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State/Territory Name: MA

State Plan Amendment (SPA) #: 09-008

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, CHIP and Survey & Certification (CMCS)

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

AUG 18 2011

RE: TN 09-008

Dear Dr. Bigby:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-008. This amendment updates the methodology used to calculate payment rates for nursing facility services. an increase of $37M of which $32M is associated with a change in the cost adjustment factor and $5M is related to the new Pay-for-Performance (P4P) Incentive Program; a new provisions for a P4P program intended to promote value-based payment for services; an update to add-on rates for Pediatric nursing facilities (NFs); new add-on payment based on utilization for NFs owned and operated by a municipality; new CPE funding for NFs owned and operated by a municipality; and revision of the user fee adjustment to reflect the FY2010 increase in NF assessments.

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 09-008 is approved effective September 1, 2009. 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,

[illegible]
Director
Center for Medicaid CHIP and Survey & Certification (CMSC)

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: **09-008**
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: **9/01/09**

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 447.300-321**

7. FEDERAL BUDGET IMPACT
a. FFY 09: $ ~~1.84 M~~ 1.88 M
b. FFY 10: $ ~~20.85 M~~ 22.5 M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: **Attachment 4.19-D (4) pp. 1-~~18~~ 19**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): **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:

13. TYPED NAME: **Judy Ann Bigby, M.D.**

14. TITLE: **Secretary**

15. DATE SUBMITTED: **09/30/09**

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

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: **AUG 18 2011**

PLAN APPROVED – ONE COPY

19. EFFECTIVE DATE OF APPROVED MATERIAL: **SEP - 1 2009**

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

I. General Description of Payment Methodology

A. **Overview.** Nursing facility payments for services rendered to publicly assisted residents are governed by the Division of Health Care Finance and Policy (DHCFP) regulation, 114.2 CMR 6.00: Standard Payments to Nursing Facilities. The following sections in this attachment describe the methods and standards used to establish payment rates for nursing facilities effective September 1, 2009

B. **Chief Components.** The payment method, described below, completes the shift away from historical facility-specific cost-based reimbursement to 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:

2005Base Year Capital Cost Per Day (114.2 CMR 6.05 (1))	Capital Payment
$ 0.00 to $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
2/1/1998-12/31/2000	$ 17.29
1/1/2001-6/30/2002	$ 18.24
7/1/2002-12/31/2002	$ 20.25
1/1/2003-8/31/2004	$ 20.25
9/1/2004 - 6/30/2006	$ 22.56
–7/1/2006 – 7/31/2007	$25.82
8/1/2007 – July 31, 2008	$27.30
8/1/2008- 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's most recently filed 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 as 9/1/08, to be established by the MassHealth agency on an annual basis;
2. have at least one paid MassHealth day during the Measurement Year;
3. complete and return a Facility Process Survey; and
4. not have an immediate jeopardy designation by the Massachusetts Department of Public Health.

(b) Facility Process Survey. An incentive payment may be computed for nursing facilities that that submit to the MassHealth agency, in a timely manner, a fully completed Facility Process Survey in accordance with deadlines established by the MassHealth agency and that meet all other criteria described above for the P4P program .

(c) FY 2010 Incentive Calculation. For State Fiscal Year 2010, an incentive payment of $12,626.26 is calculated for 398 nursing facilities that were enrolled as a MassHealth-participating nursing facility as of July 1, 2009, that had at least one paid MassHealth day during the Measurement Year of SFY 2009, that submitted to the MassHealth agency a fully completed 2009 Facility Process Survey within the timeframe specified by the MassHealth Agency for survey completion and that did not have an immediate jeopardy designation by the Massachusetts Department of Public Health. All payments were made for FY 2010 dates of service. For State Fiscal Year 2010, the sum of all P4P incentive payments is approximately $5 million.

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. If a facility fails to hold this bed open, it will be ineligible to receive payments pursuant to 114.2 CMR 6.06(5), or allowances for DMR requirements pursuant to 114.2 CMR 6.06(6). DHCFP may make further adjustment to the facility's rate to comply with the provisions of Chapter 42 of the Acts of 2003.

(b) The payment rate for a medical or non-medical leave of absence day 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.

   For the rate period commencing September 1, 2009, the adjustment will be based on the Nursing Facility Class under 114.5 CMR 12.04, as follows:

Nursing Facility Class	Adjustment Amount
1	$15.51
2	$1.55
3	$1.55
4	0

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.

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 .

Final Adoption
October 8, 2009

114.2 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY

114.2 CMR 6.00: STANDARD PAYMENTS TO NURSING FACILITIES

6.01: General Provisions

Microsoft Office Word 2003.lnk 6.02: General Definitions

6.03: General Payment Provisions
6.04: Nursing and Other Operating Costs
6.05: Capital
6.06: Other Payment Provisions
6.07: Pay for Performance
6.08: Reporting Requirements
6.09: Special Provisions

6.01: General Provisions

(1) Scope and Purpose. 114.2 CMR 6.00 governs the payments effective September 1, 2009 for services rendered to Publicly Aided and Industrial Accident Residents by Nursing Facilities including residents in a Residential Care Unit of a Nursing Facility. 114.2 CMR 6.00 does not govern nursing facility payments pursuant to a contract with the Office of Medicaid.

(2) Authority. 114.2 CMR 6.00 is adopted pursuant to M.G.L. c. 118G.

6.02: General Definitions

As used in 114.2 CMR 6.00, unless the context requires otherwise, terms have the following meanings. All defined terms in 114.2 CMR 6.00 are capitalized.

Actual Utilization Rate. The occupancy of a Nursing Facility calculated by dividing total Patient Days by Maximum Available Bed Days.

Additions. New Units or enlargements of existing Units that may or may not be accompanied by an increase in Licensed Bed Capacity.

Administrative and General Costs. Administrative and General Costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs.

Administrator-in-Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR.

Audit. An examination of the Provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Base Year. The calendar year used to compute the standard payments.

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Building. Building Costs include the direct cost of construction of the structure that houses residents and expenditures for service Equipment and fixtures such as elevators, plumbing and electrical fixtures made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees and certain legal fees. Building Costs include interest paid during construction to Building Costs but not Mortgage Acquisition Costs.

Capital Costs. Capital Costs include Building Depreciation, Financing Contribution, Building Insurance, Real Estate Taxes, non-income portion of Massachusetts Corp. Excise Taxes, Other Rent and Other Fixed Costs.

Case-Mix Category. One of six categories of resident acuity that represents a range of Management Minutes.

Change of Ownership. A bona fide transfer, for reasonable consideration, of all the powers and indicia of ownership. A Change of Ownership may not occur between Related Parties. A Change of Ownership must be a sale of assets of the Provider rather than a method of financing. A change in the legal form of the Provider does not constitute a Change of Ownership unless the other criteria are met.

CMS. The federal Centers for Medicare and Medicaid Services.

Clinical Measures. A set of quality measures selected by the MassHealth agency for performance measurement for use in the Nursing Facility Pay for Performance Program.

