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, 2019 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.

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.

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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.

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 Department of Elder Affairs 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.

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

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.

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.

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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 pursuant to M.G.L. c. 111, and certified by the Department 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.

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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 100.505(A)(5). 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 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 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. The base year for the standard payments effective October 1, 2019 is 2014. Nursing facility payments include the nursing standard payments and other operating cost standard payment established in 101 CMR 206.04 and the capital payment established in 101 CMR 206.05. 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.

(a) Effective October 1, 2019, nursing facilities will receive the following nursing standard payments.

Payment Group	Management Minute Range	Nursing Standard Payment
H	0 - 30	$14.60
JK	30.1 - 110	$39.97
LM	110.1 - 170	$69.57

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Payment Group	Management Minute Range	Nursing Standard Payment
NP	170.1 - 225	$97.73
RS	225.1 - 270	$119.83
T	270.1 and above	$148.71

(b) For the period from October 1, 2019 through June 30, 2020, nursing standard payments will include an annualization adjustment as listed in 101 CMR 206.04(1)(b):

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

(2) Operating Cost Standard Payments.

(a) Effective October 1, 2019, nursing facilities will receive operating cost standard payments based on the facility's group as defined in 101 CMR 512.03(1). Effective October 1, 2019, operating cost standard payments will be as listed in 101 CMR 206.04(2)(a):

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

(b) For the period from October 1, 2019 through June 30, 2020, operating cost standard payments will include an annualization adjustment as listed in 101 CMR 206.04(2)(b):

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

206.05: Capital Standard Payments

(1) Effective October 1, 2019, nursing facilities will receive capital standard payments based on the county in which the facility is located, with exceptions as described in 101 CMR 206.05(2), 101 CMR 206.05(3) and 101 CMR 206.05(4):

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

(2) Effective October 1, 2019, if a nursing facility capital standard payment as listed in 101 CMR 206.05(1) is less than the facility's rebased capital payment that it would have received based on the capital standard payment calculation methodology in effect prior to October 1, 2019, the facility will be eligible for an upward adjustment to its capital payment as follows:

The facility's upward adjustment is calculated as the difference between the standard capital payment listed in 101 CMR 206.05(1) and its rebased capital payment that it would have received based on the capital standard payment calculation methodology in effect prior to October 1, 2019.

(3) A nursing facility will be eligible for an adjustment to its capital standard payment as described in 101 CMR 206.05(2) after October 1, 2019 if:

(a) The facility has expended at least 50% of the maximum capital expenditure for an approved determination of need;

(b) The facility has submitted a notification request for a revised capital payment to EOHHS; and

(c) Such notification request for such revised capital payment is submitted to EOHHS between November 1, 2009 and November 1, 2019.

(4) Notwithstanding 101 CMR 206.05(3)(c), a facility that meets the requirements of 101 CMR 206.05(5) will be eligible for an upward adjustment to its capital standard payment as described in 101 CMR 206.05(2) in accordance with 101 CMR 206.05(3).

(5) A nursing facility will be eligible for an upward adjustment to its capital standard payment as described in 101 CMR 206.05(2) after October 1, 2019, if, prior to March 31, 2020, the facility provides EOHHS with documentation of one of the following:

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

(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 for development of the project authorized by an approved determination of need; or

(f) An application for a determination of need submitted to the Department of Public Health prior to January 1, 2020 and detailed architectural or engineering plans, dated prior to January 1, 2020, for the capital project contemplated in the facility's determination of need application.

(6) A nursing facility that becomes operational on or after November 1, 2019, an existing nursing facility that replaces its current building on or after November 1, 2019, or an existing nursing facility that fully relocates to a newly constructed location on or after November 1, 2019, will be eligible for a capital standard payment in the amount of $37.60. Such facility will not be eligible for additional capital payments as listed 101 CMR 206.05(1) or for an adjustment to its capital standard payment as described in 101 CMR 206.05(2).

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(7) A nursing facility will not receive an adjustment to its capital standard payment rate solely because of an increase or decrease in its number of licensed beds.

(8) Rate Adjustments. EOHHS 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: Other Payment Provisions

(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.

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

(a) Eligibility. Eligible nursing facilities are identified by DDS as nursing facility providers of care to residents with mental retardation or developmental disabilities as of July 28, 2016.

(b) Calculation of Allowance. For each eligible nursing facility identified by DDS, the number of residents identified by DDS as having developmental disabilities and communicated to EOHHS as of July 28, 2016, times $3.00, times 365 days, will equal the total allowance amount. To calculate a per day amount to be included in the payment rates, EOHHS will divide the allowance amount calculated above by the number of Massachusetts Medicaid Non-managed Care days, as the term is used in the Nursing Facility Cost Report, projected for FY2017.

