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State/Territory Name: MA

State Plan Amendment (SPA) #: 11-013

This file contains the following documents in the order listed:

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and CHIP Services (CMCS)

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

MAY 31 2012

RE: TN 11-013

Dear Dr. Bigby:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-013. This amendment updates the methodology used to calculate payment rates for nursing facility services. Specifically it: applies a total increase of $23.3 million to the current nursing facility user fee adjustment for fiscal year 2012 only; applies a total increase of $3.7 million for an additional one-time add on payment based on each facility's user fee class; revises the determination of the Pediatric nursing facility rate based on 2006 cost reports instead of the most recently filed cost report; clarifies the criteria and documentation requirements for eligibility to receive P4P payments; and clarifies the provision for leave of absence days.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) 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 11-013 is approved effective September 1, 2011. 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 (CMCS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICIAD SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES	1. TRANSMITTAL NUMBER: 011-013	2. STATE MA
	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 9/01/11	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
42 CFR 447.300-321	**a. FFY 11 $ 1.24 M** **b. FFY 12 $ 13.66M**
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D (4) pp. 1-18	**Attachment 4.19-D (4) pp 1-15**

10. SUBJECT OF AMENDMENT:

Methods for Establishing Payment Rates – Nursing Facilities

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☑ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12(b)(2)(ii)

12. SIGNATURE OF STATE AGENCY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **JudyAnn Bigby, M.D.**	**Michael P. Coleman** **State Plan Coordinator** **Office of Medicaid** **Executive Office of Health and Human Services** **One Ashburton Place, 11th Floor** **Boston, MA 02108**
14. TITLE: **Secretary**	
15. DATE SUBMITTED: **09/29/11**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MAY 31 2012
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2011	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS-179 (07-92)

State Plan under Title XIX of the Social Security Act
State. Massachusetts
Methods for Establishing Payment Rates - Nursing Facilities

General Description of Payment Methodology

A. **Overview.** Nursing facility payments for services rendered to MassHealth members are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: Standard Payments to Nursing Facilities. This attachment describes the methods and standards used to establish payment rates for nursing facilities effective September 1, 2011

B. **Chief Components.** The payment method describes standard payments for nursing facility services. Standard payments are derived from reported median base-year costs for Nursing and Other Operating Costs as well as a capital payment component. Nursing and Other Operating Standard Payment rates were calculated using Calendar Year (CY) 2005 costs The allowable basis for capital was updated using CY 2005 data.

II. Cost Reporting Requirements and Cost Finding

A. **Required Reports.** Each provider of long-term care facility services under the State Plan must complete an annual report (the "Annual Cost Report") containing cost information for the cost reporting year on the basis of generally accepted accounting principles and the accrual method of accounting. There are six reports required: a) Nursing Facility Cost Report; b) Realty Company Cost Report; c) Management Company Cost Report, d) Financial Statements, and e) Clinical Data. All cost reporting must meet the requirements set forth in 114.2 CMR 6.08 (1) There are special cost reporting requirements for Hospital-Based Nursing Facilities and facilities that operate other programs such as Adult Day Health, Assisted Living or Outpatient Services. These requirements are outlined in 114.2 CMR 6.08 (2)(f)

B. **Filing Dates: Required Reports.** Except as provided below, providers must file Required Reports for the calendar year by 5:00 PM of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the Required Reports are due by 5.00 PM of the following business day.

1. **Change of Ownership.** Where there has been a change of ownership, the transferor shall file the report(s) within 60 days after the transfer of ownership. Where the transferor fails to submit the Report(s), DHCFP may request the Commonwealth's Medicaid program ("MassHealth Program") to withhold payment to the transferee until such reports are appropriately filed.

2. **New Facilities and Facilities with Major Additions.** For the first two calendar years of operation, New Facilities and Facilities with Major Additions shall file year-end Required Reports within sixty (60) days after the close of the calendar year.

