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State/Territory Name: MA

State Plan Amendment (SPA): 22-0038

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 17, 2023

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

RE: State Plan Amendment (SPA) TN 22-0038

Dear Secretary Sudders:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 22-0038. Effective October 1, 2022, this amendment makes comprehensive updates for rate year (RY) 2023 reimbursement methods and standards for nursing facilities.

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 Part 447. This letter is to inform you that Massachusetts 22-0038 is approved effective October 1, 2022. The CMS-179 and approved plan pages are enclosed.

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

Sincerely,

Rory Howe
Director

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22 — 0038

2. STATE: MA

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR Part 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 23 $ 138,990,000
b. FFY 24 $ 126,640,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D(4) pp. 1 - 28

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D(4) pp.1-28

9. SUBJECT OF AMENDMENT
An amendment regarding methods of payment for nursing facilities

10. GOVERNOR'S REVIEW *(Check One)*
- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☑ OTHER, AS SPECIFIED:
  Not required under 42 CFR 430.12(b)(2)(i)

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Marylou Sudders

13. TITLE
Secretary

14. DATE SUBMITTED
12/30/2022

15. RETURN TO
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
One Ashburton Place, Room 1109
Boston, MA 02108

FOR CMS USE ONLY

16. DATE RECEIVED
December 30, 2022

17. DATE APPROVED
March 17, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

Instructions on Back

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

I. General Description of Payment Methodology

A. Overview. Nursing facility payments for services provided to MassHealth members are governed by the Executive Office of Health and Human Services (EOHHS) regulation, 101 CMR 206.00: Standard Payments to Nursing Facilities as of October 1, 2022. This attachment describes the methods and standards used to establish payment rates for nursing facilities effective October 1, 2022.

B. Chief Components. The payment method describes standard payments for nursing facility services. Standard payments are derived from reported median base-year costs for Nursing and Operating Costs as well as a capital payment component. Nursing and Operating Standard Payment rates were calculated using Calendar Year (CY) 2019 costs. The allowable basis for capital was updated using CY 2019 data.

II. Cost Reporting Requirements and Cost Finding

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

1. For each cost reporting year, the Cost Report must contain detailed cost information based on generally accepted accounting principles and the accrual method of accounting that meets the requirements of 101 CMR 206.08 as of October 1, 2022.

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

3. A facility that closes prior to November 30 is not required to submit a cost report for the following calendar year.

4. There are special cost reporting requirements outlined in 101 CMR 206.08(1)(f) and 101 CMR 206.08(2)(g) as of October 1, 2022 for hospital-based nursing facilities, state-operated nursing facilities, and facilities that operate other programs such as Adult Day Health, Assisted Living or Outpatient Services.

5. A facility may be subject to penalties in accordance with 101 CMR 206.08(7) as of October 1, 2021 if a facility does not file the required cost reports by the due date.

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

1. the cost is ordinary, necessary, and directly related to the care of publicly aided patients;
2. the cost is for goods or services actually provided in the nursing facility;

3. the cost must be reasonable; and
4. the provider must actually pay the cost.

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

A provider may not report any of the costs that are listed in 101 CMR 206.08(3)(h) as of October 1, 2022 as related to MassHealth patient care.

III. Methods and Standards Used to Determine Payment Rates

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

B. Nursing Cost Component.

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

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 – 30	$17.70
JK	30.1 – 110	$47.10
LM	110.1 – 170	$84.42
NP	170.1 – 225	$118.00
RS	225.1 – 270	$143.05
T	270.1 & above	$168.40

2. The base year used to develop the Nursing Standard Payments is 2019. Nursing costs reported in CY 2019 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, 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 2019 median nursing costs times the CY 2019 industry median management minutes for each of six payment groups listed in 101 CMR 206.04(1) as of October 1, 2022. The base year amounts for each group are increased by a cost adjustment factor of 15.59%. This cost adjustment factor is based on Massachusetts-specific consumer price index (CPI) forecasts as well as national and regional indices supplied by Global Insight, Inc.

C. Operating Cost Component.

1. The Operating Cost component of the prospective per diem payment rates for nursing facilities, is $117.38.
2. The base year used to develop the Operating Standard Payments is CY2019. The following operating costs reported in CY 2019 are included in the calculation: variable, and administrative and general costs. The Operating Standard Payment is set equal to the CY2019 industry median of these cost amounts, except for administrative and general costs, which are set at the 85th percentile of the 2018 statewide administrative and general costs before being combined with other cost components. The base year Operating Standard Payment amount is then increased by a cost adjustment factor of 15.59%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by Global Insight, Inc.

D. Capital Cost Component.

1. The Capital Cost component of the prospective per diem payment rates for nursing facilities comprises the Capital Cost Standard Payments (per diems). The base year for the Capital Cost Standard Payments is 2019. The capital payments are increased from the base year by a cost adjustment factor of 1.05%. Effective October 1, 2022, individual nursing facilities will receive capital payments calculated as follows, with exceptions as described in III.D.2 through III.D.5:

    a. Calculate the sum of a facility's allowable capital expenses during the base year, including the allowable portion of depreciation expense, long-term interest, real estate taxes, personal property taxes on nursing facility equipment, the non-income portion of the Massachusetts corporate excise tax, building insurance, and other allowable capital expenses claimed in the facility's cost reports, less any recoverable fixed cost income. Apply a cost adjustment factor of 1.05% to this sum.
    b. Multiply the number of beds in the facility by the number of days in the rate year and then multiply the product by the greater of 90% or the actual utilization rate in the base year.
    c. The provider's capital payment is calculated by dividing the product calculated in III.D.1.a. by the product calculated in III.D.1.b. and is subject to the limitations described in III.D.4.

