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# 101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

## 101 CMR 204.00: RATES OF PAYMENT TO RESIDENT CARE FACILITIES

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### 204.01: General Provisions

(1) Scope. 101 CMR 204.00 governs the payment rates for services provided by resident care facilities to publicly aided and industrial accident residents. Residential care units of nursing facilities are governed by 101 CMR 206.00: *Standard Payments to Nursing Facilities*.

(2) Applicable Dates of Service. Rates contained in 101 CMR 204.00 apply for services provided on or after December 1, 2021.

(3) Disclaimer of Authorization of Services. 101 CMR 204.00 is not authorization for or approval of the substantive services or the time period for which rates are determined pursuant to 101 CMR 204.00. Governmental units and insurers that purchase services from eligible providers are responsible for the definition, authorization, and approval of services provided to publicly aided or industrial accident residents.

### 204.02: General Definitions

As used in 101 CMR 204.00, unless the context requires otherwise, terms have the meanings in 101 CMR 204.02.

Actual Utilization Rate. The percentage of occupancy of a resident care facility. It is calculated by dividing total resident days by maximum available bed days.

Additions. New units or enlargements of existing units that may or may not be accompanied by an increase in licensed bed capacity.

Average Equity Capital. The average of the difference between a provider's beginning and ending allowable book value and the provider’s beginning and ending balances for allowable long-term liabilities, calculated pursuant to 101 CMR 204.06.

Base Year. The calendar year or portion of the calendar year that is used to compute the prospective rates as defined in 101 CMR 204.04. The base year for rates effective December 1, 2021, is 2019.

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 (CHIA), established under M.G.L. c. 12C.

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 Support Facility. A resident care facility licensed by the Department in compliance with 105 CMR 150.000: *Standards for Long-term Care Facilities* that provides or makes arrangements to provide appropriate mental health services in addition to the minimum basic care and services required by 105 CMR 150.000 for residents who do not routinely require nursing or other medically related services.

Community Support Resident. An individual in need of resident care facility services, who is 50 years of age or older, and who, upon the written consent of the individual (if he or she is competent to give such consent) or guardian (if he or she is not competent), and a physical evaluation by a psychiatrist or other physician, and a psychiatric evaluation by a psychiatrist, is deemed appropriate by both for residency and services provided by a community support facility pursuant to 105 CMR 150.000: *Standards for Long-term Care Facilities* or its most recent applicable regulation. Any exceptions and additional factors used to determine whether a resident is a community support facility resident will be in accordance with 105 CMR 150.000.

Community Support Resident Days. The number of days of occupancy by community support residents in a community support facility or a resident care facility with community support residents. Community support resident days include the day of admission, but not the day of discharge. Where admission and discharge occur on the same day, one community support resident day will be used. Those days a bed is held vacant for a publicly aided community support resident temporarily placed in a different care situation, pursuant to an agreement between the provider and the Department of Transitional Assistance in accordance with duly established policies of said Department, are included as community support resident days. Those days a bed is held vacant for a non-publicly aided resident, whether or not there is a charge for such reservation by the facility, are included as community support resident days.

Constructed Bed Capacity. A resident care facility's bed capacity (or clinical bed capacity) as defined in 105 CMR 100.100: *Definitions*, which states: the capacity of a building to accommodate a bed and the necessary physical appurtenances in accordance with the applicable standards imposed as a condition of operation under state law. It includes a room designed or able to accommodate a bed and necessary physical appurtenances, whether or not a bed and all such

appurtenances are actually in place, with any necessary utilities (*e.g.*, drinking water, sprinkler lines, oxygen, electric current, electric signals, *etc.*), with either outlets or capped lines within the room.

Deferred Charges. Expenditures, such as prepaid insurance, rent or licenses, not recognized as a cost of operations for the period in which they were incurred, but carried forward to be written off in one or more future periods. Deferred charges are not expenditures that can be identified with and justified as relating to physical assets that will contribute services to future operations.

Department. The Massachusetts Department of Public Health.

Department of Transitional Assistance Days (DTA Days). Days of resident care facility services provided to residents who are recipients of Emergency Assistance for the Elderly, Disabled and Children (EAEDC) or Supplemental Security Income/State Supplemental Payments (SSI/SSP) funded by DTA.

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.

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.

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.

Exit Conference. A conference conducted at the close of an on-site field audit at which the Center auditors present audit findings and recommendations to the provider. The provider may respond to the Center's findings and may present additional information for review. The conference may take place at a scheduled meeting or by telephone.

Field Audit. An audit performed on site at the resident care facility 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 facility by evaluating internal controls, observing the physical plant, and interviewing resident care facility 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.

Generally Available Employee Benefits. The employee benefits that are reasonable and necessary for the efficient operation of the facility including, but not limited to, insurance, pensions, bonuses, child care, and non-required but job-related education. Such benefits must be nondiscriminatory and available to all full-time employees.

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 facility's increased productivity, greater capacity, or longer life.

Imputed Value. An alternative cost based on a standard amount to be used by EOHHS in *lieu* of other costs.

Indirect Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing, and language therapists to provide orientation programs for aides and assistants, in-service training to staff, and consultation and planning for continuing care after discharge.

Industrial Accident Resident. A person receiving resident care facility services for which an employer or an insurer is liable under M.G.L. c. 152 (the Workers' Compensation Act).

Land Costs. The purchase price plus the cost of bringing land to productive use including, but not limited to, commissions to agents, attorney's fees, demolition of buildings, clearing and grading the land, site-survey, soil investigation, streets, off-site sewer and water lines, and public utility charges necessary to service the land. Land must be necessary for the care of publicly aided residents.

Licensed Bed Capacity. A resident care facility's licensed bed capacity as defined by 105 CMR 100.100: *Definitions*, 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 patient occupancy, or in the case of a facility operated by a government agency, the number of beds approved by the Department.

Limited Life Assets. Limited life assets include software, wallpaper, and painting.

Long-term Interest Expense. Reasonable and necessary expense that is incurred for the use of legitimate loans related to the care of publicly aided residents and that is supported by allowable, depreciable fixed assets. It includes all of the costs of borrowing money including, but not limited to, interest, allowable mortgage acquisition costs, and mortgage insurance premiums.

Major Additions. A newly constructed addition to a facility that increases the licensed bed capacity of the 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 355, Business/Manufacturing Corporate Excise Return.

Maximum Available Bed-days. The total number of licensed bed-days for the calendar year, determined by multiplying the mean licensed bed capacity for the calendar year by the days in the calendar year.

Mean Licensed Bed Capacity. A facility's weighted average licensed bed capacity for the calendar year. The value is calculated by multiplying the licensed bed capacity by the number of days in the calendar year for which the facility was licensed to determine the maximum available bed-days. The maximum available bed-days is divided by the number of days in the calendar year to determine the mean licensed bed capacity.

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.

Nonprofit Provider. A provider either organized for charitable purposes or recognized as a nonprofit entity by the Internal Revenue Service. This includes Massachusetts corporations organized under M.G.L. c. 180; clubs, associations, organizations, or tax-exempt entities; corporations organized under M.G.L. c. 156B and granted a tax exemption under the Internal Revenue Code, § 501(c)(3); and facilities owned or operated by governmental units.

Nursing Facility. A nursing or convalescent home, infirmary maintained in a town, or 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 the MassHealth program, or facilities licensed to operate a residential care unit within a nursing facility or those exempt from licensure under M.G.L. c. 111, § 73B.

