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State/Territory Name: Massachusetts

State Plan Amendment (SPA) #: 19-0031

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 S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 24, 2020

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

Reference: TN 19-0031

Dear Secretary Sudders:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0031. This amendment makes comprehensive changes to reimbursement methods for nursing facility services for FY 2020.

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.

This is to inform you that Medicaid State plan amendment TN 19-0031 is approved effective October 1, 2019. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at (617) 565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

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: 19-031

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: 10/01/2019

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 2020 $ 26,460,000
b. FFY 2021 $ 26,460,000

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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 1-15ii

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
12/31/2019

16. RETURN TO

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 12/30/2019

18. DATE APPROVED 03/24/20

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
10/1/2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME Kristin Fan

22. TITLE Director

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 October 1, 2019. This attachment describes the methods and standards used to establish payment rates for nursing facilities effective October 1, 2019.

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 Operating Costs as well as a capital payment component. Nursing and Operating Standard Payment rates were calculated using Calendar Year (CY) 2014 costs. The allowable basis for capital was updated using CY 2014 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 October 1, 2019.

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 30 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 October 1, 2019 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 October 1, 2019 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 October 1, 2019 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, Operating, and Capital Cost components. Each of these components is described in detail in the following sections.

B. Nursing Cost Component.

1. The Nursing Cost component of prospective per diem payment rates comprises the following Nursing Standard Payments (per diem).

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 – 30	$14.60
JK	30.1 – 110	$39.97
LM	110.1 – 170	$69.57
NP	170.1 – 225	$97.73
RS	225.1 – 270	$119.83
T	270.1 & above	$148.71

2. The rates for payment groups RS and T, listed above, include an additional $1.26 added to the prospective per diem payment rates to account for the higher costs associated with complex patient care.
3. For the period from October 1, 2019, through June 30, 2020, the Nursing Cost component of the prospective per diem payment rates also includes the following annualization adjustment.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 – 30	$0.01
JK	30.1 – 110	$0.02
LM	110.1 – 170	$0.19
NP	170.1 – 225	$0.17
RS	225.1 – 270	$0.36
T	270.1 & above	$0.36

4. The base year used to develop the Nursing Standard Payments is 2014. Nursing costs reported in CY 2014 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 2014 median nursing costs times the CY 2014 industry median management minutes for each of six payment groups listed in 101 CMR 206.04(1) as of October 1, 2019. The base year amounts for each group are updated to the second quarter of rate year 2015 by a cost adjustment factor of 0.10%. 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. Operating Cost Component.

1. The Operating Cost component of the prospective per diem payment rates for nursing facilities comprises the following Operating Cost Standard Payments (per diems).

Nursing Facility Group	Operating Cost Standard Payment
1	$99.96
2	$82.88
3	$82.88
4	$80.98

2. For the period from October 1, 2019, through June 30, 2020, the Operating Cost component of the prospective per diem payment rates also includes the following annualization adjustment.

Nursing Facility Group	Operating Cost Annualization Adjustment
1	$1.35
2	$1.35
3	$1.35
4	$1.35

3. The Operating Cost Standard Payments and the annualization adjustments are based on the facility's Nursing Facility Group under 101 CMR 512.04.
4. The base year used to develop the Operating Standard Payments is CY2014. The following operating costs reported in CY 2014 are included in the calculation: variable, and administrative and general costs. The Operating Standard Payment is set equal to the CY 2014 industry median of these cost amounts, except for administrative and general costs, which are subject to a ceiling of $20.88 before combining with other cost components. The calculation of the Operating Standard Payment is reduced by 4.20% to exclude non-allowable reported costs. The allowable base-year amount is updated to rate year 2015 by a CAF of 0.1%. 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 Cost Component.

1. The Capital Cost component of the prospective per diem payment rates for nursing facilities comprises the Capital Cost Standard Payments (per diems). The Capital Cost payments are based on the county in which the facility is located, with exceptions as described in III.D.2-4.