2. Nursing Facility Capital Payment Adjustments. Effective October 1, 2022, nursing facilities will receive capital payment adjustments equal to the capital payment adjustments in effect September 30, 2022, which were calculated as follows:
    i. If a nursing facility capital payment as calculated in III.D.1 is less than 90% of the facility's capital payment that it received as of September 30, 2021, the facility will receive the capital payment listed in III.D.1., plus an upward adjustment equal to the difference between the capital payment as calculated in III.D.1. and 90% of the capital payment the facility received as of September 30, 2021, subject to the limitations described in III.D.4.

ii. If a nursing facility capital payment as calculated in III.D.1. is greater than 130% of the facility's capital payment that it received as of September 30, 2021, the facility will receive the capital payment calculated in III.D.1., less a downward adjustment equal to the difference between the capital payment as calculated in III.D.1. and 130% of the capital rate that the facility received as of September 30, 2021.

3. Revised Capital Payment.
   i. Eligibility Requirements. A nursing facility will be eligible for a revised capital payment if:
      1. The facility has expended at least 50% of the maximum capital expenditure for an approved determination of need, or in the instance of a second request, at least 25% additional from the previous approved request, and in the instance of a third request only upon completion of the project, and the facility has submitted a notification request for a revised capital payment to EOHHS between November 1, 2009, and November 1, 2019; or
      2. The facility expends at least 50% of the maximum capital expenditure for an approved determination of need, or in the instance of a second request, at least 25% additional from the previous approved request, and in the instance of a third request only upon completion of the project, and the facility submits a notification request for a revised capital payment to EOHHS, provided that prior to September 30, 2023, the facility provided documentation to EOHHS of at least one of the criteria:
         a. Department of Public Health plan review approval pursuant to an approved determination of need dated prior to January 1, 2020;
         b. Detailed architectural or engineering plans developed in response to an approved determination of need and submitted to the Department of Public of Health prior to January 1, 2020;
         c. Evidence of funding received, or a firm commitment to fund, from an outside lender dated prior to January 1, 2020, in an amount equal to or in excess of 50% of the maximum capital expenditure as specified in an approved determination of need;
         d. Evidence of applications made on or before January 1, 2020, to local government agencies for planning, zoning or building permits or other regulatory approvals required in connection with the implementation of an approved determination of need;
         e. Evidence of the acquisition of land required on or before January 1, 2020, for development of the project authorized by an approved determination of need;
         f. An application for a determination of need submitted to the Department of Public Health prior to January 1, 2020, and detailed architectural or engineering plans, dated prior to January 1, 2020, for the capital project contemplated in the facility's determination of need application; or
      3. The facility submitted detailed architectural or engineering plans for, or

evidence of, applications made to local government agencies for planning, zoning, or building permits or other regulatory approvals, including approvals required by Department of Public Health, required in connection with conversion of rooms with three or more residents to one- and two-bedded rooms, or conversion of rooms with two residents to one-bedded rooms, prior to September 30, 2023.

ii. Required Documentation. Providers meeting the criteria in III.D.3.i. must submit the following to the Center with its request for a revised capital payment, as well as any additional information that EOHHS determines necessary to calculate a revised capital payment:
   1. a copy of the approved determination of need and any approved amendments, or, in the case of capital projects that do not require a determination of need, a detailed description of the project,
   2. a copy of the construction contract,
   3. a listing of construction costs,
   4. copies of invoices and cancelled checks for construction costs,
   5. a copy of the Department of Public Health's licensure notification associated with the increase or decrease in licensed beds,
   6. a copy of the mortgage or financing obtained, and
   7. a copy of the calculation of the requested increase, in a format specified by EOHHS.
   8. A listing of any assets such as land, building, improvements, or equipment that are either destroyed or no longer used for patient care.

iii. Revised Capital Payment. Nursing facilities that meet the criteria listed in III.D.3.i and that have submitted all required documentation under III.D.3.ii. will be eligible for a revised capital payment in place of the capital rates calculated under III.D.1., subject to the limitations of III.D.4., as follows:
   1. Adding the following costs:
      a. the allowed capital expenses associated with a project described in III.D.3.i., subject to the divisor described in III.D.1.b. adjusted for any increase or decrease in licensed beds; and
      b. the lesser of the following costs, subject to the divisor described in III.D.1.b. adjusted for any increase or decrease in licensed beds,
         i. III.D.1., or
         ii. The sum of the amount calculated in III.D.1. and the amount calculated in III.D.2.
   2. The revised capital payment shall be the total calculated in III.D.3.iii.1., and shall be the new capital rate, in place of the rate calculated under III.D.1. or III.D.2., effective on the later of the date the facility submits their request for the revised capital payment, including all required documentation, or the effective date of the change in licensed beds.

4. Maximum Capital Payment. Capital payments shall not exceed $37.60.

5. New or Relocated Nursing Facilities. A nursing facility that becomes operational on or after November 1, 2019, an existing nursing facility that replaces its current building on

or after November 1, 2019, or an existing nursing facility that fully relocates to a newly constructed location on or after November 1, 2019, will be eligible for a capital payment in the amount of $37.60. Such facility will not be eligible for additional capital payments as listed under III.D.1 or for an adjustment to its capital payment as described in III.D.2

6. Licensed Bed Changes. A nursing facility will not receive an adjustment to its capital payment rate solely because of an increase or decrease in its number of licensed beds, except as described in III.D.3.i.3.

7. Rate Adjustments. EOHHS may adjust any capital payment upon EOHHS's determination that there was a material error in the calculation of the payment or in the facility's documentation of its capital costs

IV. Special Conditions

A. Innovative and Special Programs. The MassHealth program may contract for special and/or innovative programs to meet special needs of certain patients, which are not ordinarily met by existing services in nursing facilities or which can only be met by existing services in nursing facilities at substantially higher cost. Currently, these programs include programs for patients with traumatic brain injury, mental illness and medical illness (MIMI's), developmental disability, technologic dependency, as well as programs for nursing facilities that have a substantial concentration of patients of the highest acuity level (i.e., Management Minute Category T), nursing facilities that have a substantial concentration of patients with multiple sclerosis or multiple sclerosis and amyotrophic lateral sclerosis, nursing facilities that have a substantial concentration of deaf patients, and nursing facilities with substantially higher costs due to island location.

