101 CMR 206.00: STANDARD PAYMENTS TO NURSING FACILITIES

Section

206.01: Scope and Purpose

101 CMR 206.00 governs the payments beginning October 1, 2024, for services rendered to publicly aided and industrial accident residents by nursing facilities including residents in a residential care unit of a nursing facility. 101 CMR 206.00 does not govern nursing facility payments pursuant to a contract with the Office of Medicaid.

206.02: General Definitions

As used in 101 CMR 206.00, unless the context requires otherwise, terms have the following meanings.

Administrative and General Costs. Administrative and general costs include the amounts reported in the following accounts: administrator salaries; payroll taxes - administrator; worker's compensation - administrator; group life/health - administrator; administrator pensions; other administrator benefits; clerical; EDP/payroll/bookkeeping services; administrator-in-training; office supplies; phone; conventions and meetings; help wanted advertisement; licenses and dues, resident-care related; education and training - administration; accounting - other; insurance - malpractice; other operating expenses; realty company variable costs; management company allocated variable costs; and management company allocated fixed costs.

Administrator in Training. A person registered with the Board of Registration of Nursing Home Administrators and involved in a course of training as described in 245 CMR: *Board of Registration of Nursing Home Administrators*.

Audit. An examination of the provider's cost report and supporting documentation to evaluate the accuracy of the financial statements and identification of Medicaid patient-related costs.

Base Year. The calendar year used to compute the standard payments.

Body Mass Index (BMI). A person's weight divided by their height.

Capital Costs. Capital costs include depreciation expenses on building, improvements, equipment, software, and other limited life assets; long-term interest expense; building insurance; real estate tax; non-income portion of Massachusetts Corporate Excise Taxes; personal property taxes on nursing facility equipment; other rental expenses for fixed costs; and other fixed costs.

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

206.02: continued

Centers for Medicare and Medicaid Services (CMS). The federal agency under the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

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

Direct Restorative Therapy. Services of physical therapists, occupational therapists, and speech, hearing, and language therapists provided directly to individual residents to reduce physical or mental disability and to restore the resident to maximum functional level. Direct restorative therapy services are provided only upon written order of a physician, physician assistant, or nurse practitioner who has indicated anticipated goals and frequency of treatment to the individual resident. Direct restorative therapy services include supervisory, administrative, and consulting time associated with provision of the services. These include, but are not limited to, reviewing preadmission referrals, informally communicating with families, scheduling treatments, completing resident care documentation including MDS documentation, screening of patients, writing orders, meeting with aides to discuss patients, consulting with physicians and nurse practitioners, managing equipment, and assessing equipment needs of patients.

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

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 Executive Office of Elder Affairs, the MassHealth program, 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 § 1902(a)(5) of the Social Security Act.

Financing Contribution. Payment for the use of necessary capital assets whether internally or externally funded.

Generally Available Employee Benefits. Employee benefits that are nondiscriminatory and available to all full-time employees.

Hospital-based Nursing Facility. A separate nursing facility unit or units located in a hospital building licensed for both hospital and nursing facility services in which the nursing facility licensed beds are less than a majority of the facility's total licensed beds and the nursing facility patient days are less than a majority of the facility's total patient days. It does not include freestanding nursing facilities owned by hospitals.

Improvements. Expenditures that increase the quality of the building by rearranging the building layout or substituting improved components for old components so that the provider is in some way better than it was before the renovation. Improvements do not add to or expand the square footage of the building. An improvement is measured by the provider's increased productivity, greater capacity, or longer life.

Indirect Restorative Therapy. Indirect restorative therapy services consist only of services of physical therapists, occupational therapists, and speech, hearing, and language therapists to provide the following: orientation programs for aides and assistants; in-service training to staff; consultation and planning for continuing care after discharge; preadmission meetings with families; quality improvement activities such as record reviews, analysis of information and writing reports; personnel activities including hiring, firing, and interviewing; rehabilitation staff scheduling; and attending team meetings including quality improvement, falls, skin team, daily admissions, interdisciplinary, departmental staff, discharge planning, and family meetings when resident is not present.

Induction Period. Days that a nursing facility patient is transported to an Opioid Treatment Program by a nursing facility direct care staff for the purpose of induction on medication assisted treatment at the Opioid Treatment Program.

206.02: continued

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

Management Minute Questionnaire (MMQ). A method of measuring resident care intensity, or case mix, by discrete care giving activities or the characteristics of residents found to require a given amount of care.

Massachusetts Corporate Excise Tax. Those taxes that have been paid to the Massachusetts Department of Revenue in connection with the filing of Form 355A, Massachusetts Corporate Excise Tax Return.

Medication for Addiction Treatment. Use of a medication approved by the federal Food and Drug Administration (FDA) for the treatment of a substance use disorder.

Minimum Data Set (MDS). A CMS-provided standardized assessment tool for nursing facilities to determine a nursing facility patient's Patient Driven Payment Model (PDPM) case mix category.

Mortgage Acquisition Costs. Those costs (such as finder's fees, certain legal fees, and filing fees) necessary to obtain long-term financing through a mortgage, bond, or other long-term debt instrument.

Nursing Costs. Nursing costs include the reported costs for director of nurses, registered nurses, licensed practical nurses, nursing aides, nursing assistants, orderlies, nursing purchased services, and the workers compensation expense, payroll tax expense, and fringe benefits, including pension expense, associated with those salaries.

Nursing Facility. A nursing or convalescent home; an infirmary maintained in a town; a charitable home for the aged, as defined in M.G.L. c. 111, § 71; or a nursing facility operating under a hospital license issued by the Department of Public Health pursuant to M.G.L. c. 111, and certified by the Department of Public Health for participation in MassHealth. It includes facilities that operate a licensed residential care unit within the nursing facility.

Operating Costs. Operating costs include, but are not limited to, the following reported costs: plant, operations and maintenance; dietary; laundry; housekeeping; ward clerks and medical records librarian; medical director; advisory physician; Utilization Review Committee; employee physical exams; other physician services; house medical supplies not resold; pharmacy consultant; social service worker; indirect restorative and recreation therapy expense; other required education; job related education; quality assurance professionals; Management Minute Questionnaire nurses; staff development coordinator; motor vehicle expenses including, but not limited to, depreciation, mileage payments, repairs, insurance, excise taxes, finance charges, and sales tax; and administrative and general costs.

Opioid Treatment Program (OTP). A program that provides opioid treatment services. An opioid treatment program must be federally certified by the Substance Abuse Mental Health Services Administration (SAMHSA) and must be licensed as an opioid treatment program by the Department of Public Health under 105 CMR 164.000: *Licensure of Substance Use Disorder Treatment Programs*. Opioid treatment programs must conform to the federal opioid treatment standards in 42 CFR 8.12: *Federal Opioid Treatment Standards*.

Opioid Treatment Services. Supervised assessment and treatment of an individual using FDA-approved medications (including methadone, buprenorphine, buprenorphine/naloxone, and naltrexone), along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to alleviate the adverse medical, psychological or physical effects incident to opioid use disorder. Opioid Treatment Services encompasses withdrawal management services and maintenance treatment.

206.02: continued

Patient Days. The total number of days of occupancy by residents in the facility. The day of admission is included in the computation of patient days; the day of discharge is not included. If admission and discharge occur on the same day, one resident day is included in the computation. It includes days for which a provider reserves a vacant bed for a publicly aided resident temporarily placed in a different care situation, pursuant to an agreement between the provider and the MassHealth agency. It also includes days for which a bed is held vacant and reserved for a non-publicly aided resident.

Patient Driven Payment Model (PDPM). The case mix classification system provided by CMS to classify nursing facility patients into payment groups.

Patient Driven Payment Model (PDPM) Nursing Case Mix. One of the five case-mix adjusted components of the CMS Patient Driven Payment Model.

Private Nursing Facility. A nursing facility that formerly served only non-Medicaid residents and does not have a provider agreement with the MassHealth agency to provide services to public residents.

Provider. A nursing facility providing care to publicly aided residents or industrial accident residents.

Prudent Buyer Concept. The assumption that a purchase price that exceeds the market price for a supply or service is an unreasonable cost.

Publicly Aided Resident. A person for whom care in a nursing facility is in whole or in part subsidized by the Commonwealth or a political subdivision of the Commonwealth. Publicly aided residents do not include residents whose care is in whole or in part subsidized by Medicare.

Rate Year. The 12-month period from October 1st through September 30th.

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

Replacement Facility. A nursing facility that replaces its entire building with a newly constructed facility pursuant to an approved determination of need under 105 CMR 100.000: *Determination of Need*. A facility that renovates a building previously licensed as a nursing facility is not a replacement facility.

Reported Costs. All costs reported in the cost report.

Required Education. Educational activities, conducted by a recognized school or authorized organization, required to maintain a professional license of employees that provide care to publicly aided residents. Required education also includes training for nurses' aides.

Residential Care. The minimum basic care and services and protective supervision required by the Department of Public Health in accordance with 105 CMR 150.000: *Licensing of Long-term Care Facilities* for residents who do not routinely require nursing or other medically related services.

