic Disease or Rehabilitation Hospitals after October 1, 2001**

- 1. The allowable overhead and capital per-diem costs will be established at the efficiency standards as calculated pursuant to Section A, paragraph 2.c) and Section A, paragraph 4, respectively.
- 2. The allowable routine and ancillary per-diem costs will be established at the median of HFY 2003 per-diem costs reported by chronic and rehabilitation hospitals.
- 3. The allowable per-diem costs will be updated by the inflation factor calculated pursuant to Section III. Paragraph A.3. and A.4.c) d) and e).

**C. Determination of Rate for Administrative Day Patients**

A hospital will be paid for Administrative Days using an Administrative Day Per-diem Rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each Administrative Day. The AD Rate is composed of three components: a statewide AD routine per-diem amount, a statewide AD ancillary per-diem amount and a hospital-specific supplementary per-diem amount. The statewide AD routine per-diem amount is derived from the weighted average Medicaid payment rate for case mix category T (10) patients in nursing facilities in 2003. The statewide AD ancillary per-diem amount is derived from the statewide weighted average Medicaid ancillary payment for AD patients in Chronic Disease and Rehabilitation Hospitals in FY 2003. The sum of the statewide AD routine and ancillary per-diem amounts for the rate year is \$513.05. The supplementary per-diem amount for each hospital is the difference between the statewide AD routine and ancillary per-diem amount of \$513.05 and 64% of each hospital's rate year Inpatient Per-Diem Rate.

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**IV. Pediatric Outlier:**

**A. For Infants Less Than One Year of Age**

1. In accordance with section 1902 of the Social Security Act, as amended by Section 4604 of OBRA 90, effective July 1, 1991, the Commonwealth will make an annual payment adjustment to Privately-owned Chronic/Rehabilitation Hospitals for inpatient hospital services furnished to infants less than one year of age involving exceptionally high costs or exceptionally long lengths of stay.
2. **Determination of Eligibility.** Determination of eligibility for infants less than one year of age shall be made as follows:
  - a. **Exceptionally long lengths of stay.**
    - (i) First, calculate the statewide weighted average Medicaid inpatient length-of-stay. This shall be determined by dividing the sum of Medicaid days for all Privately-owned Chronic/Rehabilitation Hospitals in the state by the sum of total discharges for all Privately-owned Chronic Disease and Rehabilitation Hospitals.
    - (ii) Second, calculate the statewide weighted standard deviation for Medicaid inpatient length-of-stay statistics.
    - (iii) Third, add one and one-half times the statewide weighted standard deviation for Medicaid inpatient length-of-stay to the statewide weighted average Medicaid inpatient length-of-stay. Any stay equal to or lengthier than the sum of these two numbers shall constitute an exceptionally long length-of-stay for purposes of payment adjustments under this section.
  - b. **Exceptionally High Cost.** For each Privately-owned Chronic/Rehabilitation Hospital providing services on or after July 1, 1991 to individuals under one year of age the Commonwealth shall:
    - (i) First, calculate the average cost per Medicaid inpatient discharge for each hospital;
    - (ii) Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital;
    - (iii) Third, add one and one-half times the hospital's standard deviation for the cost per Medicaid inpatient discharge to the hospital's average cost per Medicaid inpatient discharge. Any cost that equals or exceeds the sum of these two numbers shall constitute an exceptionally high cost for purposes of payment adjustments.

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- (a) The amount of funds allocated shall be twenty five thousand dollars (\$25,000) annually. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Non-acute hospitals.
- (b) Any hospital that qualifies for a payment adjustment for infants less than one year of age shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying Privately-owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.

**B. Children under age Six**

- 1. **Eligibility for Payment.** Consistent with section 4604 of the Omnibus Reconciliation Act of 1990 (OBRA 90) outlier adjustments for medically necessary inpatient hospital services, effective July 1, 1991, involving exceptionally high costs or exceptionally long lengths of stay (as defined in sections V. A. 2a. and 2b. of this Plan) are extended to services for children who have not reached the age of six, if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923 (a) of the Social Security Act.
- 2. **Amount of Payment Adjustment**
  - a. The amount of funds allocated shall be twenty five thousand dollars (\$25,000) annually. This includes Chronic/Rehabilitation, Psychiatric and State-Owned Non-acute hospitals.
  - b. Any hospital that qualifies for a payment adjustment for children under six, pursuant to Section V. A.1. above, shall receive one percent of the total funds allocated for such payments. In the event that the payments to qualifying Privately-owned Chronic/Rehabilitation Hospitals would exceed the total, each share shall be proportionately reduced to stay within the allocation.