101 CMR 206.00: STANDARD PAYMENTS TO NURSING FACILITIES

Section

206.01: Scope and Purpose

101 CMR 206.00 governs the payments effective October 1, 2021 for services rendered to publicly aided and industrial accident residents by nursing facilities, including residents in a residential care unit of a nursing facility. 101 CMR 206.00 does not govern nursing facility payments pursuant to a contract with the Office of Medicaid.

206.02: General Definitions

As used in 101 CMR 206.00, unless the context requires otherwise, terms have the following meanings.

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: *Board of Registration of Nursing Home Administrators*.

Advanced Dementia Exclusion. A determination by the Department of Mental Health or its designee, the Massachusetts Medical School Pre-admission Screening and Resident Review (PASRR) Unit, that a diagnosis of serious mental illness does not apply to an individual, for the purposes of PASRR, when that individual has a diagnosis of dementia or Alzheimer's disease and/or related disorder (ADRD) that co-occurs with a mental illness/disorder diagnosis, and the dementia/ADRD is both primary and so severe that the individual would be unable to benefit from treatment.

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.

Capital Costs. Capital costs include building depreciation, financing contribution, building insurance, real estate taxes, non-income portion of Massachusetts Corporate Excise Taxes, other rent, and other fixed costs.

Center. The Center for Health Information and Analysis established under M.G.L. c. 12C.

206.02: continued

Centers for Medicare and Medicaid Services (CMS). The federal agency under the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 17, § 1.

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 preadmission 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.

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

Executive Office of Health and Human Services (EOHHS). The executive department of the Commonwealth of Massachusetts established under M.G.L. c. 6A, § 2 that, through the Executive Office of Elder Affairs, the MassHealth program, and other agencies within EOHHS, as appropriate, operates and administers the programs of medical assistance and medical benefits under M.G.L. c. 118E and that serves as the single state agency under section 1902(a)(5) of the Social Security Act.

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 freestanding 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; preadmission 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.

206.02: continued

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.

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.

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.

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, § 71; or a nursing facility operating under a hospital license issued by the Department of Public Health pursuant to M.G.L. c. 111, and certified by the Department of Public Health for participation in MassHealth. It includes facilities that operate a licensed residential care unit within the nursing facility.

Operating Costs. 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.

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 subdivision 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 §§ 267(b) and (c) of the Internal Revenue Code of 1954; provided, however, that 10% is the operative factor as set out in §§ 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mothers-in-law, brothers-in-law, and sisters-in-law.

206.02: continued

Replacement Facility. A nursing facility that replaces its entire building with a newly constructed facility pursuant to an approved determination of need under 105 CMR 100.000: *Determination of Need*. 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 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 of Public Health in accordance with 105 CMR 150.000: *Licensing of Long-term Care Facilities* 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 of Public Health to provide residential care.

State Fiscal Year (SFY). The 12-month period from July 1st through June 30th.

Unit. A unit is an identifiable section of a nursing facility such as a wing, floor, or ward as defined in 105 CMR 150.000: *Licensing of Long-term Care Facilities*.

206.03: General Payment Provisions

(1) General. Nursing facility payments are prospective rates based on reported costs for a prior base year.

(a) The nursing standard payments and the operating cost standard payments are established in 101 CMR 206.04. The base year for the nursing standard payments and the operating cost standard payments effective October 1, 2021 is 2019. The nursing and operating payments are increased from the base year by a cost adjustment factor of 3.75%.

(b) The capital payments are established in 101 CMR 206.05. The base year for the capital payments effective October 1, 2021 is 2019. The capital payments are increased from the base year by a cost adjustment factor of 1.05%.

(c) Payments may be adjusted to include additional payments in accordance with 101 CMR 206.06.

(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. 101 CMR 206.00 is not authorization for or approval of the substantive services, or lengths of time, for which rates are determined pursuant to 101 CMR 206.00. 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.

206.04: Nursing Standard Payments and Operating Cost Standard Payments

(1) Nursing Standard Payments. Effective October 1, 2021, nursing facilities will receive the following nursing standard payments.

206.04: continued

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 - 30	$17.55
JK	30.1 - 110	$46.72
LM	110.1 - 170	$83.74
NP	170.1 - 225	$117.04
RS	225.1 - 270	$141.89
T	270.1 and above	$167.03

(2) Operating Cost Standard Payments. Effective October 1, 2021, nursing facilities will receive operating cost standard payments of $105.36.

206.05: Capital Payments

(1) Nursing Facility Capital Payments. Effective October 1, 2021, nursing facilities will receive capital payments calculated as follows, with exceptions as described in 101 CMR 206.05(2), 101 CMR 206.05(3), 101 CMR 206.05(4), and 101 CMR 206.05(5):

(a) Calculate the sum of allowable capital expenses 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 as described in 101 CMR 206.03(1)(b).

(b) Multiply the number of beds by 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) EOHHS will calculate the provider's capital payment by dividing the result of 101 CMR 206.05(1)(a) by the result of 101 CMR 206.05(1)(b), subject to the limitations described in 101 CMR 206.05(4).

