

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 512.00: NURSING FACILITY USER FEES

Section

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512.01: General Provisions

101 CMR 512.00 governs the collection of nursing facility user fees.

512.02: Definitions

As used in 101 CMR 512.00, unless the context requires otherwise, terms have the following meanings.

Assessment. The total payment due each quarter for each non-Medicare patient day, as set forth in 101 CMR 512.00.

Centers for Medicare & 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.

Changes in Ownership (CHOW). Changes in ownership of a nursing facility will, in the case of a corporation, mean transfer of a majority of the stock thereof, and in all other cases, a transfer of a majority interest therein, pursuant to M.G.L. c. 111, s. 71.

Continuing Care Retirement Community (CCRC). A community that furnishes board and lodging together with nursing services, medical services, or other health-related services, regardless of whether or not the lodging and services are provided at the same location, to individuals, other than those related by consanguinity or affinity to the person furnishing such care, pursuant to a contract effective for the life of the individual or for a period in excess of one year, and that has filed disclosure information with the Massachusetts Executive Office of Elder Affairs pursuant to M.G.L. c. 93, § 76(e). Licensed nursing facility beds not under the direct control of the board of the CCRC are not considered part of the CCRC.

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

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.

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Facility. A nursing facility licensed by DPH under M.G.L. c. 111, § 71, including nursing or convalescent homes, an infirmary maintained in a town, a charitable home for the aged, and transitional care units.

Fiscal Year (FY). The state fiscal year from July 1st through June 30th.

MassHealth Program (MassHealth). The medical assistance benefits plans operated and administered by EOHHS pursuant to M.G.L. c. 118E, § 1 *et seq.* and 42 U.S.C. § 1396 *et seq.* Title XXI of the Social Security Act (42 U.S.C. 1397), and other applicable laws and waivers to provide and pay for medical services to eligible members (Medicaid).

Medicaid Bed Day. A patient day for nursing facility services for which one of the following applies.

- (a) MassHealth is the primary payer and the nursing facility resident is a MassHealth Fee-for-Service member;
- (b) a Senior Care Options (SCO) plan, One Care plan, or Program of All-inclusive Care for the Elderly (PACE) organization is the primary payer and the patient day is a Non-skilled Day; or
- (c) MassHealth, a SCO plan, a One Care plan, or a PACE organization is the primary payer and the nursing facility resident is enrolled in hospice.

Medicare. The federal health insurance program for people who are 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) established by Title XVIII of the Social Security Act.

Medicare Patient Day. A patient day for nursing facility services that is covered by Medicare Part A under an indemnity fee-for-service arrangement (“Original Medicare”) or under a Medicare managed care plan (“Medicare Advantage plan”). For a resident enrolled in Senior Care Options (SCO), One Care, or Program of All-inclusive Care for the Elderly (PACE), a Medicare Patient Day is a Skilled Day.

MassHealth-affiliated Accountable Care Organization (ACO). An entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs.

Non-Medicare Patient Day. A patient day for nursing facility services that is not covered by Medicare Part A under Original Medicare or a Medicare Advantage plan. For a resident enrolled in Senior Care Options (SCO), One Care, or Program of All-inclusive Care for the Elderly (PACE), a Non-Medicare Patient Day is a Non-skilled Day. Non-Medicare Patient Days do not include residential care patient days.

Non-skilled Day. A patient day for nursing facility services provided to a Senior Care Options (SCO), One Care, or Program of All-inclusive Care for the Elderly (PACE) member for which Medicare would **not** be the primary payer if the member received such services through Original

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Medicare or a Medicare Advantage plan instead of through the member's SCO, One Care, or PACE plan.

One Care (also known as an Integrated Care Organization (ICO)). An organization with a comprehensive network of medical, behavioral health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and CMS and has been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Patient Day. A day of care provided to an individual by a facility regardless of whether the facility has been paid for the day. The date an individual is admitted to the facility is a patient day. The date an individual is discharged is not a patient day, unless the individual is admitted and discharged on the same day. Patient days include days for which a facility reserves and customarily charges for a vacant bed for an individual temporarily placed in a different care situation ("bed hold days"). Patient days also include Medicaid "medical leave of absence days" and "non-medical leave of absence days" in accordance with 130 CMR 456.425: *Medical Leave of Absence: Introduction* through 130 CMR 456.433: *Nonmedical Leave of Absence: Payment*.

