

957 CMR 6.00: COST REPORTING REQUIREMENTS

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6.01: General Provisions

- (1) Scope and Purpose. 957 CMR 6.00 governs the filing requirements for certain Providers to report their costs and other data to the Center for Health Information and Analysis.
- (2) Interpretation of Regulatory References. Any references to 114 CMR: *Division of Health Care Finance and Policy* shall, if necessary, be construed as referring to analogous regulations issued by EOHHS under the authority of M.G.L. c. 118E and appearing in 101 CMR: *Executive Office of Health and Human Services*.

6.02: Definitions

All defined terms in 957 CMR 6.00 are capitalized. As used in 957 CMR 6.00, unless the context otherwise requires, the following words shall have the following meanings:

ADH Provider. Any person, partnership, corporation, or other entity that is authorized in the Commonwealth of Massachusetts to engage in the business of furnishing Adult Day Health Services to the public and also meets such conditions of participation as may be adopted by a governmental unit.

Adult. Any person 18 years of age or older.

Adult Day Health Services. Programs approved by the Office of Medicaid under 130 CMR 404.000: *Adult Day Health Services* and that provide for adult recipients an alternative to 24-hour long-term institutional care through an organized program of health care and supervision, restorative services and socialization.

Adult Foster Care. Services as defined in 130 CMR 408.000: *Adult Foster Care* that are ordered by a physician and delivered to a member in a qualified setting as described in 130 CMR 408.415: *Scope of Adult Foster Care Services* by a multidisciplinary team and qualified AFC caregiver, that includes assistance with activities of daily living, instrumental activities of daily living, other personal care as needed, nursing services and oversight, and AFC care management.

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AFC Provider. An organization that meets the requirements of 130 CMR 408.000: *Adult Foster Care* and that contracts with MassHealth to provide Adult Foster Care to eligible MassHealth members.

Building. The structure that houses Residents. Building costs include the direct cost of construction of the shell and expenditures for service Equipment and fixtures such as elevators, plumbing, and electrical fixtures that are made a permanent part of the structure. Building Costs also include the cost of bringing the Building to productive use, such as permits, engineering and architect's fees, and certain legal fees. Building Costs include interest paid during construction but not Mortgage Acquisition Costs. When the fixed assets of a Facility are sold, the allowable book value of all Improvements will become part of the allowable basis of the Building for the buyer.

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

Certified Financial Statement. A certified financial statement is one that has been reviewed and approved by a certified, independent auditor.

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

Community Health Center (CHC). A clinic which provides comprehensive ambulatory services and which is not financially or physically an integral part of a hospital and which meets the conditions of participation that have been or may be adopted by a Governmental Unit purchasing community health center services. Minimally, a Community Health Center must meet the following criteria:

(a) In State:

1. Be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51, and
2. meet the qualifications for certification (or provisional certification) by and enter into a provider agreement with MassHealth pursuant to 130 CMR 405.000: *Community Health Center Services*.

(b) Out of State: Meet criteria for CHC Provider eligibility and enter into a provider agreement with MassHealth pursuant to 130 CMR 405.000: *Community Health Center Services*.

Continuous Skilled Nursing Care. The provision of skilled nursing services for at least two consecutive hours in duration in the home by eligible providers.

Cost Report. The document used to report cost and other financial and statistical data in a format requested by and approved by the Center.

Desk Audit. A comprehensive audit performed at the Center's offices in which the auditor evaluates the accuracy of the information in the Cost Reports and supporting documentation in accordance with an audit program.

Eligible Provider of Ambulance and Chair Car Services. A person, partnership, corporation, Governmental Unit or other entity that provides authorized emergency ambulance, transfer ambulance, and/or chair car services and that also meets such conditions of participation that have been or may be adopted by a Governmental Unit purchasing ambulance services.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Equipment. Tangible fixed assets, usually moveable, that are accessory or supplemental to such larger items as Buildings and structures.

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Field Audit. An audit performed at the Provider's office or site in which the auditor evaluates the accuracy of the information in the Cost Reports and claim for reimbursement by examining the books and records of the Provider by evaluating internal controls, observing the physical plant, and interviewing the Provider's staff.