(2) Nursing Facility Capital Payment Adjustments. Effective October 1, 2021, if a nursing facility capital payment as calculated in 101 CMR 206.05(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 101 CMR 206.05(1), plus an upward adjustment equal to the difference between the capital payment as calculated in 101 CMR 206.05(1) and 90% of the capital payment the facility received as of September 30, 2021, subject to the limitations described in 101 CMR 206.05(4). If a nursing facility capital payment as calculated in 101 CMR 206.05(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 101 CMR 206.05(1), less a downward adjustment equal to the difference between the capital payment as calculated in 101 CMR 206.05(1) and 130% of the capital rate that the facility received as of September 30, 2021.

(3) Revised Capital Payment.

(a) 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

206.05: continued

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, 2022, the facility provided documentation to EOHHS of at least one of the criteria:

i. Department of Public Health plan review approval pursuant to an approved determination of need dated prior to January 1, 2020;

ii. 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;

iii. 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;

iv. 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;

v. 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;

vi. 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, prior to September 30, 2022.

(b) Required Documentation. Providers meeting the criteria in 101 CMR 206.05(3)(a) 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;
7. a copy of the calculation of the requested increase, in a format specified by EOHHS; and
8. a listing of any assets such as land, building, improvements, or equipment that are either destroyed or no longer used for patient care.

(c) Revised Capital Payment. Nursing facilities that meet the criteria listed in 101 CMR 206.05(3)(a) and that have submitted all required documentation under 101 CMR 206.05(3)(b) will be eligible for a revised capital payment in place of the capital rates calculated under 101 CMR 206.05(1), subject to the limitations of 101 CMR 206.05(4):

1. Adding the following costs:

a. the allowed capital expenses associated with a project described in 101 CMR 206.05(3)(a), subject to the divisor described in 101 CMR 206.05(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 101 CMR 206.05(1)(b) adjusted for any increase or decrease in licensed beds,

i. 101 CMR 206.05(1), or

ii. The sum of the amount calculated in 101 CMR 206.05(1) and the amount calculated in 101 CMR 206.05(2).

206.05: continued

2. The revised capital payment shall be the total calculated in 101 CMR 206.05(3)(c)1., and shall be the new capital rate, in place of the rate calculated under 101 CMR 206.05(1) or 101 CMR 206.05(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 101 CMR 206.05(1) or for an adjustment to its capital payment as described in 101 CMR 206.05(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.

(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.

206.06: Adjustments to Standard Nursing Facility Rates

(1) Certification of Public Expenditures of a Nursing Facility Owned and Operated by a Municipality.

(a) 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 will be based on the inpatient routine service cost reported on the CMS-2540 Medicare cost report.

(b) Following review of the nursing facility's submission, EOHHS will, within 60 days of the submission, approve, deny, or revise the amount of the CPE 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. This final determined amount will be certified by the municipality as eligible for federal match.

(c) Interim payments are based on the standard payment methodology pursuant to 101 CMR 206.00.

(d) EOHHS will determine total allowable Medicaid costs based on the Medicare CMS-2540 Cost Report and will determine a *per diem* rate calculated as follows.

1. Medicaid Allowable Skilled Nursing Facility Costs. Total allowable costs (Worksheet B, Part I, Line 30, Col 18), divided by total days (Worksheet S-3, Line 1, Col 7), times Medicaid days (Worksheet S-3, Line 1, Col 5).

2. Medicaid Allowable Nursing Facility Costs. Total allowable costs (Worksheet B, Part I, Line 31, Col 18), divided by total days (Worksheet S-3, Line 3, Col 7), times Medicaid days (Worksheet S-3, Line 3, Col 5).

3. Total Allowable Medicaid Costs. The sum of the amount determined in 101 CMR 206.06(1)(d)1. and 2.

(e) 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. The nursing facility must notify EOHHS immediately if the CMS-2540 is reopened or an audit is completed. Within 60 days after receiving notification of the final Medicare settlement EOHHS will retroactively adjust the final settlement amount.

206.06: continued

(2) Quality Adjustments. Effective October 1, 2021, 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 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 2021, as follows:

CMS Overall Score as of June 2021	Adjustment Percentage
1	-1.00%
2	-0.75%
3	0.00%
4	0.75%
5	1.00%

(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 2021, 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 2021	2%
Facility experienced an increase of 2 or more Stars from June 2020 to June 2021	1.5%
Facility experienced an increase of 1 Star from June 2020 to June 2021	1%
Facility experienced no change to its Star rating from June 2020 to June 2021	0%
Facility experienced a decrease of 1 Star from June 2020 to June 2021, and had a score of 5 Stars as of June 2020	0%
Facility experienced a decrease of 1 Star from June 2020 to June 2021, and did not have a score of 5 Stars as of June 2020	-2%
Facility experienced a decrease of 2 or more Stars from June 2020 to June 2021	-2.5%
CMS Chronic Low Quality: The average of a facility's scores as of June 2018, June 2019, June 2020, and June 2021 is less than or equal to 1.5 Stars	-3%

(c) 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, 2021, as follows:

DPH NFSPT Score as of July 1, 2021	Adjustment Percentage
110 or less	-1.00%
111 – 115	-0.75%
116 – 119	0.00%
120 – 123	0.75%
124+	1.00%

206.06: continued

(d) 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, 2021, 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, 2021	2.0%
Facility experienced an increase of 4 or more points from July 1, 2020 to July 1, 2021	1.5%
Facility experienced an increase of 1, 2, or 3 points from July 1, 2020 to July 1, 2021	1.0%
Facility experienced no change to its score from July 1, 2020 to July 1, 2021	0.0%
Facility experienced a decrease of 1, 2, or 3 points from July 1, 2020 to July 1, 2021, and had a score of 124 or higher as of July 1, 2020	0.0%
Facility experienced a decrease of 1, 2, or 3 points from July 1, 2020 to July 1, 2021, and did not have a score of 124 or higher as of July 1, 2020	-2.0%
Facility experienced a decrease of 4 or more points from July 1, 2020 to July 1, 2021	-2.5%
DPH Chronic Low Quality: Facility had a score of less than 100 as of each of the following dates: July 1, 2019; July 1, 2020; and July 1, 2021	-3%

(3) Kosher Food Services. Nursing 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 nursing 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 Center 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 101 CMR 206.06(3)(a)2., the phrase "certifying authority" will 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 50%; and
4. upon request, provide the Center with documentation of expenses related to the provision of kosher food services including, but not limited to, invoices and payroll records.

(b) Payment Amounts.

1. To determine the add-on amount, EOHHS will determine the statewide median dietary expense per day for all facilities. The add-on equals the difference between the eligible nursing 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, EOHHS 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 nursing facility's actual days or 96% of available bed days.
2. EOHHS will compare the sum of the add-on amounts multiplied by each nursing facility's projected annual rate period Medicaid days to the state appropriation. In the event that the sum exceeds the state appropriation, each nursing facility's add-on will be proportionally adjusted.

206.06: continued

(5) Leaves of Absence. If a purchasing agency pays for leaves of absence, the payment rate for a leave of absence day is $80.10 per day, unless otherwise determined by the purchasing agency.

(6) 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 of Public Health must certify to EOHHS that over 75% of the nursing facility's residents have a primary diagnosis of multiple sclerosis.

(7) Pediatric Nursing Facilities.

(a) Effective October 1, 2021, EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and other operating costs, excluding administrative and general costs, from the nursing facility's 2019 Cost Report. EOHHS will include an administrative 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, other operating, and administrative and general costs.

(b) The nursing and operating components of the rate is increased by a cost adjustment factor of 3.75%.

(c) Facilities licensed to provide pediatric nursing facility services will receive the rates which are the greater of

1. the rates calculated as described in 101 CMR 206.06(7)(a) and (b); or
2. the Nursing Standard and Operating Cost Standard rates as listed in 101 CMR 206.04(1) and (2).

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

(10) Residential Care Beds. Effective October 1, 2021, the total payment for nursing and other operating costs for residential care beds in a dually licensed nursing facility is $119.47.

(11) State-operated Nursing Facilities. A nursing facility operated by the Commonwealth will be paid at the nursing facility's reasonable cost of providing covered Medicaid services to eligible Medicaid recipients.

(a) 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 101 CMR 206.06(11)(b) and a final rate using the final rate year CMS-2540 cost report.

(b) 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.

(c) EOHHS may retroactively adjust the final settled amount when the Medicare CMS-2540 cost report is reopened or for audit adjustments.

(12) Low Occupancy Adjustment. Effective October 1, 2020, and each rate year thereafter, a nursing facility may 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:

1. Determine the facility's total resident days as reported on User Fee Reports covering the rate year of October 1, 2019 through September 30, 2020;
2. Determine the facility's total number of licensed beds as of the last day of the same rate year, September 30th, minus licensed Level IV beds. Multiply the result by the number of days in the year.
3. Calculate the facility's occupancy by dividing the result of 101 CMR 206.06(12)(a)1. by the result of 101 CMR 206.06(12)(a)2.

(b) Based on the occupancy calculated in 101 CMR 206.06(12)(a), a facility may face a reduction to its nursing standard rate and operating rate, applied at each acuity level as follows

206.06: continued

1. Except as described in 101 CMR 206.06(12)(b)2., the reduction is applied in accordance with the following chart:

Occupancy Rate	Low Occupancy Penalty
Occupancy below 80%	-3.0%
Occupancy of at least 80%, but below 84%	-2.0%
Occupancy of at least 84%, but below 88%	-1.0%
Occupancy of at least 88%	0.0%

2. For the rate year running from October 1, 2021, through September 30, 2022, 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 101 CMR 206.06(12)(b) to be applied beginning April 1, 2022, if the nursing facility:

1. Reduces by any amount its number of licensed beds from the number of licensed beds in the facility as of October 1, 2020, by March 1, 2022; and

2. Submits a completed Low Occupancy Adjustment Request form, along with supporting documentation indicated on the form to EOHHS by March 1, 2022.

