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Administrative Bulletin 26-21

101 CMR 206.00: *Standard Payments to Nursing Facilities*

Effective October 01, 2026

Nursing Facility Direct Care Cost Quotient

Introduction

The Executive Office of Health and Human Services (EOHHS) is issuing this administrative bulletin under 101 CMR 206.12: *Direct Care Cost Quotient* (DCC-Q) to state the compliance criteria, reporting requirements, penalty amount, and recovery and referral procedures for the nursing facility direct care cost quotient. This administrative bulletin supersedes [Administrative Bulletin 25-12](#): 101 CMR 206.00: *Standard Payments to Nursing Facilities: Nursing Facility Direct Care Cost Quotient*.

DCC-Q Compliance Threshold

Under 101 CMR 206.12(1)(a):

- For rate years beginning on or after October 1, 2023, a nursing facility rate will be subject to a downward adjustment if the facility fails to be at or above the 75% DCC-Q threshold in the previous full fiscal year.
- For rate years beginning on or after October 1, 2026, a nursing facility rate will be subject to a downward adjustment if the facility fails to be at or above the 75% DCC-Q threshold in the previous full calendar year.

DCC-Q Calculation

- a) The DCC-Q will be calculated for each facility by dividing the facility's *Total Direct Care Expenses* by its *Total Adjusted Nursing Revenue*, as defined in this bulletin.
- b) *Total Direct Care Expenses* means the total amount calculated when adding together the following eligible expenses:

- i. Eligible direct care workforce expenses attributable to the following workforce categories: registered nurses; licensed practical nurses, certified nurse aides; non-certified or resident care aides; director of nurses; in-house clerical staff regularly interacting with residents and caregivers (e.g., receptionists, business office staff working onsite), including administrator expenses up to \$200,000; security staff; staff development coordinator; dietary; housekeeping/laundry; quality assurance professional; unit clerks; MMQ evaluation nurse/MDS coordinator; social service worker; behavioral health staff; plant operations/maintenance; interpreter service; restorative therapy; recreational therapy; physician services; pharmacy consultant; provided however that expenses attributable to recreational therapy and social service worker workforce categories will be multiplied by 1.5 before being added to the overall direct care workforce expense amount.
 - ii. Eligible additional direct care expenses attributable to the following categories, for resident care only: food and dietary supplies; laundry and housekeeping supplies; and medical supplies.
- c) *Total Adjusted Nursing Revenues* includes eligible facility total revenue from the following revenue categories: Nursing Facility Payer Revenue and Residential Care Revenue (Level IV), but only if revenue adjustments are made to subtract expenses for the following categories: user fee expense and Medicare ancillary costs including laboratory, pharmacy, x-ray, ambulance, and specialty beds.

Reporting Requirements

- a) All nursing facilities, including facilities with less than 5,000 Massachusetts Medicaid Days in any given fiscal year, will be required to submit an interim compliance report and a final compliance report each year (see Section 4(c) of this administrative bulletin). Both the interim compliance report and the final compliance report must be submitted using the submission form available at the [University of Massachusetts Portal](#).
- b) All nursing facilities are required to submit both an interim compliance report by July 31 of each year (covering the period from January 1 through June 30 of that calendar year) and a final compliance report by March 1 of the subsequent year (covering the full calendar year prior to the March 1 deadline). The interim report will be used to inform nursing facilities if they are on track to meet the 75% DCC-Q threshold set forth in 101 CMR 206.12(1) by the final report deadline. The final compliance report will be used to determine whether the facility met that threshold.

Rate Adjustment Calculation and Enforcement

- a) If a facility fails to meet the 75% DCC-Q threshold, based on the data in its final compliance report, the facility's standard rate will be subject to a downward adjustment in the following rate year. The downward adjustment will be calculated as follows.
 - i. For every 1% below the 75% DCC-Q threshold, a 0.5% downward adjustment will be applied to the nursing and operating components of the facility's standard payments, subject to the limitations in Section 4(a)(ii) of this administrative bulletin.
 - ii. The maximum downward adjustment calculated for a facility may be no more than 5% of the nursing and operating components of the facility's standard payments in the following rate year.
- b) EOHHS may apply the maximum downward adjustment of 5% in the following rate year for facilities that fail to submit the final compliance report by the March 1st due date.
- c) Nursing facilities that have fewer than 5,000 Massachusetts Medicaid Days in the previous fiscal year, as reported on their Quarterly User Fee Assessment Forms for the period of July 1 through June 30, will be exempt from the downward adjustment. However, any facilities that fail to comply with the final compliance report submission requirements may be subject to an administrative fine of up to \$5,000. Administrative fines will be applied in accordance with [130 CMR 450.239](#):
Sanctions: Calculation of Administrative Fine.

Exemption Criteria for the DCC-Q Downward Adjustment

- a) For rate years beginning on or after October 1, 2026, nursing facilities that had fewer than 5,000 Massachusetts Medicaid days, as reported on their quarterly User Fee Assessment Forms for the full calendar year immediately preceding the current rate year will be exempt from the downward adjustment set forth in 101 CMR 206.12(4).
- b) For rate years beginning on or after October 1, 2026, a nursing facility will be exempt from the DCC-Q downward adjustment under 101 CMR 206.12(4) if the facility is at or above an average Hours Per Patient Day (HPPD) of 4.00, calculated as described in 101 CMR 206.13(3), in each of the four calendar quarters of the calendar year used to determine DCC-Q downward adjustments for the rate year.

Contact Information for Provider Questions Regarding the Direct Care Cost Quotient

For any technical questions regarding the interim or final compliance form, or abbreviated compliance report, please email NFReporting@umassmed.edu. For all

other questions, please email Pamela Murdock, Senior Manager of Institutional Programs, at Pamela.Murdock@mass.gov.