B. Rate for Innovative and Special Programs. A provider who seeks to participate in an innovative and special program must contract with the MassHealth program to provide special care and services to distinct categories of patients designated by the MassHealth program. This is usually done through a Request for Responses by the MassHealth program for special or innovative programs to address special needs of certain patients that are not ordinarily met by existing services in nursing facilities. Payment under the innovative and special programs may be calculated based on the added reasonable and necessary costs and expenses that must be incurred (as determined by the MassHealth program) by a provider in connection with that program. The provider must verify that such items or services are furnished because of the special needs of the patients treated as contemplated in the contract with the MassHealth Program, and that such items or services are reasonable and appropriate in the efficient delivery of necessary health care. The rate for an innovative and special program may be established as an add-on to a rate established by EOHHS under 101 CMR 206.00 as of October 1, 2022 or as a stand-alone rate established by contract under M.G.L. c. 118E, s.12 that is not subject to the provisions of 101 CMR 206.00 as of October 1, 2022. In either instance, the rate must be consistent with the payment methodology established herein for long-term care facilities. In the event that the special program is located within a

special unit, the remaining costs of the unit are to be integrated into the cost report for the entire facility.

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

1. at least ninety percent (90%) of its residents must have Management Minute ("MM") scores that fall in either MM category 9 or 10 and at least seventy-five percent (75%) of its residents must have MM scores that fall in MM category 10;
2. or (ii) the facility must be a former acute hospital that has undergone conversion to a nursing facility under the auspices of the Massachusetts Acute Hospital Conversion Board;
3. the mean MM score for all residents of the facility in MM category 10 must be at least fifteen percent (15%) higher than the minimum score needed to qualify for MM category 10; and
4. the facility must be a geriatric nursing facility.

D. Pediatric Nursing Facilities.

1. EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and operating costs, excluding administration and general costs, from the facility's 2019 Cost Report. EOHHS will include an administration and general payment based on the 85th percentile of the 2019 statewide administrative and general costs. EOHHS will apply an appropriate cost adjustment factor to nursing, operating, and administration and general costs.
2. The nursing and operating components of the rate is increased by a cost adjustment factor of 15.59%. This cost adjustment factor is based on Massachusetts-specific CPI forecasts as well as national and regional indices supplied by Global Insight, Inc.
3. Effective October 1, 2022, facilities licensed to provide pediatric nursing facility services will receive the rates which are the greater of: (a) the rates calculated as described IV.D.1 and IV.D.2; or (b) the Nursing Standard and Operating Cost Standard rates calculated as described in III.B. and III.C.

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

F. Receivership under M.G.L. c.111, s.72N *et seq.* In accordance with 101 CMR 206.06(9) as of October 1, 2022, provider rates of a nursing facility in receivership may be adjusted by EOHHS to reflect the reasonable and necessary costs associated with the court-approved

closure of the facility.

G. Review and Approval of Rates and Rate Methodology by the MassHealth Program. Pursuant to M.G.L c 118E, s.13, the MassHealth program shall review and approve or disapprove any change in rates or in rate methodology proposed by EOHHS. The MassHealth program shall review such proposed rate changes for consistency with federal and state policy and budget requirements prior to certification of such rates by EOHHS.

The MassHealth program shall, whenever it disapproves a rate increase, submit the reasons for disapproval to EOHHS together with such recommendations for changes. Such disapproval and recommendations for changes, if any, are submitted to EOHHS after the MassHealth program is notified that EOHHS intends to propose a rate increase for any class of provider under Title XIX but in no event later than the date of the public hearing held by EOHHS regarding such rate change; provided that no rates shall take effect without the approval of the MassHealth program. EOHHS and the MassHealth program shall provide documentation on the reasons for increases in any class of approved rates that exceed the medical component of the CPI to the Massachusetts House and Senate Committees on Ways and Means.

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

I. Appeals. A provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 101 CMR 206.00 as of October 1, 2022 within 30 calendar days after EOHHS files the rate with the Secretary of the Commonwealth. EOHHS may amend a rate or request additional information from the provider even if the provider has filed a pending appeal.

J. Low Occupancy Adjustment.

1. Effective October 1, 2022, a nursing facility will be subject to a Low Occupancy Adjustment to its payment rate, according to the following methodology:
    a. Each facility's occupancy is calculated as follows:
        i. Determine the facility's total resident days as reported on User Fee Reports covering the period from July 1, 2021 through June 30, 2022 ;
        ii. Determine the facility's total number of licensed beds as of the last day of the same period, June 30, 2022, minus licensed Level IV beds. Multiply the result by the number of days in the year.
        iii. Calculate the facility's occupancy by dividing the result of IV.J.1.a.i. by the result of IV.J.1.a.ii.

b. Based on the occupancy calculated in IV.J.1.a.iii., a facility may face a reduction to its nursing standard rate and operating rate, applied at each management minute category, except as described in IV.J.1.b.i. Reductions are applied as follows: a facility with an occupancy rate below 80% will face a reduction of -3%; a facility with an occupancy rate of at least 80% but below 84% will face a reduction of -2%; and a facility with an occupancy of at least 84% but below 88% will face a reduction of -1%.
    i. Notwithstanding the foregoing, for the rate year running from October 1, 2022, through September 30, 2023, the downward adjustment for nursing facilities with occupancy rates at 80% or higher shall be waived and the downward adjustment for nursing facilities with occupancy rates below 80% shall be -2%.