(c) Ineligibility. If DDS notifies EOHHS that a nursing facility has failed to comply with its requirements or failed to cooperate with the planning activities under the active treatment policy, EOHHS may deem the nursing facility to be ineligible for this adjustment and rescind this allowance for a provider.

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(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.

(4) Quality Achievement and Improvement Payments. Effective October 1, 2019, a nursing facility may be eligible for one of two quality achievement and improvement payments as follows. A nursing facility may receive either the Quality Achievement and Improvement Add-on or the High Medicaid Quality Achievement and Improvement Add-on, but may not receive both add-ons concurrently.

(a) Quality Achievement and Improvement Add-on.

1. Eligibility. A nursing facility will be eligible for a quality achievement and improvement payment if at least one of the following criteria is met:

a. the nursing facility received a score of at least 124 on the Department's Nursing Facility Survey Performance Tool as of July 1, 2019, and at least four stars in the overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of July 1, 2019;

b. the nursing facility received a score of at least 124 on the Department's Nursing Facility Survey Performance Tool as of July 1, 2019, and at least four stars in the staffing rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of July 1, 2019; or

c. the nursing facility's score on the Department's Nursing Facility Survey Performance Tool increased by at least three points between July 1, 2018, and July 1, 2019, or the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool increased by at least one star between July 1, 2018, and July 1, 2019.

2. Calculation of Add-on. A nursing facility will receive $1.35 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

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(b) High Medicaid Quality Achievement and Improvement Add-on.

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

a. the nursing facility meets one of the criteria in 101 CMR 206.06(4)(a)1.a. through c.; and

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

2. Calculation of Add-on. A nursing facility will receive $2.96 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

(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 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, 2019, EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported costs for nursing and other operating costs, excluding administration and general costs, from the nursing facility's 2014 Cost Report. EOHHS will include an administration and general payment based on 85% of 2014 median statewide administration and general costs. EOHHS will apply an appropriate cost adjustment factor to nursing, other operating, and administration and general costs.

(b) The nursing and operating components of the rate is increased by a cost adjustment factor of 0.10%. This factor is derived from a composite market basket. The labor component on the market basket is the Massachusetts Consumer Price Index, optimistic forecast, as provided by Global Insight. The non-labor component is based on the CMS Nursing Home without Capital market basket, except for the Food subcomponent, which is based on the Regional CPI for New England, as published by Global Insight.

(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 101 CMR 206.06(7)(b), plus an additional $1.26 added to the rates in 101 CMR 206.06(7)(c) for payment groups RS and T;

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

3. the rates facilities received prior to October 1, 2019, plus an additional $1.26 added to the rates in 101 CMR 206.06(7)(c) for payment groups RS and T.

(8) Publicly Operated Facilities. There will be a supplemental payment of $3.80 to certain publicly operated nursing facilities owned and operated by a town, city, or state government entity or transferred from municipal ownership since 2001, in which the municipality retains the power to appoint at least one member of the board, and is operating on land owned by the municipality.

(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.

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(10) Residential Care Beds.

(a) Effective October 1, 2019, the total payment for nursing and other operating costs for residential care beds in a dually licensed nursing facility is $84.08.

(b) For the period from October 1, 2019 through June 30, 2020, the total payment for nursing and other operating costs for residential care beds in 101 CMR 206.06(10) will include an annualization adjustment in the amount of $1.23.

(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) SFY 2020 Add-ons. Effective October 1, 2019, a nursing facility may be eligible for the "Three Star Plus" Add-on, the "High Medicaid Occupancy" Add-on, the "Cape and the Islands" Add-on, or a combination of these three add-ons.

(a) "Three Star Plus" Add-on.

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

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

(b) "High Medicaid Occupancy" Add-on.

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

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

(c) "Cape and the Islands" Add-on.

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

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

(13) Direct Care Staff Add-on. For the period from October 1, 2019 through June 30, 2020, providers will receive a rate add-on for wages, benefits, and related employee costs of direct care staff of nursing facilities. EOHHS may, *via* administrative bulletin or other written issuance, establish rules governing various aspects of the add-on including, but not limited to, reporting and compliance requirements, penalties for noncompliance, recovery, and application to providers that close during SFY 2020.

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(a) Calculation of the Add-on. EOHHS will calculate the add-on as described in 101 CMR 206.06(13)(a).

