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State/Territory Name: MA

State Plan Amendment (SPA) #: 17-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

DEC 07 2017

Marylou Sudders, Secretary
Executive Office of Health and Human Services
State of Massachusetts
One Ashburton Place, Room 1109
Boston, MA 02108

RE: Massachusetts 17-0013

Dear Secretary Sudders:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 17-0013. This amendment revises references to the October 1, 2016 effective date for nursing facility reimbursement described in Massachusetts regulations (101 CMR 206.06). Specifically, the revision extends the effective date for user fee add-on rates, as listed in 101 CMR 206.06(12)(b), from July 1, 2017 through June 30, 2018.

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 17-0013 is approved effective July 1, 2017. 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,

[redacted]

Kristin Fan
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID 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: 17 — 013

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: 07/01/17

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: 42 CFR Part 447

7. FEDERAL BUDGET IMPACT
a. FFY 2017 $ 0
b. FFY 2018 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D(4) pages 1-15

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D(4) pages 1-15

10. SUBJECT OF AMENDMENT

Nursing Facility Rates

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)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Marylou Sudders

14. TITLE
Secretary

15. DATE SUBMITTED
09/29/17

16. RETURN TO
Kaela Konefal
State Plan Coordinator
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, 11th Floor
Boston, MA 02108

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED: DEC 07 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JUL 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME: KRISTIN FAN

22. TITLE: Director, FMCP

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

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

I. General Description of Payment Methodology

A. Overview. Nursing facility payments for services provided to MassHealth members are governed by the Executive Office of Health and Human Services (EOHHS) regulation,101 CMR 206.00: Standard Payments to Nursing Facilities as of July 1, 2017. This attachment describes the methods and standards used to establish payment rates for nursing facilities effective July 1, 2017.

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) 2007 costs The allowable basis for capital was updated using CY 2007 data.

II. Cost Reporting Requirements and Cost Finding

A. Required Reports. Except as provided below, each provider of long-term care facility services under the State Plan must complete an annual Cost Report.

1. For each cost reporting year, the Cost Report must contain detailed cost information based on generally accepted accounting principles and the accrual method of accounting that meets the requirements of 101 CMR 206.08 as of July 1, 2017.

2. There are five types of cost reports: a) Nursing Facility Cost Report; b) Realty Company Cost Report (if the facility is leased from another entity); c) Management Company Cost Report (if the facility reports management expenses paid to another entity); d) Financial Statements, and e) Clinical Data.

3. A facility that closes prior to November 1 is not required to submit a cost report for the following calendar year.

4. There are special cost reporting requirements outlined in 101 CMR 206.08(2)(g) as of July 1, 2017_for hospital-based nursing facilities, state-operated nursing facilities, and facilities that operate other programs such as Adult Day Health, Assisted Living or Outpatient Services.

5. A facility may be subject to penalties in accordance with 101 CMR 206.08 (7) as of July 1, 2017 if a facility does not file the required cost reports by the due date.

B. 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 101 CMR 206.08 (3) (h) as of July 1, 2017 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	$14.45
JK	30.1 – 110	$39.54
LM	110.1 – 170	$68.38
NP	170.1 – 225	$96.34
RS	225.1 – 270	$117.67
T	270.1 & above	$146.39

The base year used to develop the Nursing Standard Payments is 2007. Nursing costs reported in CY 2007 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 2007 median nursing costs times the CY 2007 industry median management minutes for each of six payment groups listed 101 CMR 206.04 (1) as of July 1, 2017 (Appendix A) The base year amounts for each group are updated to rate year 2008 by a cost adjustment factor of 3.79%.This cost adjustment factor is based on Massachusetts-specific consumer price index (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 July 1, 2017, is $76.96.

The base year used to develop the Other Operating Standard Payment of $76.96 is CY 2007. Other operating costs reported in CY 2007 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 2007 industry median of these cost amounts, except for administrative and general costs, which are subject to a ceiling of $18.45 before combining with other cost components. The calculation of the Other Operating Standard Payment is reduced by 2.95% to exclude non-allowable reported costs. The allowable base-year amount is updated to rate year 2008 by a CAF of 3.79%. 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 101 CMR 206.05 as of July 1, 2017.

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 September 30, 2014 is less than $17.29, its capital payment will be the greater of its September 30, 2014 capital payment or the payment determined as follows:

2007 Base Year Capital Cost Per Day (101 CMR 206.05 (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
$20.26 to $22.56	$22.56
$22.57 to $25.82	$25.82
>$25.83	$27.30

   (b) If a facility's revised capital payment effective September 30, 2014 is greater than or equal to $17.29, the facility's revised capital payment will equal its September 30, 2014 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 101 CMR 206.05(2)(a) as of July 1, 2017 or (2) the facility's most recent capital payment rates.

(d) If a provider's capital payment is based on a Determination of Need (DON) approved prior to March 7, 1996 and the provider receives a temporary capital payment in accordance with 101 CMR 206.05 (4) (b) (3), the provider's capital payment will be revised in accordance with 101 CMR 206.05 (4) (b) (4) as of July 1, 2017.