Residential Care Unit. A unit within a nursing facility licensed by the Department of Public Health to provide residential care.

State Fiscal Year (SFY). The 12-month period from July 1st through June 30th.

206.02: continued

Unit. A unit is an identifiable section of a nursing facility such as a wing, floor, or ward as defined in 105 CMR 150.000: *Licensing of Long-term Care Facilities*.

206.03: General Payment Provisions

(1) General. Nursing facility payments are prospective rates based on reported costs for a prior base year.

(a) The nursing standard payments and the operating cost standard payments are established in 101 CMR 206.04. The base year for the nursing standard payments and the operating cost standard payments beginning October 1, 2024, is 2019. The nursing and operating payments are increased from the base year by a cost adjustment factor of 23.50%.

(b) The capital payments are established in 101 CMR 206.05. The base year for the capital payments beginning October 1, 2024, is 2019. The capital payments are increased from the base year by a cost adjustment factor of 8.02%.

(c) Payments may be adjusted to include additional payments in accordance with 101 CMR 206.06.

(2) Ancillary Costs. Unless a provider participates in the Ancillary Pilot Program with the MassHealth agency, or a provider's payments include ancillary services pursuant to the regulations or written policy of the purchasing agency, the provider must bill ancillary services directly to the purchaser in accordance with the purchaser's regulations or policies.

(3) Disclaimer of Authorization of Services. 101 CMR 206.00 is not authorization for or approval of the substantive services, or lengths of time, for which rates are determined pursuant to 101 CMR 206.00. Governmental units that purchase services from eligible providers are responsible for the definition, authorization, and approval of services and lengths of time provided to publicly aided individuals. Information concerning substantive program requirements must be obtained from purchasing governmental units.

206.04: Nursing Standard Payments and Operating Cost Standard Payments

(1) Nursing Standard Payments.

(a) Nursing Standard Payment Calculation. Beginning October 1, 2024, nursing facilities will receive the following nursing standard payments:

PDPM Nursing HIPPS Code (Acuity Level)	PDPM Nursing Case Mix Index (2022)	Nursing Standard Payment
A (ES3)	3.95	$ 395.75
B (ES2)	2.99	$ 299.57
C (ES1)	2.85	$ 285.54
D (HDE2)	2.33	$ 233.44
E (HDE1)	1.94	$ 194.37
F (HBC2)	2.18	$ 218.41
G (HBC1)	1.81	$ 181.34
H (LDE2)	2.02	$ 202.38
I (LDE1)	1.68	$ 168.32
J (LBC2)	1.67	$ 167.32
K (LBC1)	1.39	$ 139.26
L (CDE2)	1.82	$ 182.35

206.04: continued

PDPM Nursing HIPPS Code (Acuity Level)	PDPM Nursing Case Mix Index (2022)	Nursing Standard Payment
M (CDE1)	1.58	$ 158.30
N (CBC2)	1.51	$ 151.29
O (CA2)	1.06	$ 106.20
P (CBC1)	1.30	$ 130.25
Q (CA1)	0.91	$ 91.17
R (BAB2)	1.01	$ 101.19
S (BAB1)	0.96	$ 96.18
T (PDE2)	1.53	$ 153.29
U (PDE1)	1.43	$ 143.27
V (PBC2)	1.19	$ 119.23
W (PA2)	0.69	$ 69.13
X (PBC1)	1.10	$ 110.21
Y (PA1)	0.64	$ 64.12

(b) Nursing Standard Payment Adjustment. Beginning October 1, 2024, eligible nursing facilities will receive adjustments to their standard nursing payments at 101 CMR 206.04(1)(a), which will be calculated and determined as follows.

1. Calculate each facility's average nursing standard payment rate in effect as of September 30, 2024, weighted by the facility's average PDPM nursing case mix during the period of October 1, 2023, through March 31, 2024. For each facility, add this value to the facility's average Nursing Standard Payment Adjustment in effect as of September 30, 2024, weighted by the facility's average PDPM nursing case mix during the period of October 1, 2023, through March 31, 2024.
2. Calculate each facility's average proposed nursing standard payment rate, beginning October 1, 2024, using the nursing rates as defined in 101 CMR 206.04(1)(a) and weighted by the facility's average PDPM nursing case mix during the period of October 1, 2023, through March 31, 2024.
3. To determine a facility's eligibility for the Nursing Standard Payment Adjustment
   a. First, determine whether the facility is a pediatric facility. If the facility is a pediatric facility, then
      i. Determine whether the value calculated in 101 CMR 206.04(1)(b)2. is less than the value calculated in 101 CMR 206.04(1)(b)1.
      ii. If the value calculated in 101 CMR 206.04(1)(b)2. is less than the value calculated in 206.04(1)(b)1., then calculate an "average nursing rate adjustment" such that the sum of this adjustment and the value calculated in 101 CMR 206.04(1)(b)2. will be equal to the value calculated in 101 CMR 206.04(1)(b)1.
      iii. Divide the "average nursing rate adjustment" by the value calculated in 101 CMR 206.04(1)(b)2. The resulting percentage, rounded to the nearest hundredth of a percent, will be the Nursing Standard Payment Adjustment.
   b. If the facility is not a pediatric facility, then determine whether the facility is a High Medicaid facility. For the purposes of the Nursing Standard Payment Adjustment, a High Medicaid facility is defined as a facility for which Massachusetts Medicaid days are at least 75.00% of its total resident days, as reported on quarterly User Fee Assessment Forms for the period April 1, 2023, through March 31, 2024. If the facility is a High Medicaid facility, then
      i. Determine whether the value calculated in 101 CMR 206.04(1)(b)2. is less than the value calculated in 206.04(1)(b)1.

206.04: continued

ii. If the value calculated in 101 CMR 206.04(1)(b)2. is less than the value calculated in 101 CMR 206.04(1)(b)1., then calculate an "average nursing rate adjustment" such that the sum of this adjustment and the value calculated in 101 CMR 206.04(1)(b)2. will be equal to the value calculated in 101 CMR 206.04(1)(b)1.

iii. Divide the "average nursing rate adjustment" by the value calculated in 101 CMR 206.04(1)(b)2. The resulting percentage, rounded to the nearest hundredth of a percent, will be the Nursing Standard Payment Adjustment.

4. For eligible facilities, the Nursing Standard Payment Adjustment will be applied as an upward adjustment to the nursing standard payment rate at each PDPM nursing case mix category.

(2) Operating Cost Standard Payments. Beginning October 1, 2024, nursing facilities will receive operating cost standard payments of $125.41.

206.05: Capital Payments

(1) Nursing Facility Capital Payments. Beginning October 1, 2024, nursing facilities will receive capital payments calculated as follows, with exceptions as described in 101 CMR 206.05(2) through 101 CMR 206.05(5).

(a) Calculate the sum of the allowable portion of capital costs during the base year, less any recoverable fixed cost income. Apply a cost adjustment factor as described in 101 CMR 206.03(1)(b).

(b) Multiply the number of beds by the number of days in the rate year and then multiply the product by the greater of 90% or the actual utilization rate in the base year.

(c) EOHHS will calculate the provider's capital payment by dividing the result of 101 CMR 206.05(1)(a) by the result of 101 CMR 206.05(1)(b), subject to the limitations described in 101 CMR 206.05(4).

(2) Nursing Facility Capital Payment Adjustments. Beginning October 1, 2024, nursing facilities will receive capital payment adjustments calculated as follows.

(a) If a nursing facility's capital payment as calculated in 101 CMR 206.05(1) is less than 90% of its capital payment as of September 30, 2021, the facility will receive the capital payment listed in 101 CMR 206.05(1), plus an upward adjustment equal to the difference between the capital payment as calculated in 101 CMR 206.05(1) and 90% of the facility's capital payment as of September 30, 2021, subject to the limitations described in 101 CMR 206.05(4).

(b) If a nursing facility's capital payment as calculated in 101 CMR 206.05(1) is greater than 150% of its capital payment as of September 30, 2021, the facility will receive the capital payment calculated in 101 CMR 206.05(1), less a downward adjustment equal to the difference between the capital payment as calculated in 101 CMR 206.05(1) and 150% of the facility's capital payment as of September 30, 2021.

(3) Revised Capital Payment.

(a) General Notification Requirements. All providers must notify the Center when they open, add new beds, renovate, or reopen beds. The notification must contain the provider's name, address, vendor payment number, date of bed change, type of change, and description of project.

(b) Request for Revised Capital Payment. Eligible providers may request a revised capital payment for capital costs associated with the change or renovation of licensed beds. Facilities that may request a revised capital payment include

1. new facilities that open pursuant to a determination of need and facilities with newly licensed beds that are added pursuant to a determination of need;

2. facilities with renovations made pursuant to a determination of need;

3. facilities that submitted detailed architectural or engineering plans for, or evidence of, applications made to local government agencies for planning, zoning, or building permits or other regulatory approvals, including approvals required by the Department of Public Health, required in connection with conversion of rooms with three or more residents to one- and two-bedded rooms or two-bedded rooms to one-bedded rooms.