1. Sum the total SFY2019 direct care staff payments for all open nursing facilities as of September 1, 2019.

2. Calculate the difference between $38.3 million and the total calculated under 206.06(13)(a)1.

3. Divide the SFY2019 total direct care staff payment for each nursing facility by the SFY2019 total direct care staff payments for all open nursing facilities in 101 CMR 206.06(13)(a)1.

4. Multiply the quotient calculated under 101 CMR 206.06(13)(a)3. by the difference calculated under 101 CMR 206.06(13)(a)2.

5. For each nursing facility, sum the facility's total SFY2019 total direct care staff payment and share of the difference for the facility calculated under 101 CMR 206.06(13)(a)4.

6. Compute the nursing facility's direct care add-on by dividing the total direct care payment calculated under 101 CMR 206.06(13)(a)5. by the nursing facility's Massachusetts Medicaid non-managed care days, as the term is used in the Nursing Facility Cost Report, projected for SFY2020.

7. Add an annualization adjustment to ensure that the full amount allocated to the Direct Care Staff Program is distributed to eligible providers during the effective period of the add-on.

(b) If a nursing facility has a reduction in its number of licensed beds as the result of a change in the physical location of the facility, its Direct Care Staff Payment Add-on may be reduced proportional to the loss in beds.

(c) Application of Rate Add-on. The amount calculated pursuant to 101 CMR 206.06(13)(a) will be included as an add-on to each provider's rate.

(d) Permissible Use. Providers must use the direct care staff payment revenue to increase wages, benefits, and related employee costs for registered nurses, licensed practical nurses, certified nursing assistants, dietary aides, housekeeping aides, laundry aides, activities staff, and social workers employed by the provider. Such expenditures may include overtime payments and bonuses. Spending for temporary nursing services, contract employees, and directors of nursing is not permissible.

(e) Direct Care Staff Payment Recovery. EOHHS reserves the right to recover any unused or misused direct care staff payments.

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

(a) Eligibility for the Add-on. In order to receive the add-on for a MassHealth member, all of the following criteria must be met:

1. The member is eligible for nursing facility services in accordance with 130 CMR 456.403: *Eligible Members*, and 130 CMR 456.409: *Services Requirement for Medical Eligibility*;

2. The conditions in 130 CMR 456.407: *Clinical Authorization of Nursing-facility Services*, and 130 CMR 456.408: *Conditions for Payment* are met;

3. The facility completed an initial Preadmission Screening and Resident Review (PASRR) on the member in accordance with 130 CMR 456.410: *Screening for Mental Illness and Mental Retardation*, and applicable subregulatory guidance;

4. The facility received a Level II Determination Notice for the member from the Department of Developmental Services and/or the Department of Mental Health stating that

a. the member meets PASRR criteria for either Intellectual Disability, Developmental Disability, or Serious Mental Illness, and that the nursing facility is an appropriate setting to meet the member's needs; or

b. the member meets PASRR criteria for the Advanced Dementia Exclusion;

5. The facility complied with applicable subregulatory guidance on PASRR with regard to resident reviews after it received the Level II Determination Notice; and

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6. The facility has not received a subsequent Level II Determination Notice stating that the nursing facility is not an appropriate setting to meet the member's needs.

(b) Add-on Amount. A nursing facility will receive $5.38 per day for each eligible MassHealth member, which will be paid separately from the nursing facility standard rates.

(c) Payment of the Add-on. Nursing facilities must comply with all EOHHS billing instructions in order to receive a PASRR Level II Add-on payment for an eligible MassHealth member.

(d) Add-on Payment Recovery. EOHHS reserves the right to recover any PASRR Level II Add-on payments made to a facility that did not comply with all requirements of 101 CMR 206.06(15)(a) and (c).

(e) Written Communication. EOHHS may, *via* administrative bulletin or other written issuance, establish rules governing various aspects of the PASRR Level II Add-on including, but not limited to, reporting and compliance requirements, penalties for noncompliance, and recovery.

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 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. Payment to the Disaster Struck Nursing Facility shall 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.

(b) Realty Company Cost Report. A provider that does not own the real property of the nursing facility and pays rent to an affiliated or non-affiliated realty trust or other business entity must file or cause to be filed a Realty Company Cost Report with the Center.

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(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*.

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(f) Other Cost Reporting Requirements.

1. Administrative Costs.

a. The following expenses must be reported as administrative:

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.

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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.

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(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;

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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., 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.

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(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.

REGULATORY AUTHORITY

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

(PAGES 419 AND 420 ARE RESERVED FOR FUTURE USE.)