3. **Hospital-Based Nursing Facilities.** A Hospital-Based Nursing Facility is a separately licensed unit housed on the premises of a facility that is licensed for both hospital and long-term care services, where the long-term care beds were converted from licensed hospital beds or otherwise acquired. Hospital-Based Nursing Facilities must file the Required Report(s) on a fiscal year basis that is consistent with the filing of such facilities' hospital cost reports. The Required Report(s) is due no later than ninety (90) days after the close of the facility's fiscal year.

4. **Termination of Provider Contract.** Whenever a provider contract between the provider and the MassHealth program is terminated, the provider shall file reports covering the current reporting period portion thereof covered by the contract and any other reports required by DHCFP, within 60 days of such termination. When the provider fails to file the Required Reports in a timely fashion, DHCFP shall notify the provider of this failure by written notice sent registered mail, return receipt requested.

5. **Appointment of Patient Protector Receiver.** If a receiver is appointed pursuant to court order under M.G.L. c. 111, s. 72N, the provider must file the Required Reports for the current reporting period or portion thereof within sixty (60) days of the receiver's appointment.

C. **Filing Extensions.** DHCFP may grant an extension, up to 30 calendar days, for submission of the Required Report(s). Extension must: (a) be submitted in writing to DHCFP by the provider and not by an agent or other representative; (b) show that exceptional circumstances exist precluding the provider from submitting the Required Report(s) in timely fashion; and (c) be submitted no later than 30 calendar days before the filing due date.

D. **Incomplete Submission.** DHCFP shall notify the provider in writing within 120 days of receipt of the Required Reports if it finds that the submission is incomplete and shall specify what additional information is required to complete the submission. The provider shall file the necessary information with DHCFP within 25 days of the date of notification or by March 1 of the year the Required Report is filed, whichever is later. The Required Reports and all accompanying schedules are deemed to be filed with the DHCFP as of the date DHCFP receives complete submission.

If DHCFP fails to notify the provider within the 120-day period, the submission is considered complete and the Required Report(s) and all accompanying schedules are deemed to be filed with DHCFP as of the date of receipt.

E. **Audits.** DHCFP and the MassHealth program may conduct desk or field audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the Required Reports, the operations of the provider and any related party as requested, even if DHCFP has accepted such Required Reports.

F. **Penalties for Failure to File Timely.** A provider's rate for current services will be reduced in accordance with 114.2 CMR 6.08 (7) if the Required Reports are not filed in a timely manner. On receipt of such Required Reports, the provider's rate will be restored effective on the date of report filing.

G. **General Cost Principles.** In order to report a cost as related to MassHealth patient care, a cost must satisfy the following criteria:

1. the cost is ordinary, necessary, and directly related to the care of publicly aided patients;

2. the cost is for goods or services actually provided in the nursing facility;

3. the cost must be reasonable; and

4. the provider must actually pay the cost.

Costs that are not considered related to the care of MassHealth patients include, but are not limited to: costs that are discharged in bankruptcy; costs that are forgiven; costs that are converted to a promissory note; and accruals of self-insured costs that are based on actuarial estimates.

A provider may not report any of the costs that are listed in 114.2 CMR 6.08 (3) (h) as related to MassHealth patient care.

III. Methods and Standards Used to Determine Payment Rates

A. Prospective Per Diem Rates. The prospective per diem payment rates for nursing facilities are derived from the Nursing, Other Operating, and Capital payment components. Each of these components is described in detail in the following sections.

B. Nursing Cost. The following Nursing Standard Payments (per diem) comprise the Nursing Cost component of the prospective per diem payment rates for nursing facilities.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 – 30	$14.08
JK	30.1 – 110	$37.55
LM	110.1 – 170	$65.72
NP	170.1 – 225	$95.76
RS	225.1 – 270	$116.69
T	270.1 & above	$137.60

The base year used to develop the Nursing Standard Payments is 2005. Nursing costs reported in CY 2005 in the following categories are included in the calculation: Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, Director of Nurses and Nursing Workers' Compensation, Payroll Tax, and Fringe Benefits, including Pension Expense. The Nursing Standard Payments are derived from the product of the industry CY 2005 median nursing costs times the CY 2005 industry median management minutes for each of six payment groups listed 114.2 CMR 6.04 (1) Appendix A. The base year amounts for each group are updated to rate year 2007 by a cost adjustment factor of 6.49%.This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by Global Insight, Inc.