Constructed Bed Capacity. A Nursing Facility's "Bed Capacity (or Clinical Bed Capacity)" as defined in the Department's regulation 105 CMR 100.020 which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes rooms designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such appurtenances are actually in place, with any necessary utilities (e.g., drinking water, sprinkler lines, oxygen, electric current) with either outlets or capped lines within the room.

Department. The Massachusetts Department of Public Health.

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing and language therapists provided directly to individual Residents to reduce physical or mental disability and to restore the Resident to maximum functional level. Direct Restorative Therapy Services are provided only upon written order of a physician, physician assistant or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual Resident. Direct Restorative Therapy Services include supervisory, administrative and consulting time associated with provision of the services. These include, but are not limited to, reviewing pre-admission referrals, informally communicating with families, scheduling treatments, completing resident care documentation including MDS documentation, screening of patients, writing orders, meeting with aides to discuss patients, consulting with physicians and nurse practitioners, managing equipment and assessing equipment needs of patients.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

Equipment. A fixed asset, usually moveable, accessory or supplemental to the Building, including such items as beds, tables, and wheelchairs.

Facility Process Survey. A survey administered by the MassHealth agency to Nursing Facilities to obtain information on the quality of care MassHealth members receive as part of the Nursing Facility P4P program, to focus on components of care that are not currently measured and to establish a baseline.

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Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Generally Available Employee Benefits. Employee benefits that are nondiscriminatory and available to all full-time employees.

Hospital-Based Nursing Facility. A separate Nursing Facility Unit or Units located in a hospital building licensed for both hospital and Nursing Facility services in which the Nursing Facility licensed beds are less than a majority of the facility's total licensed beds and the Nursing Facility patient days are less than a majority of the facility's total patient days. It does not include free-standing Nursing Facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the Building by rearranging the Building layout or substituting improved components for old components so that the Provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the Building. An improvement is measured by the Provider's increased productivity, greater capacity, or longer life.

Indirect Restorative Therapy. Indirect Restorative Therapy Services consist only of services of physical therapists, occupational therapists, and speech, hearing and language therapists to provide the following: orientation programs for aides and assistants; in-service training to staff; consultation and planning for continuing care after discharge; pre-admission meetings with families; quality improvement activities such as record reviews, analysis of information and writing reports; personnel activities including hiring, firing, and interviewing; rehabilitation staff scheduling; and attending team meetings including quality improvement, falls, skin team, daily admissions, interdisciplinary, departmental staff, discharge planning, and family meetings when resident is not present.

Industrial Accident Resident. A person receiving Nursing Facility services for which an employer or an insurer is liable under the workers compensation act, M.G.L. c. 152, et seq.

Land. Land Costs include the purchase price plus the cost of bringing land to a productive use including, but not limited to, commissions to agents, attorneys' fees, demolition of Buildings, clearing and grading the land, constructing access roads, off-site sewer and water lines, and public utility charges necessary to service the land; and land Improvements completed before the purchase. The land must be necessary for the care of Publicly-Aided Residents.

Licensed Bed Capacity. The number of beds for which the Nursing Facility is either licensed by the Department of Public Health pursuant to 105 CMR 100.020, or for a Nursing Facility operated by a government agency, the number of beds approved by the Department. The Department issues a license for a particular level of care.

Major Addition. A newly constructed addition to a Nursing Facility that increases the Licensed Bed Capacity of the facility by 50% or more.

Management Minutes. A method of measuring resident care intensity, or case mix, by discrete care-giving activities or the characteristics of residents found to require a given amount of care.

Management Minutes Questionnaire. A form used to collect resident care information including but not limited to case-mix information as defined by the MassHealth Agency.

Massachusetts Corporate Excise Tax. Those taxes that have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

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Maximum Available Bed Days. The total number of licensed beds for the calendar year, determined by multiplying the Mean Licensed Bed Capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A Provider's weighted average Licensed Bed Capacity for the calendar year, determined by (1) multiplying Maximum Available Bed Days for each level of care by the number of days in the calendar year for which the Nursing Facility was licensed for each level and (2) adding the Maximum Available Bed Days for each level and (3) dividing the total Maximum Available Bed Days by the number of days in the calendar year.

Measurement Year. The fiscal year in which performance rates are calculated and distributed to facilities.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) necessary to obtain long-term financing through a mortgage, bond or other long-term debt instrument.

New Facility. A facility that opens after the effective date of the regulation. A Replacement Facility is not a New Facility.

Nursing Costs. Nursing costs include the Reported Costs for Director of Nurses, Registered Nurses, Licensed Practical Nurses, Nursing Aides, Nursing Assistants, Orderlies, Nursing Purchased Services, and the Workers Compensation expense, Payroll Tax expense, and Fringe Benefits, including Pension Expense, associated with those salaries.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, s.71; or a Nursing Facility operating under a hospital license issued by the Department pursuant to M.G.L. c. 111, and certified by the Department for participation in the State Medical Assistance Program. It includes facilities that operate a licensed residential care Unit within the Nursing Facility.

Other Fixed Costs. Other Fixed Costs include Real Estate Taxes, Personal Property Taxes on the Nursing Facility Equipment, the Non-Income portion of the Massachusetts Corporate Excise tax, Building Insurance, and Rental of Equipment located at the facility.

Other Operating Costs. Other Operating Costs include, but are not limited to the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical Director; Advisory Physician; Utilization Review Committee; Employee Physical Exams; Other Physician Services; House Medical Supplies Not Resold; Pharmacy Consultant; Social Service Worker; Indirect Restorative and Recreation Therapy Expense; Other Required Education; Job Related Education; Quality Assurance Professionals; Management Minute Questionnaire Nurses; Staff Development Coordinator; Motor Vehicle Expenses including, but not limited to depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and Administrative and General Costs.

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of Patient Days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a Provider reserves a vacant bed for a Publicly-Aided Resident temporarily placed in a different care situation, pursuant to an agreement between the Provider and the MassHealth Agency. It also includes days for which a bed is held vacant and reserved for a non-publicly-aided resident.

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Pay for Performance (P4P) Program. A value-based purchasing program implemented by the MassHealth agency to pay providers to perform activities related to improving the quality of care delivered to MassHealth members.
Private Nursing Facility. A Nursing Facility that formerly served only non-Medicaid residents and does not have a Provider agreement with the MassHealth Agency to provide services to public Residents.

Provider. A Nursing Facility providing care to Publicly Aided Residents or Industrial Accident Residents.

Prudent Buyer Concept. The assumption that a purchase price that exceeds the market price for a supply or service is an unreasonable cost.

Publicly-Aided Resident. A person for whom care in a Nursing Facility is in whole or in part subsidized by the Commonwealth or a political sub-Division of the Commonwealth. Publicly Aided Residents do not include residents whose care is in whole or in part subsidized by Medicare.

Related Party. An individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or is related to the Provider, or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended provided, however, that 10% is the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mother-in-law, brothers-in-law and sisters-in-law.