c. A nursing facility will be eligible for a one-time reconsideration of its Low Occupancy Adjustment as determined in IV.J.1.b. to be applied beginning February 1, 2023, if the nursing facility:
    i. Reduces by any amount its number of licensed beds from the number of licensed beds in the facility as of June 30, 2022, by January 1, 2023; and
    ii. Submits a completed Low Occupancy Adjustment Request form, along with supporting documentation indicated on the form to EOHHS by January 1, 2023.

d. Upon receiving a Low Occupancy Adjustment Request form and supporting documentation from a nursing facility as described in IV.J.1.c.ii., EOHHS will recalculate the facility's occupancy, as follows:
    i. Determine the facility's total resident days as reported on User Fee Reports covering the period July 1, 2021, through June 30, 2022;
    ii. Determine the facility's total number of licensed beds as of January 1, 2023, minus licensed Level IV beds. Multiply the result by number of days in the year.
    iii. Calculate the facility's occupancy by dividing the result of IV.J.1.d.i. by the result of IV.J.1.d.ii.

e. The facility's new occupancy rate, as calculated in IV.J.1.d.iii, will be used to redetermine the amount or applicability of the Low Occupancy Adjustment, as described IV.J.1.b. Any changes to a facility's Low Occupancy Adjustment as a result of a new occupancy rate will apply solely prospectively, beginning February 1, 2023.

K. Kosher Kitchens. Nursing facilities with kosher kitchen and food service operations shall receive an add-on of up to $5.00 per day to reflect any additional cost of these operations. Eligibility requirements and determination of payment amounts are described in 101 CMR 206.06(3) as of October 1, 2022.

L. Quality Achievement and Improvement Adjustments.

1. Effective October 1, 2022, a nursing facility may be eligible for a quality adjustment in the form of an increase or decrease applied to the facility's nursing standard rate

and operating standard rate at each acuity level. The quality adjustment will be equal to the sum of the percent increase or decrease assessed for performance on each of the following four quality measures: Quality Achievement Based on CMS Score, Quality Improvement Based on CMS Score, Quality Achievement Based on MassHealth Department of Public Health (DPH) Score, and Quality Improvement based on DPH Score.

a. Quality Achievement Based on CMS Score. The quality adjustment a nursing facility will incur under the measure "Quality Achievement Based on CMS Score" will be based on the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of June 2022, as follows:

CMS Overall Score as of June 2022	Adjustment Percentage
1	-1.00%
2	-0.75%
3	0.00%
4	0.75%
5	1.00%

Facilities that CMS has designated as not rated due to a history of serious quality issues (i.e., Special Focus Facilities) will be considered to have a score of 1 for the purposes of this quality adjustment.

b. Quality Improvement Based on CMS Score. The quality adjustment a nursing facility will incur under the measure "Quality Improvement Based on CMS Score" will be based on the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool, as follows. If a facility has a score of 5 Stars as of June 2022, its adjustment for this measure will be 2.0%, regardless of whether it meets any other criteria in the following table. If a facility meets the criteria for "CMS Chronic Low Quality", its adjustment for this measure will be -3.0%, regardless of whether it meets any other criteria in the following table.

Criteria based on CMS Rating	Adjustment Percentage
Facility has a score of 5 Stars as of June 2022	2%
Facility experienced an increase of 2 or more Stars from June 2021 to June 2022	1.5%
Facility experienced an increase of 1 Star from June 2021 to June 2022	1%
Facility experienced no change to its Star rating from June 2021 to June 2022	0%
Facility experienced a decrease of 1 Star from June 2021 to June 2022, and had a score of 5 Stars as of June 2021	0%
Facility experienced a decrease of 1 Star from June 2021 to June 2022, and did not have a score of 5 Stars as of June 2021	-2%
Facility experienced a decrease of 2 or more Stars from June 2021 to June 2022	-2.5%
CMS Chronic Low Quality: The average of a facility's scores as of June 2019, June 2020, June 2021, and June 2022 is less than or equal to 1.5 Stars	-3%

Facilities that CMS has designated as not rated due to a history of serious quality issues (i.e., Special Focus Facilities) will be considered to meet the criteria for "CMS Chronic Low Quality" for the purposes of this quality adjustment.

Quality Achievement Based on DPH Score. The quality adjustment a nursing facility will incur under the measure "Quality Achievement Based on DPH Score" will be based on the facility's performance on the Department of Public Health's Nursing Facility Survey Performance Tool (DPH NFSPT) as of July 1, 2022, as follows:

DPH NFSPT Score as of July 1, 2022	Adjustment Percentage
110 or less	-1.00%
111 – 115	-0.75%
116 – 119	0.00%
120 – 123	0.75%
124+	1.00%

c. Quality Improvement Based on DPH Score. The quality adjustment a nursing facility will incur under the measure "Quality Improvement Based on DPH Score" will be based on the facility's performance on the DPH NFSPT, as

follows. If a facility has a DPH NFSPT score of 124 or higher as of July 1, 2022, its adjustment for this measure will be 2.0%, regardless of whether it meets any other criteria in the following table. If a facility meets the criteria for "DPH Chronic Low Quality", its adjustment for this measure will be -3.0%, regardless of whether it meets any other criteria in the following table.