C. Other Operating Cost. The Other Operating Cost Standard Payment (per diem) comprises the other operating component of the prospective per diem payment rates for nursing facilities. The Other Operating Standard Payment, effective September 1, 2009, is $71.73.

The base year used to develop the Other Operating Standard Payment of $71.73 is CY 2005. Other operating costs reported in CY 2005 in the following categories are included in the calculation: variable, administrative and general, and motor vehicle costs. The Other Operating Standard Payment is set equal to the CY 2005 industry median of these cost amounts, except for administrative and general costs, which are subject to a ceiling of $17.99 before combining with other cost components. The calculation of the Other Operating Standard Payment is reduced by 3.17% to exclude non-allowable reported costs. The allowable base-year amount is updated by a CAF of 6.49%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by Global Insight, Inc.

D. Capital. The Capital component is computed in accordance with 114.2 CMR 6.05

1. **Capital Payments.** Capital payments for all facilities except for those identified in D.2 below, shall be based on the facility's allowable capital costs, including allowable depreciation, financing contribution and other fixed costs.
   (a) If a facility's capital payment effective July 31, 2007 is less than $17.29, its capital payment will be the greater of its July 31, 2007 capital payment or the payment determined as follows:

2005 Base Year Capital Cost Per Day (114.2 CMR 6.05 (1))	Capital Payment
$ 0.00 - $4.00	$4.45
$ 4.01 - $ 6.00	$6.18
$ 6.01 - $ 8.00	$8.15
$ 8.01 - $10.00	$10.13
$10.01 - $12.00	$12.11
$12.01 - $14.00	$14.08
$14.01 - $16.00	$16.06
$16.01 - $17.29	$17.29
$17.30 - $18.24	$18.24
$18.25 - $20.25	$20.25
>$20.25	$22.56

   (b) If a facility's revised capital payment effective July 31, 2007 is greater than or equal to $17.29, the facility's revised capital payment will equal its July 31, 2007 capital payment.
   (c) If a provider re-licensed beds during the rate period that were out of service, its capital payment will be the lower (1) the capital payment rate established under 114.2 CMR 6.05(2)(c) or (2) the facility's most recent capital payment rates.
   (d) If a provider's capital payment is based on a DON approved prior to March 7, 1996 and the provider receives a temporary capital payment in accordance with 6.05 (4) (b) (3), the provider's capital payment will be revised in accordance with 6.05 (4) (b) (4).

2. **Capital Payments Exceptions.** The capital payment for new facilities constructed pursuant to a Determination of Need approved after March 7, 1996; replacement facilities that open pursuant to a Determination of Need approved after March 7, 1996; new facilities in urban under bedded areas that are exempt from the Determination of Need process; new beds that are licensed pursuant to a Determination of Need approved after March 7, 1996; new beds in twelve-bed expansion projects not associated with an approved Determination of Need project; hospital-based nursing facilities; and private nursing facilities that sign their first provider agreement on or after September 1, 2004 shall be as follows:

Date that New Facilities & Licensed Beds became Operational	Payment Amount
Prior to 2/1/1998 (for Hospital based NFs Only)	$ 17.29
02/01/1998 - 12/31/2000	$ 17.29
01/01/2001 - 06/30/2002	$ 18.24
07/01/2002 - 12/31/2002	$ 20.25
01/01/2003 - 08/31/2004	$ 20.25
09/01/2004 - 06/30/2006	$ 22.56
07/01/2006 - 07/31/2007	$ 25.82
08/01/2007 - 07/31/2008	$ 27.30
08/01/2008 - forward	$ 28.06

3. **Notification of Substantial Capital Expenditures.** Any nursing facility that opens, adds new beds, adds substantial renovations, or re-opens beds after September 1, 2004, is required to notify DHCFP in accordance with 114.2 CMR 6.05 (4) (a) At that time, the Capital component may be recomputed in accordance with 114.2 CMR 6.05 (4) (b)

E. **Retroactive Adjustments.** DHCFP will retroactively adjust the Capital Payment component of the rates if HCFP learns that there was a material error in the rate calculation or if a nursing facility made a material error in its cost report. A material error is any error that would result in a change to a provider's rate.