Replacement Facility. A Nursing Facility licensed prior to January 1, 2002 that replaces its entire building with a newly-constructed facility pursuant to an approved Determination of Need under 105 CMR 100.505(a)(6). A facility that renovates a building previously licensed as a nursing facility is not a Replacement Facility.

Reported Costs. All costs reported in the cost report, less costs adjusted and/or self-disallowed in Schedules 13 and 14 of the HCF-1.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to Publicly-Aided Residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department in accordance with 105 CMR 150.000 for Residents who do not routinely require nursing or other medically-related services.

Residential Care Unit. A Unit within a Nursing Facility licensed by the Department to provide residential care.

State Fiscal Year (SFY). The twelve month period from July 1 through June 30.

Unit. A Unit is an identifiable section of a Nursing Facility such as a wing, floor or ward as defined by the Department in 105 CMR 150.000 (Licensing of Long-Term Care Facilities).

6.03: General Payment Provisions

(1) Nursing Facility Payments are prospective rates based on reported costs for a prior Base Year. The Base Year for the standard payments effective September 1, 2009 is 2005. Nursing Facility Payments include the Nursing Standard Payments and Other Operating Cost Standard Payment established in 114.2 CMR 6.04

and the Capital Payment established in 114.2 CMR 6.05. Payments may be adjusted to include additional payments in accordance with 114.2 CMR 6.06 and 6.07.

(2) Ancillary Costs. Unless a Provider participates in the Ancillary Pilot Program with the MassHealth Agency, or a Provider's payments include Ancillary Services pursuant to the regulations or written policy of the purchasing agency, the Provider must bill Ancillary Services directly to the purchaser in accordance with the purchaser's regulations or policies.

(3) Disclaimer of Authorization of Services. 114.2 CMR 6.00 is not authorization for or approval of the substantive services, or lengths of time, for which rates are determined pursuant to 114.2 CMR 6.00. Governmental units that purchase services from eligible providers are responsible for the definition, authorization, and approval of services and lengths of time provided to publicly-aided individuals. Information concerning substantive program requirements must be obtained from purchasing governmental units.

6.04 Nursing and Other Operating Costs

(1) Nursing Standard Payments. Facilities will be paid at the following Nursing Standard Payments:

Payment Group	Management Minute Range	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 and above	$137.60

(2) For all payment groups, the Other Operating Cost Standard Payment is $71.73.

6.05 Capital

(1) Allowable Basis of Fixed Assets and Capital Cost

(a) Allowable Basis of Fixed Assets.

1. Fixed Assets include Land, Building, Improvements, Equipment and Software.

2. Allowable Basis. The Allowable Basis is the lower of the Provider's actual construction cost or the Maximum Capital Expenditure approved for each category of assets by the Massachusetts Public Health Council and used for Nursing Facility services. The Division will classify depreciable land improvements such as parking lot construction, on-site septic systems, on-site water and sewer lines, walls and reasonable and necessary landscaping costs as Building cost.

3. Allowable Additions. The Division will recognize Fixed Asset Additions made by the Provider if the Additions are related to the care of publicly-assisted Residents. If Additions relate to a capital project for which the Department has established a Maximum Capital Expenditure, the allowable amount will be limited to the amount approved by the Department. The Division will not recognize Fixed Asset Additions made or Equipment Rental expense incurred within 12 months after a DON project becomes operational.

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4. Change of Ownership. If there is a Change of Ownership, the Allowable Basis will be determined as follows:

a. Land. The Allowable Basis is the lower of the acquisition cost or the seller's Allowable Basis.

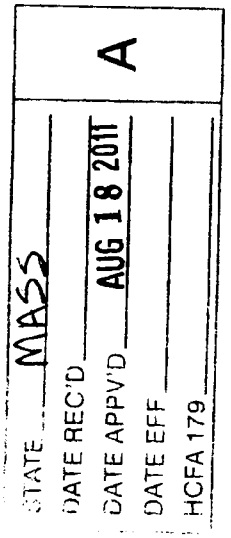
b. Building. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates for the years 1968 through June 30, 1976 and 1993 forward.

c. Improvements. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

d. Equipment. The Allowable Basis is the lower of the acquisition cost or the seller's allowable basis, reduced by the amount of actual depreciation allowed in the Medicaid rates.

e. Upon transfer, the seller's allowable Building Improvements will become part of the new owner's Allowable Basis of Building.

f. If the Division cannot determine the amount of actual depreciation allowed in a prior year from its records, the Division will determine the amount using the best available information including, among other things, documentation submitted by the Provider.



5. Special Provisions.

a. Non-Payment of Acquisition Cost. The Division will reduce Allowable Basis if the Provider does not pay all or part of the acquisition cost of a reimbursable fixed asset or if there is a forgiveness, discharge, or other non-payment of all or part of a loan used to acquire or construct a reimbursable fixed asset. The Division will reduce the basis to the extent that the basis was derived from the acquisition or construction cost of the fixed asset.

b. Repossession by Transferor. The Division will recalculate Allowable Basis if a transferor repossesses a facility to satisfy the transferee's purchase obligations; becomes an owner or receives an interest in the transferee's facility or company, or acquires control of a facility. The Allowable Basis will not exceed the transferor's original allowable basis under Division regulations applicable at the date of Change of Ownership, increased by any allowable capital Improvements made by the transferee since acquisition, and reduced by depreciation since acquisition.

(b) Capital Costs. The Division will calculate the Provider's Capital Costs including depreciation, Financing Contribution, and Other Capital Costs as defined below.

1. Depreciation. The Division will allow depreciation on Buildings, Improvements and Equipment based on the Allowable Basis of Fixed Assets as of December 31, 2005. Depreciation of Buildings, Improvements, and Equipment will be allowed based on generally accepted accounting principles using the Allowable Basis of Fixed Assets, the straight line method, and the following useful lives:

LIFE	YEARS	RATE
Buildings and Additions	40	2.5%
Improvements (including septic systems and freestanding waste water treatment systems)	20	5%
Equipment, Furniture and Fixtures	10	10%
Software	3	33.3%

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2. Financing Contribution. The Division will calculate a Financing Contribution by multiplying 7.625% by the Allowable Net Book Value as of December 31, 2005. The Allowable Net Book Value is the allowable basis less all accumulated depreciation calculated for the period through December 31, 2005, except allowed Building depreciation expense that occurred between January 1, 1983 and December 31, 1992.
3. Rent and Leasehold Expense. The Division will allow reasonable rental and leasehold expenses for Land, Building and Equipment at the lower of: average rental or ownership costs of comparable Providers, or the reasonable and necessary costs of the Provider and lessor including interest, depreciation, real property taxes and property insurance. The Division will not allow rent and leasehold expense unless a Realty Company Cost Report is filed.
4. Capital Costs. The Division will calculate the Provider's Capital Costs by adding allowable 2005 depreciation and Other Fixed Costs and the Financing Contribution.
5. 2005 Capital Cost Per Day. The Division will calculate the Provider's 2005 Capital Cost per day by dividing 2005 Capital Costs by the greater of: (a) 96% or (b) the Actual Utilization Rate times the Constructed Bed Capacity times 366.