Fixed Costs. Indirect Resident care costs, independent of the level of occupancy, including interest associated with long term debt; depreciation of Buildings; Building Improvements, Equipment and software; Equipment; insurance on Buildings and Equipment; real estate taxes; rent; the non income related portion of the Massachusetts Corporate Excise Tax; personal property tax; and Equipment rental.

Fixed-term Travel Employees. Employees who:

- (a) work exclusively at a particular health-care facility for a specified period of at least 90 days pursuant to a contract between the provider and a Temporary Nursing Agency;
- (b) must relocate a distance of at least 200 miles and establish a temporary residence for the contract term to work at the contracting provider; and
- (c) incur expenses for temporary accommodations paid by the Agency. Providers are required to maintain documentation concerning fixed-term travel employees for a period of two years following the expiration of the contract.

Governmental Unit. The Commonwealth, any board, commission, department, division, or agency of the Commonwealth and any political subdivision of the Commonwealth.

Home Health Aide Service. The provision of personal care in the home, under the supervision of a registered professional nurse, or, if appropriate, a physical, speech or occupational therapist. Home Health Aide Services are performed by trained personnel who assist clients to follow physicians' instructions and established plans of care. Additional services include, but are not limited to, assisting the patient with activities of daily living, exercising, taking medications ordered by a physician that are ordinarily self administered, assisting the patient with necessary self help skills, and reporting to the professional supervisor any changes in the patient's condition or family situation.

Home Health Agency. An agency that provides health services in a home setting. These services include skilled nursing, physical therapy, occupational therapy, speech therapy, medical social work and home health aide services.

Home Health Provider. An individual practitioner or an organization certified as a provider of services under the Medicare Health Insurance Program for the Aged (Title XVIII) and meets such conditions of participation as have been or may be adopted by a governmental unit purchasing home health services.

ICF Cost Report. The Cost Report for ICFs beginning with fiscal year 1996.

Improvements. Expenditures that increase the quality of the existing Building by rearranging the Building layout or substituting improved components for old components so that facilities are in some way better than before the renovation. Improvements do not add to the existing Building nor do they expand the square footage of the Building. An improvement is measured by the Resident Care Facility's increased productivity, greater capacity or longer life.

Intermediate Care Facility (ICF). An institution whether operated for the purpose of providing diagnostic, medical, surgical, or restorative treatment for patients within or centrally based in an institution licensed as a hospital by the Department of Public Health under M.G.L. c. 111, § 51 and any hospital licensed under M.G.L. c. 19, § 19.

Licensed Bed Capacity. A Resident Care Facility's "Licensed Bed Capacity" as defined by 105 CMR 100.020: *Definitions*: Licensed Bed Capacity, which states: the portion of bed capacity, by number of beds, which a Provider under its license, as issued or subsequently modified, is authorized to use for Resident care occupancy, or in the case of a Facility operated by a government agency, the number of beds approved by the Department.

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Major Additions. A newly constructed addition to a Resident Care Facility that increases the Licensed Bed Capacity of the Resident Facility by 50% or more.

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, including finder's fees, points, certain legal fees, and filing fees, that are necessary to obtain long term financing through a mortgage, bond or other long term debt instrument.

New CHC. A community health center which has experienced less than one year of operation as a CHC Provider of community health care services, or has instituted a significant change in service.

Provider. Any individual, group, partnership, trust, corporation or other legal entity that offers services for purchase by a Governmental Unit and that meets the conditions of purchase or licensure that have been or may be adopted by a purchasing Governmental Unit.

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 Individual. A person whose medical care and other services a governmental unit is in whole or in part liable for under a statutory program.

Publicly-aided Resident. A person as to whose care in a Resident Care Facility the Commonwealth or a political subdivision of the Commonwealth is in whole or in part financially liable.

Rate Year. The period in which the rate determined under 101 CMR 204.00: *Rates of Payment to Resident Care Facilities* is effective.

Related Party. An individual or organization associated or affiliated with, or that has control of, or is controlled by, the Provider; or any director, stockholder, trustee, partner or administrator of the Provider by common ownership or control or in a manner specified in sections 267(b), 267(c) and 318 of the Internal Revenue Code of 1954 as amended provided, however, that 10% must be the operative factor as set out in sections 267(b)(2) and (3). Related individuals include spouses, parents, children, spouses of children, grandchildren, siblings, fathers-in-law, mothers-in-law, brothers-in-law, and sisters-in-law.