County	Capital Standard Payment
Berkshire, Franklin, Hampden, Hampshire	$14.08
Middlesex, Suffolk	$16.06
Barnstable, Dukes, Nantucket	$18.04
Bristol, Essex, Norfolk, Plymouth, Worcester	$14.08

2. If a nursing facility capital standard payment as listed in subsection III.D.1 is less than the facility's rebased capital payment that it would have received based on the capital standard payment calculation methodology in effect prior to October 1, 2019, the facility may be eligible for an upward adjustment to its capital payment as follows.
    a. The facility's upward adjustment is calculated as the difference between the standard capital payment listed in III.D.1 and its rebased capital payment that it would have received based on the capital standard payment calculation methodology in effect prior to October 1, 2019.
3. A nursing facility may be eligible for an adjustment to its capital standard payment as described in III.D.2 after October 1, 2019 if:

a. The facility has expended at least 50% of the maximum capital expenditure for an approved determination of need; and
b. The facility has submitted a notification request for a revised capital payment to EOHHS; and
c. Such notification request for such revised capital payment is submitted to EOHHS between November 1, 2009 and November 1, 2019.

4. Notwithstanding III.D.3(c), a facility that meets the requirements of III.D.5. will be eligible for an upward adjustment to its capital standard payment as described in III.D.2 in accordance with III.D.3.
5. A nursing facility will be eligible for an upward adjustment to its capital standard payment as described in III.D.2 after October 1, 2019, if, prior to March 31, 2020, the facility provides EOHHS with documentation of one of the following:
    a. Department of Public Health plan review approval pursuant to an approved determination of need dated prior to January 1, 2020; or
    b. Detailed architectural or engineering plans developed in response to an approved determination of need and submitted to the Department of Public of Health prior to January 1, 2020; or
    c. Evidence of funding received, or a firm commitment to fund, from an outside lender dated prior to January 1, 2020, in an amount equal to or in excess of 50 per cent of the maximum capital expenditure as specified in an approved determination of need; or
    d. Evidence of applications made on or before January 1, 2020, to local government agencies for planning, zoning or building permits or other regulatory approvals required in connection with the implementation of an approved determination of need;
    e. Evidence of the acquisition of land required for development of the project authorized by an approved determination of need; or
    f. An application for a determination of need submitted to the Department of Public Health prior to January 1, 2020 and detailed architectural or engineering plans, dated prior to January 1, 2020, for the capital project contemplated in the facility's determination of need application.
6. A nursing facility that becomes operational on or after November 1, 2019, an existing nursing facility that replaces its current building on or after November 1, 2019, or an existing nursing facility that fully relocates to a newly constructed location on or after November 1, 2019 will be eligible for a capital standard payment in the amount of $37.60. Such facility will not be eligible for additional capital payments as listed in subsection III.D.1 or for an adjustment to its capital standard payment as described in subsection III.D.2.
7. A nursing facility will not receive an adjustment to its capital standard payment rate solely because of an increase or decrease in its number of licensed beds.
8. Rate Adjustments. EOHHS will adjust any capital payment upon EOHHS's determination that there was a material error in the calculation of the payment or in the facility's documentation of its capital costs.

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), developmental disability, 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 October 1, 2019 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 October 1, 2019. 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;

2. 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;

3. 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

4. the facility must be a geriatric nursing facility.

D. Pediatric Nursing Facilities.

1. EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and operating costs, excluding administration and general costs, from the facility's 2014 Cost Report. EOHHS will include an administration and general payment based on 85% of 2014 median statewide administration and general costs. EOHHS will apply an appropriate cost adjustment factor to nursing, operating, and administration and general costs.
2. The nursing and operating components of the rate is increased by a cost adjustment factor of 0.10%. 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 Nursing Home without Capital market basket, except for the Food subcomponent, which is based on the Regional CPI for New England, as published by Global Insight.
3. Effective October 1, 2019, facilities licensed to provide pediatric nursing facility services will receive the rates which are the greater of: (a) the rates calculated as described IV.D.1 and IV.D.2, plus an additional $1.26 added to the rates in IV.D.3 for payment groups RS and T; (b) the Nursing Standard and Operating Cost Standard rates calculated as described in III.B. and III.C; or (c) the rates facilities received prior to October 1, 2019, plus an additional $1.26 added to the rates in IV.D.3 for payment groups RS and T.