(2) Capital Payment.

(a) The Division will include capital payments listed in 114.2 CMR 6.05(2)(d) for the following facilities:

(b) New Facilities and Licensed Beds that become operational on or after February 1, 1998 and are:

1. New or Replacement Facilities constructed pursuant to a Determination of Need approved after March 7, 1996;
2. New Facilities constructed in Urban Underbedded areas exempt from the Determination of Need process;
3. New beds licensed pursuant to a Determination of Need approved after March 7, 1996;
4. New beds in twelve-bed expansion projects not associated with an approved Determination of Need project; and
5. Beds acquired from another Facility that are not subject to a Determination of Need, to the extent that the additional beds increase the Facility's licensed bed capacity.

(b) Private Nursing Facilities that sign a Provider Agreement with the MassHealth Agency after October 1, 2008.

(c) The capital payment will be as follows:

Date that New Facilities and Licensed Beds Became Operational	*Payment Amount*
February 1, 1998 – December 31, 2000	$17.29
January 1, 2001 – June 30, 2002	$18.24
July 1, 2002 – December 31, 2002	$20.25
January 1, 2003 – August 31, 2004	$20.25
September 1, 2004 – June 30, 2006	$22.56
July 1, 2006 – July 31, 2007	$25.82
August 1, 2007 - July 31, 2008	$27.30
August 1, 2008 - Forward	$28.06

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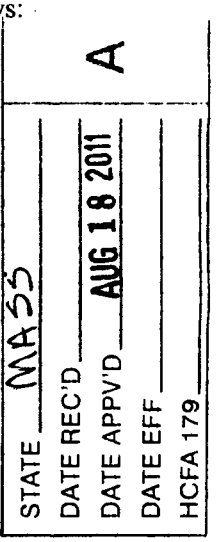
(3) Capital Payment – Other Facilities. For all other facilities, the Capital Payment is based on the facility's Capital Costs, including allowable depreciation, Financing Contribution, and Other Fixed Costs.

(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 Capital Costs Per Day (114.2 CMR 6.05(1))	*Capital Payment Effective August 1, 2007*
$0.00 to $4.00	$4.45
$4.01 to $6.00	$6.18
$6.01 to $8.00	$8.15
$8.01 to $10.00	$10.13
$10.01 to $12.00	$12.11
$12.01 to $14.00	$14.08
$14.01 to $16.00	$16.06
$16.01 to $17.29	$17.29
$17.30 to $18.24	$18.24
$18.25 to $20.25	$20.25
>$20.25	$22.56



2. If a facility's 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.
3. If a Provider relicensed beds that were out of service during the rate period, its Capital Payment will be the lower of (1) the capital payment rate established under 114.2 CMR 6.05(2)(c) or (2) the facility's most recent capital payment rates.
4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, and the Provider receives a temporary Capital Payment in accordance with 6.05(4)(b)(3), then the Division will revise the Provider's Capital Payment in accordance with 6.05(4)(b)(4).

(4) Revised Capital Payment for Substantial Capital Expenditure.

(a) General Notification Requirements. All Providers must notify the Division when they open, add new beds, renovate or re-open beds. The notification must contain the Provider's name, address and vendor payment number, date of bed change, type of change and description of project.
(b) Request for Revised Capital Payment. Eligible Providers may request a revised Capital Payment for capital costs associated with the change or renovation of licensed beds.

1. Facilities that may request a revised Capital Payment include:
   a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need;
   b. Replacement Facilities that open on or after September 1, 2005 pursuant to a Determination of Need;
   c. Facilities with Renovations made pursuant to a Determination of Need;
   d. Facilities with twelve bed additions; and

e. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

2. If a Provider listed in 114.2 CMR 6.05(4)(b)1 requests a revised Capital Payment to reflect a change in beds, it must submit the following, as well as any additional information that the Division determines necessary to calculate a revised Capital Payment:

:

a. a description of the project;
b. a copy of the construction contract;
c. copies of invoices and cancelled checks for construction costs;
d. a copy of the Department's licensure notification associated with the new beds;
e. a copy of the mortgage; and
f. a hard copy and electronic version of the calculation of the requested increase, in a format specified by the Division.

3. The Division will certify a temporary Capital Payment of $25.82 upon receipt of the notification of the change in beds, rate adjustment request, and required supporting documentation.

4. If the Provider's Capital Payment is based on a Determination of Need approved prior to March 7, 1996, in order to calculate the final revised Capital Payment the Division will determine the amount of new allowable assets and apply the Financing Factor in 114.2 CMR 6.05(1)(b)2.

(c) Revised Capital Payment.

1. For the Providers specified in 114.2 CMR 6.05(2)(a), the Division will certify a Capital Payment of $28.06.

2. For the following facilities, the final revised Capital Payment will be the greater of 90% of the amount calculated under 114.2 CMR 6.05(4)(b)4 or $28.06:

a. New Facilities and newly-licensed beds that open pursuant to a Determination of Need approved on or before March 7, 1996;
b. Replacement Facilities that open on or after July 1, 2002 pursuant to a Determination of Need approved on or before March 7, 1996;
c. Facilities with twelve bed additions associated with a Determination of Need approved on or before March 7, 1996; and
d. Facilities that requested and received an approved Determination of Need pursuant to the delegated review process in 1996 under Department of Public Health regulation 105 CMR 100.505(a)(4).

3. For the following facilities, the revised Capital Payment will be the lower of the amount calculated under 114.2 CMR 6.05(4)(b)4 or $28.06:

a. facilities that renovate pursuant to a Determination of Need approved after March 7, 1996;
b. facilities that implement a transferred Determination of Need approved before March 7, 1996 but did not file a Notice of Intent to Acquire the facility before March 7, 1996. This provision will not apply if the transfer occurred on or after February 1, 1998 and before May 30, 1998. If the transfer occurred during this period, the revised Capital Payment will be determined under 114.2 CMR 6.05(3)(c)1; and
c. facilities with a twelve-bed addition and simultaneously renovate pursuant to a Determination of Need approved after March 7, 1996.

4. For Facilities with Renovations made pursuant to a Determination of Need approved before March 7, 1996, if the revised amount calculated under 114.2 CMR 6.05(4)(b)4 is greater than $28.06, the Capital Payment will be 90% of the amount calculated under 114.2 CMR 6.05(4)(b)4. If the calculated amount is lower than $28.06, the Capital Payment will be the amount calculated under 114.2 CMR 6.05(4)(b)4.

(d) Effective Date. The effective date of the revised Capital Payment will be the date upon which the Provider submits the notification and all information and documentation required in 114.2 CMR 6.05(4)(b)2.