Proprietary Provider. A provider that does not meet the criteria specified in 101 CMR 204.02: *General Definitions*: Nonprofit Provider.

Provider. A resident care facility providing care to publicly aided 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 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 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 the Internal Revenue Code of 1954, §§ 267(b), 267(c), and 318; provided, however, that 10% must be 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.

Resident Care Facility (Facility). A facility licensed by the Department in compliance with 105 CMR 150.000: *Standards for 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 for residents who do not routinely require nursing or other medically related services.

Resident Days. The number of days of occupancy by residents in a facility. Included in the computation of resident days is the day of admission, but not the day of discharge. Where admission and discharge occur on the same day, one resident day is used. Those days in which a bed is held vacant and reserved for a publicly aided resident temporarily placed in a different care situation, are included as resident days. Those days on which a bed is held vacant and reserved for a non-publicly aided resident, whether or not there is a charge for such reservation by the facility, are included as resident days.

Responsible Person. A person 21 years of age or older who has received a high school diploma, is of good moral character, and has the ability to communicate orally and in writing in English or the primary language used by residents of the facility, and who will make mature and accurate judgments regarding the care needs of the residents as required by 105 CMR 150.000: *Standards for Long-term Care Facilities.*

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

Support Service Coordinator. A person who has received a BA or BS degree in a human service field of study such as psychology, nursing, or social work and who is employed by a community support facility to identify, monitor, and meet the support service needs of community support residents.

Support Services. Those services provided for the benefit of community support resident(s) in order to enhance psycho-social and physical functioning as defined by the Department in 105 CMR 150.000: *Standards for Long-term Care Facilities*.

Unit. Unit has the same definition as in 105 CMR 150.000: *Standards for Long-term Care Facilities*.

Variable Costs. Costs that change depending on the volume of occupancy. Variable costs include the allowable amounts reported in the following accounts from the cost report: administrator/responsible person salaries and benefits; clerical salaries; EDP/payroll/bookkeeping services; office supplies; telephone, except directory advertising; motor vehicle expense; conventions and meetings; advertising, help wanted; licenses and dues, resident care related; total education and training; total employee benefits, except officers, profit sharing and other benefits; accounting services not related to appeals; total payroll taxes, except officer; nonprofit DES claims; malpractice and general liability insurance; total Workers' Compensation, except officer; total group life/health, except officer; total plant operations; total dietary; total laundry; total

housekeeping; total nursing; quality assurance professional; community support coordinator; total physician services; house supplies, not resold; pharmacy consultant; social service worker; indirect therapy salaries; indirect therapy consultants; total recreation, except transportation; realty company variable add-back; management company variable and fixed cost add-back, less non-allowable self-disallowances; vending machine income; and other operating cost recoverable income.

204.03: General Rate Provisions

(1) General. EOHHS will determine a payment rate for dates of service on or after December 1, 2021, for each facility as follows.

(a) Preliminary Rate. The facility's preliminary rate is equal to the sum of

1. allowable variable costs determined under 101 CMR 204.04;
2. allowable capital and other fixed costs and working capital allowance as determined under 101 CMR 204.05; and
3. allowable equity or use and occupancy allowance determined under 101 CMR 204.06.

(b) Rate Adjustments. The preliminary rate as calculated in 101 CMR 204.03(1)(a) will be adjusted as follows.

1. DTA Days Percentage Adjustment.
   a. For each facility, calculate its DTA days percentage by dividing its DTA days by the facility's total resident days, as reported on Schedule 3 of the 2019 HCF-4.
   b. Each facility will receive a DTA Days Percentage Adjustment equal to $5.00 multiplied by the percentage calculated in 101 CMR 204.03(1)(b)1.a.
2. GAFC Adjustment. For each eligible facility, apply the GAFC adjustment in the same amount as applied to the rate in effect on November 30, 2021.

(c) Payment Rate. The facility's December 1, 2021, payment rate is equal to the greater of

1. the sum of the preliminary rate as determined in 101 CMR 204.03(1)(a) and the payment rate adjustments as determined in 101 CMR 204.03(1)(b), plus $6.80; or
2. the facility's certified rate in effect on November 30, 2021, plus $6.80

(d) Annualization Adjustment. For the period from December 1, 2021 through December 31, 2021, EOHHS will apply an annualization adjustment of 496.77% of the difference between the facility's December 1, 2021, rate as determined in 101 CMR 204.03(1)(c) and its certified rate in effect on November 30, 2021, which accounts for the period July 1, 2021 through November 30, 2021.

(2) Other Provisions.

(a) Audits. EOHHS will establish rates after a comprehensive desk audit of the base year cost report. The Center may also, whenever possible, conduct on-site field audits to ensure the accuracy of the claims for reimbursement and consistency in reporting. EOHHS will disallow any cost for which the provider does not produce adequate documentation requested by the Center during a desk or field audit.

(b) General Cost Principles. In order to be reimbursed, a cost must

1. be ordinary, necessary, and directly related to the care of publicly aided residents;
2. be consistent with the prudent buyer concept;
3. be for goods and services actually provided in the resident care facility;
4. not have the transaction effect of circumventing 101 CMR 204.00 under the principle that the substance of the transaction must prevail over form;

5. actually be paid by the provider. Examples of costs that are not considered paid for purposes of reimbursement include, but are not limited to, costs that are discharged in bankruptcy; forgiven; converted to a promissory note; and accruals of self-insured costs based on actuarial estimates; and

6. not be paid to a related party that has not been identified on the reports.

(c) Non-allowable Costs. Rates will not include those costs that are not reimbursable, as defined below, are reimbursed through an allowance, or are for services that are billed directly.

1. Costs that are not reimbursable include

a. bad debts, refunds, charity and courtesy allowances, and contractual adjustments to the Commonwealth and other third parties;

b. 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 the variable cost, included in the variable cost allowance;

c. federal and state income taxes, except the non-income related portion of the Massachusetts corporate excise tax;

d. expenses that are not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fundraising, 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 or contracts for special projects;

e. compensation and fringe benefits for residents on a provider's payroll;

f. any amounts in excess of any schedule or limitation contained in 101 CMR 204.00;

g. 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;

h. any increase in compensation or fringe benefits granted as an unfair labor practice after a final adjudication by the court of last resort;

i. accrued expenses that remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, are not 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. Except as provided above, a cost must actually be paid by the provider in order to be reimbursable. Examples of costs that are not considered paid for purposes of reimbursement include, but are not limited to, costs that are discharged in bankruptcy; costs that are forgiven; costs that are converted to a promissory note; and accruals of self-insured costs that are based on actuarial estimates;

j. expenses for purchased service nursing services purchased from temporary nursing agencies that are not registered with the Department under 105 CMR 157.000: *The Registration and Operation of Temporary Nursing Service Agencies*;

k. any expense or amortization of a capitalized cost relating to costs incurred prior to the opening of the facility;

l. expenses relating to the financing of or otherwise supporting political or lobbying activities regarding legislation to affect reimbursement methods; campaign contributions; and advertising to create goodwill or otherwise affect payments made by governmental units;

m. all legal expenses; and those accounting expenses and filing fees associated with any appeal process;

n. additional rental payments or charges based upon receipts or income will not be considered as additional rental expense;

o. interest payments and charges based upon the provider's receipts or income will not be considered as allowable interest expense;

p. any costs that were incurred in periods other than the base year;

q. an adjustment to base year costs to reflect the difference between the rates charged to private residents in the base year if those rates are less than the public rates certified in the base year. EOHHS will multiply the difference between the base year rate for publicly aided residents and the average rate charged private residents corresponding to the base year above. The adjustment is calculated as follows: [(private income/resident private patient days) - public base year rate *per diem*] x (base year resident private patient days/base year patient days) = the *per diem* amount by which the publicly aided rate will be reduced. In no instances will the certified rate be lower than the lowest private rate assigned to an individual for that period;

r. any costs, including rental and leasehold expenses, for buildings and equipment that are not located at the site of the resident care facility will not be allowable as fixed costs; and

s. costs of ancillary services that are required to be billed on a direct basis to the purchasing government agency.