(d) Upon receiving a completed Low Occupancy Adjustment Request form and supporting documentation from a nursing facility as described in 101 CMR 206.06(12)(c)2., EOHHS will recalculate the facility's occupancy, as follows:

1. Determine the facility's total resident days as reported on User Fee Reports covering the period October 1, 2019 through September 30, 2020;

2. Determine the facility's total number of licensed beds as of March 1, 2022, minus licensed Level IV beds. Multiply the result by 365 days.

3. Calculate the facility's occupancy rate by dividing the result of 101 CMR 206.06(12)(d)1. by the result of 101 CMR 206.06(12)(d)2.

(e) The facility's new occupancy rate, as calculated in 206.06(12)(d)3., will be used to redetermine the amount or applicability of the Low Occupancy Adjustment, as described 206.06(12)(b). Any changes to a facility's Low Occupancy Adjustment as a result of a new occupancy rate will apply solely prospectively, beginning April 1, 2022.

(13) Behavioral Indicator Adjustment. Effective October 1, 2021, a nursing facility may be eligible for a Behavioral Indicator Adjustment to its payment rate as follows. Eligibility for the Behavioral Indicator Adjustment will be determined based on the proportion of the facility's MassHealth residents in FY2020 who were 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).

(a) A facility for which at least 25% and less than 40% of its MassHealth residents meet the eligibility criteria described in 101 CMR 206.06(13) will receive a 4% upward adjustment applied to its nursing standard rate and operating standard rate at each acuity level.

(b) A facility for which at least 40% and less than 50% of its MassHealth residents meet the eligibility criteria described in 101 CMR 206.06(13) will receive a 6% upward adjustment applied to its nursing standard rate and operating standard rate at each acuity level.

(c) A facility for which at least 50% of its MassHealth residents meet the eligibility criteria described in 101 CMR 206.06(13) will receive a 10% upward adjustment applied to its nursing standard rate and operating standard rate at each acuity level.

(14) High Medicaid Adjustment. Effective October 1, 2021, a nursing facility may be eligible for a High Medicaid Adjustment to its payment rate, 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 October 1, 2019 through September 30, 2020.

206.06: continued

(a) A facility for which its 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.
(b) 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.

(15) Maximum Increase Adjustment. Effective October 1, 2021, a nursing facility will be subject to a downward adjustment to its total standard nursing facility *per diem* rate established through 101 CMR 206.04, 101 CMR 206.05, and 101 CMR 206.06(2) through (14), if such rate is greater than 110% of the facility's total standard nursing facility rate that was in effect as of September 30, 2021. The downward adjustment will be calculated as follows:
(a) Determine the facility's standard nursing facility rate as calculated pursuant to 101 CMR 206.04, 101 CMR 206.05, and 101 CMR 206.06(2) through (14);
(b) Determine 110% of the facility's standard nursing facility rate that was in effect on September 30, 2021;
(c) Subtract the rate in 101 CMR 206.06(15)(b) from 101 CMR 206.06(15)(a); and
(d) The downward adjustment will equal the amount calculated in 101 CMR 206.06(15)(c).

206.07: Payments for Individuals in a Disaster Struck Nursing Facility

(1) Payment 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.

(2) Payment will be the same as if the individual was residing in the Disaster Struck Nursing Facility. No other payment 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 payment for evacuated individuals:
(a) The Disaster Struck Nursing Facility must have a contract with the Resident Accepting Nursing Facility. The contract must include:
1. terms of payment and mechanisms to resolve any contract disputes;
2. protocols for sharing care and treatment information between the two facilities; and
3. requirements that both facilities meet all conditions of Medicaid participation, as determined by the MassHealth agency.
(b) The Disaster Struck Nursing Facility must notify the MassHealth agency 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 the MassHealth agency 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 precludes an evacuated individual from asking to be discharged and admitted to another facility or alternative placement. Payment to the Disaster Struck Nursing Facility will cease when an individual is discharged from the facility.

206.08: 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 with the Center. 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 30th, the provider is not required to file an HCF-1 report.

206.08: continued

(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 nonaffiliated realty trust or other business entity must file, or cause to be filed, a Realty Company Cost Report with the Center.

(c) Management Company Cost Report. A provider must file a separate Management Company Cost Report with the Center 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 101 CMR 206.00, the provider must file a complete copy of its audited financial statements with the Center, 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 101 CMR 206.00, the provider must file with the Center 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 101 CMR 206.08(1)(d) will be construed as an additional requirement that nursing homes complete audited, reviewed, or compiled financial statements solely to comply with the Center's reporting requirements.

(e) Clinical Data. EOHHS may require providers to submit patient level data for the purpose of measuring clinical performance in a format specified by EOHHS. EOHHS 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 433.50(a)(i) must file a CMS-2540 report with the Center 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.

(e) Indirect Restorative Therapy Services Record. Providers must maintain a record of indirect restorative therapy services documented by a written summary available for inspection in the nursing facility as required by 105 CMR 150.010(F): *Records and Reports*.

(f) Other Cost Reporting Requirements.

1. Administrative Costs.

a. The following expenses must be reported as administrative:

206.08: continued

i. 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;

ii. 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

iii. 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.

b. 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.

c. 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. Major Repair Projects. 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.

206.08: continued

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.