Program of All-inclusive Care for the Elderly (PACE). A comprehensive service delivery and financing model that integrates medical and long-term services and supports (LTSS) under dual capitation agreements with Medicare and Medicaid as described under federal regulations for PACE at 42 CFR 460. The PACE program is open to eligible MassHealth members 55 years of age and older who meet MassHealth's skilled-nursing-facility level of care criteria and reside in a PACE service area.

Residential Care. The minimum basic care and services and protective supervision required by DPH 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.

Senior Care Organization (SCO). An organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS) to provide a comprehensive network of medical, health-care, and social-service providers and that integrates components of care, either directly or through subcontracts. Senior Care Organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth covered services.

Skilled Day. A patient day for nursing facility services provided to a Senior Care Options (SCO), One Care, or Program of All-inclusive Care for the Elderly (PACE) member for which Medicare would be the primary payer if the member received such services through Original Medicare or a Medicare Advantage plan instead of through the member's SCO, One Care, or PACE plan.

512.03: Facility Groups

(1) Nursing facility user fee payment liability will vary by facility group. The two groups of facilities for purposes of 101 CMR 512.00 are defined in 101 CMR 512.03(1)(a) and (b):

(a) Group I: All facilities that do not meet the criteria for group II; and

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- (b) Group II: Any nursing facility meeting one or more of the following criteria:
1. a non-profit continuing care retirement community or non-profit residential care facility;
 2. a non-profit facility that provides at least 39,000 annual Medicaid bed days, as determined by EOHHS; or
 3. a facility with a Medicaid utilization rate of 87% or higher, as determined by EOHHS.

(2) New facilities that come into operation after the effective date of EOHHS's approved waiver under 42 CFR 433.68(e)(2), or facilities otherwise not included in the approved waiver application, will be considered Group I facilities until EOHHS determines the facility's group eligibility. Facilities that undergo a change in status that alters their group eligibility after January 1, 2023, will remain in their original group until EOHHS determines eligibility. If the determination of eligibility for a new facility or a facility's change in status would result in noncompliance with EOHHS's approved federal waiver, the facility will remain in its current group until such time as EOHHS is able to amend its approved waiver.

512.04: Calculation of User Fee

- (1) EOHHS or its designee calculates the *per diem* user fee annually. The user fee is calculated as follows.
- (a) Determine the amount of revenue to be collected in a fiscal year in accordance with M.G.L. c. 118E, s. 63.
 - (b) Determine the expected number of non-Medicare patient days in Group I facilities.
 - (c) Determine the expected number of non-Medicare patient days in Group II facilities.
 - (d) Determine the standard rate such that the product of estimated non-Medicare patient days in Group I facilities and the Group I facility user fee rate and the product of estimated non-Medicare patient days in Group II facilities and the Group II facility user fee rate equal the amount of revenue to be collected in a fiscal year in accordance with M.G.L. c. 118E, s. 63.
- (2) Group I will pay the standard rate per non-Medicare patient day.
- (3) Group II will pay 30% of the standard rate.
- (4) The total collections for each fiscal year shall equal 6% of the revenues received by the taxpayer class for such fiscal year.
- (5) (Reserved)
- (6) For each fiscal year, the Group I and Group II *per diem* user fee rates shall be established in accordance with 101 CMR 512.04(1) through (4), and shall be published, via Administrative Bulletin, by October 1 each year. Further, if, during the course of a fiscal year, EOHHS determines that the total amount of user fee revenue will be significantly different than previously estimated, it may recalculate the user fee and may change the user fee prospectively by administrative bulletin to reflect such changes based on the methodology described in 101 CMR 512.04(1) through (4).

512.05: Payment of User Fee

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(1) Quarterly Assessment. Each facility must pay a quarterly assessment to EOHHS. Each facility must determine the amount of the assessment owed for each quarter by multiplying (1) its total Non-Medicare Patient Days by (2) the *per diem* user fee established by EOHHS.

(2) User Fee Form. Each facility must submit its quarterly assessment on a form prepared by EOHHS. Each facility must report its total patient days by payer and its non-Medicare patient days on the user fee form. A facility is still obligated to pay the user fee even if they have not received or accessed the form.

(3) Due Date.