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 Operating Costs.

F. Receivership under M.G.L. c.111, s.72N *et seq.* In accordance with 101 CMR 206.06(10) as of October 1, 2019, 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 federal and state policy and budget requirements 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 October 1, 2019 within 30 calendar days after EOHHS files the rate with the Secretary of the Commonwealth. 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 October 1, 2019 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 101 CMR 206.06(3) as of October 1, 2019.

L. Quality Achievement and Improvement Payments

1. **Quality Achievement and Improvement Payments.** Effective October 1, 2019, a nursing facility may be eligible for one of two quality achievement and improvement payments as follows. A nursing facility may receive either the Quality Achievement and Improvement Add-on or the High Medicaid Quality Achievement and Improvement Add-on, but may not receive both add-ons concurrently.
   a. Quality Achievement and Improvement Add-on
      i. Eligibility. A nursing facility will be eligible for a quality achievement and improvement payment if at least one of the following criteria is met:
         (a) the nursing facility received a score of at least 124 on the Department's Nursing Facility Survey Performance Tool as of July 1, 2019 and at least 4 stars in the overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of July 1, 2019;
         (b) the nursing facility received a score of at least 124 on the Department's Nursing Facility Survey Performance Tool as of July 1, 2019 and at least 4 stars in the staffing rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of July 1, 2019; or
         (c) the nursing facility's score on the Department's Nursing Facility Survey Performance Tool increased by at least 3 points between July 1, 2018 and July 1, 2019 or the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool increased by at least 1 star between July 1, 2018 and July 1, 2019.
      ii. Calculation of Add-on. EOHHS will calculate the amount of the add-on received by each eligible facility as follows.
         (a) A nursing facility will receive $1.35 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

b. High Medicaid Quality Achievement and Improvement Add-on

i. Eligibility. A nursing facility will be eligible for a high Medicaid quality achievement and improvement payment if:

(a) the nursing facility meets one of the criteria in IV.L.1.a.i.(a) – (c); and

(b) the nursing facility's combined Massachusetts Medicaid managed care days, Massachusetts Medicaid and non-managed care days, and Senior Care Options (SCO) and Program of All-Inclusive Care for the Elderly (PACE) days, as reported in its 2017 Nursing Facility Cost Report, divided by total patient days excluding residential care days, as reported in its 2017 Nursing Facility Cost Report, is equal to or greater than 75%.

ii. Calculation of Add-on. EOHHS will calculate the amount of the add-on received by each eligible facility as follows.

(a) A nursing facility will receive $2.96 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

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 2.96% cost adjustment factor for the period FY2016 through FY2018 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 October 1, 2019.

O. PASRR Level II Add-on. Effective October 1, 2019, a nursing facility will be able to receive this member-based add-on for providing services to certain MassHealth members as follows.

1. Eligibility for the add-on. In order to receive the add-on for a MassHealth member, all of the following criteria must be met:
   a. The member is eligible for nursing facility services in accordance with 130 CMR 456.403 and 456.409;
   b. The conditions in 130 CMR 456.407 and 456.408 are met;
   c. The facility completed an initial Preadmission Screening and Resident Review (PASRR) on the member in accordance with 130 CMR 456.410 and applicable subregulatory guidance;
   d. The facility received a Level II Determination Notice for the member from the Department of Developmental Services and/or the Department of Mental Health stating that (1) the member meets PASRR criteria for either Intellectual Disability, Developmental Disability, or Serious Mental Illness, and that the nursing facility is an appropriate setting to meet the member's needs; or (2) the member meets PASRR criteria for the Advanced Dementia Exclusion.
   e. The facility complied with applicable subregulatory guidance on PASRR with regard to resident reviews after it received the Level II Determination Notice; and
   f. The facility has not received a subsequent Level II Determination Notice stating that the nursing facility is not an appropriate setting to meet the member's needs.
2. Add-on amount: A nursing facility will receive a per diem of $5.38 for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.
3. Payment of the add-on. Nursing facilities must comply with all EOHHS billing instructions in order to receive a PASRR Level II Add-on payment for an eligible MassHealth member.