IV. Special Conditions

A. **Innovative and Special Programs.** The MassHealth program may contract for special and/or innovative programs to meet special needs of certain patients, which are not ordinarily met by existing services in nursing facilities. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as a program for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e., Management Minute Category T).

B. **Rate for Innovative and Special Programs.** A provider who seeks to participate in an innovative and special program must contract with the MassHealth program to provide special care and services to distinct categories of patients designated by the MassHealth program. This is usually done through a Request for Responses by the MassHealth program for special or innovative programs to address special needs of certain patients that are not ordinarily met by existing services in nursing facilities. Payment under the innovative and special programs may be calculated based on the added reasonable and necessary costs and expenses that must be incurred (as determined by the MassHealth program) by a provider in connection with that program. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the MassHealth Program, and that such items or services are reasonable and appropriate in the efficient delivery of necessary health care. The rate for an innovative and special program may be established as an add-on to a rate established by DHCFP under 114.2 CMR 6.00 or as a stand-alone rate established by contract under M.G.L. c. 118E, §12 that is not subject to the provisions of 114.2 CMR 6.00 . In either instance, the rate must be consistent with the payment methodology established herein for long-term care facilities. In the event that the special program is located within a special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

C. **Facilities with High-Acuity High-Nursing Need Residents.** A provider whose resident population primarily and consistently consists of high-acuity high-nursing need residents such that the aggregate need of the entire population requires a staffing level significantly greater than a typical nursing facility may be reimbursed as a special program, in which case the increment added to the facility's rate may apply to all residents of the facility and will be calculated based on allowable costs associated with the higher care needs of the patients. In order to be eligible for reimbursement under this paragraph, a nursing facility must meet each of the following criteria:

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10; or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board;

2. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to qualify for MM category 10; and

3. the facility must be a geriatric nursing facility.

D. **Pediatric Nursing Facilities.** DHCFP will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and other operating costs, excluding administration and general costs, from the facility's2006 Cost Report. DHCFP will include an administration and general payment based on 85% of 2005 median statewide administration and general costs. DHCFP will apply an appropriate cost adjustment factor to nursing, other operating, and administration and general costs.

The nursing and other operating component of the rate is increased by a cost adjustment factor of 3.89%. This factor is derived from a composite market basket. The labor component on the market basket is the Massachusetts Consumer Price Index, optimistic forecast, as provided by Global Insight. The non-labor component is based on the CMS Skilled Nursing Facility without capital market basket, except for the Food and Health Care Services subcomponents, which are based on the Regional CPI for New England, as published by Global Insight.

E. **Beds Out of Service.** Facilities with licensed beds that were out of service prior to 2001 that re-open in 2001 will receive the lower of the Standard Payment rates or the most recent prior payment rates adjusted by the applicable CAF for Nursing and Other Operating Costs.

F. **Legislative Mandate for Rate Relief.** A nursing facility with the following conditions shall have all of its variable costs and nursing cots recognized by DHCFP and its MassHealth rate adjusted accordingly:

(i) with rate of public utilization consisting of Medicare, MassHealth, and Commission for the Blind patients, of ninety percent or more;
(ii) located in the service area of a federally designated sole community hospital; and
(iii) with more than 10% of its variable costs and nursing costs disallowed by DHCFP pursuant to 114.2 CMR 5.00 or any successor regulations.

DHCFP shall adjust the prospective rates for any nursing home that meets the aforementioned criteria for the rates that were effective January 1, 1994, and for each succeeding rate year that such nursing home complies with aforementioned criteria. The amount of variable costs and nursing costs recognized as allowable by DHCFP for any rate for a nursing home is limited to an amount that will not increase costs to MassHealth in an amount greater than $3,000.

Notwithstanding anything to the contrary contained in this paragraph, in no case shall the provisions of this paragraph apply to any services rendered prior to February 1, 1998.