Resident Care Facility. A Facility licensed by the Department of Public Health in compliance with 105 CMR 150.000: *Licensing of Long-term Care Facilities* or exempt from licensure under M.G.L. c. 111, § 73B providing protective supervision in addition to the minimum basic care required by 105 CMR 150.000: *Licensing of Long-term Care Facilities*, for Publicly-aided Residents who do not routinely require nursing or other medically related services.

Sole Proprietor. A business enterprise other than a corporation or partnership in which the net worth belongs entirely to one individual.

Temporary Nursing Services Agency. An Agency is defined in accordance with the provisions of 105 CMR 157.020: *Definitions: Temporary Nursing Services Agency*. It includes any person, firm, corporation, partnership, or association registered with the Department of Public Health that is engaged for hire in the business of procuring or providing temporary employment in health-care facilities for medical personnel, referred to as "nursing pools" in M.G.L. c. 111, § 72Y. Each separate location of the business of an Agency registered with the Department of Public Health is an Agency. An Agency shall not include a medical personnel staff arrangement set up by a health-care facility solely for its own use in which the only costs are the salaries paid to such medical personnel; or an individual who engages in providing his or her own services on a temporary basis to health-care facilities.

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Type I Provider. Any Provider of the type listed in 957 CMR 6.00: *Appendix A, Part 1*.

Type II Provider. Any Provider of a type listed specifically in 957 CMR 6.00 which must file a Cost Report specific to that type of Provider.

Type III Provider. Any Provider of the type listed in 957 CMR 6.00: *Appendix A, Part 2*.

340B Covered Entities. Facilities and programs eligible to purchase discounted drugs through a program established by Section 340B of Public Health Law 102-585, the Veterans Health Act of 1992.

6.03: Reporting Requirements for Type I Providers

Each Type I Provider shall file:

(1) An annual Uniform Financial Statement and Independent Auditor's Report (UFR) completed in accordance with:

- (a) The filing requirements and schedule of 808 CMR 1.00: *Compliance, Reporting and Auditing for Human and Social Services*; and
- (b) Any special instructions appearing in the *UFR Audit & Preparation Manual* which may require that certain providers distinguish among certain of their cost centers or programs by filing separate UFR-Schedule Bs for each cost center or program; and

(2) Any cost report supplemental schedule or any additional information requested by the Center within the timeframe specified by the Center on the request.

6.04: Reporting Requirements for Type II Providers

Each Type II Provider shall file the applicable reports listed in 957 CMR 6.00. Reports by Type II Providers are due within the timeframe specified by the Center or, if applicable, within the timeframe provided in 957 CMR 6.00.

6.05: Reporting Requirements for Type III Providers

Each Type III Provider shall file upon request of the Center and within the timeframe specified by the Center a complete and accurate Cost Report, budget, certified financial statements, records and books relating to its operations, data or other information as the Center may reasonably require.

6.06: 340B Covered Entities

Each 340B Covered Entity shall file within 90 days following the end of its fiscal year a complete and accurate Cost Report and certified financial statements in the format specified by the Center. Each Provider shall also make available within the timeframe specified by the Center all records and books relating to said operations, including such data, statistics, and records as the Center may from time to time request.

6.07: Adult Day Health

An ADH Provider that was paid by a Governmental Unit for Adult Day Health Services provided in a prior Fiscal Year, and whose program operated for the entire prior fiscal year must submit the following information to the Center:

(1) A complete Adult Day Health Center Cost Report for the prior Fiscal Year;

(2) Financial Statements certified by a certified public accountant. In the absence of certified statements, the ADH Provider may submit uncertified financial statements or a Balance Sheet and Operating Statement prepared by the agency, and approved by the Center; and

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- (3) Statistical data which shall be designated by the Center, including but not limited to the total number of resident days.