(g) 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 facility operations and remove such equipment from the nursing facility 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 facility must file cost reports on a fiscal year basis consistent with the fiscal year used in the DHCFP-403 Hospital Cost Report.

a. The provider must identify the existing building and improvement costs associated with the nursing facility. The provider must allocate such costs on a square footage basis.

b. The provider must 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 101 CMR 206.02. The provider may elect to report major moveable and fixed equipment by one of two methods.

i. 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 facility. 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 Center with its first Notification of Change in Beds.

ii. If the provider elects not to identify specifically each item of major moveable and fixed equipment, EOHHS 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 facility within the hospital as additions. EOHHS 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 facility. The provider must allocate all costs shared by the hospital and the nursing facility using the statistics specified in the Hospital Cost Report instructions. The provider must disclose all analysis, allocations, and statistics used in preparing the Nursing Facility 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) Expenses otherwise allowable will not be included for purposes of determining rates under 101 CMR 206.00 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 101 CMR 206.00 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 Center 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 whether the expenses are allowable.

206.08: continued

(d) Only the provider's contribution of generally available employee benefits will 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 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 will not be included for calculation of prospective rates. Benefits that are related to salaries will 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, will 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.

(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;

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 105 CMR 157.000: *The Registration and Operation of Temporary Nursing Service Agencies* or paid for at rates greater than the rates established by EOHHS pursuant to 101 CMR 345.00: *Temporary Nursing Services*;

8. any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the nursing 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 will be recovered against other operating costs. Other recoverable income will 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 that is generated from special services rendered to private patients will be identified and eliminated from claims for reimbursement. Special services are those services not rendered to all patients (*e.g.*, dry cleaning, *etc*.). If the cost of special services cannot be determined, laundry income will be recovered against laundry expense;

206.08: continued

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; and

13. accrued expenses that remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, will not be included in the prospective rates. When the Center receives satisfactory evidence of payment, EOHHS may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates.

(4) Filing Deadlines.

(a) General. Except as provided in 101 CMR 206.08(4)(a)1. and 2., or in accordance with alternative deadlines established by EOHHS or the Center through administrative bulletin or other written issuance, providers must file required cost reports for the calendar year by 5:00 P.M. on April 1st of the following calendar year. If April 1st falls on a weekend or holiday, the reports are due by 5:00 P.M. on 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, § 72N, the provider must file cost reports for the current reporting period or portion thereof within 60 days of the receiver's appointment.

(b) Extension of Filing Date. The Center 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 Center no later than 30 calendar days before the due date.

(c) Administrative Bulletin. The Center 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 Center will notify the provider in writing within 120 days of receipt. The Center 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 1st of the year the cost reports are filed, whichever is later. If the Center 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 Center 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 Center has accepted the provider's cost reports.

(7) Penalties. If a provider does not file the required cost reports by the due date, EOHHS 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 noncompliance 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 first of the month following the date the cost report is filed.

206.09: Special Provisions

(1) Rate Filings. EOHHS 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 101 CMR 206.00 within 30 calendar days after EOHHS files the rate with 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.

206.09: continued

(3) Administrative Bulletins. EOHHS and the Center may issue administrative bulletins to clarify provisions of 101 CMR 206.00 or to specify data collection requirements. Such bulletins will be deemed to be incorporated in the provisions of 101 CMR 206.00. EOHHS and the Center will file the bulletins with the Secretary of the Commonwealth, distribute copies to providers, and make the bulletins accessible to the public at EOHHS's and the Center's offices during regular business hours.

(4) Severability. The provisions of 101 CMR 206.00 are severable. If any provision of 101 CMR 206.00 or the application of any provision of 101 CMR 206.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 101 CMR 206.00 or the application of any other provision.

206.10: Other Payment Provisions

(1) Temporary Resident Add-on. For dates of service beginning October 1, 2021, a nursing facility will be eligible for a member-specific temporary resident add-on of $130 per member per day 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 under 130 CMR 456.409: *Services Requirement for Medical Eligibility*;

(c) The resident was transferred to the nursing facility for temporary residence purposes directly from their home on or after October 1, 2021; and

(d) The resident was discharged from the nursing facility to their home within 30 calendar days of the admission date.

(2) 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 established through administrative bulletin or other written issuance; and

(e) The facility is not receiving the communication-limited resident ventilator add-on described in 101 CMR 206.10(3) for the resident.

(3) 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, such as certain individuals with advanced amyotrophic lateral sclerosis (ALS);

(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;

206.10: continued

(d) The facility maintains a program for specialized ventilator services, in accordance with MassHealth requirements established through administrative bulletin or other written issuance; and

(e) The facility is not receiving the ventilator add-on described in 101 CMR 206.10(2) for the resident.

(4) COVID-19 Staff Testing Supplemental Payment.