Criteria based on DPH FSPT Score	Adjustment Percentage
Facility has a score of 124 or higher as of July 1, 2022	2.0%
Facility experienced an increase of 4 or more points from July 1, 2021 to July 1, 2022	1.5%
Facility experienced an increase of 1, 2, or 3 points from July 1, 2021 to July 1, 2022	1.0%
Facility experienced no change to its score from July 1, 2021 to July 1, 2022	0.0%
Facility experienced a decrease of 1, 2, or 3 points from July 1, 2021 to July 1, 2022, and had a score of 124 or higher as of July 1, 2021	0.0%
Facility experienced a decrease of 1, 2, or 3 points from July 1, 2021 to July 1, 2022, and did not have a score of 124 or higher as of July 1, 2021	-2.0%
Facility experienced a decrease of 4 or more points from July 1, 2021 to July 1, 2022	-2.5%
PH Chronic Low Quality: Facility had a score of less than 100 as of each of the following dates: July 1, 2020; July 1, 2021; and July 1, 2022	-3%

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

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

2. EOHHS will 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. EOHHS will use the Massachusetts CPI as proxy for wages and salaries.

3. EOHHS will retroactively adjust the final settled amount when the Medicare CMS- 2540 cost report is re-opened or for audit adjustments.

N. Behavioral Indicator Add-on.

1. Effective October 1, 2022, an eligible nursing facility be eligible for a member-specific behavioral indicator add-on of $50 per member per day for each member residing in the facility for whom MassHealth is the primary payer and who was coded as 2 or 3 on one or more of the following Minimum Data Set 3.0 (MDS 3.0) indicators: Behavioral Health (E0200A, E0200B, or E0200C), Rejection of Care (E0800), or Wandering (E0900).

O. High Medicaid Adjustment.

1. Effective October 1, 2022, an eligible nursing facility will receive a High Medicaid Adjustment to its payment rate. Eligibility and the magnitude of the adjustment are based on the proportion of the facility's total resident days which are MassHealth resident days, as reported on the facility's quarterly User Fee Assessment Forms covering the period July 1, 2021, through June 30, 2022.
    1. A facility for which MassHealth resident days are at least 75% and less than 90% of its total resident days will receive a 7% upward adjustment applied to its nursing standard rate and operating standard rate at each acuity level.
    2. A facility for which MassHealth resident days are at least 90% of its total resident days will receive a 9% upward adjustment applied to its nursing standard rate and operating standard rate at each acuity level.

P. Direct Care Cost Quotient Adjustment

Beginning October 1, 2020, Massachusetts nursing facilities must have a direct care cost quotient of at least 75%. The direct care cost quotient (DCC-Q) is calculated by dividing eligible direct care workforce expenses by the facility's total revenue, excluding non-nursing facility lines of business revenue, and minus certain Medicare resident expenses and the User Fee assessment. For the rate year beginning October 1, 2022, a nursing facility rate will be subject to a downward adjustment if the facility failed to be at or above the 75% DCC-Q threshold for the period of July 1, 2021, through June 30, 2022. For rate years beginning on or after October 1, 2023, a nursing facility will be subject to a downward adjustment if the facility fails to meet the 75% threshold in the previous full fiscal year. Downward adjustments to facilities' rates will be applied as follows:

1. For every 1% below the 75% threshold, a 0.5% downward adjustment will be applied to the facility's nursing and operating standard payments.
2. The maximum downward adjustment is not more than 5% of the facility's nursing and operating standard payments.
3. EOHHS will apply the maximum downward adjustment to facilities that fail to submit required reports on their direct care cost quotient compliance.
4. Nursing facilities that report less than 5,000 Massachusetts Medicaid Days in state fiscal year 2022 will be exempt from the downward adjustment.

Q. Average Staffing Hours Incentive

Beginning October 5, 2020, EOHHS requires each nursing facility to report its direct care staffing hours per patient day. Facilities that fail to meet an average of 3.58 direct care hours per patient day in any calendar quarter beginning on or after January 1, 2021 will receive a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter.

R. Certification of Public Expenditures of a Nursing Facility Owned and Operated by a Municipality.

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

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

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

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

I. Skilled Nursing Facility Inpatient Routine Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *30*, Column 18
(B) Total Days - Worksheet *S*-3, Line 1, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line 1, Column 5
(E) Medicaid Allowable *Skilled Nursing Facility* Costs - (C) X (D)

II. Nursing Facility Inpatient Service Costs

(A) Total Allowable Costs - Worksheet B, Part I, Line *31*, Column 18
(B) Total Days - Worksheet *S*-3, Line *3*, Column 7
(C) Per Diem Rate - (A)/(B)
(D) Medicaid Days - Worksheet S-3, Line *3*, Column 5
(E) Medicaid Allowable *Nursing Facility* Costs - (C) X (D)

III. Total Allowable Medicaid Costs

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

5. EOHHS will calculate an interim reconciliation based on the difference between the interim payments and total allowable Medicaid costs from the as filed CMS - 2540 Cost Report. When the CMS-2540 is reopened, or an audit is completed, the facility must immediately notify EOHHS. Within 60 days after receiving notification of the final Medicare settlement EOHHS will retroactively adjust the final settlement amount.

S. Leaves of Absence.

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

T. Maximum Increase Adjustment.

Effective October 1, 2021, a nursing facility will be subject to an adjustment to its total standard nursing facility per diem rate if such rate is greater than 119% or less than 95% of the facility's total standard nursing facility rate that was in effect as of September 30, 2022. The adjustment will be calculated as follows:

a) Determine the facility's standard nursing facility rate in effect on October 1, 2022, inclusive of nursing, operating and capital rates, and any other adjustments to such standard rate components applicable to the facility, but exclusive of any rate add-ons;
b) Determine 119% of the facility's standard nursing facility rate that was in effect on September 30, 2022;
c) If the rate in IV.T.a. is greater than the rate in IV.T.b., the downward adjustment is equal to the difference between the rate in IV.T.a. and the rate in IV.T.b.
d) Determine 95% of the facility's standard nursing facility rate that was in effect on September 30, 2022;
e) If the rate in IV.T.a. is less than the rate in IV.T.b., the upward adjustment is equal to the difference between the rate in IV.T.a. and the rate in IV.T.b.