2. **Capital Payments Exceptions**. The capital payment for new facilities constructed pursuant to a DON approved after March 7, 1996; replacement facilities that open pursuant to a DON approved after March 7, 1996; new facilities in urban under bedded areas that are exempt from the DON process; new beds that are licensed pursuant to a DON approved after March 7, 1996; new beds in twelve-bed expansion projects not associated with an approved DON project; beds acquired from another facility that are not subject to a DON, to the extent that the additional beds increase the facility's licensed bed capacity; and private nursing facilities that sign their first provider agreement on or after October 1, 2008 shall be as follows:

Date that New Facilities & Licensed Beds became Operational	Payment Amount
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 – 09/30/2016	$ 28.06
10/01/2016- forward	$37.60

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 EOHHS in accordance with 101 CMR 206.05 (4) (a) as of July 1, 2017. At that time, the Capital component may be recomputed in accordance with 101 CMR 206.05 (4) (b) as of July 1, 2017.

E. **Retroactive Adjustments**. EOHHS will retroactively adjust the Capital Payment component of the rates if it 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 or which can only be met by existing services in nursing facilities at substantially higher cost. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), technologic dependency, as well as programs for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e., Management Minute Category T), nursing facilities that have a substantial concentration of patients with multiple sclerosis or multiple sclerosis and amyotrophic lateral sclerosis, nursing facilities that have a substantial concentration of deaf patients, and nursing facilities with substantially higher costs due to island location.

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 EOHHS under 101 CMR 206.00 as of July 1, 2017 or as a stand-alone rate established by contract under M.G.L. c. 118E, s.12 that is not subject to the provisions of 101 CMR 206.00 as of July 1, 2017. 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. EOHHS 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's 2007 Cost Report. EOHHS will include an administration and general payment based on 85% of 2007 median statewide administration and general costs. EOHHS 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 3.79%. 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. Receivership under M.G.L. c.111, s.72N *et seq.* In accordance with 101 CMR 206.06 (10) as of July 1, 2017, provider rates of a nursing facility in receivership may be adjusted by EOHHS to reflect the reasonable and necessary costs associated with the court-approved closure of the facility.

G. 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 EOHHS. 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 EOHHS. The MassHealth program shall, whenever it disapproves a rate increase, submit the reasons for disapproval to EOHHS together with such recommendations for changes. Such disapproval and recommendations for changes, if any, are submitted to EOHHS after the MassHealth program is notified that EOHHS 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 EOHHS regarding such rate change; provided that no rates shall take effect without the approval of the MassHealth program. EOHHS 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 CPI to the Massachusetts House and Senate Committees on Ways and Means.

H. **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 EOHHS 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.

I. **Appeals.** A provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 101 CMR 206.00 as of July 1, 2017 within 30 calendar days after EOHHS files the rate with the State Secretary. EOHHS may amend a rate or request additional information from the provider even if the provider has filed a pending appeal.

J. **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 101 CMR 206.06(2) as of July 1, 2017 for nursing facilities that serve persons with intellectual disabilities 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 DDS as providers of care to nursing facility residents with intellectual disabilities or developmental disabilities as of July 28, 2016. 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 DDS as of July 28, 2016 as having intellectual disabilities or developmental disabilities, times $3.00, times 365 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 365,
   b. Reported 2014 actual utilization percentage, times
   c. Reported 2014 Medicaid utilization percentage

K. **Kosher Kitchens.** 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 101 CMR 206.06 (3) as of July 1, 2017.

L. **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 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:

Large Medicaid Provider Payment. 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 in 2014
   2. the facility's 2014 Medicaid days divided by total patient days, as report in its 2014 HCF-1, was equal to or greater than 70% and
   3. the facility received a score of at least 122 on the Department of Public Health's Nursing Facility Survey Performance Tool as received by the Division on July 8, 2016

(b) Calculation of Payment. The EOHHS will calculate the amount of the payment received by each eligible facility as follows:
   1. EOHHS will divide the number of reported 2014 Medicaid days for each eligible facility by the total number of Medicaid days in all eligible facilities
   2. EOHHS will multiply the resulting percentage by $1,786,153
   3. EOHHS will divide the amount calculated above by the product of:
      a. current licensed bed capacity for the rate period, times 365, times
      b. reported 2014 Actual Utilization, time
      c. reported 2014 Medicaid Utilization

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

M. **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.

1. EOHHS will establish an interim per diem rate using a FY2014 base year CMS-2540 cost report inflated to the rate year using the cost adjustment factor calculated pursuant to (2) below and a final rate using the final CMS-2540 cost report from the rate year.

2. EOHHS will use a 1.72% cost adjustment factor for the period FY2014 through FY2016 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. EOHHS will use the Massachusetts CPI as proxy for wages and salaries.