206.05: continued

(c) Eligibility Requirements. A nursing facility specified in 101 CMR 206.05(3)(b)2. will be eligible for a revised capital payment if the facility has expended at least 50% of the maximum capital expenditure for an approved determination of need, or in the instance of a second request, at least 25% additional from the previous approved request and in the instance of a third request, only upon completion of the project.

(d) Required Documentation. Providers meeting the criteria in 101 CMR 206.05(3)(b) must submit the following to the Center with its request for a revised capital payment, as well as any additional information that EOHHS determines necessary to calculate a revised capital payment:

1. a copy of the approved determination of need and any approved amendments, or, in the case of capital projects that do not require a determination of need, a detailed description of the project;
2. a copy of the construction contract;
3. a listing of construction costs;
4. copies of invoices and cancelled checks for construction costs;
5. a copy of the Department of Public Health's licensure notification associated with the increase or decrease in licensed beds, as applicable;
6. a copy of the mortgage or financing obtained;
7. a copy of the calculation of the requested increase, the format of which may be specified by EOHHS; and
8. a listing of any assets such as land, building, improvements, or equipment that are either destroyed or no longer used for patient care.

(e) Revised Capital Payment Calculation. Nursing facilities that meet the criteria listed in 101 CMR 206.05(3)(b) and that have submitted all required documentation under 101 CMR 206.05(3)(d) will be eligible for a revised capital payment in place of the capital rates calculated under 101 CMR 206.05(1), subject to the limitations of 101 CMR 206.05(4):

1. Adding the following costs:
   a. the allowed capital expenses associated with a project described in 101 CMR 206.05(3)(b), subject to the divisor described in 101 CMR 206.05(1)(b) adjusted for any increase or decrease in licensed beds; and
   b. the lesser of the following costs, subject to the divisor described in 101 CMR 206.05(1)(b) adjusted for any increase or decrease in licensed beds,
      i. 101 CMR 206.05(1); or
      ii. The sum of the amount calculated in 101 CMR 206.05(1) and the amount calculated in 101 CMR 206.05(2).
2. The revised capital payment must be the total calculated in 101 CMR 206.05(3)(c), and must be the new capital rate, in place of the rate calculated under 101 CMR 206.05(1) or 101 CMR 206.05(2), effective on the later of the date the facility submits their request for the revised capital payment, including all required documentation, or the effective date of the change in licensed beds.

(4) Maximum Capital Payment. Capital payments must not exceed $50.00.

(5) New or Relocated Nursing Facilities. A nursing facility that becomes operational on or after October 1, 2023, an existing nursing facility that replaces its current building on or after October 1, 2023, or an existing nursing facility that fully relocates to a newly constructed location on or after October 1, 2023, will be eligible for a capital payment in the amount of $50.00. Such facility will not be eligible for additional capital payments as listed 101 CMR 206.05(1) or for an adjustment to its capital payment as described in 101 CMR 206.05(2).

(6) Licensed Bed Changes. A nursing facility will not receive an adjustment to its capital payment rate solely because of an increase or decrease in its number of licensed beds, except as described in 101 CMR 206.05(3)(b)3.

(7) Rate Adjustments. EOHHS may adjust any capital payment upon EOHHS's determination that there was a material error in the calculation of the payment or in the facility's documentation of its capital costs.

206.06: Adjustments to Standard Nursing Facility Rates

(1) Certification of Public Expenditures of a Nursing Facility Owned and Operated by a Municipality.

(a) Within 60 days after the filing of its Medicare CMS-2540 cost report, a nursing facility, which is owned and operated by a municipality, may submit a request for Certified Public Expenditures (CPE) to EOHHS. This CPE will account for its public expenditures of providing Medicaid services to eligible Medicaid members. The submission will be based on the inpatient routine service cost reported on the CMS-2540 Medicare cost report.

(b) Following review of the nursing facility's submission, EOHHS will, within 60 days of the submission, approve, deny, or revise the amount of the CPE request based upon its evaluation of the reported costs and payments. The final approved amount will be equal to the difference between the Medicaid interim payments and the total allowable Medicaid costs as determined by EOHHS. This final determined amount will be certified by the municipality as eligible for federal match.

(c) Interim payments are based on the standard payment methodology pursuant to 101 CMR 206.00.

(d) EOHHS will determine total allowable Medicaid costs based on the Medicare CMS-2540 Cost Report and will determine a *per diem* rate calculated as follows.

1. Medicaid Allowable Skilled Nursing Facility Costs. Total allowable costs (Worksheet B, Part I, Line 30, Col 18), divided by total days (Worksheet S-3, Line 1, Col 7), times Medicaid days (worksheet S-3, Line 1, Col 5).

2. Medicaid Allowable Nursing Facility Costs. Total allowable costs (Worksheet B, Part I, Line 31, Col 18), divided by total days (Worksheet S-3, Line 3, Col 7), times Medicaid days (Worksheet S-3, Line 3, Col 5).

3. Total Allowable Medicaid Costs. The sum of the amount determined in 101 CMR 206.06(1)(d)1. and 2.

(e) EOHHS will calculate an interim reconciliation based on the difference between the interim payments and total allowable Medicaid costs from the as-filed CMS-2540 Cost Report. The nursing facility must notify EOHHS immediately if the CMS-2540 is reopened or an audit is completed. Within 60 days after receiving notification of the final Medicare settlement EOHHS will retroactively adjust the final settlement amount.

(2) Quality Adjustments. Beginning October 1, 2024, a nursing facility may be eligible for a quality adjustment in the form of an increase or decrease applied to the facility's nursing standard rate and operating standard rate at each PDPM nursing case mix category. The quality adjustment will be equal to the sum of the percent increase or decrease assessed for performance on each of the following four quality measures: Quality Achievement Based on CMS Score, Quality Improvement Based on CMS Score, Quality Achievement Based on DPH Score, and Quality Improvement based on DPH Score.

(a) Quality Achievement Based on CMS Score. The quality adjustment a nursing facility will incur under the measure "Quality Achievement Based on CMS Score" will be based on the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of June 2023, as described in the table below. Facilities that CMS has designated as not rated due to a history of serious quality issues (*i.e.*, Special Focus Facilities) will be considered to have a score of 1 for the purposes of this quality adjustment.

CMS Overall Score as of June 2023	Adjustment Percentage
1	-1.00%
2	-0.75%
3	0.00%
4	0.75%
5	1.00%

206.06: continued

(b) Quality Improvement Based on CMS Score. The quality adjustment a nursing facility will incur under the measure "Quality Improvement Based on CMS Score" will be based on the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool, as follows. If a facility has a score of 5 Stars as of June 2023, its adjustment for this measure will be 2.0%, regardless of whether it meets any other criteria in the following table. If a facility meets the criteria for "CMS Chronic Low Quality," its adjustment for this measure will be -3.0%, regardless of whether it meets any other criteria in the following table. Facilities that CMS has designated as not rated due to a history of serious quality issues (*i.e.*, Special Focus Facilities) will be considered to meet the criteria for "CMS Chronic Low Quality" for the purposes of this quality adjustment.

Criteria Based on CMS Rating	Adjustment Percentage
Facility has a score of five Stars as of June 2023	2%
Facility experienced an increase of two or more Stars from June 2022, to June 2023	1.5%
Facility experienced an increase of one Star from June 2022, to June 2023	1%
Facility experienced no change to its Star rating from June 2022, to June 2023	0%
Facility experienced a decrease of one Star from June 2022, to June 2023, and had a score of five Stars as of June 2022	0%
Facility experienced a decrease of one Star from June 2022, to June 2023, and did not have a score of five Stars as of June 2022	-2%
Facility experienced a decrease of two or more Stars from June 2022, to June 2023	-2.5%
CMS Chronic Low Quality: The average of a facility's scores as of June 2020, June 2021, June 2022, and June 2023 is less than or equal to 1.5 Stars	-3%

(c) Quality Achievement Based on DPH Score. The quality adjustment a nursing facility will incur under the measure "Quality Achievement Based on DPH Score" will be based on the facility's performance on the Department of Public Health's Nursing Facility Survey Performance Tool (DPH NFSPT) as of July 1, 2023, as follows:

DPH NFSPT Score as of July 1, 2023	Adjustment Percentage
110 or less	-1.00%
111 - 115	-0.75%
116 - 119	0.00%
120 - 123	0.75%
124+	1.00%

(d) Quality Improvement Based on DPH Score. The quality adjustment a nursing facility will incur under the measure "Quality Improvement Based on DPH Score" will be based on the facility's performance on the DPH NFSPT, as follows. If a facility has a DPH NFSPT score of 124 or higher as of July 1, 2023, its adjustment for this measure will be 2.0%, regardless of whether it meets any other criteria in the following table. If a facility meets the criteria for "DPH Chronic Low Quality," its adjustment for this measure will be -3.0%, regardless of whether it meets any other criteria in the following table.