U. Temporary Resident Add-on.

1. For dates of service beginning October 1, 2022, a nursing facility will be eligible for a member-specific temporary resident add-on if the resident meets all of the following criteria:
   a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;
   b) The resident is medically eligible for nursing facility services;
   c) The resident was transferred to the nursing facility for temporary residence purposes directly from their home on or after October 1, 2022; and
   d) The resident is discharged from the nursing facility to their home within 30 calendar days of the admission date.
2. For individuals younger than 22 years of age, the add-on is $250 per member per day. For individuals aged 22 years and older, the add-on is $130 per member per day.

V. Medicaid Transitional Add-on.

For dates of service beginning January 15, 2022, a nursing facility will be eligible for a transitional

add-on of $200 per member per day for the first 60 days of the resident's nursing facility stay, not including any leaves of absence, if the resident meets all of the following criteria:

a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;
b) The resident was transferred to the nursing facility directly from an acute or a non-acute inpatient hospital on or after January 15, 2022; and
c) The resident is not returning to the nursing facility from a medical leave of absence.

W. COVID-19 Treatment and Prevention Claims

a) For dates of service beginning January 15, 2023, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for the administration of COVID-19 monoclonal antibody treatments COVID-19 antiviral treatments, and COVID-19 vaccine administration services, provided to eligible MassHealth members in a manner supported by medical evidence or in accordance with the emergency use authorization (EUA) issued by the federal Food and Drug Administration (FDA) or full FDA approval, and in accordance with any guidance issued by DPH, the FDA or CMS with respect to such treatment.
b) The costs of services described in IV.W.a. are not included in the nursing facility's prospective payment system operating or nursing standard per diem payment rates. The costs of providing such services are considered non-allowable costs on nursing facility cost reports.
c) MassHealth payments for separate fee-for-service claims submitted by the nursing facility for COVID-19 monoclonal antibody treatment services antiviral treatment services, or vaccine administration services shall be paid at the same rates established by MassHealth for community health care providers.

X. Add-ons for Severe mental and Neurological Disorder Services.

a) Effective January 15, 2022, qualifying nursing facilities will be able to receive a member-based per diem rate for residents with severe mental or neurological disorders who are receiving specialized rehabilitation services for such disorders. In order to qualify for this member-based per diem rate, a nursing facility must
    i. as of August 1, 2020, operate to provide nursing facility services, including the specialized rehabilitative services described in IV.X.ii., to residents with mental or neurological disorders, including residents with acquired brain injuries;
    ii. demonstrate to the state that the percentage of the facility's annual resident days for residents with mental or neurological disorders, including residents with acquired or traumatic brain injuries, is at least 90% of its total annual resident days;
    iii. provide a suite of specialized rehabilitation services for its residents;
    iv. Maintain a program staff of specially trained professionals, including but not limited to, a neuropsychiatrist, a neuropsychologist, licensed mental health counselors, vocational specialists, life skills counselors, certified brain injury specialists, substance abuse counselors, and therapeutic technicians. All such staff must be trained in behavior modification and de-escalation techniques.

b) Qualifying nursing facilities will receive a flat member-based per diem rate of $461 for members with a mental or neurological disorder that severely affects the member's behavior who are admitted on or after August 1, 2020, provided that the qualifying nursing facility receives approval from MassHealth prior to the member's admission that the member requires specialized rehabilitative services described in IV.X.a. and is therefore eligible for this enhanced rate.

c) Qualifying nursing facilities will receive an additional member-based rate of $150 in addition to the per diem rate set by IV.X.b. for any member approved for admittance to the nursing facility for whom reasonable and allowable direct care costs associated with providing for such member's clinical care needs is more than 100% greater than the facility's average direct care costs per resident, provided that the facility:
   i. certifies that the direct care costs associated with providing services to such member meets the requirements of this section;
   ii. submits a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of this section have been met; and
   iii. receives approval from the MassHealth agency for the additional rate, to be applied prospectively from the date of approval, with respect to such member. The MassHealth agency reserves the right to request additional documentation in support of the expected direct care costs prior to granting approval for this additional rate.

Y. Ventilator Add-on.

For dates of service beginning November 1, 2021, a nursing facility that provides ventilator services to ventilator-dependent MassHealth members will receive a member-specific ventilator add-on of $343 per member per day, provided all of the following criteria are met:

a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;
b) The resident requires ventilator services at least daily;
c) The facility was an approved specialized ventilator service vendor under an EOHHS-issued request for applications for nursing facilities to provide specialized ventilator-dependent services, with an executed special conditions contract for such specialized ventilator-dependent services under such request for applications in effect as of October 1, 2021;
d) The facility maintains a program for specialized ventilator services, in accordance with MassHealth requirements; and
e) The facility is not receiving the communication-limited resident ventilator add-on described in IV.Z.

Z. Communication-limited Resident Ventilator Add-on.

For dates of service beginning November 1, 2021, a nursing facility that provides services to ventilator-dependent MassHealth members will receive a member-specific add-on of $457 per member per day, provided all of the following criteria are met:

a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;
b) The resident requires ventilator services at least daily and is unable to communicate without the assistance of specialized communication technology that relies on eye movements;
c) The facility was an approved specialized ventilator service vendor under an EOHHS-issued request for applications for nursing facilities to provide specialized ventilator-dependent services, with an executed special conditions contract for such specialized ventilator-dependent services under such request for applications in effect as of October 1, 2021;
d) The facility maintains a program for specialized ventilator services, in accordance with MassHealth requirements; and
e) The facility is not receiving the ventilator add-on described in IV.Y. for the resident or the tracheostomy add-on described in IV.BB for the resident.