6.08: Home Health Services

- (1) Required Reports. Each Home Health Provider or Home Health Agency must file the following information in a format specified by the Center:
  - (a) The Nursing Service Cost Report for the agency's most recent fiscal year; and
  - (b) A home health agency Cost Report (CMS 1728) in which the Continuous Skilled Nursing hours and costs are separated from the Home Health skilled nursing visits, costs and other statistics, and any supplemental schedules as supplied and/or required by the Center.
- (2) Financial statements. Home Health Agencies must submit copies of financial statements and other external documentation supporting the accuracy of the data reported on the cost report. Acceptable documentation includes one of the following items (in descending order of preference):
  - (a) Audited, reviewed, or compiled financial statements prepared by a Certified Public Accountant;
  - (b) A certification from a Certified Public Accountant attesting to the accuracy and validity of the data reported on the Cost Report. The CPA must not be a related party to the principal owners or partners of the agency;
  - (c) Copies of tax returns filed with the Internal Revenue Service for the reporting year; and
  - (d) Agencies that apply for an Administrative Adjustment under the provisions of 114.3 CMR 50.06: *Administrative Adjustment* must submit separate documentation of costs associated with security escort and/or interpreter services.
- (3) Contracts. Each agency that contracts for home health services shall file with the Center a copy of all contracts into which it has entered.

6.09: Intermediate Care Facilities

- (1) On an annual basis, each ICF shall file with the Center one copy of the ICF Cost Report in portable document format, within 120 days of the close of its fiscal year. The ICF Cost Report is to be completed in accordance with the instructions set forth therein and pursuant to requirements of Administrative Bulletin 97-1 and any pertinent administrative bulletins issued by EOHHS pursuant to 101 CMR 129.09: *Administrative Bulletins*.
- (2) Each ICF shall file, when required, trial balances and supplemental financial information to support the facility's ICF Cost Report filing.
- (3) Each ICF shall make available all books and records relating to its operation for audit and/or screening, if requested by the Center.

6.10: Ambulance Services

Each Eligible Provider of Ambulance and Chair Car Services, except Governmental Units, shall complete and file an ambulance service Cost Report and supplemental schedules as specified by the Center and within 60 days of the close of the Provider's fiscal year. The submission must include financial statements audited, certified, reviewed or compiled by a certified public accountant or copies of tax returns filed with the Internal Revenue Service for the reporting year.

6.11: Community Health Centers

- (1) Required Reports: Existing CHC Providers.
  - (a) Unless exempted, each CHC shall file with the Center the following information in a format specified by the Center:

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1. A community health center Cost Report and any supplemental schedules as supplied and/or required by the Center; and
  2. A financial statement certified by a certified public accountant. In the absence of certified statements, the agency may submit uncertified statements or a Balance Sheet and Operating Statement prepared by the health center;
- (b) Each CHC shall file the reports required under 957 CMR 6.12(1)(a) within 60 days following the close of the CHC's fiscal year;
- (c) Each CHC shall file an annual Uniform Financial Statement and Independent Auditor's Report (UFR) completed in accordance with:
1. The filing requirements of Division of Purchased Services Regulation 808 CMR 1.00: *Compliance, Reporting and Auditing for Human and Social Services*; and
  2. Any special instructions appearing in the *UFR Audit & Preparation Manual* which may require that certain providers distinguish among certain of their cost centers or programs by filing separate UFR-Schedule Bs for each cost center or program.
- (2) Special Provisions.
- (a) New CHCs. New CHCs shall submit the required documentation cited in 957 CMR 6.11(1) and in accordance with the schedule set forth in 957 CMR 6.11(1) upon completion of a full fiscal year of operation.
- (b) Mergers, Acquisitions, Other Transfers. Any CHC involved in a merger, acquisition, purchase, pooling of interest or other arrangement involving the transfer of business between two or more CHCs becomes a single CHC for purposes of filing information under 957 CMR 6.11(2).

6.12: AFC Providers

Each Provider shall file an AFC Cost Report as required by the Center and on the date specified by the Center.