2. Cost reimbursed through an allowance or other specified methodology include the following.

a. Other Recoverable Income. Other recoverable income will be recovered against an account in the appropriate cost group category, such as variable cost allowance and fixed costs.

b. Working Capital Interest. Interest on short-term or working capital obligations is not allowed, but will be reimbursed pursuant to the working capital allowance under 101 CMR 204.05(4)(a).

3. Costs for Services Billed Directly. The following supplies or services must be billed directly to the purchaser in accordance with the purchaser's regulations or policies.

a. Physician. Direct physician services to individual residents, including emergency physician services required by 105 CMR 150.000: *Standards for Long-term Care Facilities.*

b. Medical Supplies. Direct medical services or supplies in accordance with the regulations or written policy of the governmental unit responsible for paying for such services or supplies in the *per diem* rates.

c. Prescriptions. Pharmacy costs related to legend drug prescriptions and prescribed legend drugs for individual residents.

d. Therapy. Direct restorative services provided upon written order of a physician.

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204.04: Variable Cost Allowance

(1) Scope. EOHHS will include in each provider's rate a variable cost allowance to compensate for variable costs.

(2) Base Year Variable Cost *Per Diem*. EOHHS will calculate the base year variable cost *per diem* for each provider by dividing the total allowable base year variable costs by the greater of base year resident days or 90% of the mean licensed bed capacity in the base year times the days in the base year. For providers that are organized as sole proprietors, EOHHS will include an imputed amount of $95,534 for the personal services of an owner.

(3) Cost Adjustment Factor. EOHHS will apply a cost adjustment factor of 5.49% to 2019 base year costs. If there has been a change of ownership in the base year, and the rates are based on the new owner's reported base year costs, EOHHS will modify the cost adjustment factor to reflect the number of months from the midpoint of the new owner's reporting period to the midpoint of the prospective rate period.

(4) Variable Cost Allowance. The variable cost allowance equals the lower of base year variable cost *per diem* or $128.96, which is further adjusted by the cost adjustment factor.

(5) Special Provisions.

(a) Accrued Expenses. EOHHS will not allow accrued expenses that remain unpaid for more than 120 days after the close of the reporting year, excluding vacation and sick time accruals. If the provider submits evidence of satisfactory payment to the Center, EOHHS may reverse the adjustment and include that cost, if otherwise allowable, in the applicable rates.

(b) Accounting and Auditing Expenses. Reasonable and necessary accounting and auditing expenses in matters directly related to providing adequate care to publicly aided residents are included, provided that the books and records of the provider are maintained in accordance with generally accepted accounting principles.

(c) Staff Training Expenses. The net cost, which is the cost of required staff training activities less any reimbursement from grants, tuition, specific donations, employee contributions, or other sources is included, only if the training is

1. conducted within the Commonwealth of Massachusetts;
2. directly related to improving resident care to publicly aided residents; and
3. conducted by a recognized school, other authorized organization, or a qualified professional as required in 105 CMR 150.000: *Standards for Long-term Care Facilities*.

(d) Advertising Expenses. The reasonable and necessary expense of newspaper or other public media advertisements for the purpose of hiring necessary employees.

(e) Generally Available Employee Benefits. The extent of the facility's contribution to the cost of generally available fringe benefits are included so long as they are nondiscriminatory.

(f) Membership Dues. Reasonable and necessary membership dues are included if the organization's function and purpose are directly related to the development and operation of the facility and providing adequate resident care.

(g) Services of Volunteer Workers. Services performed under an agreement between the organization and the provider for the performance of the services without direct payment. The value of services normally provided on a voluntary basis, such as distribution of magazines and newspapers to residents, does not constitute a reasonable variable cost. The net value of

services for unpaid persons in positions customarily held by paid employees, performing such services on a regular basis as unpaid members of religious or other organizations, is allowable as a variable cost if

1. the amount allowed does not exceed that which would be paid others for similar work;
2. the amount paid by the provider to the organization is identifiable in the records of the provider as a legal obligation; and
3. the services are performed on a regular, scheduled basis and are necessary for the provision of adequate resident care to publicly aided residents and for the efficient operation of the provider.

(h) Non-legend Drugs. The reasonable and necessary costs of providing the non-legend drugs, including non-legend drugs ordered by a doctor. Non-legend drugs must not be billed directly to any governmental unit or charged against the personal care funds of any resident.

(i) Pension Plans. Reasonable and necessary expenses incurred by a provider relating to a pension plan are included as a generally available employee benefit. Reimbursable pension plans must provide for either a fixed determinable amount to be contributed by the employer on a regular basis or for a fixed determinable benefit to be received by the employee at retirement. Reimbursement of pension costs is subject to the following specific provisions.

1. Required by State Statute. Providers required by enabling statute to make payments to municipal or county pension funds will be reimbursed for the compensation paid by the plan, provided that the provider submits detail of the allocations provided to the Public Employees Retirement Administration Commission, and for funded pension plans, a schedule of the individuals associated with the resident care facility, to the Center.
2. Not Required by State Statute. Providers not required by state statute to make payments to a municipal pension fund will be reimbursed for expenses incurred to the extent that
    a. the claimed expenses represent an amount based on fair, reasonable, and necessary compensation for services performed by employees;
    b. the claimed expenses are costs incurred on current year payroll and do not include payments for prior year payroll;
    c. the plan does not provide for contributions by the employer based on the contingency of profit or is at the discretion of the employer;
    d. the pension plan must have met the current requirements of and, if applicable, received the approval of the Internal Revenue Service. All applicable Internal Revenue Service forms documenting Internal Revenue Service approval must be filed with the Center along with copies of the plan;
    e. the employer's contribution to a pension plan will be included, along with other increments in the calculation of limits to the reimbursement of individual employee compensation as referred to in 101 CMR 204.00; and
    f. any forfeiture by an employee must be applied against the cost to reduce the premiums paid by the employer. A forfeiture is considered to have occurred when any employee who participated in the pension plan terminates employment prior to becoming vested. This reduction in the claim for reimbursement must be made notwithstanding the terms or lack of terms in the pension plan.

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204.05: Capital and Other Fixed Costs

(1) Allowable Fixed Costs.
(a) Allowable fixed costs include the allowable portion of depreciation, long-term interest, real estate taxes, personal property taxes on resident care facility equipment, the non-income portion of the Massachusetts corporate excise tax, building insurance, and rental of equipment located at the facility, less any recoverable fixed cost income.
(b) EOHHS will calculate the provider's capital and other fixed costs *per diem* by dividing allowable fixed costs by the constructed bed capacity times the days in the rate year times the greater of 90% or the actual utilization rate in the base year.