206.06: continued

Criteria based on DPH FSPT Score	Adjustment Percentage
Facility has a score of 124 or higher as of July 1, 2023	2.0%
Facility experienced an increase of four or more points from July 1, 2022, to July 1, 2023	1.5%
Facility experienced an increase of one, two, or three points from July 1, 2022, to July 1, 2023	1.0%
Facility experienced no change to its score from July 1, 2022, to July 1, 2023	0.0%
Facility experienced a decrease of one, two, or three points from July 1, 2022, to July 1, 2023, and had a score of 124 or higher as of July 1, 2022	0.0%
Facility experienced a decrease of one, two, or three points from July 1, 2022, to July 1, 2023, and did not have a score of 124 or higher as of July 1, 2022	-2.0%
Facility experienced a decrease of four or more points from July 1, 2022, to July 1, 2023	-2.5%
DPH Chronic Low Quality: Facility had a score of less than 100 as of each of the following dates: July 1, 2021; July 1, 2022; and July 1, 2023	-3%

(3) Kosher Food Services. Nursing facilities with kosher kitchen and food service operations may receive an add-on of up to $5 per day to reflect the additional costs of these operations.

(a) Eligibility. To be eligible for this add-on, the nursing facility must

1. maintain a fully kosher kitchen and food service operation that is, at least annually, rabbinically approved or certified; and in accordance with all applicable requirements of law related to kosher food and food products including, but not limited to, M.G.L. c. 94, § 156;
2. provide to the Center a written certification from a certifying authority, including the complete name, address, and phone number of the certifying authority, that the applicant's nursing facility maintains a fully kosher kitchen and food service operation in accordance with Jewish religious standards. For purpose of 101 CMR 206.06(3)(a)2., the phrase "certifying authority" will mean a recognized kosher certifying organization or rabbi who has received Orthodox rabbinical ordination and is educated in matters of Orthodox Jewish law;
3. provide a written certification from the administrator of the nursing facility that the percentage of the nursing facility's residents requesting kosher foods or products prepared in accordance with Jewish religious dietary requirements is at least 50%; and
4. upon request, provide the Center with documentation of expenses related to the provision of kosher food services, including but not limited to, invoices and payroll records.

(b) Payment Amounts.

1. To determine the add-on amount, EOHHS will determine the statewide median dietary expense per day for all facilities. The add-on equals the difference between the eligible nursing facility's dietary expense per day and the statewide median dietary expense per day, not to exceed $5 per day. In calculating the per day amount, EOHHS will include allowable expenses for dietary and dietician salaries, payroll taxes and related benefits, food, dietary purchased service expense, dietician purchased service expense, and dietary supplies and expenses. The days used in the denominator of the calculation will be the higher of the nursing facility's actual days or 96% of available bed days.
2. EOHHS will compare the sum of the add-on amounts multiplied by each nursing facility's projected annual rate period Medicaid days to the state appropriation. In the event that the sum exceeds the state appropriation, each nursing facility's add-on will be proportionally adjusted.

206.06: continued

(5) Leaves of Absence. If a purchasing agency pays for leaves of absence, the payment rate for a leave of absence day is $80.10 per day, unless otherwise determined by the purchasing agency.

(6) Nursing Cost. Eligible facilities will receive an $91.79 *per diem* add-on to reflect the difference between the standard payment amounts and actual base year nursing spending. To be eligible for such payment, the Department of Public Health must certify to EOHHS that over 75% of the nursing facility's residents have a primary diagnosis of multiple sclerosis.

(7) Pediatric Nursing Facilities.

(a) Beginning October 1, 2024, EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported operating costs, excluding administrative and general costs, from the nursing facility's 2019 Cost Report. EOHHS will include an administrative and general payment capped at the 85th percentile of the 2019 statewide administrative and general costs. EOHHS will apply an appropriate cost adjustment factor to operating, and administrative and general costs.

(b) The operating component of the rate is increased by a cost adjustment factor of 23.50%.

(c) Facilities licensed to provide pediatric nursing facility services will receive the operating rate which is the greater of

1. the rates calculated as described in 101 CMR 206.06(7)(a) and 101 CMR 206.06(7)(b); or
2. the Operating Cost Standard rate as listed in 101 CMR 206.04(2).

(9) Receiverships. EOHHS may adjust a nursing facility's standard rates if a receiver has been appointed under M.G.L. c. 111, § 72N solely to reflect the reasonable costs, as determined by EOHHS and the MassHealth agency, associated with the court-approved closure or sale of the nursing facility or other appropriate situation.

(10) Residential Care Beds. Beginning October 1, 2024, the total payment for nursing and other operating costs for residential care beds in a dually licensed nursing facility is $140.41.

(11) State-operated Nursing Facilities. A nursing facility operated by the Commonwealth will be paid at the nursing facility's reasonable cost of providing covered Medicaid services to eligible Medicaid members.

(a) EOHHS will establish an interim *per diem* rate using a base year CMS-2540 cost report inflated to the rate year using the cost adjustment factor calculated pursuant to 101 CMR 206.06(11)(b) and a final rate using the final rate year CMS-2540 cost report.

(b) EOHHS will determine a cost adjustment factor using a composite index using price level data from the CMS Nursing Home without capital forecast, and regional health care consumer price indices, and the Massachusetts-specific consumer price index (CPI), optimistic forecast. EOHHS will use the Massachusetts CPI as proxy for wages and salaries.

(c) EOHHS may retroactively adjust the final settled amount when the Medicare CMS-2540 cost report is reopened or for audit adjustments.

(13) Direct Care Add-on.

(a) General. Beginning October 1, 2024, a nursing facility will be eligible for an upward adjustment of 3.177% applied to its nursing standard rate and operating standard rate at each PDPM nursing case mix category. Facilities must use the funds from this direct care add-on solely for direct care staff wages, benefits, incentive payments, or other direct care compensation.

(b) Reporting.

1. Each facility will be required to report to EOHHS on the ways in which it uses its received direct care add-on funds. The required reporting will be incorporated in the interim or final DCC-Q reports that facilities are required to submit by March 1, 2025, and July 31, 2025, respectively, in accordance with 101 CMR 206.12(3). Failure to complete the required supplemental payment reporting on the interim or final DCC-Q reports, as specified and required by MassHealth through administrative bulletin or other written issuance, failure to timely submit the interim or final DCC-Q reports, or failure to use direct care add-on funds on anything other than direct care staff wages, benefits, incentive payments, or other direct care compensation may result in partial or full recoupment of direct care add-on funds as an overpayment under 130 CMR 450.237: *Overpayments: Determination.*

206.06: continued

2. All information included in the reports regarding the direct care add-on funds is subject to verification and audit by MassHealth. Failure to submit the required reporting or comply with audits or document requests with respect to the requirements herein may result in partial or full recoupment of the direct care add-on funds as overpayments under 130 CMR 450.237: *Overpayments: Determination*, or sanctions under 130 CMR 450.238: *Sanctions: General*.

(14) High Medicaid Adjustment. Beginning October 1, 2024, a nursing facility may be eligible for a High Medicaid Adjustment to its payment rate, based on the proportion of the facility's total resident days which are Massachusetts Medicaid days, as reported on the facility's quarterly User Fee Assessment Forms covering the period April 1, 2023, through March 31, 2024. For the purpose of determining eligibility for the High Medicaid Adjustment, the proportion of the facility's total resident days which are Massachusetts Medicaid days will be rounded to the nearest hundredth of a percent.

(a) A facility for which its Massachusetts Medicaid days are at least 75.00% and less than 90.00% of its total resident days will receive a 7% upward adjustment applied to its nursing standard rate and operating standard rate at each PDPM nursing case mix category.

(b) A facility for which Massachusetts Medicaid days are at least 90.00% of its total resident days will receive a 9% upward adjustment applied to its nursing standard rate and operating standard rate at each PDPM nursing case mix category.

(c) EOHHS will not adjust any High Medicaid Adjustment solely because a facility under-reported Massachusetts Medicaid days in its quarterly User Fee Assessment Form.

(15) Maximum Change Adjustment. Beginning October 1, 2024, a nursing facility will be subject to an adjustment to its total standard nursing facility *per diem rate* at each PDPM nursing case mix category established through 101 CMR 206.04, 101 CMR 206.05, 101 CMR 206.06(2) through (14), and 101 CMR 206.12(4), if a facility's proposed total average *per diem* rate, beginning October 1, 2024, calculated using the facility's average PDPM nursing case mix in the period October 1, 2023, through March 31, 2024, is greater than 130% of the facility's total average *per diem* standard nursing facility rate that was in effect on September 30, 2023, calculated using the facility's average MMQ case mix in rate year 2022. The adjustment will be calculated as follows:

(a) determine the facility's proposed total average *per diem* rate, calculated using the facility's average PDPM nursing case mix in the period October 1, 2023, through March 31, 2024, pursuant to 101 CMR 206.04, 101 CMR 206.05, 101 CMR 206.06(2) through (14), and 101 CMR 206.12(4);

(b) determine 130% of the facility's average *per diem* rate that was in effect on September 30, 2023, calculated using the facility's average MMQ case mix in rate year 2022;

(c) subtract the amount calculated in 101 CMR 206.06(15)(a) from the amount calculated in 101 CMR 206.06(15)(b);

(d) divide the amount calculated in 101 CMR 206.06(15)(c) by the amount calculated in 101 CMR 206.06(15)(a);

(e) the percentage calculated in 101 CMR 206.06(15)(d) will be applied as a downward adjustment to the total proposed standard nursing facility *per diem* rate, as established through 101 CMR 206.04, 101 CMR 206.05, 101 CMR 206.06(2) through (14), and 101 CMR 206.12(4), at each PDPM nursing case mix category.