(e) Weighted Capital Payment. If a Provider receives a revised capital payment for new beds and also has beds for which payment is determined under 114.2 CMR 6.05(3)(a), the Division will calculate a weighted capital payment. The provider's capital payment will be determined in accordance with the schedule in 114.2 CMR 6.05(3)(a). The payment rate will be the next highest payment rate from the weighted rate as calculated by the Division.

(f) Retroactive Adjustments. The Division may retroactively adjust capital payments if it learns there was a material error in the rate calculation or if the Provider made a material error in the cost report.

6.06 Other Payment Provisions

(1) Annualization Adjustment. Nursing facilities will receive an additional, one-time adjustment to annualize rate increases. The adjustment amount is equal to the annualization adjustment in the facility's rates effective August 31, 2009.

(2) Certification of Public Expenditures of a Nursing Facility owned and operated by a municipality.

(a) Within 60 days after the filing of its Medicare-2540 cost report, a nursing facility owned and operated by a municipality may submit a request for a Certified Public Expenditure (CPE) to the Division, accounting for its public expenditures of providing Medicaid services to eligible Medicaid recipients. The submission shall be based on its CMS-2540 cost report and shall fully account for and offset from the cost calculation any amounts attributable to the rates established under 114.2 CMR 6.00 for the cost reporting period covered by the Medicare-2540 cost report.

(b)Following review of the facility's submission, the Division will determine and certify the amount of the Certified Public Expenditure made by the municipality..

(3) Department of Developmental Services (DDS) Requirements. Eligible nursing facilities will receive a one-time allowance to establish and maintain clinical and administrative procedures in a manner that complements DDS interdisciplinary service planning activities under the "Active Treatment Policy" for nursing facility residents with mental retardation and developmental disabilities, which was issued by the Executive Office of Health and Human Services in December, 2002.

(a) Eligibility. Eligible nursing facilities are identified by DDS as nursing facility providers of care to nursing facility residents with mental retardation or development disabilities as of July 25, 2003.

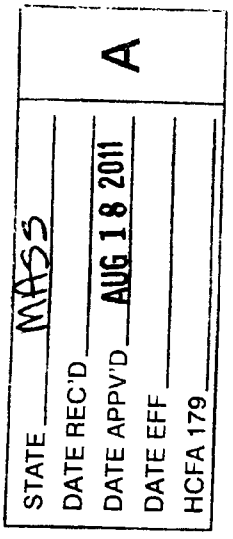
(b) Calculation of Allowance. For each eligible nursing facility identified by DDS, the number of residents identified by DDS as having mental retardation or developmental disabilities and communicated to the Division as of June 14, 2007 times $3.00, times 366 days, will equal the total allowance amount. To calculate a per day amount to be included

in the payment rates, the Division will divide the allowance amount calculated above by the product of items 1 through 3 below:
1. current licensed bed capacity for the rate period, times 366,
2. reported 2005 Actual Utilization percentage, times
3. reported 2005 Medicaid Utilization percentage.
(c) If DDS notifies the Division that a facility has failed to comply with its requirements or failed to cooperate with the planning activities under the Active Treatment Policy, the Division may deem the facility to be ineligible for this adjustment and rescind this allowance for a provider.

(4) Kosher Food Services. Facilities with kosher kitchen and food service operations may receive an add-on of up to $5 per day to reflect the additional costs of these operations.

(a) Eligibility. To be eligible for this add-on, the facility must:

1. maintain a fully kosher kitchen and food service operation that is, at least annually, rabbinically approved or certified; and in accordance with all applicable requirements of law related to kosher food and food products, including but not limited to, M.G.L. c. 94, §156;
2. provide to the Division a written certification from a certifying authority, including the complete name, address and phone number of the certifying authority, that the applicant's nursing facility maintains a fully kosher kitchen and food service operation in accordance with Jewish religious standards. For purpose of this paragraph, the phrase "certifying authority" shall mean a recognized Kosher certifying organization or rabbi who has received Orthodox rabbinical ordination and is educated in matters of Orthodox Jewish law;
3. provide a written certification from the Administrator of the nursing facility that the percentage of the nursing facility's residents requesting kosher foods or products prepared in accordance with Jewish religious dietary requirements is at least fifty percent (50%); and
4. upon request, provide the Division with documentation of expenses related to the provision of kosher food services, including but not limited to, invoices and payroll records.



(b) Payment Amounts. To determine the add-on amount, the Division will

1. determine the statewide median dietary expense per day for all facilities. The add-on equals the difference between the eligible facility's dietary expense per day and the statewide median dietary expense per day, not to exceed $5 per day. In calculating the per day amount, the Division will include allowable expenses for dietary and dietician salaries, payroll taxes and related benefits, food, dietary purchased service expense, dietician purchased service expense, and dietary supplies and expenses. The days used in the denominator of the calculation will be the higher of the facility's actual days or 96% of available bed days.
2. The Division will compare the sum of the add-on amounts multiplied by each facility's projected annual rate period Medicaid days to the state appropriation. In the event that the sum exceeds the state appropriation, each facility's add-on shall be proportionally adjusted.

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

(a) Eligibility. A facility will be eligible for the payment if:

1. the facility had at least 188 licensed beds in 2002;

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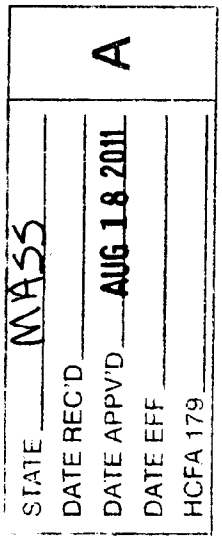

2. the facility's 2002 Medical days divided by total patient days, as reported in its 2002 HCF-1, was equal to or greater than 70%; and
5. the facility received a score of at least 123 on the Department's Nursing Facility Survey Performance Tool as received by the Division on March 25, 2005.

(b) Calculation of Supplemental Payment. The Division will calculate the amount of the supplemental 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 the amount of the surplus.
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, times
   3. reported 2002 Medicaid Utilization.
   c. This amount will be included as an add-on to each Provider's rate.

(6) 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. If a facility fails to hold this bed open, it will be ineligible to receive payments pursuant to 114.2 CMR 6.06(5), or allowances for DMR requirements pursuant to 114.2 CMR 6.06(6). The Division may make further adjustment to the facility's rate to comply with the provisions of Chapter 42 of the Acts of 2003.
(b) The payment rate for a medical or non-medical leave of absence day is $80.10 per day.

(7) Nursing Cost. Eligible facilities will receive an add-on to reflect the difference between the standard payment amounts and actual Base Year nursing spending. To be eligible for such payment, the Department must certify to the Division that over 75% of the facility's residents have a primary diagnosis of multiple sclerosis.

(8) Pediatric Nursing Facilities. The Division 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 most recently filed Cost Report. The Division will include an administration and general payment based on 85% of 2005 median statewide administration and general costs. The Division will apply an appropriate cost adjustment factor to nursing, other operating, and administration and general costs.