(a) Completed Qualifying COVID-19 Staff Tests. Effective October 1, 2020, EOHHS pays nursing facilities, in accordance with 101 CMR 206.10(4)(b), for COVID-19 testing administered on staff that meet all of the following criteria:

1. Staff tests that were paid for directly by the nursing facility, which does not include tests that were completed or facilitated by the staff member on their own time or at their own cost;

2. Staff tests that were conducted as bi-weekly, weekly, or other periodic surveillance testing as part of an adaptive surveillance testing system developed by DPH and applicable to MassHealth nursing facility providers in accordance with an administrative bulletin or other written issuance, provided that in the event that such adaptive surveillance testing system is no longer in effect or no longer applicable to MassHealth nursing facility providers, staff tests will not be qualifying COVID-19 staff tests for the purposes of payment under 101 CMR 2016.10(4)(b);

3. Not more than one test per individual staff member per testing period;

4. Staff tests that include the collection of specimens sufficient for diagnostic testing, the processing of a COVID-19 diagnostic test by an FDA approved method, and the furnishing of results to all appropriate parties in accordance with DPH and Centers for Disease Control and Prevention guidance;

5. Staff tests that are able to detect an active SARS-CoV-2 virus infection, with a polymerase chain reaction (PCR) of greater than 95% sensitivity and greater than 90% specificity, within 48 hours of conducting the test, or such other testing method or standard as specified by EOHHS *via* administrative bulletin or other written issuance;

6. Staff tests that were reported to EOHHS, in the manner requested by EOHHS, as tests administered on the nursing facility's staff; and

7. Staff tests for which results were reported by the nursing facility as either positive, negative, or inconclusive; provided that if EOHHS determines that the rate of inconclusive test results is unreasonably high, EOHHS may exclude those inconclusive results from the number of completed qualifying COVID-19 staff tests.

(b) Calculation of Supplemental Payments.

1. Effective October 1, 2020, the staff surveillance testing supplemental payments for each eligible nursing facility are equal to the number of completed qualifying COVID-19 staff tests administered each month in accordance with 101 CMR 206.10(4) multiplied by $80.

2. Effective January 1, 2021, the staff surveillance testing supplemental payments for each eligible nursing facility are equal to the number of completed qualifying COVID-19 staff tests administered each month in accordance with 101 CMR 206.10(4) multiplied by the lesser of

i. the average market rate for COVID-19 testing in long-term care facilities and residential congregate care providers and settings in the Commonwealth as determined by EOHHS, which may be updated quarterly by EOHHS based on the previous calendar quarter; or

ii. $80.

3. Payments for staff surveillance testing shall be paid in accordance with 101 CMR 206.10(4), provided that no federal funds were used specifically for the same staff surveillance testing and that any federal funds available or provided to the facility that were permitted to be used for staff surveillance testing were fully expended or earmarked on other permitted expenditures. EOHHS may require facilities to report federal funding received by the facility and may require facilities to supply supporting documentation or otherwise verify any such federal funding received.

206.10: continued

(c) Disbursement of Supplemental Payments. The supplemental payments are paid on a monthly basis within 60 days after each month, with each monthly supplemental payment based on the applicable months' number of completed qualifying COVID-19 staff tests.

(d) Additional Guidance. EOHHS may, *via* administrative bulletin or other written issuance, establish additional rules governing the staff surveillance test payments under 101 CMR 206.10(5) including, but not limited to, further information on the relevant staff that must be tested, the frequency of testing and the infection thresholds that may affect the frequency of testing and required testing periods, reporting requirements, or qualifying COVID-19 diagnostic tests.

(6) Disallowance of COVID-19 Staff Testing Supplemental Payments.

(a) Except as provided in 101 CMR 206.10(6)(b), a nursing facility will not be eligible for any further supplemental payments under 101 CMR 206.10(4) if it fails to meet the COVID-19 testing and reporting requirements under 101 CMR 206.10(4) for three or more testing periods within a 60-day period.

(b) Nursing facilities with a history of non-compliance with testing and reporting requirements under 101 CMR 206.10(4) rendering them ineligible for payment or at risk of losing eligibility for payment according to 101 CMR 206.10(6)(a), shall be given a one-time amnesty, clearing their record of past non-compliance as of October 1, 2021. This one-time record adjustment does not permit a nursing facility to be paid for non-qualifying surveillance tests or to claim supplemental payment for tests that did not occur. It does not exempt a nursing facility from any audit, overpayment, administrative fine, or other sanction issued for surveillance testing or reporting non-compliance. It does not exempt a nursing facility from admissions freezes or other measures taken by the Department of Public Health due to the facility's surveillance testing non-compliance or other indicators. It does not render a nursing facility eligible for any payments that it would otherwise be ineligible for, other than prospective surveillance testing supplemental payments. The payment limitations in 101 CMR 206.10(6)(a) shall apply again, beginning with the first full testing period to start after October 1, 2021, with all nursing facilities having a record of zero testing periods of non-compliance prior to that testing period.

(7) Medicaid Transitional Add-on. For dates of service beginning October 1, 2021, a nursing facility will be eligible for a transitional add-on of $130 per member per day for the first 30 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 October 1, 2021; and

(c) The resident is not returning to the nursing facility from a medical leave of absence.

(8) Monoclonal Antibody Treatment Claims.