206.07: Payments for Individuals in a Disaster Struck Nursing Facility

(1) Payment to a Disaster Struck Nursing Facility for individuals that must be temporarily evacuated to another facility (Resident Accepting Nursing Facility) may continue for up to 30 days after the disaster event.

(2) Payment will be the same as if the individual was residing in the Disaster Struck Nursing Facility. No other payment will be made to either the Disaster Struck Nursing Facility or the Resident Accepting Nursing Facility for evacuated individuals. The Disaster Struck Nursing Facility must meet the following conditions in order to receive payment for evacuated individuals:

206.07: continued

(a) The Disaster Struck Nursing Facility must have a contract with the Resident Accepting Nursing Facility. The contract must include:

1. terms of payment and mechanisms to resolve any contract disputes;
2. protocols for sharing care and treatment information between the two facilities; and
3. requirements that both facilities meet all conditions of Medicaid participation, as determined by the MassHealth agency.

(b) The Disaster Struck Nursing Facility must notify the MassHealth agency of the disaster event, maintain records of all evacuated individuals that include each individual's name, date of evacuation, and Resident Accepting Nursing Facility, and update the MassHealth agency on the status of any necessary repairs.

(c) The Disaster Struck Nursing Facility must determine within 15 days of the disaster event whether evacuated individuals will be able to return to the facility within 30 days of the disaster event. If the Disaster Struck Nursing Facility determines that it is not able to reopen within 30 days, it must discharge all evacuated individuals and work with them to choose admission to other facilities or alternative placements. Nothing precludes an evacuated individual from asking to be discharged and admitted to another facility or alternative placement. Payment to the Disaster Struck Nursing Facility will cease when an individual is discharged from the facility.

206.08: Reporting Requirements

(1) Required Cost Reports.

(a) Nursing Facility Cost Report. Each provider must complete and file a Nursing Facility Cost Report (SNF-CR) each calendar year with the Center. The Nursing Facility Cost Report must contain the complete financial condition of the provider, including all applicable management company, central office, and real estate expenses. If a provider has closed on or before November 30th, the provider is not required to file an SNF-CR report.

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

(c) Management Company Cost Report. A provider must file a separate Management Company Cost Report with the Center for each entity for which it reports management or central office expenses related to the care of Massachusetts publicly aided residents. If the provider identifies such costs, the provider must certify that costs are reasonable and necessary for the care of publicly aided residents in Massachusetts.

(d) Financial Statements. If a provider or its parent organization is required or elects to obtain independent audited financial statements for purposes other than filing an annual Nursing Facility Cost Report in accordance with 101 CMR 206.00, the provider must file a complete copy of these financial statements with the Center, that most closely correspond to the provider's Nursing Facility Cost Report fiscal period. If the Provider or its parent organization does not obtain audited financial statements, the Provider must file with the Center a complete copy of its unaudited financial statements that most closely correspond to the Nursing Facility cost report fiscal period. Nothing in 101 CMR 206.08(1)(d) will be construed as an additional requirement that nursing homes complete audited financial statements solely to comply with the Center's annual cost reporting requirements.

(e) Clinical Data. EOHHS may require providers to submit patient level data for the purpose of measuring clinical performance in a format specified by EOHHS. EOHHS may designate required data, data specifications, and other data collection requirements by administrative bulletin.

(f) CMS-2540 Reports. State operated nursing facilities that meet the definition in 42 CFR 433.50(a)(i) must file a CMS-2540 report with the Center annually. The state-operated nursing facility must report the final disposition made by the Medicare intermediary.

(2) General Cost Reporting Requirements.

(a) Accrual Method. Providers must complete all required reports using the accrual method of accounting.

206.08: continued

(b) Documentation of Reported Costs. Providers must maintain accurate, detailed, and original financial records to substantiate reported costs for a period of at least five years following the submission of required reports or until the final resolution of any appeal of a rate for the period covered by the report, whichever is later. Providers must maintain complete documentation of all of the financial transactions and census activity of the provider and affiliated entities including, but not limited to, the books, invoices, bank statements, canceled checks, payroll records, governmental filings, and any other records necessary to document the provider's reported costs. Providers must be able to document expenses relating to affiliated entities for which it has identified costs related to the care of Massachusetts publicly aided residents whether or not they are related parties.

(c) Fixed Asset Ledger. Providers must maintain a fixed asset ledger that clearly identifies each asset for which expenses are reported, including location, date of purchase, cost, salvage value, accumulated depreciation, and the disposition of sold, lost, or fully depreciated assets.

(d) Job Descriptions and Time Records. Providers and management companies must maintain written job descriptions including qualifications, duties, responsibilities, and time records such as time cards for all positions that the provider identifies as related to the care of Massachusetts publicly aided residents. Facilities organized as sole proprietors or partnerships in which the sole proprietor or partner functions as administrator with no reported administrator salary or benefits must maintain documentation to support the provision of administrator services by the sole proprietor or partner.

(e) Indirect Restorative Therapy Services Record. Providers must maintain a record of indirect restorative therapy services documented by a written summary available for inspection in the nursing facility as required by 105 CMR 150.010(F): *Records and Reports*.

(f) Other Cost Reporting Requirements.

1. Administrative Costs.

a. The following expenses must be reported as administrative:

i. all compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the nursing facility;

ii. expenses related to tasks performed by persons at a management level above that of an on-site provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a nursing facility as well as legal, accounting, financial, and managerial services or advice including computer services and payroll processing; and

iii. expenses related to policy making, planning, and decision making activities necessary for the general and long-term management of the affairs of a nursing facility, including but not limited to the following: the financial management of the provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies, and the planning of the expansion and financing of the provider.

b. Providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries, or other compensation.

c. Providers may allocate administrative costs among two or more accounts. The provider must maintain specific and detailed time records to support the allocation.

2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.

3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.

4. Fixed Costs.

a. Additions. If the square footage of the building is enlarged, providers must report all additions and renovations as building additions.

b. Allocation. Providers must allocate all fixed costs, except equipment, on the basis of square footage. A provider may elect to specifically identify equipment related to the nursing facility. The provider must document each piece of equipment in the fixed asset ledger. If a provider elects not to identify equipment, it must allocate equipment on the basis of square footage.

206.08: continued

c. Replacement of Beds. If a provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to publicly aided residents and may not identify associated expenses as related to the care of Massachusetts publicly aided residents.

d. Fully Depreciated Assets. Providers must separately identify fully depreciated assets. Providers must report the costs of fully depreciated assets and related accumulated depreciation on all cost reports unless they have removed such costs and accumulated depreciation from the provider's books and records. Providers must attach a schedule of the cost of the retired equipment, accumulated depreciation, and the accounting entries on the books and records of the provider to the cost report when equipment is retired.

e. Major Repair Projects. Providers must report all expenditures for major repair projects whose useful life is greater than one year, including, but not limited to, wallpapering and painting as improvements. Providers may not report such expenditures as prepaid expenses.

5. Laundry Expense. Providers must separately identify the expense associated with laundry services for which non-publicly aided residents are billed. Providers must identify such expense as non-related to Medicaid patient care.

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

7. Nursing Costs. The costs must be associated with direct resident care personnel and be required to meet federal and state laws.

8. Related Parties. Providers must disclose salary expense paid to a related party and must identify all goods and services purchased from a related party. If a provider purchases goods and services from a related party, it must disclose the related party's cost of the goods and services.

(g) Special Cost Reporting Requirements.

1. Facilities in Which Other Programs Are Operated. If a provider operates an adult day health program, an assisted living program, or provides outpatient services, the provider must exclude the expenses of such programs because they are not related to the provision of nursing facility care of Massachusetts publicly aided residents.

a. If the provider converts a portion of the facility to another program, the provider must identify the existing equipment no longer used in nursing facility operations and remove such equipment from the nursing facility records. Related depreciation expense for these fixed assets is no longer an allowable expense.

b. The provider must identify the total square footage of the existing building, the square footage associated with the program, and the equipment associated with the program.

c. The provider must allocate all shared costs, including shared capital costs, using a well-documented and generally accepted allocation method. The provider must directly assign to the program any additional capital expenditures associated with the program.

2. Hospital-based Nursing Facilities. A hospital-based nursing facility must file cost reports on a fiscal year basis consistent with the fiscal year used in the Massachusetts Hospital Cost Report.

a. The provider must identify the existing building and improvement costs associated with the nursing facility. The provider must allocate such costs on a square footage basis.

b. The provider must report major moveable equipment and fixed equipment in a manner consistent with the Hospital Cost Report. In addition, the provider must classify fixed equipment as either building improvements or equipment in accordance with the definitions contained in 101 CMR 206.02. The provider may elect to report major moveable and fixed equipment by one of two methods.

i. A provider may elect to specifically identify the major moveable and fixed equipment directly related to the care of publicly aided residents in the nursing facility. The provider must maintain complete documentation in a fixed asset ledger that clearly identifies each piece of equipment and its cost, date of purchase, and accumulated depreciation. The provider must submit this documentation to the Center with its first Notification of Change in Beds.

ii. If the provider elects not to identify specifically each item of major moveable and fixed equipment, EOHHS will allocate fixed equipment on a square footage basis.