(9) Publicly-Operated Facilities. Subject to available funding, there will be a supplemental payment to certain publicly-operated nursing facilities owned and operated by a town, city, or state government entity. The payments will be allocated as follows:

(a) 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.
(b) The Division will multiply the resulting percentage by the sum of total supplemental payments.
(c) The Division will divide the amount calculated above by the product of:
   1. current licensed bed capacity for the rate period , times 365, times
   2. reported 2002 Actual Utilization, times

3. reported 2002 Medicaid Utilization.
d. This amount will be included as an add-on to each Provider's rate.

(10) Receiverships. The Division may adjust the rate of a receiver appointed under M.G.L. c. 111, § 72N solely to reflect the reasonable costs, as determined by the Division and the MassHealth Agency, associated with the court-approved closure of the facility.

(11) Residential Care Beds. The total payment Nursing and Other Operating costs for Residential Care Beds in a dually-licensed facility is $76.60.

(12) 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) The Division will establish an Interim per diem rate using a base year CMS-2540 cost report inflated to the rate year using the cost adjustment factor calculated pursuant to 114.6 CMR 6.06(10)(b).and a final rate using the final rate year CMS-2540 cost report.
(b) The Division will determine a cost adjustment factor 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. The Division will use the Massachusetts CPI as proxy for wages and salaries.
(c) The Division may retroactively adjust the final settled amount when the Medicare CMS-2540 cost report is re-opened or for audit adjustments

(13) User Fee.
(a) Nursing Facility payments will include an add-on for the Medicaid portion of the nursing facility user fee assessment under 114.5 CMR 12.00. The add-on will be based on the Nursing Facility Class under 114.5 CMR 12.04.

Nursing Facility Class	Add-on Amount
1	$15.51
2	$1.55
3	$1.55
4	0

(b) The Division may recertify a prior period rate to exclude this add-on if the Facility fails to incur the cost of the nursing facility user fee assessment within 120 days of the assessment due date.
(c) The Division may adjust the add-on amount to reflect a change in the amount of the nursing facility user fee assessment under 114.5 CMR 12.04.

6.07 Nursing Facility Pay for Performance Incentive Payments.

(1) General. Subject to MassHealth's determination of the availability of funds, nursing facilities receive incentive payments through the Nursing Facility Pay for Performance (P4P) Program as described in MassHealth regulation at 130 CMR 450.118 subject to the following criteria.

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(2) Payment Eligibility. The MassHealth agency pays eligible Nursing Facilities that return a completed 2009 Facility Process Survey within the time frame specified by the MassHealth agency. Payments may also be made to eligible Facilities for each of the five Clinical Measures in accordance with the criteria below.

(a) General Eligibility. To be eligible for an incentive payment, a facility must:

1. be enrolled as a MassHealth Nursing Facility as of a certain date, to be established by the MassHealth agency on an annual basis;
2. have at least one paid MassHealth day during the Measurement Year;
3. complete and return a Facility Process Survey; and
4. not have an immediate jeopardy designation by the Department.

(b) Facility Process Survey. To be eligible for a payment for the 2009 Facility Process Survey, a facility must meet the criteria in 114.2 CMR 6.07(2)(a) and return, in a timely manner, a fully completed 2009 Facility Process Survey. In FY 2010, the MassHealth agency will pay a total of $5 million in Facility Process Survey payments, distributed to all eligible Facilities that complete the Survey.

(c) Clinical Measures. To be eligible for payments for attainment of Clinical Measures, a facility must meet the criteria in 114.2 CMR 6.07(2)(a) and have a minimum number of assessments that meet specific Clinical Measures criteria, as established by the MassHealth agency, during the period for which performance is being measured and not have a CMS special focus facility designation by the Department.

(3) Clinical Measures. Each Clinical Measure is calculated to produce aggregate numbers that will be used to establish baseline information, attainment thresholds and performance benchmarks, relative to the distribution of nursing facilities. Clinical measure rates are calculated by dividing the numerator by the denominator for each measure to obtain a percentage. A measure's denominator is the number of assessments performed by a nursing facility that meet the eligibility criteria for the clinical measure and the numerator is the subset of the denominator who meets the measure's specific clinical criteria

(a) Performance Score. For each Clinical Measure for which the nursing facility is eligible, nursing facilities will be scored for either achieving a benchmark or for improving their performance over their previous year's performance. Points will be awarded to a nursing facility for each indicator, according to the methodologies noted below:

1. Attainment Points. Each Nursing facility may earn points based on its performance relative to the attainment threshold and to the benchmark set for each Clinical Measure. The attainment threshold is set at the median of all nursing facilities' performance rates. The benchmark is set at the **75th percentile of all Massachusetts nursing facilities' performance rates. The attainment threshold and benchmark rates are obtained from CMS's Nursing Home Compare and calculated by CMS. Nursing facilities will receive attainment points between the range of zero (0) and ten (10) for each Clinical Measure, as noted below:

a. If a nursing facility's performance rate is below the attainment threshold, it will receive zero (0) attainment points.

b. If a nursing facility's performance rate is greater than or equal to the benchmark it will receive ten (10) attainment points.

c. If a nursing facility's performance rate is below the benchmark, but at or above the attainment threshold, the nursing facility will receive

anywhere from one (1) to ten (10) attainment points, as calculated using the following formula:

Nursing Facility's Attainment Points =

$$\left(\frac{(NF's\ Performance\ Rate) - (Attainment\ Threshold)}{(Benchmark\ Rate) - (Attainment\ Threshold)} \times 9 \right) + 1$$

2. Improvement Points: Nursing facilities may earn improvement points if the nursing facility has demonstrated improvement from their previous year's performance rate. The nursing facility's improvement points will be calculated based on the following formula:

$$\left(\frac{(NF's\ Performance\ Rate) - (NF's\ Previous\ Year\ Performance\ Rate)}{(Benchmark\ Rate) - (NF's\ Previous\ Year\ Performance\ Rate)} \right) \times 10$$

3. Nursing Facility Awarded Points: For each Clinical Measure, the awarded points is the higher of the attainment or improvement points earned by the nursing facility. In no event will the number of points awarded exceed ten (10) for each Clinical Measure. Each Clinical Measure's awarded points are then summed across all the measures a nursing facility is eligible for to determine the total awarded points for a nursing facility.

Nursing Facility Awarded Points =

(Points Awarded Measure 1) + *(Points Awarded Measure 2)* +.... *(Points Awarded Measure N)*

4. Nursing Facility Potential Points. The total potential points for a nursing facility is determined by multiplying the number of Clinical Measures for which the Nursing Facility is eligible by the maximum number of points per Clinical Measure (ten).

Potential Points =

(Number of Clinical Measures for which a nursing facility is Eligible) X 10

5. Nursing Facility Performance Score: The nursing facility's performance score reflects a percentage between 0% to 100%. The nursing facility awarded points is divided by the nursing facility potential points to obtain the nursing facility performance score based on the following formula:

Nursing Facility Performance Score =

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(Nursing Facility Awarded Points)/(Nursing Facility Potential Points)

(4) Per MassHealth Day Payment Amount. The per day payment amount is determined as follows:

(a) The aggregate dollar figure for Facility Process Survey incentive payments made under 114.3 CMR 53.03(2)(a) is subtracted from the total dollar amount MassHealth determines annually is available for the P4P program, to determine the aggregate dollar figure available for Clinical Measure incentive payments.