Any nursing facility that meets all of either the standards set forth in either Alternative A or Alternative B below shall have its total acquisition costs allowed as the allowable basis of fixed assets, notwithstanding any limits on the same that appear elsewhere in this State Plan, when the MassHealth program calculates the facility's payment rates. This provision shall only apply to services rendered on or after February 1, 1998.

a. **Alternative A**

- The owner purchased the nursing home on or after January 1, 1987.
- The owner has received a determination letter from the Internal Revenue Service that it is an organization described in section 501 (c) (3) of the Internal Revenue Code of 1986.
- The owner (i) owns a nonprofit hospital (the "Hospital") located within the Commonwealth of Massachusetts that is licensed by the Department of Public Health or (ii) is a nonprofit organization affiliated with a nonprofit hospital that is organized and operated for the benefit of, to perform one or more functions of, or to carry out one or more of the purposes of the nonprofit hospital it is affiliated with, including operation of freestanding nursing homes licensed by the Department of Public Health.
- The owner's patient population is, on average, not less than 85% MassHealth recipients.
- The Hospital has, on average, not less than 80% occupancy of medical or surgical beds.
- When the owner purchased the nursing facility (i) the change of ownership did not occur between a person or organization that is associated or affiliated with or has control of or is controlled by the owner or is related to the owner or any director, trustee, partner, shareholder, or administrator of the owner by common ownership or control or in manner specified in section 267 (b) and (c) of the Internal Revenue Code of 1986; (ii) the change of ownership was made for reasonable consideration; (iii) the change in ownership was a bona fide transfer of all powers and indicia of ownership; and (iv) the change of ownership manifested an intent to sell the assets of the facility rather than implement a method of financing or refinancing.

b. **Alternative B**

- The owner acquired the nursing facility from an acute care hospital to operate the facility pursuant to relief granted to the acute care hospital by the Acute Care Hospital Conversion Board pursuant to M.G.L. c.6A, s.101.
- The Acute Care Hospital Conversion Board approved the owner's acquisition

costs of the facility.

- On average, no less than 85% of the nursing facility's patient population is MassHealth recipients.

G. **Receivership under M.G.L. C.111 s.72N *et seq.*** In accordance with 114.2 CMR 6.06 (10), effective January 1, 2000 provider rates of a nursing facility in receivership may be adjusted by DHCFP to reflect the reasonable and necessary costs associated with the court-approved closure of the facility.

H **Review and Approval of Rates and Rate Methodology by the MassHealth program.** Pursuant to M.G.L c 118E, s.13, the MassHealth program shall review and approve or disapprove any change in rates or in rate methodology proposed by DHCFP. The MassHealth program shall review such proposed rate changes for consistency with state policy and federal requirements, and with the available funding authorized in the final budget for each fiscal year prior to certification of such rates by DHCFP. The MassHealth program shall, whenever it disapproves a rate increase, submit the reasons for disapproval to DHCFP together with such recommendations for changes. Such disapproval and recommendations for changes, if any, are submitted to DHCFP after the MassHealth program is notified that DHCFP intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by DHCFP regarding such rate change; provided that no rates shall take effect without the approval of the MassHealth program. DHCFP and the MassHealth program shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the consumer price index to the Massachusetts House and Senate Committees on Ways and Means.

I. **Statistical Information from DHCFP.** DHCFP shall supply the MassHealth program with all statistical information necessary to carry out the MassHealth Program's review responsibilities under this Section.

J **Supplemental Funding.** If projected payments from rates necessary to conform to applicable requirements of Title XIX are estimated by the MassHealth program to exceed the amount of funding appropriated for such purpose in the budget for the fiscal year, the MassHealth program and DHCFP shall jointly prepare and submit to the Governor a proposal for the minimum amount of supplemental funding necessary to satisfy the requirements of the State Plan developed by the MassHealth program under Title XIX of the federal Social Security Act.

K. **Appeals.** A provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 114.2 CMR 6.00 within 30 calendar days after DHCFP files the rate with the State Secretary. DHCFP may amend a rate or request additional information from the provider even if the provider has filed a pending appeal.