206.08: continued

c. The provider must report additional capital expenditures directly related to the establishment of the nursing facility within the hospital as additions. EOHHS will allocate capital expenditures that relate to the total plant on a square footage basis.

d. The provider must use direct costing whenever possible to obtain operating expenses associated with the nursing facility. The provider must allocate all costs shared by the hospital and the nursing facility using the statistics specified in the Hospital Cost Report instructions. The provider must disclose all analysis, allocations, and statistics used in preparing the Nursing Facility Cost Report.

(3) General Cost Principles. In order to report a cost as related to Medicaid patient care, a cost must satisfy the following criteria.

(a) The cost must be ordinary, necessary, and directly related to the care of publicly aided residents.

(b) The cost must adhere to the prudent buyer concept.

(c) Expenses otherwise allowable will not be included for purposes of determining rates under 101 CMR 206.00 where such expenses are paid to a related party unless the provider identifies any such related party and expenses attributable to it in the reports submitted under 101 CMR 206.00 and demonstrates that such expenses do not exceed the lower of the cost to the related party or the price of comparable services, facilities, or supplies that could be purchased elsewhere. The Center may request either the provider or the related party, or both, to submit information, books, and records relating to such expenses for the purpose of determining whether the expenses are allowable.

(d) Only the provider's contribution of generally available employee benefits will be deemed an allowable cost. Providers may vary generally available employee benefits by groups of employees at the option of the employer. To qualify as a generally available employee benefit, the provider must establish and maintain evidence of its nondiscriminatory nature. Generally available employee benefits include, but are not limited to, group health and life insurance, pension plans, seasonal bonuses, child care, and job related education and staff training. Bonuses related to profit, private occupancy, or directly or indirectly to rates of reimbursement will not be included for calculation of prospective rates. Benefits that are related to salaries will be limited to allowable salaries. Benefits, including pensions, related to non-administrative and non-nursing personnel must be included as part of operating costs. Benefits that are related to the director of nurses, including pensions and education, must be included as part of nursing costs. Providers may accrue expenses for employee benefits such as vacation, sick time, and holidays that employees have earned but have not yet taken, provided that these benefits are both stated in the written policy and are the actual practice of the provider and that such benefits are guaranteed to the employee even upon death or termination of employment. Such expenses may be recorded and claimed for reimbursement purposes only as of the date that a legal liability has been established.

(e) The cost must be for goods or services actually provided in the nursing facility.

(f) The cost must be reasonable.

(g) The cost must actually be paid by the provider. Costs not considered related to the care of Massachusetts publicly aided residents include, but are not limited to, costs discharged in bankruptcy; costs forgiven; costs converted to a promissory note; and accruals of self-insured costs based on actuarial estimates.

(h) A provider must report the following costs as non-allowable costs:

1. bad debts, refunds, charitable contributions, and courtesy allowances and contractual adjustments to the Commonwealth and other third parties;

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

3. expenses not directly related to the provision of resident care including, but not limited to, expenses related to other business activities and fund raising, gift shop expenses, research expenses, rental expense for space not required by the Department and expenditure of funds received under federal grants for compensation paid for training personnel and expenses related to grants of contracts for special projects;

4. compensation and fringe benefits of residents on a provider's payroll;

5. penalties and interest, incurred because of late payment of loans or other indebtedness, late filing of federal and state tax returns, or from late payment of municipal taxes;

206.08: continued

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

7. expenses for purchased service nursing services purchased from temporary nursing agencies not registered with the Department under 105 CMR 157.000: *The Registration and Operation of Temporary Nursing Service Agencies* or paid for at rates greater than the rates established by EOHHS pursuant to 101 CMR 345.00: *Temporary Nursing Services*;

8. any expense or amortization of a capitalized cost that relates to costs or expenses incurred prior to the opening of the nursing facility;

9. all legal expenses, including those accounting expenses and filing fees associated with any appeal process;

10. prescribed legend drugs for individual patients;

11. recovery of expense items, that is, expenses that are reduced or eliminated by applicable income including, but not limited to, rental of quarters to employees and others, income from meals sold to persons other than residents, telephone income, vending machine income, and medical records income. Vending machine income will be recovered against other operating costs. Other recoverable income will be recovered against an account in the appropriate cost group category, such as administrative and general costs, other operating costs, nursing costs, and capital costs. The cost associated with laundry income that is generated from special services rendered to private patients must be identified and eliminated from the facility's claim for reimbursement. Special services are those services not rendered to all patients (*e.g.*, dry cleaning, *etc*.). If the cost of special services cannot be determined, laundry income will be recovered against laundry expense;

12. costs of ancillary services required by a purchasing agency to be billed on a direct basis, such as prescribed drugs and direct therapy costs;

13. accrued expenses that remain unpaid more than 120 days after the close of the reporting year, excluding vacation and sick time accruals, will not be included in the prospective rates. When the Center receives satisfactory evidence of payment, EOHHS may reverse the adjustment and include that cost, if otherwise allowable, in the applicable prospective rates;

14. interest expense from related-party loans or on long-term debt that was not used to finance the purchase of nursing facility fixed asset additions; and

15. expenses paid for using funds from any low-interest or forgivable loan administered by EOHHS.

(4) Filing Deadlines.

(a) General. Except as provided in 101 CMR 206.08(4)(a)1. and 2., or in accordance with alternative deadlines established by EOHHS or the Center through administrative bulletin or other written issuance, providers must file required cost reports for the calendar year within 60 days of the deployment of the annual Nursing Facility Cost Report. If the 60th day falls on a weekend or holiday, the reports are due by 5:00 P.M. on the following business day.

1. Hospital-based Nursing Facilities. Hospital-based nursing facilities must file cost reports no later than 90 days after the close of the hospital's fiscal year.

2. Appointment of a Resident Protector Receiver. If a receiver is appointed pursuant to M.G.L. c. 111, § 72N, the provider must file cost reports for the current reporting period or portion thereof, within 60 days of the receiver's appointment.

(b) Extension of Filing Date. The Center may grant a request for an extension of the filing due date for a maximum of 30 calendar days. In order to receive an extension, the provider must

1. submit the request itself, and not by agent or other representative;

2. demonstrate exceptional circumstances that prevent the provider from meeting the deadline; and

3. file the request with the Center no later than 30 calendar days before the due date.

(c) Administrative Bulletin. The Center may modify the filing deadlines by issuing an administrative bulletin 30 days prior to any proposed change.

206.08: continued

(5) Incomplete Submissions. If the cost reports are incomplete, the Center will notify the provider in writing within 120 days of receipt. The Center will specify the additional information that the provider must submit to complete the cost reports. The provider must file the required information within 25 days of the date of notification or by April 1st of the year the cost reports are filed, whichever is later. If the Center fails to notify the provider within the 120-day period, the cost reports will be considered complete and will be deemed to be filed on the date of receipt.

(6) Audits. The Center and the MassHealth agency may conduct desk audits or field audits to ensure accuracy and consistency in reporting. Providers must submit additional data and documentation relating to the cost report, the operations of the provider and any related party as requested during a desk or field audit even if the Center has accepted the provider's cost reports.

(7) Penalties. If a provider does not file the required cost reports by the due date, EOHHS may reduce the provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of noncompliance thereafter. The reduction accrues cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late, and so on. The rate will be restored effective on the first of the month following the date the cost report is filed.

206.09: Special Provisions

(1) Rate Filings. EOHHS will file certified rates of payment for nursing facilities with the Secretary of the Commonwealth.

(2) Appeals. A provider may file an appeal at the Division of Administrative Law Appeals of any rate established pursuant to 101 CMR 206.00 within 30 calendar days after EOHHS files the rate with the Secretary of the Commonwealth. EOHHS may amend a rate or request additional information from the provider even if the provider has filed a pending appeal.

(3) Administrative Bulletins. EOHHS and the Center may issue administrative bulletins to clarify provisions of 101 CMR 206.00 or to specify data collection requirements. Such bulletins will be deemed to be incorporated in the provisions of 101 CMR 206.00. EOHHS and the Center will file the bulletins with the Secretary of the Commonwealth, distribute copies to providers, and make the bulletins accessible to the public at EOHHS's and the Center's offices during regular business hours.

(4) Severability. The provisions of 101 CMR 206.00 are severable. If any provision of 101 CMR 206.00 or the application of any provision of 101 CMR 206.00 is held invalid or unconstitutional, such provision will not be construed to affect the validity or constitutionality of any other provision of 101 CMR 206.00 or the application of any other provision.

206.10: Other Payment Provisions

(1) Temporary Resident Add-on.