(b) The per day payment amount is determined by dividing the aggregate dollar figure for Clinical Measures incentive payments by the statewide adjusted days calculated as described below.

Per Day Payment Amount =

$$\frac{\text{Aggregate Dollar Amount for Clinical Measures}}{\text{Statewide Adjusted Days}}$$

1. Statewide adjusted days. The statewide adjusted days figure is calculated by summing over all Nursing Facilities, each Nursing Facility's adjusted days number.

Statewide Adjusted Days =

(NF 1 Adjusted Days) + (NF 2 Adjusted Days) + ... (NF N Adjusted Days)

2. Nursing facility adjusted days. Each nursing facility's MassHealth paid days is multiplied by the nursing facility's Performance Score to derive the "adjusted days" figure.

(5) Total Clinical Measure Payment Amount. A Nursing Facility's Clinical Measure incentive payment is calculated as the product of: (1) the nursing facility's Performance Score (2) the number of nursing facility MassHealth paid days as of the end of the measurement period; and (3) the MassHealth Day Payment Amount.

Nursing Facility Total Clinical Measure Payment Amount =

(Nursing Facility Performance Score) x (Number of Paid MassHealth Days for the Year Ending with the Last Day of the Measurement Period) x (Per Day Payment Amount)

6.08 Reporting Requirements

(1) Required Cost Reports

(a) Nursing Facility Cost Report. Each Provider must complete and file a Nursing Facility Cost Report each calendar year. The Nursing Facility Cost Report must contain the complete financial condition of the Provider, including all applicable management company, central office, and real estate expenses. If a Provider has closed on or before November 30, the Provider is not required to file an HCF-1 report.

(b) Realty Company Cost Report. A Provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report.
(c) Management Company Cost Report. A Provider must file a separate Management Company Cost Report for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly-aided residents. If the Provider identifies such costs, the Provider must certify that costs are reasonable and necessary for the care of Publicly-Aided Residents in Massachusetts.
(d) Financial Statements. If a Provider or its parent organization is required or elects to obtain independent audited financial statements for purposes other than 114.2 CMR 6.00, the Provider must file a complete copy of its audited Financial Statements that most closely correspond to the provider's Nursing Facility Cost Report fiscal period. If the Provider or its parent organization does not obtain audited Financial Statements but is required or elects to obtain reviewed or compiled Financial Statements for purposes other than 114.2 CMR 6.00, the Provider must file a complete copy of its Financial Statements that most closely correspond to the Nursing Facility Cost Report fiscal period. Financial Statements must accompany the provider's Nursing Facility Cost Report filing. Nothing in this section shall be construed as an additional requirement that nursing homes complete audited, reviewed, or compiled Financial Statements solely to comply with the Division's reporting requirements.
(e) Clinical Data. The Division may require Providers to submit patient level data for the purpose of measuring clinical performance in a format specified by the Division. The Division may designate required data, data specifications and other data collection requirements by Administrative Bulletin.
(f) CMS-2540 Reports. State operated Nursing Facilities that meet the definition in 42 CFR 443.50(a)(1) must file a CMS-2540 report with the Division annually. The State operated Nursing Facility must report the final disposition made by the Medicare intermediary.

(2) General Cost Reporting Requirements

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.
(b) Documentation of Reported Costs. Providers must maintain accurate, detailed and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the Provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the Provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly-aided residents whether or not they are Related Parties.
(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.
(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions that the Provider identifies as related to the care of Massachusetts publicly-aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

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(e) Other Cost Reporting Requirements.

1. Administrative Costs. The following expenses must be reported as administrative:

a. All compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the Nursing Facility;

b. Expenses related to tasks performed by persons at a management level above that of an on-site Provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a Nursing Facility as well as legal, accounting, financial and managerial services or advice including computer services and payroll processing; and

c. Expenses related to policy-making, planning and decision-making activities necessary for the general and long-term management of the affairs of a Nursing Facility, including but not limited to the following: the financial management of the Provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies and the planning of the expansion and financing of the Provider.

d. providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries or other compensation.

e. Providers may allocate administrative costs among two or more accounts. The Provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.

4. Fixed Costs.

a. Additions. If the square footage of the Building is enlarged, Providers must report all additions and renovations as Building Additions.

b. Allocation. Providers must allocate all fixed costs, except Equipment, on the basis of square footage. A Provider may elect to specifically identify Equipment related to the Nursing Facility. The Provider must document each piece of Equipment in the fixed asset ledger. If a Provider elects not to identify Equipment, it must allocate Equipment on the basis of square footage.

c. Replacement of Beds. If a Provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to Publicly-Aided Residents and may not identify associated expenses as related to the care of Massachusetts publicly-aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all Cost Reports unless they have removed such costs and accumulated depreciation from the Provider's books and records. Providers must attach a schedule of the cost of the retired Equipment, accumulated depreciation, and the accounting entries on the books and records of the Provider to the Cost Report when Equipment is retired.

e. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as Improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-Publicly-Aided Residents are billed. Providers must identify such expense as non-related to Medicaid patient care.
6. Mortgage Acquisition Costs. Providers must classify Mortgage Acquisition Costs as Other Assets. Providers may not add Mortgage Acquisition Costs to fixed asset accounts.
7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.
8. Related Parties. Providers must disclose salary expense paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Provider purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services.

(f) Special Cost Reporting Requirements.

1. Facilities in which other programs are operated. If a Provider operates an adult day health program, an assisted living program, or provides outpatient services, the Provider may not identify expenses of such programs as related to the care of Massachusetts publicly-aided Residents.

a. If the Provider converts a portion of the Provider to another program, the Provider must identify the existing Equipment no longer used in Nursing Provider operations and remove such Equipment from the Nursing Provider records.
b. The Provider must identify the total square footage of the existing Building, the square footage associated with the program, and the Equipment associated with the program.
c. The Provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The Provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-Based Nursing Facilities. A Hospital-Based Nursing Provider must file Cost Reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report. The Provider must:

a. identify the existing Building and Improvement costs associated with the Nursing Provider. The Provider must allocate such costs on a square footage basis.
b. report major moveable Equipment and fixed Equipment in a manner consistent with the Hospital Cost Report. In addition, the Provider must classify fixed Equipment as either Building Improvements or Equipment in accordance with the definitions contained in 114.2 CMR 6.02. The Provider may elect to report major moveable and fixed Equipment by one of two methods:

1. A Provider may elect to specifically identify the major moveable and fixed Equipment directly related to the care of Publicly-Aided Residents in the Nursing Provider. The Provider must maintain complete documentation in a fixed asset ledger, that clearly identifies each piece of Equipment and its cost, date of purchase, and accumulated depreciation. The Provider must submit this documentation to the Division with its first Notification of Change in Beds.
2. If the Provider elects not to identify specifically each item of major moveable and fixed Equipment , the Division will allocate fixed Equipment on a square footage basis.

c. The Provider must report additional capital expenditures directly related to the establishment of the Nursing Provider within the hospital as Additions. The

Division will allocate capital expenditures that relate to the total plant on a square footage basis.

d. The Provider must use direct costing whenever possible to obtain operating expenses associated with the Nursing Provider. The Provider must allocate all costs shared by the hospital and the Nursing Provider using the statistics specified in the Hospital Cost Report instructions. The Provider must disclose all analysis, allocations and statistics used in preparing the Nursing Provider Cost Report.