(a) For dates of service beginning October 1, 2021, and notwithstanding any regulatory provision to the contrary, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for the administration of monoclonal antibody treatments, provided to eligible MassHealth members 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 the FDA or CMS with respect to such treatment. Nursing facilities are required to ensure that any such monoclonal antibody treatments administered at the facility are administered by individuals whose education, credentials, and training qualify them to render such services.

(b) The costs of services described in 101 CMR 206.10(8)(a) are not included in the prospective payment system operating or nursing standard payment rates determined under 101 CMR 206.03 and 101 CMR 206.04. The costs of providing such services will be considered non-allowable costs under 101 CMR 206.08(3)(h)12.

(c) MassHealth payments for separate fee-for-service claims submitted by the nursing facility for the services described in 101 CMR 206.10(8)(a) shall be paid at the rates established under 101 CMR 446.03(2). Such fee-for-service claims payments shall be considered payment in full for such services.

206.10: continued

(d) EOHHS shall establish, through administrative bulletin or other written issuance, the specific monoclonal antibody treatments that may be administered by the nursing facility, as well as the specific codes and billing instructions for such services.

(9) COVID-19 Vaccine Administration Claims.

(a) For dates of service beginning October 1, 2021, and notwithstanding any regulatory provision to the contrary, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for COVID-19 vaccine administration services, provided to eligible MassHealth members in accordance with an EUA issued by the FDA or full FDA approval, and in accordance with any guidance issued by the FDA or CMS with respect to such services. Nursing facilities are required to ensure that any such services administered by the facility are administered by individuals whose education, credentials, and training qualify them to render such services.

(b) The costs of services described in 101 CMR 206.10(9)(a) are not included in the prospective payment system operating or nursing standard payment rates determined under 101 CMR 206.03 and 101 CMR 206.04. The costs of providing such services will be considered non-allowable costs under 101 CMR 206.08(3)(h)12.

(c) MassHealth payments for separate fee-for-service claims submitted by the nursing facility for the services described in 101 CMR 206.10(9)(a) shall be paid at the rates established under 101 CMR 446.03(2): *Medicine*. Such fee-for-service claims shall be considered payment in full for such services.

(d) EOHHS shall establish, through administrative bulletin or other written issuance, the specific codes and billing instructions for such services.

(10) Additional Guidance. EOHHS may, *via* administrative bulletin or other written issuance, establish additional rules governing various aspects of the COVID-19 Payment Provisions established under 101 CMR 206.10 including, but not limited to, reporting and compliance requirements, and penalties for noncompliance, or may rely on existing rules already issued in this manner.

206.11: Rates for Severe Mental and Neurological Disorder Services.

(1) Qualifying Nursing Facility. Effective October 1, 2021, 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

(a) as of August 1, 2020, operate exclusively to provide nursing facility services, including the specialized rehabilitative services described in 101 CMR 206.11(b), to residents with mental or neurological disorders, including residents with acquired brain injuries;

(b) provide the following specialized rehabilitation services for its residents:

1. an individualized therapeutic skill development plan for each member;
2. individual counseling;
3. group counseling (therapeutic and life skills groups), with group sessions offered multiple times each week to ensure access based on member needs and preferences;
4. sensory modulation and cognitive rehabilitation;
5. neuropsychological testing, evaluation, and intervention;
6. alcohol and substance abuse counseling and prevention;
7. all mental health services as indicated by each resident's PASSR Level II evaluation, or coordinate with additional providers and practitioners, who may separately bill or be paid under the appropriate provider regulations, for services designated as specialized services under the PASRR program and therefore are services that are not included in standard nursing facility services;
8. vocational programming; and
9. community reintegration.

206.11: continued

(c) 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.

(2) *Per Diem* Rate for Approved Admitted Members. Qualifying nursing facilities may 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 101 CMR 206.11(1) and is therefore eligible for this enhanced rate. The specialized rehabilitative services program is designed to transition the member back to community-based care or less-restrictive placement, and such rate applies only during the time that the member has been approved by MassHealth for the enhanced rate. Qualifying nursing facilities receiving this *per diem* rate are not eligible for any other *per diem* rates or payments established under 101 CMR 206.00 with respect to such approved members, except as provided in 101 CMR 206.11(3) or, if applicable, 101 CMR 206.10. Qualifying facilities may also admit members without seeking approval from the MassHealth agency. In such circumstances qualifying nursing facilities will receive the standard nursing facility rate established under 101 CMR 206.00 with respect to those members.

(3) High-cost Member Additional Rate. Qualifying nursing facilities may receive an additional member-based rate of $150 in addition to the *per diem* rate set by 101 CMR 206.11(2) 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

(a) certifies that the direct care costs associated with providing services to such member meets the requirements of 101 CMR 206.11;

(b) submits a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of 101 CMR 206.11 have been met; and

(c) 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.

206.12: Direct Care Cost Quotient

(1) Beginning October 1, 2020, nursing facilities must have a Direct Care Cost Quotient (DCC-Q), as described in 101 CMR 206.12(2), of at least 75%. For the rate year beginning October 1, 2022, a nursing facility rate may be subject to a downward adjustment if the facility fails 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 rate may be subject to a downward adjustment if the facility fails to be at or above the 75% DCC-Q threshold in the previous full fiscal year.