(a) For dates of service beginning October 1, 2022, a nursing facility will be eligible for a member-specific temporary resident add-on if the resident meets all of the following criteria:

1. MassHealth is the resident's primary payer for nursing facility services at the time of admission;
2. the resident is medically eligible for nursing facility services under 130 CMR 456.409: *Services Requirement for Medical Eligibility*;
3. the resident was transferred to the nursing facility for temporary residence purposes directly from their home; and
4. the resident was discharged from the nursing facility to their home within 30 calendar days of the admission date.

(b) Payment Amount. For individuals younger than 22 years old, the add-on is $250 per member per day. For individuals 22 years of age or older, the add-on is $130 per member per day.

206.10: continued

(2) Ventilator Add-on. For dates of service beginning October 1, 2024, a nursing facility that provides ventilator services to ventilator-dependent MassHealth members will receive a member-specific ventilator add-on of $343 per member per day, provided all of the following criteria are met:

(a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;

(b) The resident requires ventilator services at least daily;

(c) The facility is approved by EOHHS to provide specialized ventilator-dependent services, in accordance with processes established through administrative bulletin or other written issuance;

(d) The facility maintains a program for specialized ventilator services, in accordance with MassHealth requirements established through administrative bulletin or other written issuance; and

(e) The facility is not receiving the communication-limited resident ventilator add-on described in 101 CMR 206.10(3) or the tracheostomy add-on described in 101 CMR 206.10(6) for the resident.

(3) Communication-limited Resident Ventilator Add-on. For dates of service beginning October 1, 2024, a nursing facility that provides services to ventilator-dependent MassHealth members will receive a member-specific add-on of $457 per member per day, provided all of the following criteria are met:

(a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;

(b) The resident requires ventilator services at least daily and is unable to communicate without the assistance of specialized communication technology that relies on eye movements, such as certain individuals with advanced amyotrophic lateral sclerosis (ALS);

(c) The facility is approved by EOHHS to provide specialized ventilator-dependent services, in accordance with processes established through administrative bulletin or other written issuance;

(d) The facility maintains a program for specialized ventilator services, in accordance with MassHealth requirements established through administrative bulletin or other written issuance; and

(e) The facility is not receiving the ventilator add-on described in 101 CMR 206.10(2) or the tracheostomy add-on described in 101 CMR 206.10(6) for the resident.

(6) Tracheostomy Add-on. For dates of service beginning October 1, 2022, a nursing facility that provides tracheostomy services to tracheostomy-dependent MassHealth members will receive a member-specific tracheostomy add-on of $220 per member per day, provided all of the following criteria are met:

(a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;

(b) the resident requires tracheostomy services; and

(c) the facility is not receiving the ventilator add-on described in 101 CMR 206.10(2) or the communication-limited resident ventilator add-on described in 101 CMR 206.10(3) for the resident.

(7) Medicaid Transitional Add-on. For dates of service beginning January 15, 2022, a nursing facility will be eligible for a transitional add-on of $200 per member per day for the first 60 days of the resident's nursing facility stay, not including any leaves of absence, if the resident meets all of the following criteria:

(a) MassHealth is the resident's primary payer for nursing facility services at the time of admission;

(b) The resident was transferred to the nursing facility directly from an acute or a non-acute inpatient hospital on or after January 15, 2022; and

(c) The resident is not returning to the nursing facility from a medical leave of absence.

206.10: continued

(8) COVID-19 Monoclonal Antibody Treatment and COVID-19 Antiviral Treatment Claims.

(a) For dates of service beginning December 22, 2021, and notwithstanding any regulatory provision to the contrary, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for the administration of COVID-19 monoclonal antibody treatments and COVID-19 antiviral treatments to eligible MassHealth members and provided in a manner supported by medical evidence, provided in accordance with the emergency use authorization (EUA) issued by the federal Food and Drug Administration (FDA) or provided in accordance with full FDA approval, and provided in accordance with any guidance issued by DPH, the FDA, or CMS with respect to such treatments. Nursing facilities are required to ensure that any such monoclonal antibody treatments or antiviral treatments administered at 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 206.10(8)(a) are not included in the prospective payment system operating or nursing standard payment rates determined under 101 CMR 206.03 and 101 CMR 206.04. The costs of providing such services will be considered non-allowable costs under 101 CMR 206.08(3)(h)12.

(c) MassHealth payments for separate fee-for-service claims submitted by the nursing facility for the services described in 101 CMR 206.10(8)(a) must be paid at the rates established under 101 CMR 446.03(2) or 101 CMR 317.00, as applicable. Such fee-for-service claims payments must be considered payment in full for such services.

(d) EOHHS must establish, through administrative bulletin or other written issuance, the specific COVID-19 monoclonal antibody treatments or COVID-19 antiviral treatments that may be administered by the nursing facility, as well as the specific codes and billing instructions for such services.

(9) COVID-19 Vaccine Administration Claims.

(a) For dates of service beginning October 1, 2021, and notwithstanding any regulatory provision to the contrary, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for COVID-19 vaccine administration services, provided to eligible MassHealth members in accordance with an EUA issued by the FDA or full FDA approval, and in accordance with any guidance issued by the FDA or CMS with respect to such services. Nursing 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 206.10(9)(a) are not included in the prospective payment system operating or nursing standard payment rates determined under 101 CMR 206.03 and 101 CMR 206.04. The costs of providing such services will be considered non-allowable costs under 101 CMR 206.08(3)(h)12.

(c) MassHealth payments for separate fee-for-service claims submitted by the nursing facility for the services described in 101 CMR 206.10(9)(a) must be paid at the rates established under 101 CMR 446.03(2): *Medicine*. Such fee-for-service claims must be considered payment in full for such services.

(d) EOHHS must establish, through administrative bulletin or other written issuance, the specific codes and billing instructions for such services.

(13) Homelessness Rate Add-on.

(a) Eligibility Criteria. For dates of service beginning January 15, 2022, a nursing facility will be eligible for a member-based homelessness rate add-on of $200 per member per day for up to the first 180 days of the member's nursing facility stay, not including any leaves of absence, if the member meets all of the following criteria.

1. MassHealth is the member's primary payer for nursing facility services at the time of admission;

2. The member is clinically eligible for nursing facility services under 130 CMR 456.409: *Services Requirement for Medical Eligibility*; and

3. The member has been approved for the member-based homelessness rate add-on by EOHHS because EOHHS has determined the member meets one or more of the following criteria:

a. The member has experienced homelessness for at least six months directly prior to admission as documented by a homeless provider agency and confirmed by EOHHS;

206.10: continued

b. The member has been homeless directly prior to admission, as documented by a homeless provider agency and confirmed by EOHHS, and has a behavioral health condition;

c. The member is at risk of homelessness and has a behavioral health condition;

d. The member experienced a sudden or unexpected loss of primary residence (for example, due to fire, flooding, eviction, *etc*.) necessitating an emergency nursing facility admission; or

e. The member's living situation directly prior to admission required the involvement of Elder Protective Services.

(b) Non-applicability with Other Payments. A nursing facility may not receive this add-on for a member for whom the facility is receiving on the same dates of service a Medicaid transitional add-on under 101 CMR 206.10(7), a substance use disorder add-on or a substance use disorder induction period add-on under 101 CMR 206.10(14), a behavioral indicator add-on under 101 CMR 206.10(16), a bariatric add-on under 101 CMR 206.10(21), a *per diem* rate for severe mental or neurological disorders under 101 CMR 206.11, or a complicated high-cost care need add-on under 101 CMR 206.15.

(c) Relevant Definitions.

1. For the purposes of the homelessness rate add-on, a member experiencing homelessness is any member who lacks a fixed, regular, and adequate nighttime residence and who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group; or who is living in a supervised publicly- or privately-operated emergency shelter designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.

2. For the purposes of the homelessness rate add-on, a member at risk of homelessness is any member who does not have sufficient resources or support networks (*e.g*., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation.

(14) Substance Use Disorder (SUD) Add-on and SUD Induction Period Add-on.

(a) Eligibility Criteria.

1. For dates of service beginning October 1, 2024, a nursing facility that meets the criteria set forth in 101 CMR 206.10(14)(a)3. or 4., as applicable, will be eligible for a member specific Substance Use Disorder (SUD) add-on of $50 per member per day for each member residing in the facility, for whom MassHealth is the primary payer, who has a documented SUD diagnosis listed in 101 CMR 206.10(14)(b) and who receives at least one SUD service or treatment listed in 101 CMR 206.10(14)(c).

2. For dates of services beginning October 1, 2024, a nursing facility that meets the criteria set forth in 101 CMR 206.10(14)(a)(3) or (4), as applicable, will be eligible for a member specific SUD induction period add-on of $200 per member per day of induction period for each member residing in the facility, for whom MassHealth is the primary payer, who has a documented SUD diagnosis listed in 101 CMR 206.10(14)(b), and who requires transportation with direct care staff to an Opioid Treatment Program (OTP) clinic for the member's induction period.

3. The facility will be eligible to receive the add-ons under 101 CMR 206.10(14)(a)(1) and (2) only if it submits to EOHHS an attestation in a form and manner specified by EOHHS by the deadline specified by EOHHS confirming that the facility has processes in place to provide services to residents with SUD. This provision applies to all facilities unless they are a High-SUD nursing facility as described in 101 CMR 206.10(14)(a)(4).