(3) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria:

(a) The cost must be ordinary, necessary and directly related to the care of Publicly-Aided Residents;

(b) The cost must adhere to the Prudent Buyer Concept;

(c) Payments to related parties. Expenses otherwise allowable shall not be included for purposes of determining rates under 114.2 CMR 6.00 where such expenses are paid to a Related Party unless the Provider identifies any such Related party and expenses attributable to it in the Reports submitted under 114.2 CMR 6.00 and demonstrates that such expenses do not exceed the lower of the cost to the Related Party or the price of comparable services, facilities or supplies that could be purchased elsewhere. The Division may request either the Provider or the Related Party, or both, to submit information, books and records relating to such expenses for the purpose of determining their allowability.

(d) Employee Benefits. Only the provider's contribution of Generally Available Employee Benefits shall be deemed an allowable cost. Providers may vary Generally Available Employee Benefits by groups of employees at the option of the employer. To qualify as a Generally Available Employee Benefit, the Provider must establish and maintain evidence of its nondiscriminatory nature. Generally Available Employee Benefits shall include but are not limited to group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. Bonuses related to profit, private occupancy, or directly or indirectly to rates of reimbursement shall not be included for calculation of prospective rates. Benefits which are related to salaries shall be limited to allowable salaries. Benefits, including pensions, related to non-administrative and non-nursing personnel will be part of the other operating cost center. Benefits that are related to the Director of Nurses, including pensions and education, shall be part of the Nursing Cost Center. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken, provided that these benefits are both stated in the written policy and are the actual practice of the Provider and that such benefits are guaranteed to the employee even upon death or termination of employment. Such expenses may be recorded and claimed for reimbursement purposes only as of the date that a legal liability has been established.

(e) The cost must be for goods or services actually provided in the nursing facility;

(f) The cost must be reasonable; and

(g) The cost must actually be paid by the Provider. Costs not considered related to the care of Massachusetts publicly-aided Residents include, but are not limited to: costs discharged in bankruptcy; costs forgiven; costs converted to a promissory note; and accruals of self-insured costs based on actuarial estimates;

(h) A Provider must report the following costs as non-allowable costs:

1. Bad debts, refunds, charity and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;

2 Federal and state income taxes, except the non-income related portion of the Massachusetts Corporate Excise Tax;

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3. Expenses not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;
4. Compensation and fringe benefits of residents on a Provider's payroll;
5. Penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;
6. Any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;
7. Expenses for Purchased Service Nursing services purchased from temporary nursing agencies not registered with the Department under regulation 105 CMR 157.000 or paid for at rates greater than the rates established by the Division pursuant to 114.3 CMR 45.00;
8. Any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the facility;
9. All legal expenses, including those accounting expenses and filing fees associated with any appeal process;
10. Prescribed legend drugs for individual patients;
11. Recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including but not limited to, rental of quarters to employees and others, income from meals sold to persons other than residents, telephone income, vending machine income and medical records income. Vending machine income shall be recovered against Other Operating Costs. Other recoverable income shall be recovered against an account in the appropriate cost group category, such as Administrative and General Costs, Other Operating Costs, Nursing Costs, and Capital Costs. The cost associated with laundry income which is generated from special services rendered to private patients shall be identified and eliminated from claims for reimbursement. Special services are those services not rendered to all patients (e.g., dry cleaning, etc.). In the event that the cost of special services cannot be determined, laundry income shall be recovered against laundry expense.
12. Costs of ancillary services required by a purchasing agency to be billed on a direct basis, such as prescribed drugs and direct therapy costs;
13. Accrued expenses which remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, shall not be included in the prospective rates. When the Division receives satisfactory evidence of payment, the Division may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates.

(4) Filing Deadlines.

(a) General. Except as provided below, Providers must file required Cost Reports for the calendar year by 5:00 P.M. of April 1 of the following calendar year. If April 1 falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

1. Hospital-Based Nursing Facilities. Hospital-Based Nursing Facilities must file Cost Reports no later than 90 days after the close of the hospital's fiscal year.
2. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, s. 72N, the Provider must file Cost Reports for the current reporting period or portion thereof, within 60 of the receiver's appointment.

(b) Extension of Filing Date. The Division may grant a request for an extension of the filing due date for a maximum of 30 calendar days. In order to receive an extension, the Provider must:

1. submit the request itself, and not by agent or other representative;
2. demonstrate exceptional circumstances that prevent the Provider from meeting the deadline; and
3. file the request with the Health Data Policy Group at the Division of Health Care Finance and Policy no later than 30 calendar days before the due date.

(c) Administrative Bulletin. The Division may modify the Filing Deadlines by issuing an administrative bulletin 30 days prior to any proposed change.

(5) Incomplete Submissions. If the Cost Reports are incomplete, the Division will notify the Provider in writing within 120 days of receipt. The Division will specify the additional information that the Provider must submit to complete the Cost Reports. The Provider must file the required information within 25 days of the date of notification or by April 1 of the year the Cost Reports are filed, whichever is later. If the Division fails to notify the Provider within the 120-day period, the Cost Reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Audits. The Division and the MassHealth Agency may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the Provider and any Related Party as requested during a Desk or Field Audit even if the Division has accepted the Provider's Cost Reports.

(7) Penalties. If a Provider does not file the required Cost Reports by the due date, the Division may reduce the Provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of non-compliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late and so on. The rate will be restored effective on the date the Cost Report is filed.

6.09 Special Provisions

(1) Rate Filings. The Division will file certified rates of payment for Nursing Facilities with the Secretary of the Commonwealth.

(2) 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 the Division files the rate with the State Secretary. The Division may amend a rate or request additional information from the Provider even if the Provider has filed a pending appeal.

(3) Administrative Bulletins. The Division may issue administrative bulletins to clarify provisions of 114.2 CMR 6.00 or to specify data collection requirements. Such bulletins shall be deemed to be incorporated in the provisions of 114.2 CMR 6.00. The Division will file the bulletins with the State Secretary, distribute copies to Providers, and make the bulletins accessible to the public at the Division's offices during regular business hours.

(4) Severability. The provisions of 114.2 CMR 6.00 are severable. If any provision of 114.2 CMR 6.00 or the application of any provision of 114.2 CMR 6.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 114.2 CMR 6.00 or the application of any other provision.

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