6.13: Resident Care Facilities

- (1) Required Reports.
- (a) Resident Care Facility Cost Report. Each Resident Care Facility must complete and file a Residential Care Cost Report each calendar year with the Center, containing the Resident Care Facility's claim for reimbursement and the complete financial condition of the Resident Care Facility, including all applicable management company, central office, and real estate expenses.
- (b) Realty Company Cost Report. A Resident Care Facility that does not own the real property of the Resident Care 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. If no report is filed, the Center will recommend that EOHHS should not reimburse the costs associated with the Resident Care Facility's rental expense.
- (c) Management Company Cost Report. A Resident Care Facility that claims management or central office expenses must file a separate management company Cost Report with the Center for each entity for which it claims management or central office expenses. If these costs are claimed for reimbursement, the Resident Care Facility must certify that costs are reasonable and necessary for the care of Publicly-aided Residents in Massachusetts.
- (2) General Cost Reporting Requirements.
- (a) Accrual Method. Resident Care Facilities must complete all required reports using the accrual method of accounting.
- (b) Documentation of Reported Costs. Resident Care Facilities 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 involving a rate for the period covered by the report, whichever occurs later. Resident Care Facilities must maintain complete documentation of all of the financial transactions and census activity of the Facility and affiliated entities, including but not limited to the books, invoices, bank statements, canceled checks, payroll records, governmental filings and any

## 6.13: continued

other records necessary to document the Resident Care Facilities' claim for reimbursement. Resident Care Facilities must be able to document expenses relating to affiliated entities for which reimbursement is claimed whether or not they are Related Parties.

(c) Fixed Asset Ledger. Resident Care Facilities must maintain a fixed asset ledger that clearly identifies each asset for which reimbursement is being claimed, including its location, the date of purchase, the cost, salvage value, accumulated depreciation, and the disposition of sold, lost or fully depreciated assets.

(d) Job Descriptions and Time Records. Resident Care Facilities and management companies must maintain written job descriptions including time records, qualifications, duties, and responsibilities for all positions for which reimbursement is claimed. The Center will recommend that EOHHS should not reimburse the salary and fringe benefits or the imputed amount for Sole Proprietors as specified in 101 CMR 204.04(2): *Base Year Variable Cost* for any individual for which the Resident Care Facilities does not maintain a job description and time record.

(e) Other Cost Reporting Requirements.

1. Expenses that Generate Income. Resident Care Facilities must identify the expense accounts that generate income. The Center will recommend that EOHHS should offset reported ancillary income if the Resident Care Facility does not identify the associated expense account.

2. Laundry Expense. Resident Care Facilities must separately identify the expense associated with laundry services not provided to all Residents. Resident Care Facilities may not claim reimbursement for such expense.

3. Fixed Costs.

a. Resident Care Facilities must allocate all Fixed Costs, except Equipment, on the basis of square footage. Resident Care Facilities may elect to specifically identify Equipment related to the Facility. The Resident Care Facilities 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.

b. If a Resident Care Facility 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 claim reimbursement for the assets.

c. Resident Care Facilities must separately identify fully depreciated assets. Resident Care Facilities must report the costs of fully depreciated assets and related accumulated depreciation on all reports unless they have removed such costs and accumulated depreciation from the Resident Care Facilities' books and records. Resident Care Facilities must attach to the Cost Report a schedule of the cost of the retired Equipment, accumulated depreciation and the accounting entries on the books and records of the Facility when the Equipment is retired.

d. Resident Care Facilities may not report expenditures for major repair projects whose useful life is greater than one year as expenses.

e. Resident Care Facilities must not report such expenditures as pre-paid expenses.

4. Mortgage Acquisition Costs. Resident Care Facilities must classify Mortgage Acquisition Costs as other Assets. Resident Care Facilities may not add Mortgage Acquisition Costs to fixed asset accounts.

5. Related Parties. Resident Care Facilities must report salary expenses paid to a Related Party and must identify all goods and services purchased from a Related Party. If a Resident Care Facility purchases goods and services from a Related Party, it must disclose the Related Party's cost of the goods and services. The Center will recommend that EOHHS should limit reimbursement for such goods and services to the lower of the Related Party's cost or the cost determined using the Prudent Buyer Concept.

6. Service of Non-paid Workers. The services must be fully disclosed in the Footnotes and Explanations section of the Cost Report. Both the total Expense and the account(s) in which the expense is reported must be identified.