AA. Add-on for Members with Complicated High-cost Care Needs.

a) Nursing facilities will receive a member-based rate add-on, as calculated according to IV.AA.b. in addition to the facility's standard per diem rate for any member for whom reasonable and allowable direct care costs associated with providing for such member's clinical care needs are significantly greater than the standard nursing facility rate, provided that all of the following conditions are met:
    i. The member was referred to the facility by MassHealth;
    ii. The facility certified that the direct care costs associated or, if prior to admission, expected to be associated with providing services to such member are necessary to provide the services recommended by the member's physician and care team, and documented in the member's care plan;
    iii. The facility submitted a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of this section have been met;
    iv. The facility provides the MassHealth agency with any requested additional or clarifying documentation in support of the actual or expected direct care costs associated with the resident's care needs; and
    v. The facility receives approval from the MassHealth agency for the add-on.

b) The add-on rate shall be a daily rate equal to the total reasonable and allowable costs associated with the high-cost member, as determined by EOHHS, above the standard nursing, capital, and operating costs considered and included in calculating the nursing facility's standard per diem rates, up to a maximum add-on of $600 per day. EOHHS shall have sole discretion over what will be considered a reasonable and allowable cost for the purposes of calculating this add-on. Nursing facilities may not receive this add-on at the same time as the add-ons or payments described in IV. X, IV. V, IV.CC, IV.DD, IV.N, or VIII.

BB. Tracheostomy Add-on.

For dates of service beginning October 1, 2022, a nursing facility that provides tracheostomy services to tracheostomy-dependent MassHealth members will receive a member-specific

tracheostomy add-on of $220 per member per day, provided all of the following criteria are met: (a) MassHealth is the resident's primary payer for nursing facility services at the time of admission; (b) the resident requires tracheostomy services; and (c) the facility is not receiving the ventilator add-on described in 101 CMR 206.10(2) or the communication-limited resident ventilator add-on described in 101 CMR 206.10(3) for the resident.

CC. Homelessness Rate Add-on.

For dates of service beginning January 15, 2022, a nursing facility will be eligible for a member-specific add-on of $200 per member per day for up to the first 180 days of a member's nursing facility stay, not including leaves of absence, if MassHealth is the primary payer for the member, the member is clinically eligible for nursing facility services, and the member meets one or more of the following criteria:

a) The state Medicaid agency has determined that the member had experienced homelessness for at least 6 months directly prior to admission;
b) The member had been homeless directly prior to admission and has a behavioral health condition;
c) The member is at risk of homelessness and has a behavioral health condition;
d) The member experienced a sudden or unexpected loss of primary residency necessitating an emergency nursing facility admission; or
e) The member's living situation directly prior to admission required the involvement of elder protective services.

Nursing facilities may not receive this add-on at the same time as the add-ons or payments described in IV. X, IV.V, IV.AA, IV.DD, IV.N, or VIII for the same member.

DD. Substance Use Disorder Rate Add-on.

a) For dates of service beginning October 1, 2022, an eligible nursing facility will receive a member-specific add-on of $50 per member per day for each member residing in the facility for whom MassHealth is the primary payer and who has a substance use disorder (SUD).
b) For the purposes of this Substance Use Disorder Rate Add-on, an eligible nursing facility is defined as a nursing facility meeting all of the following criteria:
    i. During the period of July 1, 2021, through June 30, 2022, at least 15% of the MassHealth fee-for-service members residing in the facility had a SUD, diagnosed within the previous five years;
    ii. During the period of July 1, 2021, through June 30, 2022, the facility had at least 15 MassHealth fee-for-service members residing in the facility that had a SUD, diagnosed within the previous five years;
    iii. The facility certifies that at least 75% of its direct care staff will complete SUD training offered to nursing facilities by the Massachusetts Department of Public Health no later than December 31, 2022 ; and
    iv. The facility complied with the SUD training requirement in the rate year of October 1, 2021, through September 30, 2022, if it was eligible for the facility-specific SUD rate add-on applicable in that rate year. For the purposes of this

Substance Use Disorder Rate Add-on, SUD includes diagnoses under the ICD-10 diagnosis groups F10 through F16, F19, and T40.

EE. Home Dialysis Rate in a Nursing Facility Setting Rate Add-ons.

a) Nursing facilities with an on-site home dialysis services program, operated in coordination with a licensed dialysis services provider, which has been approved by the Massachusetts Department of Public Health, will receive a member-specific rate add-on of $85 per member residing in the facility and receiving home dialysis services in the facility, for each instance of the home dialysis treatment received in the nursing facility for whom the following conditions are concurrently met:
    i. Medicaid is not the primary payer for the member's home dialysis services received in the nursing facility; and
    ii. Medicaid is the primary payer for the member's nursing facility services at the time of the home dialysis treatment.
b) Nursing facilities with an on-site home dialysis services program, operated in coordination with a licensed dialysis services provider, which has been approved by the Massachusetts Department of Public Health, will receive a member-specific rate add-on of $379 per member residing in the facility and receiving home dialysis services in the facility, for each instance of the home dialysis treatment received in the nursing facility for whom the following conditions are concurrently met:
    i. Medicaid would be the primary payer for the dialysis services if they were received outside of the nursing facility; and
    ii. Medicaid is the primary payer for the member's nursing facility services at the time of the home dialysis treatment.

FF. Direct Care Add-on

Effective October 1, 2022, a nursing facility will be eligible for an upward adjustment of 3.6386% applied to its nursing standard rate and operating standard rate. Facilities must use the funds from this Direct Care Add-on solely for direct care staff wages, benefits, incentive payments, or other direct care compensation. Each facility will be required to report to EOHHS on the ways in which it uses its received direct care add-on funds. Facilities that fail to complete required reporting or fail to use funds in the required manner w ll be subject to a penalty.