L. **Department of Developmental Services (DDS) Requirements.** As part of the per diem rate calculation, an adjustment to the per diem rate will be calculated under 114.2 CMR 6.06(6) for nursing facilities that serve persons with mental retardation and developmental disabilities and that maintain clinical and administrative procedures in a manner that complements DDS interdisciplinary service planning activities.

1. **Eligibility.** Eligible facilities are those identified by DMR as providers of care to nursing facility residents with mental retardation or developmental disabilities as of .July 25, 2003. A facility may become ineligible for the allowance and its calculated per diem add-on may be rescinded if the facility fails to comply with DDS interdisciplinary service planning requirements.

2. **Total Add-On Allowance Amount.** The total allowance amount to be allocated to all eligible facilities be equal to the number of Medicaid eligible residents identified by DMR as of June 14, 2007 as having mental retardation or developmental disabilities, times $3.00, times 366 days.

3. **Add-On Calculation.** The per diem amount to be included in the payment rate for an eligible facility is calculated by dividing the total add-on allowance amount calculated above by the product of:

   a. Current licensed bed capacity for the rate period, times 366,
   b. Reported 2005 actual utilization percentage, times
   c. Reported 2005 Medicaid utilization percentage

M. **Kosher Kitchens.** Pursuant to Chapter 149 of the Acts of 2004, nursing facilities with kosher kitchen and food service operations shall receive an add-on of up to $ 5.00 per day to reflect any additional cost of these operations. Eligibility requirements and determination of payment amounts are described in section 114.2 CMR 6.06 (4)

N. **Annualization Adjustment.** This adjustment modifies nursing facility per diem rate increases to make prospective payments for reasonable costs of nursing facility over the expected duration of the rate period, rather than the customary July 1 State Fiscal Year (SFY) start date. The adjustment is applied solely to the per diem rates paid for the dates of service beginning on and after August 1, 2007. The adjustment is computed under 114.2 CM 6.06 (7)

O. **Large Medicaid Provider Add-On.** The payment of this add-on amount is contingent on Medicaid utilization in nursing facilities. In the event that Medicaid utilization is reduced in a fiscal year, an add-on payment is calculated based on the amount of authorized funds remaining in the Health Care Quality Improvement Trust Fund account at the close of the fiscal year. Funds in the account are authorized legislatively for Medicaid payments to nursing facilities. In the event that Medicaid utilization does not decline, no add-on payment is made.

The method of this add-on, which is unchanged from prior years and is contained in Appendix A:

(5) Large Medicaid Provider Payment. Subject to available funding, a facility will be eligible for a Large Medicaid Provider Payment as follows.

(a) Eligibility. A facility will be eligible for payment if:
   1. The facility had at least 188 licensed beds
   2. the facility's 2002 Medicaid days divided by total patient days, as report in its 2002 HCF-1, was equal to or greater than 70% and
   3. the facility received a score of at least 123 on the Department's Nursing Facility Survey Performance Tool as received by the Division on March 25, 2005

(b) Calculation of Payment. The Division will calculate the amount of the payment received by each eligible facility as follows:
   1. The Division will divide the number of reported 2002 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities
   2. The Division will multiply the resulting percentage by $3,198,812
   3. The Division will divide the amount calculated above by the product of:
      a. current licensed bed capacity for the rate period, times 365, times
      b. reported 2002 Actual Utilization, time
      c. reported 2002 Medicaid Utilization

(c) The amount will be included as add-on to each Provider's rate.

P. **State-operated Nursing Facilities.** A Facility operated by the Commonwealth will be paid at the Facility's reasonable cost of providing covered Medicaid services to eligible Medicaid recipients.

(a) DHCFP will establish an Interim per diem rate using a FY06 base year CMS-2540 cost report inflated to the rate year using the cost adjustment factor calculated pursuant to (b) below,

(b) DHCFP will use a 5.19% cost adjustment factor for the period FY06 through FY08 using a composite index using price level data from the CMS Nursing Home without capital forecast, and regional health care consumer price indices, and the Massachusetts-specific consumer price index (CPI), optimistic forecast. DHCFP will use the Massachusetts CPI as proxy for wages and salaries.