7. Facilities in which other Programs are Operated. If a Resident Care Facility operates an adult day health program, an assisted living program, or provides outpatient services, the Resident Care Facility must not claim reimbursement for the expenses of such programs. If the Resident Care Facility converts a portion of the Facility to another program, the Resident Care Facility must:



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- a. identify existing Equipment no longer used in Facility operations. Such Equipment must be removed from the Facility's records;
- b. identify the square footage of the existing Building and improvement costs associated with the program, and the Equipment associated with the program; and
- c. allocate shared costs, including shared capital costs, using a well documented and generally accepted allocation method. The Resident Care Facility must directly assign to the program any additional capital expenditures associated with the program.

(3) Filing Deadlines.

(a) General. All Resident Care Facilities must file required Cost Reports for the calendar year by 5:00 P.M. April 1<sup>st</sup> of the following calendar year. If April 1<sup>st</sup> falls on a weekend or holiday, the reports are due by 5:00 P.M. of the following business day.

(b) Special Provisions.

1. Change of Ownership. The transferor must file Cost Reports with the Center within 60 days after a Change of Ownership. The Center will notify the Department of Transitional Assistance if required reports are not filed timely for payments to be withheld or other appropriate action by that agency.
2. New Facilities and Facilities with Major Additions. New Facilities and Facilities with Major Additions that become operational during the Rate Year must file year end Cost Reports with the Center within 60 days after the close of the first and second Rate Years.
3. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, § 72N, the Resident Care Facilities must file Cost Reports for the pre-receivership reporting period or portion thereof with the Center, within 60 days of the receiver's appointment.
4. Closed Facilities. A Facility that permanently closes is not required to file the reports cited in 101 CMR 204.07(1): *Required Reports* for the year in which the Facility closed.

(4) Incomplete Submissions. If the Cost Reports are incomplete, the Center will notify the Resident Care Facility in writing within 120 days of the receipt. The Center will specify the additional information that the Resident Care Facility must submit to complete the Cost Reports. The Resident Care Facility must file the necessary information within 25 days of the date of notification or by April 1<sup>st</sup> of the year the Cost Reports are filed, whichever is later. If the Center fails to notify the Resident Care Facility within the 120-day period, the Cost Reports will be considered complete and deemed to be filed on the date of receipt.

(5) Amended Reports. Amended Reports will be accepted no later than August 15<sup>th</sup> of the year in which the Cost Reports are due. Amended Reports must be accompanied by a complete list of the corrections made to the reports with sufficient supporting documentation along with an explanation of the reasons therefore.

6.14: Temporary Nursing Services

*See 101 CMR 345.00: Temporary Nursing Services.*

6.15: Additional Information

Each Provider shall also make available all records, books and reports relating to its operations, including such data and statistics as the Center may from time to time request, whether or not that Provider is of a type specifically listed in 957 CMR 6.00 or 957 CMR 6.00: *Appendix A.*

6.16: Accuracy of Reported Data

All reports, schedules, additional information, books and records that are filed or made available to the Center will be certified under the penalties of perjury as true, correct, and accurate by the Executive Director, Financial Officer, owner, partner, or other officer or director of the Provider, as the Center may specify.

6.17: Audits

The Center may conduct Desk Audits or Field Audits to ensure accuracy and consistency in reporting. Providers may be required to 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. All Providers must maintain supporting documentation sufficient to demonstrate compliance with all provisions of 957 CMR 6.00.

6.18: Extensions of Deadlines, Exemptions from Filing and Alternate Cost Reports

- (1) The Center may at its discretion grant allowances that:
  - (a) Extend the filing due date to any Provider;
  - (b) Exempt any Provider from some or all of the Cost-Reporting requirements of 957 CMR 6.00; or
  - (c) Allow any Provider to file alternate Cost Reports in *lieu* of the Cost Reports specified in 957 CMR 6.00.
- (2) In exercising its discretion to grant allowances, the Center may consider the Provider(s) service volume, revenues, current MassHealth volumes and revenues, amount and value of uncompensated care, expenditures, hardship in filing or meeting filing deadlines, and any other relevant factors.
- (3) The Center may attach reasonable conditions or requirements to any allowance granted under 957 CMR 6.18.
- (4) The Center will limit the duration of any allowance to one fiscal year of the Provider(s) granted the allowance; however, the Center may renew the Provider's allowance for an additional fiscal year following the expiration of the previous allowance.