(a) Assessment payments and the user fee form are due according to the following schedule.

Assessment Period	Payment and Form Due Date
July 1 st – September 30 th	November 1 st
October 1 st – December 31 st	February 1 st
January 1 st – March 31 st	May 1 st
April 1 st – June 30 th	August 1 st

(b) If a facility closes, it must pay any outstanding user fee obligations within 30 days of the date of closure.

(c) Mergers, Acquisitions, and CHOW. The assessment obligation of any nursing facility is applied to an obligation of any successor in interest or assignee of such nursing facility, as determined by EOHHS. A successor in interest may include, but is not limited to, any purchaser of the assets or stock, any new operator or licensee of an existing nursing facility, any surviving entity resulting from merger or liquidation, or any receiver or any trustee of the original nursing facility.

(4) Administration. EOHHS will inform facilities by administrative bulletin of the procedures for the payment and collection of the user fee. EOHHS may update these procedures by administrative bulletin.

(5) Interest and Late Fees. EOHHS may assess interest and late fees on unpaid assessments. If a facility pays an assessment within 30 days following the due date, EOHHS may assess pro-rated interest at a rate equivalent to 1.5% per month on the outstanding balance calculated from the due date. If a facility fails to pay an assessment within 30 days after the due date, EOHHS may assess a one-time late fee of 6.5% on the outstanding balance and no additional interest will be assessed.

(6) Assessment Revenue. The total amount of assessments collected, any federal financial participation generated from the payments to facilities based on the collected assessments, penalties, and any interest earned will be credited to the general fund of the Commonwealth of Massachusetts.

(7) Enforcement Provisions. In addition to interest and late fees imposed under 101 CMR 512.05(5), EOHHS may take enforcement actions including but not limited to the following:

(a) recoupment of a nursing facility's claims not to exceed an amount established by administrative bulletin or other appropriate written issuance;

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- (b) creation, after demand for payment, of a lien in favor of the Commonwealth; and
- (c) notifying DPH if a facility fails to pay a required assessment. Under M.G.L. 118E, s. 63(f), DPH will impose a limitation on new admissions or revoke licensure of a facility that fails to pay a delinquent assessment.

512.06: Reporting Requirements

- (1) General. Each facility must file or make available information that is required or that EOHHS deems reasonably necessary for calculating and collecting the user fee.
- (2) Required Reports. Each facility must file required reports and forms with EOHHS or its designee and must submit any additional documentation requested by EOHHS or its designee to verify the accuracy of the data submitted.
- (3) Audit. EOHHS or its designee may request or inspect and copy the records of a facility for purposes of auditing its calculation of the assessment.
 - (a) If EOHHS or its designee determines that a facility has either overpaid or underpaid the assessment, it will notify the facility of the amount due or refund the overpayment.
 - (b) EOHHS or its designee may offset overpayments against amounts due EOHHS for the assessment.
 - (c) If a facility is aggrieved by a decision of EOHHS or its designee as to the amount due, it may file an appeal to the Division of Administrative Law Appeals within 60 days of the date of the notice of underpayment or the date the notice is received, whichever is later. The filing of an appeal will not toll the collection of interest and penalties.
- (4) Penalties.
 - (a) EOHHS may impose a penalty of \$100 per day if a facility fails to submit required reports or furnish other documentation required under 101 CMR 512.00 by the dates specified in 101 CMR 512.05(3) or as specified by EOHHS in administrative bulletins or other written issuances.
 - (b) If a nursing facility fails to produce records requested by EOHHS for the purpose of auditing the facility's calculation of the assessment by the due date specified by EOHHS in accordance with 101 CMR 512.06(3), EOHHS may impose a penalty of \$100 per day for 30 days. If the facility does not produce the records within 30 days, EOHHS will establish a presumptive assessment amount for the audit period based on the data available to EOHHS and will notify the facility of that amount.

512.07: Other Provisions

- (1) Severability. The provisions of 101 CMR 512.00 are severable. If any provision of 101 CMR 512.00 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 512.00 or application of those provisions to applicable individuals, entities, or circumstances.

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(2) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify policies, update administrative requirements, and specify information and documentation necessary to comply with 101 CMR 512.00.

REGULATORY AUTHORITY

101 CMR 512.00: M.G.L. c. 118E.

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