(c) DHCFP will retroactively adjust the final settled amount when the Medicare CMS-2540 cost report is re-opened or for audit adjustments. Adjustments will be made on an annual basis to update the base year and cost adjustment factor with the most recent data.

Q. **Publicly-operated Nursing Facilities. Effective September 1, 2009,** the payment of this add-on amount is contingent upon overall Medicaid utilization in nursing facilities. In the event that overall Medicaid utilization is reduced in a fiscal year, an add-on payment is calculated based on the funds in the Health Care Quality Improvement Trust Fund Account at the close of the fiscal year. Funds in the account are authorized legislatively for Medicaid payments to nursing facilities. In the event that overall Medicaid utilization does not decline, no add-on payment is made. Nursing facilities will be eligible for an add-on if they are owned and operated by a town, city or state government entity. The add-on will be calculated as follows:

(a) will divide the number of reported 2002 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities.

(b) will multiply the resulting percentage by the sum of the total add-on payments

(c) will divide the amount calculated by the product of:
   1. current licensed bed capacity for the rate period, times 365, times
   2. reported 2003 Actual Utilization times
   3. reported 2002 Medicaid Utilization

(d) This amount will be included as an add-on to the rates established by DHCFP under 114.2 CMR 6.06 (9).

R. Nursing Facility Pay for Performance Incentive Payments

(1) General. An incentive payment will be calculated for nursing facilities through the Nursing Facility Pay for Performance (P4P) Program. Incentive Payments are calculated subject to the following criteria.

(a) Criteria: To be eligible for any P4P incentive payment, a nursing facility must:

1. be enrolled as a MassHealth Nursing Facility for at least one day between September 1, 2011, and June 30, 2012;
2. have at least one paid MassHealth day during the Measurement Year of FY 2012 (September 1, 2011 through June 30, 2012);
3. not be designated by CMS as a Special Focus Nursing Facility and
4. not have an immediate jeopardy designation by the Massachusetts Department of Public Health.

(b) SFY 2012 Incentive Payments:

(1) SFY 2012 incentive payments will be made on a pro rata basis to nursing facilities who demonstrate that they meet the threshold criteria described above and:

Provide documentation on or before March 20, 2012, to the MassHealth Office of long Term Care Services and Support that includes all pertinent information and data documenting the existence of the:

- nursing facility's consistent staff assignment policy and
- nursing facility's cooperative effort policy.

(2) For SFY 2012, the sum of all Pay for Performance incentive payments will be $2.8M and will be paid to all Nursing Facilities that meet the general eligibility criteria described in 114.2 CMR 6.07 (2) and attain performance measures in the Nursing Facility Pay for Performance program.

S. Certification of Public Expenditures of a Nursing Facility owned and operated by a municipality.

1. Within 60 days after the filing of its Medicare CMS-2540 cost report, a nursing facility, which is owned and operated by a municipality, may submit a request for Certified Public Expenditures (CPE) to the Division of Health Care Finance and Policy (DHCFP). This CPE will account for its public expenditures of providing Medicaid services to eligible Medicaid recipients. The submission shall be based on the *inpatient routine service cost reported* on the 2540 Medicare cost report.

2. Following review of the facility's submission, DHCFP within 60 days of the submission, will approve, deny, or revise the amount of the Certified Public Expenditure request based upon its evaluation of the reported costs and payments. The final approved amount will be equal to the difference between the Medicaid interim payments and the total allowable Medicaid costs as determined by DHCFP and this final determined amount will be certified by the municipality as eligible for federal match.

3. Interim Payments are based on the reimbursement methodology contained in Section III of the State plan Attachment 4.19 - D (4).