(2) Allowable Basis of Fixed Assets.
(a) Fixed Assets. Fixed assets include land, building, improvements, equipment, and limited life assets/software.
(b) Allowable Basis.
1. If there has been no change of ownership, the allowable basis of fixed assets equals the reasonable construction costs.
2. For a newly constructed facility opening for resident care on or after January 1, 1984, the basis of such assets will be limited to reasonable, audited construction and equipment costs based upon the minimum standards and requirements of the Massachusetts Department of Public Safety. Once operations commence, interest and acquisition fees will be treated as a cost of borrowing and treated as interest expense. In no case will the allowable basis exceed the cost of construction approved in accordance with M.G.L. c. 111, § 25C. The basis of fixed assets will be limited to construction and equipment costs based upon the minimum standards and requirements of the Massachusetts Public Health Council. EOHHS will reimburse only those costs associated with meeting the above-mentioned standards.
3. If there has been a change of ownership, the allowable basis for fixed assets will be determined as follows.
a. Land. EOHHS will include the lower of the acquisition cost or the basis allowed the immediate prior owner.
b. Equipment. EOHHS will include the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility in calculating rates of payment for publicly aided residents.
c. Building and Building Improvements. EOHHS will include the lower of the acquisition cost or the basis allowed the immediate prior owner, reduced by the amount of actual depreciation allowed to the prior owner of the facility for publicly aided residents for the years from 1968 to the date of change of ownership. The seller's allowable building improvements will become part of the new owner's allowable basis of building.
d. If the amount of actual depreciation allowed in a prior year is not known, the buyer must furnish the information to the Center. If this information is not available, EOHHS will calculate the amount using the best available information.
(c) Other Provisions.
1. Allowable Additions. EOHHS will recognize fixed asset additions made by the provider if the additions are related to the care of publicly aided residents.

2. Forgiveness of Debt. Where, subsequent to a change of ownership, the transferor forgives or reduces the debt of the transferee, such forgiveness or reduction of debt will be retroactively applied to reduce the acquisition cost to the transferee.
3. Repossession by Transferor. The basis of fixed assets will be recomputed if the transferor repossesses a facility to satisfy in whole or in part the transferee's purchase obligations, becomes a direct or indirect owner, or receives an interest in the transferee's facility or company. The recomputed basis will not exceed the transferor's original allowable basis under EOHHS regulations applicable at the date of change of ownership increased by any allowable capital improvements made by the transferee since acquisition and reduced by depreciation since acquisition.
4. Rental and Leasehold Expense. EOHHS will allow reasonable rental and leasehold expenses for land, building, and equipment, but reimbursement is limited to the lower of the average rental or ownership costs of comparable providers, or the reasonable and necessary costs of the provider and lessor including interest, depreciation, real property taxes, and property insurance. EOHHS will not allow rent and leasehold expense, unless a realty company cost report is filed.

(3) Depreciation
(a) Depreciation Allowed. EOHHS will allow depreciation of building, building improvements, and equipment based on accepted accounting principles using as a basis the lower of the original acquisition cost of the facility, an amount based on a cost per bed for the year of construction of the facility set forth in the regulation governing the rate year of the original acquisition, or the principles set forth in 101 CMR 204.05 if a change of ownership occurred on or after January 1, 1984.
(b) Depreciation Methodology. EOHHS will use the straight-line method to calculate allowable depreciation. EOHHS will exclude depreciation on an asset upon expiration of the useful life.
(c) Useful Life. EOHHS will use the schedule in 101 CMR 204.05(3)(c) to calculate depreciation on fixed assets.

| Asset | Life | Rate |
|---|---|---|
| Building<br>Class I or II as classified by the Dept. of Public Safety | 40 years | 2.5% |
| Class III or IV as classified by the Dept. of Public Safety | 33 years | 3.0% |
| Building Improvements and Leasehold Improvements | Varies | up to 5% |
| Equipment, Furniture, and Fixtures | ten years | 10% |
| Motor Vehicle Equipment | four years | 25% |
| Limited Life Assets Acquired after December 31, 1996 | three years | 33.3% |

(d) Change of Ownership.

1. Building and Building Improvements. EOHHS will add building and building improvements to determine the buyer's allowable basis for building. The buyer's allowable basis will be depreciated over the remaining useful life of the building.
2. Equipment and Limited Life Assets. Equipment and limited life assets will be depreciated in accordance with 101 CMR 204.05(3)(c).
3. Depreciation on Assets. EOHHS will limit the annual amount of depreciation on transferred assets to the seller's annual allowed depreciation.

(4) Interest. A facility's rate will include reasonable and necessary interest expense determined as follows.

(a) Interest on Working Capital. EOHHS will not reimburse interest on short-term working capital. In *lieu* of this expense, EOHHS will add an allowance for the financing of current operations, determined by multiplying the variable cost allowance by 1/12 of the annual prime lending rate. The prime lending rate of 3.25% was used to determine rates effective December 1, 2021.

(b) Interest on Long-term Debt. EOHHS will include reasonable and necessary interest on allowable long-term debt, supported by depreciable fixed assets subject to 101 CMR 204.05(2). EOHHS will not reimburse long-term interest expense on debt that exceeds the allowable basis of fixed assets.

1. Long-term Loans. Long-term interest will be limited to an annually determined percentage of simple interest on all outstanding long-term loans, weighted by the dollar amount of the funds borrowed. For allowable long-term loans secured prior to January 1, 1984, the annually determined percentage will be the rate as stated in the debt instrument at the time of borrowing. For allowable long-term loans secured on or after January 1, 1984, the annually determined percentage will be the lower of the rate as stated in the debt instrument at the time of borrowing or the percentage equal to the monthly rate of interest on special issues of public debt obligations issued to the federal Hospital Insurance Trust Fund for the third month prior to the month in which the financing occurred, plus 3%. EOHHS will limit the allowable interest rate to 15%.
2. Refinancing.

a. EOHHS will recognize the refinancing of an existing allowable debt under the following circumstances.

i. Crossover. When the accumulated principal payments on the existing allowable debt exceeds the accumulated depreciation allowed by EOHHS on the allowable fixed assets financed by that debt;

ii. Demand Note. When an existing, allowable debt becomes payable on demand;

iii. Lowered Expense. When the long-term interest expense over the life of the refinanced debt is lower than it would have been under the remainder of the existing, allowable debt. The provider must submit comparative schedules showing total long-term interest expense under the existing allowable debt and the refinanced debt; or

iv. Allowable Additions. When a provider refinances for an amount greater than the existing allowable debt, and the purpose of the additional indebtedness is to finance a significant addition of allowable fixed assets. EOHHS will not

reimburse long-term interest expense for additional refinancing that exceeds the amount of allowable fixed assets.

b. Allowable Interest Rate. The allowable interest rate for an allowable or partially allowable refinancing will be determined in accordance with 101 CMR 204.05(4)(b)1.

c. When a refinancing, or a portion of a refinancing, is not allowable under 101 CMR 204.05(4)(b)2., EOHHS will calculate allowable long-term interest as though the non-allowable refinancing did not occur.

(c) Other Provisions.

1. Interest. Interest related to the financing of newly acquired fixed assets will be allowed only if the asset acquisition and financing occur concurrently. If the provider presents documentation sufficient to demonstrate that all reasonable attempts were made to finance the asset at the time of acquisition, EOHHS will recognize financing obtained no more than 90 days after the date of acquisition of the assets.

2. Loans from Owner, Officer, or Related Party. Interest expense does not include interest on loans to the facility from an owner, officer, or related party.