(2) The DCC-Q will be calculated by dividing certain direct care workforce expenses, such as nursing, dietary, restorative therapy, or social worker staff expenses, by the facility's total revenue, excluding the revenue for non-nursing facility lines of business and subtracting the User Fee Assessments, certain prescription drug expenses, and certain other ancillary costs related to services provided to Medicare residents, to be identified *via* administrative bulletin or other written issuance.

(a) A multiplier may be applied to one or more direct care workforce position types as an incentive. A multiplier must be calculated by multiplying the cost associated with a given direct care workforce position type in the numerator by 1.5 or more, but not to exceed 3.

(b) The workforce position types eligible for any multiplier described in 101 CMR 206.12(2) and the magnitude of such multiplier in calculating the DCC-Q may be established by EOHHS *via* administrative bulletin or other written issuance.

206.12: continued

(3) All nursing facilities, including facilities in 101 CMR 206.12(5), will be required to submit an interim compliance report by March 1st of each year and a final compliance report by July 30th of each year. The interim report will be used to inform nursing facilities if they are on track to meet the 75% DCC-Q threshold set forth in 101 CMR 206.12(1). The final compliance report will be used for determining whether the facility met that threshold.

(4) The downward adjustment to the rate will be applied in the following rate year to facilities that failed to meet the 75% DCC-Q threshold. Such downward adjustment will be calculated as follows:

(a) For every 1% below the 75% DCC-Q threshold, a 0.5% downward adjustment will be applied to the facility's nursing and operating standard payments.

(b) The maximum downward adjustment calculated in 101 CMR 206.12(3)(a) may be no more than 5% of the facility's nursing and operating standard payments. EOHHS may apply the maximum downward adjustment of 5% in the following rate year for facilities that fail to submit the final report by the due date established in 101 CMR 206.12(3).

(5) Nursing facilities that will have less than 5,000 Massachusetts Medicaid Days in SFY 2022, as reported on their Quarterly User Fee Assessment Forms for the period of July 1, 2021 through June 30, 2022, will be exempt from the downward adjustment set forth in 101 CMR 206.12(4).

(6) EOHHS may issue an administrative bulletin or other written issuance to clarify provisions of 101 CMR 206.12, and to provide further detail on the types of staffing and direct care expenditures that qualify towards the DCC-Q and the data reporting requirements.

206.13: Average Staffing Hours Incentive

(1) As of October 5, 2020, each nursing facility is required to submit information on its staffing levels, including information demonstrating the facility's average hours per patient day to EOHHS, in the manner and format requested by EOHHS *via* administrative bulletin or other written issuance.

(2) As of January 1, 2021, a nursing facility that fails to meet an average of at least 3.58 hours per patient day, in accordance with 101 CMR 206.13(1), is subject to a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235: *Overpayments*.

(3) To determine a facility's average hours per patient day in each calendar quarter, EOHHS will divide the facility's total number of productive hours worked by nursing staff, including registered nurses, licensed practical nurses and nurses' aides, in the calendar quarter by the facility's total number of patient days in that calendar quarter.

(4) EOHHS may issue administrative bulletins or other written issuance to further clarify these provisions and to provide additional guidance regarding what qualifies as productive hours, what staff types are included in nursing staff, and the reporting requirements.

206.15: Add-on for Members with Complicated High-cost Care Needs

(1) Members with Complicated High-cost Care Needs. Nursing facilities may receive a member-based rate add-on, in addition to the facility's standard *per diem* rate established under 101 CMR 206.00, 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. The facility may receive an add-on for such member, as calculated according to 101 CMR 206.15(2), provided that all of the following conditions are met:

(a) The member was referred to the facility by MassHealth;

(b) 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;

206.15: continued

(c) The facility submitted a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of 101 CMR 206.15 have been met;
(d) The facility provides the MassHealth agency with any additional or clarifying documentation in support of the actual or expected direct care costs associated with the resident's care needs; and
(e) The facility receives approval from the MassHealth agency for the add-on.

(2) Complicated and High-cost Care Add-on Calculation. 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 established under 101 CMR 206.00, up to a maximum add-on of $600 per day. EOHHS shall have sole discretion over what may be considered a reasonable and allowable cost for the purposes of calculating this add-on. The add-on for each resident shall be effective on the later of the date the nursing facility receives MassHealth approval for the add-on or the date of the member's admission to the nursing facility. A nursing facility may not receive this add-on for a member for whom the facility is receiving on the same dates of service a rate add-on under 101 CMR 206.07, 101 CMR 206.10(2), 101 CMR 206.10(3), or 101 CMR 206.11.

(3) Periodic Recertification. A nursing facility that receives the add-on under 101 CMR 206.15 may be required periodically to recertify to MassHealth that all conditions established under 101 CMR 206.15(1)(a) continue to be met with respect to each member for whom it receives the add-on, and must submit updated direct care cost information for each member. If the facility fails to provide such certification and information, MassHealth may terminate the add-on received by the nursing facility for the member.

REGULATORY AUTHORITY

101 CMR 206.00: M.G.L. c. 118E.