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.

V. State Legislative Changes

A. **SFY2020 Add-ons.** Effective October 1, 2019, a nursing facility may be eligible for the "Three Star Plus" Add-on, the "High Medicaid Occupancy" Add-on, the "Cape and the Islands" Add-on, or a combination of these three add-ons.

a. "Three Star Plus" Add-on

i. Eligibility. A nursing facility will be eligible for the "Three Star Plus" Add-on if the nursing facility received at least three stars in the overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of July 1, 2019.

ii. Calculation of Add-on. A nursing facility will receive $1.26 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

(a) For the period from October 1, 2019, through June 30, 2020, the "Three Star Plus" Add-on will include an annualization adjustment in the amount of $0.42.

b. "High Medicaid Occupancy" Add-on

i. Eligibility. A nursing facility will be eligible for the "High Medicaid Occupancy" Add-on if the nursing facility's combined Massachusetts Medicaid managed care days, Massachusetts Medicaid non-managed care days, and Senior Care Options (SCO) and Program of All-Inclusive Care for the Elderly (PACE) days, as reported in its 2017 Nursing Facility Cost Report, divided by total patient days excluding residential care days, as reported in its 2017 Nursing Facility Cost Report, is equal to or greater than 75%.

ii. Calculation of Add-on. A nursing facility will receive $1.26 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

(a) For the period from October 1, 2019, through June 30, 2020, the "High Medicaid Occupancy" Add-on will include an annualization adjustment in the amount of $0.42.

c. "Cape and the Islands" Add-on

i. Eligibility. A nursing facility will be eligible for the "Cape and the Islands" Add-on if the nursing facility's physical location is in one of the following counties: Dukes, Nantucket, or Barnstable.

ii. Calculation of Add-on. A nursing facility will receive $1.26 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.
(a) For the period from October 1, 2019, through June 30, 2020, the "Cape and the Islands" Add-on will include an annualization adjustment in the amount of $0.42.

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. **Payments for Direct Care Workers**. For the period from October 1, 2019 through June 30, 2020, nursing facilities will receive a rate add-on for wages, benefits, and related employee costs of direct care workers.
a. Calculation of the Add-on. EOHHS will:
i. Sum the total SFY2019 direct care staff payments for all open nursing facilities as of September 1, 2019.
ii. Calculate the difference between $38.3 million and the total calculated under V.C.(a)(i).
iii. Divide the SFY2019 total direct care staff payment for each nursing facility by the SFY2019 total direct care staff payments for all open nursing facilities in V.C.(a)(i).
iv. Multiply the quotient calculated under V.C.(a)(iii) by the difference calculated under V.C.(a)(ii).
v. For each nursing facility, sum the facility's total SFY2019 total direct care staff payment and share of the difference for the facility calculated under V.C.(a)(iv).
vi. Compute the nursing facility's direct care add-on by dividing the total direct care payment calculated under V.C.(a)(v). by the nursing facility's Massachusetts Medicaid non-managed care days, as the term is used in the Nursing Facility Cost Report, projected for SFY2020.
vii. Add an annualization adjustment to ensure that the full amount allocated to the Direct Care Staff Program is distributed to eligible providers during the effective period of the add-on.
b. If a nursing facility has a reduction in its number of licensed beds as the result of a change in the physical location of the facility, its Direct Care Staff Payment Add-on may be reduced proportional to the loss in beds.
c. Application of Rate Add-on. The amount calculated pursuant to V.C.(a). will be included as an add-on to each nursing facility 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.