3. Mortgage Acquisition Costs. Mortgage acquisition costs must be amortized over the life of the mortgage. Amortized mortgage acquisition costs are treated as long-term interest expense. For allowable long-term debts secured on or after January 1, 1984, mortgage acquisition costs are subject to the ceiling on maximum interest rates in accordance with 101 CMR 204.05(4)(b).

204.06: Equity and Use and Occupancy Allowance

(1) General. EOHHS will include a return on average equity capital for proprietary providers. EOHHS will include a use and occupancy allowance for nonprofit providers.

(2) Average Equity Capital Allowance. Average equity capital is the difference between the provider's allowable book value of fixed assets, including land, at the beginning and end of the year, and the provider's allowable long-term liabilities at the beginning and end of the year. The average equity capital is then multiplied by a rate of 1.50%.

(a) EOHHS will reduce average equity capital by building, improvements, equipment, and software depreciation allowed in prior years.

(b) EOHHS will not include mortgage acquisition costs, such as capitalized legal fees and prepaid interest on long-term obligations, or equity in buildings or equipment not located at the resident care facility, in average equity capital.

(c) EOHHS will not reduce average equity capital by long-term loans for which interest has been excluded as a result of debt not supported by allowable fixed assets.

(d) If a facility replaces beds, reimbursable equity will be recalculated using the newly established allowable fixed assets and allowable debt.

(e) EOHHS will calculate the *per diem* average equity capital by multiplying the average equity capital by a rate of 1.50% then dividing by the constructed bed capacity times the days in the rate year times the greater of 90% or the actual utilization rate in the base year.

(3) Use and Occupancy Allowance. EOHHS will increase nonprofit providers' rates to reflect the cost of use and occupancy of net allowable fixed assets. The use and occupancy allowance equals ⅓ of the allowance calculated pursuant to 101 CMR 204.06(2).

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 204.00: RATES OF PAYMENT TO RESIDENT CARE FACILITIES

204.07: Reporting Requirements

(1) Required Reports.
(a) Resident Care Facility Cost Report. Each provider must complete and file a residential care cost report each calendar year with the Center, containing the facility's claim for reimbursement and the complete financial condition of the facility, including all applicable management company, central office, and real estate expenses.
(b) Realty Company Cost Report. A provider that does not own the real property of the 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, EOHHS will not reimburse the costs associated with the provider's rental expense.
(c) Management Company Cost Report. A provider 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 expense. If these costs are claimed for reimbursement, the provider 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. 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 involving a rate for the period covered by the report, whichever occurs later. Providers 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 other records necessary to document the provider's claim for reimbursement. Providers 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. Providers 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. Providers and management companies must maintain written job descriptions including time records, qualifications, duties, and responsibilities for all positions for which reimbursement is claimed. EOHHS will not reimburse the salary and fringe benefits or the imputed amount for sole proprietors as specified in 101 CMR 204.04(2) for any individual for which the provider does not maintain a job description and time record.
(e) Other Cost Reporting Requirements.
1. Expenses that Generate Income. Providers must identify the expense accounts that generate income. EOHHS will offset reported ancillary income if the provider does not identify the associated expense account.

2. Laundry Expense. Providers must separately identify the expense associated with laundry services not provided to all residents. Providers may not claim reimbursement for such expense.

3. Fixed Costs.

a. Providers must allocate all fixed costs, except equipment, on the basis of square footage. Providers may elect to specifically identify equipment related to the 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.

b. 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 claim reimbursement for the assets.

c. Providers must separately identify fully depreciated assets. Providers 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 provider's books and records. Providers 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. Providers may not report expenditures for major repair projects whose useful life is greater than one year as expenses. Providers must not report such expenditures as pre-paid expenses.

4. Mortgage Acquisition Costs. Providers must classify mortgage acquisition costs as other assets. Providers may not add mortgage acquisition costs to fixed asset accounts.

5. Related Parties. Providers must report salary expenses 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. EOHHS will 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 provider operates an adult day health program, an assisted living program, or provides outpatient services, the provider must not claim reimbursement for the expenses of such programs. If the provider converts a portion of the facility to another program, the provider must

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 provider must directly assign to the program any additional capital expenditures associated with the program.

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 204.00: RATES OF PAYMENT TO RESIDENT CARE FACILITIES

(3) Filing Deadlines.

(a) General. All resident care facilities 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. 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 provider 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) for the year in which the facility closed.

(c) Extension of Filing Date. The director of the Center's pricing group 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 rather than through agents or other representatives;
2. demonstrate exceptional circumstances that prevent the provider from meeting the deadline; and
3. file the request no later than 15 calendar days before the due date.

(4) Incomplete Submissions. If the cost reports are incomplete, the Center will notify the provider in writing within 120 days of the receipt. The Center will specify the additional information that the provider must submit to complete the cost reports. The provider must file the necessary 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 deemed to be filed on the date of receipt.

(5) Amended Reports. Amended reports will be accepted no later than August 15th 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) Additional Information. The Center may require the provider to submit additional data and documentation during a desk or field audit even if the Center has accepted the provider's cost reports. In addition, the Center may request additional information and data relating to the operations of the provider and any related party.

(7) Failure to File Timely. If the provider does not file the required cost reports by the due date, EOHHS may reduce the provider's rate 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 reduction will be reversed effective on the date the cost reports are filed.

204.08: Other Provisions

(1) Special Rate Provisions.

(a) New Facilities and Major Additions. EOHHS will calculate projected rates for new facilities and facilities with major additions in the rate year. The provider must file a projected cost report that projects the reasonably anticipated costs and anticipated resident days for a 12-month period commencing with the first date of licensure.

1. New Facilities and Facilities with Major Additions Becoming Operational Prior to July 1st of the Rate Year.

a. First Rate Year. EOHHS will calculate a projected rate based on the projected cost report. The effective date of the rate will be the first date of licensure through December 31st of the first rate year that the facility becomes operational.

b. Second Rate Year. EOHHS will calculate the rate for the second rate year based on the projected cost report described in 101 CMR 204.07.

c. Third Rate Year. The rate for the third rate year is based on the first calendar year cost report of actual expenditures.

2. New Facilities and Facilities with Major Additions Becoming Operational on or after July 1st of the Rate Year.

a. First Rate Year. EOHHS will calculate the rates based upon the projected cost report as described in 101 CMR 204.07. The effective dates of the rate will be the first date of licensure through December 31st of the first rate year that the facility becomes operational.

b. Second Rate Year. The rate for the second rate year is based on the same projected cost report that was used for the first rate year.

c. Third Rate Year. EOHHS will calculate the rate for the third rate year based on the cost report of actual expenditures filed for the second calendar year.

3. Cost Ceilings. EOHHS will use the cost reports as described in 101 CMR 204.07(1) subject to appropriately inflated ceilings and limitations for each cost center.

4. EOHHS will recalculate projected rates based upon actual cost data, once a provider files a cost report(s) that covers the projected rate period.

(b) Facilities Sold during the Base Year. If a provider is sold during the base year, EOHHS will use the buyer's cost reports for the buyer's period of ownership to determine allowable base year costs. If the Center determines that the buyer's period of ownership was not long enough to ensure that it is representative of annualized costs, EOHHS may determine the rate using the seller's cost report.

(c) Facilities Closed after the Base Year. If a provider closed after the base year and subsequently reopened, EOHHS will use the base year cost report to calculate the rate. If no base year cost report was filed, EOHHS will calculate the rate using the latest filed cost report and increase the variable cost allowance by an appropriate cost adjustment factor.