GG. Patient Transitions Program

a. A nursing facility will be eligible for a supplemental payment as described in IV.GG.b. if it is an approved patient transitions program vendor selected via EOHHS procurement for nursing facilities to provide patient transition services.
b. EOHHS will use the following methodology to calculate patient transition program payments for each eligible nursing facility:
    i. Determine the total number of Massachusetts Medicaid days as reported by eligible nursing facilities in their Quarterly User Fee Assessment Forms for the period of

July 1, 2021, through June 30, 2022.

ii. Divide the total amount of available funds, $11,250,000, by the total number of Massachusetts Medicaid days as determined in IV.GG.b.i.

iii. For each eligible nursing facility, multiply the quotient calculated in IV.GG.b.ii. by the eligible nursing facility's Massachusetts Medicaid days, as reported in the nursing facility's Quarterly User Fee Assessment Forms for the period of July 1, 2021, through June 30, 2022.

iv. The patient transition program payments will equal the total calculated in IV.GG.b ii. for each eligible nursing facility.

HH. Clubhouse Services Rates

a. For dates of service on or after January 1, 2023, MassHealth will pay the rates described below for Department of Mental Health (DMH) clubhouse services for nursing facility residents who have been determined to meet the preadmission screening and resident review (PASRR) criteria for serious mental illness and determined to required clubhouse services as a PASRR specialized service by DMH or its agent as part of the PASRR process.

b. Clubhouse service rates are as follows:

i. A rate of $66.57, per service day per member meeting the criteria described in Section IV.HH.a., for a DMH clubhouse with total average daily attendance for services, across all payers, of 29 clients or less.

ii. A rate of $63.66, per service day per member meeting the criteria described in Section IV.HH.a., for a DMH clubhouse with total average daily attendance for services, across all payers, of 30 to 70 clients.

iii. A rate of $83.19, per service day per member meeting the criteria described in Section HH.a., for a DMH clubhouse with total average daily attendance for services, across all payers, of 71 clients or more.

c. For the purposes of this Section HH:

i. "Clubhouse services" are defined as services provided under a clubhouse program to individuals with behavioral and/or mental health issues, including employment, educational, social, and support services. Clubhouse services assist individuals to develop social networking, independent living, budgeting, self-care, and other skills that will assist them to live in the community and to secure and retain employment.

ii. "Service day" is defined as a day during which a member either participates in a clubhouse services activity or activities related to a specific goal or objective documented in the member's care plan, PASRR evaluation, or clubhouse action plan. A provider can invoice only one unit of service per member per day.

V. State Legislative Changes

A. 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. COVID-19 Ongoing Supplemental Payments to Nursing Facilities

A. COVID-19 Surveillance Testing Supplemental Payments. Massachusetts will pay supplemental payments, on a monthly basis, to all eligible nursing facilities conducting staff COVID-19 surveillance testing in accordance with Massachusetts public health requirements for long term care facilities. Effective October 1, 2022, monthly supplemental payments will be calculated as follows for each facility:

i. Determine the total quarterly average number of staff who were up to date with their COVID-19 vaccination status in accordance with DPH COVID-19 vaccination guidance and multiply by 4.
ii. Determine the total quarterly average number of staff who are not up to date with their COVID-19 vaccination status in accordance with DPH COVID-19 vaccination guidance and multiply by 8.
iii. Determine the total quarterly average resident census and multiply by 5 to account for resident and visitor testing.
iv. Add together the three products calculated in VI.A.1. through 3.
v. Multiply the sum calculated in VI.A.4. by $12.

The supplemental payments are paid on a monthly basis, and payment amounts will be updated every three months, based on previous calendar quarter data.

B. Payments for Quality Improvements through COVID-19 Preparedness. A nursing facility will be eligible for a COVID-19 preparedness payment, to be made upon verification of eligibility criteria. A nursing facility will be eligible for a COVID-19 preparedness payment if the facility meets certain minimum requirements, including meeting criteria for up-to-date COVID-19 vaccinations, implementing and attesting to infection control standards, meeting thresholds for staffing hours per patient day, and COVID-19 treatment planning. Payments will cumulatively total $16.55 million, to be paid out as pro-rata supplemental payments to eligible facilities in proportion to each such facility's Medicaid days out of total Medicaid days reported by all eligible facilities.

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

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

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

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

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

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

VIII. Reimbursement for Individuals in a Disaster Struck Nursing Facility

A. Reimbursement to a Disaster Struck Nursing Facility for individuals that must be temporarily evacuated to another facility (Resident Accepting Nursing Facility) may continue for up to 30 days after the disaster event. Reimbursement will be the same as if the individual was residing in the Disaster Struck Nursing Facility. No other reimbursement will be made to either the Disaster Struck Nursing Facility or the Resident Accepting Nursing Facility for evacuated individuals. The Disaster Struck Nursing Facility must meet the following conditions in order to receive reimbursement for evacuated individuals:

a) The Disaster Struck Nursing Facility must have a contract with the Resident Accepting Nursing Facility. The contract must include: (i) terms of reimbursement and mechanisms to resolve any contract disputes; (ii) protocols for sharing care and treatment information between the two facilities; and (iii) requirements that both facilities meet all conditions of Medicaid participation, as determined by MassHealth.

b) The Disaster Struck Nursing Facility must notify MassHealth of the disaster event, maintain records of all evacuated individuals that include each individual's name, date of evacuation, and Resident Accepting Nursing Facility, and update MassHealth on the status of any necessary repairs.

c) The Disaster Struck Nursing Facility must determine within 15 days of the disaster event whether evacuated individuals will be able to return to the facility within 30 days of the disaster event. If the Disaster Struck Nursing Facility determines that it is not able to reopen within 30 days, it must discharge all evacuated individuals and work with them to choose admission to other facilities or alternative placements. Nothing shall preclude an evacuated individual from asking to be discharged and admitted to another facility or alternative placement. Reimbursement to the Disaster Struck Nursing Facility shall cease when an individual is discharged from the facility.

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

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