6.19: Penalties

- (1) The Center may impose a fine of up to \$500 on Providers that knowingly fail to file or that knowingly file falsified data.
- (2) If a Provider has without justifiable cause refused to furnish the Center with information, as required by 957 CMR 6.00, the Center may petition the Superior Court to issue an order directing all Governmental Units to withhold payment to the Provider until further order of the Court.
- (3) The Center may refer delinquent Providers to EOHHS, with recommendations that EOHHS impose penalties, including:
  - (a) Reduction in delinquent Providers' rates;
  - (b) Removal of delinquent Providers from the list of eligible Providers;
  - (c) Any other penalty authorized by M.G.L. c. 118E or applicable regulations.
- (4) The Center may refer delinquent Providers or Providers that knowingly file falsified information to the appropriate licensing authority, which may seek suspension or revocation of the Provider's license.

6.20: Administrative Bulletins

The Center may issue Administrative Bulletins to clarify its policies on and understanding of substantive provisions of 957 CMR 6.00 and to specify information and documentation necessary to implement 957 CMR 6.00.

6.21: Severability

The provisions of 957 CMR 6.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 957 CMR 6.00 or the application of such provisions.

REGULATORY AUTHORITY

957 CMR 6:00: M.G.L. c. 12C.

6.00: continued

**Appendix A****Part 1 - Type I Providers**

- 101 CMR 356.00: *Money Follows the Person Demonstration Services*
- 101 CMR 357.00: *Money Follows the Person Waiver Services*
- 101 CMR 411.00: *Placement and Support Services*
- 101 CMR 412.00: *Family Transitional Support Services*
- 101 CMR 414.00: *Family Stabilization Services*
- 101 CMR 417.00: *Certain Elder Care Services*
- 101 CMR 418.00: *Youth Short-term Stabilization and Emergency Placement Services*
- 101 CMR 419.00: *Supported Employment Services*
- 101 CMR 420.00: *Adult Long Term Residential Services*
- 101 CMR 346.00: *Substance Abuse Programs*
- 101 CMR 352.00: *Children's Behavioral Health Services*
- 114.3 CMR 6.00: *Mental Health Services Provided in Community Health Centers and Mental Health Centers*
- 114.3 CMR 7.00: *Psychiatric Day Treatment Center Services*
- 114.3 CMR 8.00: *Outpatient Tuberculosis Control Center Services*
- 114.3 CMR 9.00: *Independent Living Services for the Personal Care Attendant Program*
- 114.3 CMR 48.00: *Day Habilitation Program Service*
- 114.3 CMR 49.00: *Early Intervention Program Services*
- 114.3 CMR 54.00: *Acquired Brain Injury Waiver and Related Services*
- 114.4 CMR 10.00: *Competitive Integrated Employment Services*
- 114.4 CMR 13.00: *Youth Intermediate-term Stabilization Services*
- 114.4 CMR 15.00: *Community Based Day Support Services*
- 114.4 CMR 16.00: *Clubhouse Services*

**Part II - Type III Providers**

- 101 CMR 334.00: *Prostheses, Prosthetic Devices and Orthotic Devices*
- 101 CMR 343.00: *Hospice Services*
- 114.3 CMR 13.00: *Freestanding Clinics Providing Abortion and Sterilization Services*
- 114.3 CMR 20.00: *Clinical Laboratory Services*
- 114.3 CMR 22.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment*
- 114.3 CMR 31.00: *Prescribed Drugs*
- 114.3 CMR 37.00: *Chronic Maintenance Dialysis Treatments and Home Dialysis Supplies*
- 114.3 CMR 39.00: *Rehabilitation Center Services, Audiological Services, Restorative Services*
- 114.3 CMR 47.00: *Freestanding Ambulatory Surgical Facilities*
- 114.3 CMR 55.00: *Freestanding Birth Centers Services*
- 114.5 CMR 4.00: *Social, Rehabilitation and Health Care Services*
- 101 CMR [Pending]: *Group Adult Foster Care*