(d) Private Resident Care Facilities. A facility that was a private facility during the base year and subsequently signs a provider agreement to provide services to publicly aided residents must file a cost report for the latest full year prior to the date of the provider agreement. EOHHS will calculate allowable variable costs using the appropriate ceilings and cost

adjustment factor. EOHHS may limit the rate to the amount of the facility's average rate charges to private patients.

(e) Facilities Purchased from a Receiver. If a facility is purchased from a receiver, the Center may use the cost report from a year different from the base year if it determines that the costs for that year more accurately reflect the reasonable and necessary costs of providing resident care, subject to approval of the Department of Transitional Assistance. In such cases, EOHHS will increase the variable cost allowance by an appropriate cost adjustment factor.

(f) Rates for Special Programs. EOHHS may include an allowance for costs and expenses to maintain a special program if the provider has received prior written approval from the purchasing agency.

(2) Administrative Adjustments.

(a) Types of Administrative Adjustments. A provider may file a petition with the Center for an administrative adjustment during the rate year for the following reasons.

1. Substantial Capital Expenditures. A provider may petition for an administrative adjustment for a substantial capital expenditure of at least $10,000 for improvements and limited life assets and $5,000 for equipment if it has either made, or expects to make, a substantial capital expenditure that meets the criteria set forth in 101 CMR 204.08(2)(a)1.a. through f.

a. Qualifying Expenses. The provider may petition for recognition of increased depreciation and interest expense as a result of the expenditure. The provider may not petition for mortgage acquisition costs, an equity adjustment, or increased operating costs as a result of the expenditure.

b. Expenditures Not Subject to Determination of Need. For improvements, the expenditure amount must be at least 1.5 times the allowable annual base year depreciation expense of building, improvements, and limited life assets. For equipment, the expenditure amount must be at least 1.5 times the allowable base year depreciation on equipment.

c. Expenditures Subject to Determination of Need. If the expenditure is subject to determination of need approval, the provider may petition for an adjustment after the Department has determined that need exists for the project and after the time for making an appeal to the Health Facilities Appeals Board has expired or all administrative and judicial reviews of the Department's determination have been concluded. The provider may petition for an adjustment before the Department has made a determination on the project if the Commissioner of Public Health requests that EOHHS determine the appropriate amount of an adjustment before a determination of need is made with respect to the provider's proposed expenditure.

d. Limitation on Capital. The maximum amount allowed for fixed costs and equity for a facility is described in 101 CMR 204.08(2)(a)1.d. If the provider has not yet incurred the expenses, it must submit satisfactory evidence of its commitment to incur the expenditure.

| **Effective Date** | **Payment Amount** |
|---|---|
| Prior to July 1, 2004 | $17.29 |
| July 1, 2004, to December 31, 2006 | $22.56 |
| January 1, 2007, to December 31, 2007 | $25.82 |
| January 1, 2008, to December 31, 2012 | $27.30 |
| January 1, 2013–November 30, 2018 | $28.06 |
| December 1, 2018–Forward | $37.60 |

e. EOHHS will certify a temporary administrative adjustment of up to $37.60 upon receipt of the notification of the petition request for the substantial capital expenditure, rate adjustment request, and required supporting documentation.

f. Whenever a capital petition is granted, the provider's allowable basis will be adjusted by increasing the accumulated depreciation by the amounts included in the rates from the effective date of the petition.

2. New Governmental Requirements. A provider may petition for an administrative adjustment if it has incurred, or presents satisfactory evidence of a commitment to incur, substantially different costs necessary to satisfy new requirements of a governmental unit of the Commonwealth or the federal government. Such requirements must be related to provision of resident care. An increase in existing government requirements is not considered a new government requirement. EOHHS will not approve a petition for costs incurred to correct Department of Public Health resident care deficiencies.

3. Certain Increases in Operating Costs. A provider may petition for an adjustment if it has experienced unusual or unforeseen increases in operating costs that are not reflected in the rate. Unusual and unforeseen circumstances are events of a catastrophic nature (for example, fire, flood, or earthquake). The cost increases must gravely threaten the financial stability of the provider. In measuring the financial stability of the provider, EOHHS will consider all of the provider's expenditures and revenues.

4. Receiver Fees. A receiver appointed under M.G.L. c. 111, § 72N may petition for a rate adjustment to reimburse reasonable receiver compensation and payment of his or her bond.

a. The receiver must submit detailed invoices that document the hours expended, a brief description of each activity, and the hourly rate. EOHHS will limit the reimbursement to the reasonable and necessary cost to safeguard the health, safety, and continuity of care to residents and to protect them from adverse health effects of unsuitable transfer.

b. EOHHS will limit reasonable receiver compensation to the lower of actual receiver fees or $10,000 for the first 30 days, $7,500 for the second 30 days, $2,500 for the third 30 days, and $1,500 for each 30-day period thereafter. EOHHS may include additional receiver compensation if both the Department of Public Health and the Department of Transitional Assistance approve additional compensation to the receiver due to unique circumstances. EOHHS, the Department, and the Department of Transitional Assistance will evaluate such requests for additional compensation for reasonableness.

5. Transfer of a Facility. If a facility is transferred during the first six months of the year subsequent to the base year, the buyer may file a petition requesting that EOHHS use the buyer's cost report to determine its rate. The buyer must demonstrate that use of the seller's base year cost report is not appropriate to project rate year costs. The Center will determine whether use of the buyer's cost report is appropriate to reflect reasonable and necessary patient care costs. EOHHS will make the appropriate adjustments to reflect the use of a non-base year cost report.

(b) General. A petition for an administrative adjustment must contain the following.

1. A petition must include the provider's name, address, a detailed explanation, under oath, of the basis of the petition and documentation supporting the amount requested including, but not limited to, invoices, canceled checks, loan documents, any construction contracts, and the project beginning and ending dates.

2. The provider must submit any other information that EOHHS requires within 30 days of the request. EOHHS will not allow the petition if the provider fails to timely submit the requested information.

3. EOHHS will suspend review of any petition if the provider has failed to submit reports or other information required by 101 CMR 204.00 in a timely manner. If the provider fails to file the required information within 60 days after notification by EOHHS, EOHHS will dismiss the petition for administrative adjustment.

4. EOHHS will suspend review of any petition if the Department notifies the provider that it has identified a quality of care problem.

5. The Center may require that the provider demonstrate that the changes in costs have actually occurred and that the year-end cost report substantiates the financial condition stated in the petition. If the provider fails to provide evidence of such costs within 45 days of the Center request, EOHHS may retroactively reverse the adjustment.

(c) Effective Date. An administrative adjustment will be effective on the later of the date the petition is filed with EOHHS or the date on which the event that is the basis of the petition is completed.

(d) Standard of Review.

1. In reviewing the petition, EOHHS will consider the following:
   a. whether the adjustment would result in a significant difference in the rate;
   b. the costs of other providers offering the same or comparable level of care; and
   c. the ability of the Department of Transitional Assistance to collect any overpayments that may result from the petition. EOHHS will notify the Department of Transitional Assistance of the petition.

2. EOHHS will review petitions in accordance with the criteria set forth in 101 CMR 204.00 in effect in the year in which they are received by EOHHS, notwithstanding the effective date.

(3) Notice of Proposed Rate. EOHHS will send the provider a notice of the proposed rate as follows.

(a) Desk Audit. Prior to certification of a prospective rate based upon a desk audit, EOHHS will send the provider a notice of the proposed rate and a copy of adjustments at least ten calendar days prior to the scheduled date of certification. The provider may comment, in writing, on the proposed rate and adjustments during the period between the notice and scheduled date of EOHHS action. Providers requiring additional time to respond may request that EOHHS postpone the scheduled certification.