4. The determination of allowable (CPE) Medicaid costs will be based on the Medicare CMS - 2540 Cost Report and will be determined on a per diem rate calculated as follows:

I. Skilled Nursing Facility Inpatient Routine Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *16*, Column 18
(B) Total Days - Worksheet *S*-3, Line 1, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line 1, Column 5
(E) Medicaid Allowable *Skilled Nursing Facility* Costs - (C) X (D)

II. Nursing Facility Inpatient Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *18*, Column 18
(B) Total Days - Worksheet *S*-3, Line *3*, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line *3*, Column 5
(E) Medicaid Allowable *Nursing Facility* Costs - (C) X (D)

III. Total Allowable Medicaid Costs

I (E) Skilled Nursing Facility Inpatient Costs + II (E) Nursing Facility Inpatient Costs

5. An interim reconciliation will be computed by the Division of Health Care Finance and Policy based on the difference between the interim payments and total allowable Medicaid costs from the as filed CMS - 2540 Cost Report. When the CMS-2540 is reopened the facility must immediately notify the Division of Health Care Finance and Policy. Within 60 days after receiving notification of the final Medicare settlement the Division will retroactively adjust the final settlement amount.

T. Leaves of Absence.

(a) For the purposes of a medical leave of absence for Medicaid eligible residents, a facility must ensure that the bed in the facility occupied by said resident before the hospitalization will be available upon the return of said resident from an inpatient acute hospital stay for a period of not less than ten (10) days. .

(b) The current payment rate for medical or non-medical leave of absence is $80.10 per day.

V. 2002 State Legislative Changes

1. **Nursing Facility Assessments.** An adjustment to nursing facility payment rates is established, effective October 1, 2002, to reimburse participating MassHealth nursing facilities for the providers' assessment costs that are incurred for the care of MassHealth members only, reflecting a portion of the providers' total assessment costs. No reimbursement is made for the providers' assessment costs that are incurred for the care of privately paying residents or others who are not MassHealth members.

   The rate adjustments for the Nursing Facility Assessment (User Fee) reflect Medicaid's partial share of the tax costs as an allowable cost for purposes of developing Medicaid payment rates and do not provide for a hold harmless arrangement with providers.

(a) Except as provided in section V.1. (b) below, the user fee adjustment will be based on the Nursing Facility Class under 114.5 CMR 12.04, as follows:

Nursing Facility Class	Adjustment Amount
1	$15.47
2	$1.55
3	$1.55
4	0

(b) In accordance with the provisions of section 139 of Chapter 68 of the Acts of 2011, for the period from September 1, 2011 through June 30, 2012, the user fee adjustment will be as follows:

Nursing Facility Class	Adjustment Amount
1	$18.41
2	$1.84
3	$1.84
4	0

(c) A prior rate period may be recertified to exclude this add-on if the Nursing Facility fails to incur the cost of the Nursing Facility user fee assessment within 120 days of the assessment due date.

(d) The add-on amount may be adjusted to reflect a change in the amount of the Nursing Facility user fee assessment under 114.5 CMR 12.04

2. **FY 2012 Rate Add-on**. In accordance with the provisions of Section 139 of Chapter 68 of the Acts of 2011, for the period from September 1, 2011 through June 30, 2012, Nursing Facility payments will include a rate add-on based on the Nursing Facility class established under 114.5 CMR 12.04, as listed below. The add-on will not be included in the Residential Care rates.

Nursing Facility Class	FY 2012 Add-on Amount
1	$0.26
2	$2.91
3	$2.91
4	$3.20

3. **Multiple Sclerosis Primary Diagnosis.** In accordance with the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, and Chapter 151 of the Acts of 1996, a rate add-on is computed, for eligible nursing facilities that serve a patient population of which more than 75% of the residents have a primary diagnosis of multiple sclerosis to reflect the difference between the standard payment amounts for nursing and the actual base year nursing costs of the eligible nursing facility. Therefore, an eligible nursing facility would get full recognition of its actual base year nursing costs in its rates.

VI. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Payments for services provided by Intermediate Care Facilities for the Mentally Retarded to publicly assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.1 CMR 29.00: Rate and Charge Determination for Certain Intermediate Care Facilities for the Mentally Retarded Operated by the Department of Mental Retardation, effective October 1, 2002 .