3. EOHHS 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.

N. **Publicly-Operated Nursing Facilities.** Certain publicly operated nursing facilities will receive an add-on payment of $3.80 per day. Nursing facilities will be eligible for an add-on if they are owned and operated by a town, city or state government entity or transferred from municipal ownership since 2001, in which the municipality retains the power to appoint at least one member of the board, and is operating on land owned by the municipality. This amount will be included as an add-on to the rates established by EOHHS under 101 CMR 206.06 (8) as of July 1, 2017.

O. **[Reserved]**

P. 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 EOHHS. 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, EOHHS 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 EOHHS 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 *30*, 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 *31*, 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. EOHHS will calculate an interim reconciliation 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 EOHHS. Within 60 days after receiving notification of the final Medicare settlement EOHHS will retroactively adjust the final settlement amount.

Q. Leaves of Absence.

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

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V. State Legislative Changes

A. Nursing Facility Assessments. An adjustment to nursing facility payment rates is established, effective July 1, 2017, 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.

1. 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.A.1. (b) and (c) below, each nursing facility's user fee adjustment will be based on the facility's Nursing Facility Group under 101 CMR 512.04 as follows:

Nursing Facility Group under 101 CMR 512.04 as of October 6, 2016	Adjustment Amount
1	$15.47
2	$1.55
3	$1.55
4	$0.00

(b) For the period from July 1, 2017 through June 30, 2018, the user fee adjustment will be as follows:

Nursing Facility Group under 101 CMR 512.04 as of October 6, 2016	Adjustment Amount
1	$17.59
2	$1.76
3	$1.76
4	$0.00

(c) FY2017 Annualization. For the period from October 1, 2016 through June 30, 2017, there will be an additional user fee adjustment as follows:

Nursing Facility Class under 114.5 CMR 12.04 on September 30, 2016	Adjustment Amount
1	$0.71
2	$0.07

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3	$0.07
4	$0.00

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

e) The add-on amount may be adjusted to reflect a change in the amount of the Nursing Facility user fee assessment under 101 CMR 512.04.

B. 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.

C. Add-On for Direct Care Workers. For the period from October 1, 2016 through June 30, 2017, providers will receive an add-on for wages, benefits, and related employee costs of direct care workers totaling $35.5 million to be distributed.

(a) Calculation of the Add-on. EOHHS will:
   1. For each provider determine the total reported 2014 salaries for direct care workers.
      a. If the provider's 2014 cost report was not open for a full year, EOHHS will annualize the reported salaries
      b. Direct care worker salaries allocated to the Residential Care will be removed
   2. Multiply the provider's total reported 2014 direct care worker salaries by the provider's Medicaid utilization as reported in the 2014 cost report to determine the provider's Medicaid direct care worker salaries.
   3. Sum the Medicaid direct care worker salaries calculated for each provider to determine total Medicaid direct care salaries for all providers.
   4. Divide each provider's Medicaid direct care worker salaries by the total direct care salaries for all providers.
   5. Multiply the resulting percentage by $35.5 million.
   6. Divide the amount determined by each provider's projected number of Medicaid Days in FY 2017.
   7. Add an annualization adjustment to ensure that the full $35.5 million is distributed to Providers during the effective period (October 1, 2016 through June 30, 2017) of the wage add-on.

(b) This amount will be included as an add-on to each provider's rate. For providers that opened after 2014, an amount equal to the median value of the add-on among providers that were open in 2014 will be included as an add-on to each such provider's rate.

VI. Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID)

Payments for services provided by Intermediate Care Facilities for the Intellectually Disabled (ICFs/ID) to publicly assisted residents are governed by EOHHS regulation, 101 CMR 129: Rate and Charge Determination for Certain Intermediate Care Facilities Operated by the Department of Developmental Services (formerly 114.1 CMR 29.00) as of July 1, 2013.

The per diem payment rates for ICFs/ID are provider-specific and are established using Center for Health Information and Analysis (CHIA) ICF Cost Reports (403A). ICFs/ID rates are interim in nature and final rates are determined based on the final cost reports for the rate year. The initial inpatient per diem rate is calculated by dividing the allowable total patient care costs by total patient days using data from the fiscal year two years prior to the rate year and then adding inflation up to the rate year. The final inpatient per diem is calculated by dividing the allowable total patient care costs by total patient days using the data from the rate year. The final rate then replaces the initial per diem for the rate year.

The inflation factor for the initial per diem rates consists of a composite index comprised of two cost categories: labor and non-labor. The Massachusetts CPI is used as a proxy for the labor cost categories and the CMS Market Basket for Prospective Payment System-exempt hospitals is used for the non-labor cost category.

Payment rates include all allowable costs that are reasonable and directly related to health care and services provided in the ICFs/ID. Allowable total patient care costs are the sum of the ICF/ID's total inpatient routine and ancillary costs plus overhead costs associated with ICFs/ID health care and services, as reviewed and adjusted pursuant to regulation 101 CMR 129.04.

An ICF/ID may apply for an administrative adjustment to its inpatient per diem rate.