(b) Field Audit. EOHHS will not send a notice prior to certification of a proposed rate that is based upon a field audit if the rate is amended solely to incorporate field audit adjustments that have been discussed at an exit conference. The Center will provide a copy of the field audit adjustments to the provider following the exit conference.

(4) Rate Filings. EOHHS will file certified rates of payment for resident care facilities with the Secretary of the Commonwealth.

(5) Appeals. Any provider aggrieved by a rate of payment established pursuant to 101 CMR 204.00 may file an appeal with the Division of Administrative Law Appeals, established under M.G.L. c. 7, § 4H within 30 days of the filing of any such rate with the Secretary of the Commonwealth.

(6) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify provisions of 101 CMR 204.00, which will be deemed to be incorporated in 101 CMR 204.00. EOHHS will file with the Secretary of the Commonwealth, distribute copies to providers, and make the bulletins accessible to the public at EOHHS's offices during business hours.

(7) Severability. The provisions of 101 CMR 204.00 are severable. If any provision of 101 CMR 204.00 or the application of any provision of 101 CMR 204.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 101 CMR 204.00 or the application of any other provision.

204.09: COVID-19 Payment Provisions

(1) COVID-19 Staff Testing Add-on Payment.

(a) COVID-19 Staff Testing Definitions. For the purposes of 101 CMR 204.09(1), the following terms have the meanings in 101 CMR 204.09(1).

1. Staff. For purposes of conducting testing and implementing a surveillance testing program and, in accordance with CMS and CDC guidance, long-term care staff includes: employees, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions reporting to the facility during the relevant testing period. For the purposes of a long-term care provider's surveillance testing program, staff does not include persons who work entirely remotely or off-site, employees on leave, such as paid family medical leave, or staffing provided at the Commonwealth's expense (such as those provided by EOHHS through a clinical rapid response team or the Massachusetts National Guard).

2. Testing Period. The period in which a resident care facility must complete baseline, biweekly surveillance, or weekly surveillance testing. For biweekly surveillance testing, the testing periods will each last for two weeks, from Thursday at 7:00 A.M. through the second subsequent Thursday at 6:59 A.M. For weekly surveillance testing, the testing periods will each last for one week, from Thursday at 7:00 A.M. through the following Thursday at 6:59 A.M.

3. Number of Completed Qualifying COVID-19 Staff Tests.
   a. Staff tests that were arranged for and paid directly by the resident care facility, which does not include tests that were completed or facilitated by the staff member on their own time or at their own cost;
   b. Staff tests that were conducted as baseline, biweekly surveillance, or weekly surveillance testing as part of an adaptive surveillance testing system developed by the Department of Public Health;
   c. Not more than one test per individual staff member per testing period;
   d. Staff tests that include the collection of specimens sufficient for diagnostic testing, the processing of a COVID-19 diagnostic test by an FDA approved method, and the furnishing of results to all appropriate parties in accordance with Department of Public Health and Centers for Disease Control and Prevention guidance;
   e. Staff tests that are able to detect SARS-CoV-2 virus, with a polymerase chain reaction (PCR) of greater than 95% sensitivity and greater than 90% specificity, or such other testing standard as specified by EOHHS by administrative bulletin, within 48 hours of conducting the test;
   f. Staff tests that were reported to EOHHS, in the manner requested by EOHHS, as tests administered on the nursing facility's staff; and
   g. Staff tests for which results were reported by the resident care facility as either positive, negative, or inconclusive; provided that if EOHHS determines that the rate of inconclusive test results is unreasonably high, EOHHS may exclude those inconclusive results from the number of completed qualifying COVID-19 staff tests.

(b) Calculation of Add-on Payments. Effective January 1, 2020, the add-on payments for each eligible resident care facility are equal to the number of completed qualifying COVID-19 staff tests administered in accordance with 101 CMR 204.09(1) multiplied by the lessor of
   1. the average market rate for COVID-19 testing in long-term care facilities and residential congregate care providers and settings in the Commonwealth as determined by EOHHS, which may be updated quarterly by EOHHS based on the previous calendar quarter; or
   2. $80.

(c) Disbursement of Add-on Payments. The add-on payments are paid on a monthly basis, with each monthly add-on payment calculated based on the previous months' number of completed qualifying COVID-19 staff tests; provided, however, that the first of such monthly add-on payments, to be paid in November 2020, does not include tests that were completed before October 1, 2020.

(d) Additional Guidance. EOHHS may issue administrative bulletins or other written communication establishing additional rules governing the COVID-19 staff testing add-on payment under 101 CMR 204.09(1) including, but not limited to, the testing period in accordance with 101 CMR 204.09(1)(a)2.; the calculation of add-on payments, inclusive of the average market rate in accordance with 101 CMR 204.09(1)(b)2.a.; further information on staff to be tested; the frequency of testing and the infection thresholds that may affect the frequency of testing and required testing periods; reporting requirements; or qualifying COVID-19 diagnostic tests.

(2) Certain Time-limited COVID-19 Staffing Add-on Payments.

(a) General Provisions and Effective Date. Effective January 15, 2022, a resident care facility will be eligible for an add-on payment to offset increased costs of providing care not

accounted for in the nursing facility's prospective payment system rates during the COVID-19 pandemic. The add-on payment will be made in six equal installments in the months of January, February, March, April, May, and June 2022.

(b) Calculation of the Time-limited COVID-19 Staffing Add-on Payments for Facilities with SSI/SSP and EAEDC Days.

1. Divide the number of Massachusetts DTA and EAEDC days annualized from the days reported by each resident care facility provider on their 2020 HCF-4 cost report, by the total number of Massachusetts DTA and EAEDC days, across all resident care facility providers, as annualized from the days reported by all SSI/SSP and EAEDC resident care facility providers on the 2020 HCF-4 cost report.
2. Multiply the quotient calculated in 101 CMR 204.09(2)(b)1. by $3,055,556.
3. Divide the product calculated in 101 CMR 204.09(2)(b)2. by six.
4. Each monthly add-on payment will equal the amount calculated in 101 CMR 204.09(2)(b)3. for each resident care facility.

(c) Calculation of the Time-limited COVID-19 Staffing Add-on Payments for Facilities with No SSI/SSP and EAEDC Days. For SSI/SSP and EAEDC resident care facilities with no SSI/SSP and EAEDC days reported in the 2020 HCF-4 cost report, the monthly payment will be equal to the average across all SSI/SSP and EAEDC resident care facilities of the amounts calculated in 101 CMR 204.09(2)(b).

(d) Correction of Material Error. EOHHS may adjust any add-on payment made or to be made in accordance with 101 CMR 204.09(2) upon EOHHS's sole determination that there was a material error in the calculation of the payment. EOHHS will not adjust any add-on payment solely because a facility under-reported SSI/SSP and EAEDC days on the 2020 HCF-4 cost report.

(e) Permissible Uses, and Timeframe for Use, of COVID-19 Staffing Add-on Payments. Facilities may use the add-on payments made in accordance with 101 CMR 204.09(2) only for the following expenses for direct-care staff identified at 101 CMR 204.09(2)(f): increases in base wages or retention bonuses for directly employed staff; signing bonuses for new employees; premium pay; shift differentials; and expenses related to temporary agency staff. Expenses related to the staffing add-on payments must be incurred on dates of service beginning January 1, 2022, through June 30, 2022.

(f) Direct-care Staff. For the purposes of the add-on payment made or to be made in accordance with 101 CMR 204.09(2), direct-care staff include the following staff categories: Resident/personal care, nursing, dietary, housekeeping, recreational therapy, social workers. Direct-care staff do not include facility administrators.

(g) Reporting Requirements. Each facility will be required to report to EOHHS, in a format prescribed by EOHHS, on the ways in which it expects to use, and the ways in which it ultimately uses, its received staffing add-on payments. The report regarding expected use of these staffing add-on payments must be submitted by March 11, 2022. The report for actual use of these add-on payments must be submitted by July 30, 2022.

(h) Report Verification, Document Request, and Audit. All information included in the reports regarding add-on payments in accordance with 101 CMR 204.09(2)(g) is subject to verification and audit by EOHHS. EOHHS may request records or documents, or conduct an audit of records or documents, pertaining to the add-on payments made in accordance with 101 CMR 204.09(2).

(i) Recoupment of Add-on Payment. EOHHS may recoup any staffing add-on payment, in whole or in part, made to a resident care facility that failed to perform any requirement described at 101 CMR 204.09(2), including, but not necessarily limited to, a facility's failure to

1. complete the required staffing add-on payment reporting in accordance with 101 CMR 204.09(2)(g);
2. timely submit the required reports in accordance with 101 CMR 204.09(2)(g);
3. use funds on anything other than permissible uses described in accordance with 101 CMR 204.09(2)(e);
4. incur permissible expenses to be funded through these add-on payments by June 30, 2022, in accordance with 101 CMR 204.09(2)(e);
5. use the add-on payments for such incurred permissible expenses in accordance with 101 CMR 204.09(2)(e); or
6. comply with report verification, document request, or audit requirements in accordance with 101 CMR 204.09(2)(h).

(j) EOHHS may, by administrative bulletin or other written issuance, establish additional reporting requirements with respect to these time-limited COVID-19 staffing add-on payments.

(3) Disallowance of COVID-19 Staff Testing Add-on Payments.

(a) A governmental unit may deny payment for an add-on payment under 101 CMR 204.09(1) if the resident care facility fails to meet the COVID-19 testing and reporting requirements established by administrative bulletin or other written issuance in accordance with 101 CMR 204.09(1)(d) or (5).

(b) If a facility has already received a payment under 101 CMR 204.09(1) and is subsequently determined to have failed to meet requirements as described in 101 CMR 204.09(3)(a), the purchasing governmental unit may recover the add-on payment as an overpayment.

(c) Except as provided in 101 CMR 204.09(3)(d), for dates of service before October 28, 2021, a resident care facility will not be eligible for any further add-on payments under 101 CMR 204.09(1) if it fails to meet the COVID-19 testing and reporting requirements under 101 CMR 204.09(1) for three or more testing periods within a 60-day period.

(d) For dates of service on and after October 28, 2021, a resident care facility will be eligible for staff testing add-on payments for testing periods for which the facility complies with the requirements of 101 CMR 204.09(1) and does not fail to comply with testing and reporting requirements described at 101 CMR 204.09(3)(a) notwithstanding its ineligibility for future payments in accordance with 101 CMR 204.09(3)(c).

(4) COVID-19 Vaccine Administration Add-on Payments.

(a) For dates of service beginning October 1, 2021, and notwithstanding any regulatory provision to the contrary, resident care facilities may submit requests for payment for COVID-19 vaccine administration services, provided to eligible residents in accordance with an Emergency Use Authorization (EUA) issued by the federal Food and Drug Administration (FDA) or full FDA approval, and in accordance with any guidance issued by the FDA with respect to such services. Resident care facilities are required to ensure that any such services administered by the facility are administered by individuals whose education, credentials, and training qualify them to render such services.

(b) The costs of services described in 101 CMR 204.09(4)(a) are not included in the resident care facility standard payment rates determined under 101 CMR 204.03. The costs of

providing such services will be considered non-allowable costs under 101 CMR 204.03(2)(c).
(c) Requests for payment submitted by the resident care facility for the services described in 101 CMR 204.09(4)(a) are paid at the rates established under 101 CMR 446.03(2): *Medicine*. Such payments are considered payment in full for such services.
(d) EOHHS or purchasing governmental unit may establish, through administrative bulletin or other written issuance, the specific codes and billing instructions for such services.

(5) Written Communication. EOHHS may establish or rely on existing rules, by administrative bulletin or other written issuance, governing various aspects of the COVID-19 payment provisions established under 101 CMR 204.09 including, but not limited to, reporting and compliance requirements, and penalties for noncompliance.

204.10: Resident Care Cost Quotient

(1) Beginning July 1, 2022, residential care facilities must have a Resident Care Cost Quotient (RCC-Q), as described in 101 CMR 204.10, that meets or exceeds a threshold to be identified by EOHHS by administrative bulletin. For the rate year beginning in SFY2024, a residential care facility's rate may be subject to a downward adjustment if the facility fails to be at or above the specified RCC-Q threshold in the previous state fiscal year.

(2) The RCC-Q will be calculated by dividing certain resident care expenses by the facility's total revenue, excluding the revenue for non-residential care facility lines of business, and excluding endowment income. EOHHS may further identify or clarify these certain resident care expenses by administrative bulletin or other written issuance. A multiplier may be applied to certain resident care expenses related to one or more resident care workforce position types. EOHHS may establish the workforce position types eligible for any multiplier, details related to application of such multiplier, and the magnitude of such multiplier in calculating the RCC-Q, by administrative bulletin or other written issuance.

(3) All residential care facilities, including facilities described in 101 CMR 204.10(5), will be required to submit an initial interim compliance report by September 1, 2022, a second interim compliance report by February 1, 2023, and a final compliance report by September 1, 2023. Thereafter, residential care facilities will be required to submit an interim compliance report by February 1st of each year and a final compliance report by September 1st of each year. The initial interim compliance report, which is due on September 1, 2022, will be used to determine the RCC-Q threshold that facilities will need to meet or exceed to avoid downward adjustments to their rates in the rate year beginning in SFY2024. The second interim report, which is due on February 1, 2023, will be used to inform facilities if they are on track to meet the RCC-Q threshold in the SFY2023 reporting period. The final compliance report, which is due on September 1, 2023, will be used for determining whether the facility met that threshold and whether a downward adjustment will be applied to the facility's rate in the following rate year.

(4) The downward adjustment to the rate will be applied in the following rate year to facilities that failed to meet the RCC-Q threshold or failed to submit the final report by the final compliance report due date. Such downward adjustment will be established by administrative bulletin or other written issuance.

(5) Residential care facilities that have fewer than the RCC-Q minimum paid DTA days for a particular state fiscal year, starting the state fiscal year of July 1, 2022, through June 30, 2023, except for the facilities that failed to submit the final compliance report by September 1st in accordance with 101 CMR 204.10(3) immediately following the end of the particular state fiscal year, will be exempt from the downward adjustment established at 101 CMR 204.10(4). For purposes of 101 CMR 204.10(5), the RCC-Q minimum paid DTA days will be established by EOHHS by administrative bulletin or other written issuance.

(6) EOHHS may issue an administrative bulletin or other written issuance to clarify provisions of 101 CMR 204.10, and as otherwise provided at 101 CMR 204.10.

REGULATORY AUTHORITY

101 CMR 204.00: M.G.L. c. 118E.