4. A facility that meets the criteria for a High-SUD nursing facility, as determined by EOHHS, will be eligible to receive the add-ons under 101 CMR 206.10(14)(a)(1) and (2) only if:

i. The facility submits to EOHHS an attestation in a form and manner specified by EOHHS by the deadline specified by EOHHS confirming that the facility has processes in place to provide services to residents with SUD; and

206.10: continued

ii. The facility submits to EOHHS: (1) an attestation in a form and manner specified by EOHHS by the deadline specified by EOHHS, certifying that the facility has executed an appropriate agreement to share data and collaborate with at least one OTP. Such agreement must include agreed-upon policies and procedures as specified by EOHHS in administrative bulletin or other written issuance; and (2) a copy of the executed agreement.

(b) ICD-10 Groups. For the purposes of the SUD add-on and the SUD induction period add-on, eligible ICD-10 diagnosis groups include F10 through F16 (mental and behavioral disorders due to psychoactive substance), F19 (other psychoactive substance related disorders), and T40 (poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics (hallucinogens)).

(c) SUD Services or Treatment. For the purposes of the SUD add-on and the SUD induction period add-on, eligible SUD services or treatment include opioid treatment services, medication for addiction treatment, and SUD-related counseling. EOHHS may establish further guidance regarding eligible SUD services and treatments through administrative bulletin or other written issuance.

(d) Denial of Payment and Overpayments. Facilities that fail to meet the requirements under 101 CMR 206.10(14)(a), (b), or (c) may be denied further SUD add-on payments and may be subject to overpayment action under 130 CMR 450.237: *Overpayments: Determination*. In addition, facilities that refuse to admit a resident with SUD solely because of their SUD diagnosis may be denied the SUD add-on for the rest of the rate year and may be subject to sanctions under 130 CMR 450.238: *Sanctions: General*.

(e) Additional Guidance. EOHHS may issue, *via* administrative bulletin or other written issuance, additional guidance regarding these add-ons, including but not limited to guidance on billing procedures and verification of medical records required to support the SUD diagnoses.

(15) Add-on for Home Dialysis in a Nursing Facility Setting.

(a) Dialysis Treatment for Members. Nursing facilities may have home dialysis services available on-site at the facility, after receiving approval from the Department of Public Health to operate an on-site home dialysis services program, in coordination with a licensed dialysis services provider.

(b) Add-on Rate of $85 per Member per Dialysis Treatment. Nursing facilities with an approved on-site home dialysis services program in accordance with 101 CMR 206.10(15)(a) may receive a rate add-on of $85 per member residing in the facility and receiving home dialysis services in the facility, for each instance of home dialysis services received in the nursing facility for which the following two conditions are concurrently met:

1. MassHealth is not the primary payer for the member's home dialysis services received in the nursing facility; and
2. MassHealth is the primary payer for the member's nursing facility services at the time of home dialysis services received in the nursing facility.

(c) Add-on Rate of $379 per Member per Dialysis Treatment. Nursing facilities with an approved on-site home dialysis services program in accordance with 101 CMR 206.10(15)(a) may receive a rate add-on of $379 per member residing in the facility and receiving home dialysis services in the facility, for each instance of home dialysis services received in the nursing facility for which the following two conditions are concurrently met:

1. MassHealth would be the primary payer for the dialysis services if they were received outside of the nursing facility; and
2. MassHealth is the primary payer for the member's nursing facility services at the time of home dialysis services received in the nursing facility.

(16) Behavioral Indicator Add-on.

(a) Eligibility Criteria. For dates of service beginning October 1, 2022, a nursing facility will be eligible for a member-specific behavioral indicator add-on of $50 per member per day for each member residing in the facility for whom MassHealth is the primary payer and who was coded as 2 or 3 on one or more of the following Minimum Data Set 3.0 (MDS 3.0) indicators: Behavioral Health (E0200A, E0200B, or E0200C), Rejection of Care (E0800), or Wandering (E0900). The add-on is meant to offset additional costs associated with certain members with behavioral conditions (for example, members with severe dementia).

206.10: continued

(b) Additional Guidance. EOHHS may issue, *via* administrative bulletin or other written issuance, additional guidance regarding this add-on, including but not limited to billing procedures for the behavioral indicator add-on and verification of medical records required to support the MDS coding for the add-on.

(17) Add-on for Dialysis Services Provided at an Affiliated Inpatient Chronic Disease and Rehabilitation Hospital.

(a) Dialysis Treatment for Members. Nursing facility residents may receive dialysis services at an affiliated inpatient chronic disease and rehabilitation hospital that is licensed by DPH and located in the same building, in coordination with a licensed dialysis services provider, as long as the dialysis services are not licensed as outpatient services. If the dialysis services are licensed by DPH as services provided by an outpatient clinic in accordance with 105 CMR 145.000, the nursing facility may not receive the rate add-on under 101 CMR 206.10(17).

(b) Add-on Rate of $85 per Member per Dialysis Treatment. Nursing facilities may receive a rate add-on of $85 per member residing in the nursing facility and receiving dialysis services in a setting that meets the criteria specified in 101 CMR 206.10(17)(a) for each instance of dialysis services received in the affiliated facility for which the following two conditions are concurrently met:

1. MassHealth is not the primary payer for the member's dialysis services received in the affiliated facility; and
2. MassHealth is the primary payer for the member's nursing facility services at the time of dialysis services received in the affiliated facility.

(c) Add-on Rate of $379 per Member per Dialysis Treatment. Nursing facilities may receive a rate add-on of $379 per member residing in the nursing facility and receiving dialysis services in a setting that meets the criteria specified in 101 CMR 206.10(17)(a), for each instance of dialysis services received in the affiliated facility for which the following two conditions are concurrently met:

1. MassHealth would be the primary payer for the dialysis services if they were received outside of the nursing facility; and
2. MassHealth is the primary payer for the member's nursing facility services at the time of dialysis services received in the affiliated facility.

(18) Payments for Quality Improvements through COVID-19 Preparedness.

(a) General. A nursing facility will be eligible for a COVID-19 preparedness payment, as calculated in 101 CMR 206.10(18)(c), to be made upon verification of eligibility criteria described in 101 CMR 206.10(18)(b).

(b) Eligibility Criteria. A nursing facility will be eligible for a COVID-19 preparedness payment if the facility meets all of the criteria in 101 CMR 206.10(18)(b)1. through 5. MassHealth may provide further detail on such criteria, including on the specific infection control requirements, attestation forms and deadlines, any necessary reporting deadlines, specific requirements for COVID-19 therapeutic plans, and other information as MassHealth determines necessary pursuant to 101 CMR 206.10(18)(f).

1. The nursing facility
   a. had an HPPD, as defined in 101 CMR 206.13(3), of 3.58 or higher for at least one calendar quarter from October 1, 2022, through December 31, 2024; or
   b. achieved a minimum of 10% improvement in HPPD in at least one calendar quarter from January 1, 2023, through December 31, 2024, as compared to the calendar quarter ending December 31, 2022.
2. The nursing facility meets a minimum threshold of staff and residents who are up-to-date with COVID-19 vaccinations, with thresholds and deadlines established by MassHealth through administrative bulletin or other written issuance.
3. The nursing facility must attest to implementing core components of infection control requirements and outline a plan for ensuring compliance with these requirements and be in continuous substantial compliance with such requirements during the rate year.
4. A nursing facility must attest to having a plan in place to administer COVID-19 therapeutics, including monoclonal antibodies and antiviral therapies, to its residents as clinically appropriate.
5. The nursing facility must meet the 75% DCC-Q threshold established under 101 CMR 206.12(1).

206.10: continued

(c) Payment Methodology. EOHHS will use the following methodology to calculate COVID-19 preparedness payments for each eligible nursing facility.

1. Determine the total number of Massachusetts Medicaid days, including fee-for-service (FFS) days and managed care days, as reported by eligible nursing facilities in their Quarterly User Fee Assessment Forms for the period of July 1, 2021, through June 30, 2022.

2. Determine which of the two thresholds of staff and residents who are up-to-date with COVID-19 vaccinations a nursing facility meets.

3. If the facility meets the higher of the two thresholds in 101 CMR 206.10(18)(c)2., multiply by 3 the number of Massachusetts Medicaid days, including fee-for-service (FFS) days and managed care days, as reported by an eligible nursing facility in its Quarterly User Fee Assessment Forms for the period of July 1, 2021, through June 30, 2022.

4. If the facility meets the lower of the two thresholds in 101 CMR 206.10(18)(c)2., keep the same the number of Massachusetts Medicaid days, including fee-for-service (FFS) days and managed care days, as reported by an eligible nursing facility in its Quarterly User Fee Assessment Forms for the period of July 1, 2021, through June 30, 2022.

5. Sum up Massachusetts Medicaid days in 101 CMR 206.10(18)(c)3. and 101 CMR 206.10(18)(c)4.

6. Divide the total amount of available funds, $16,550,000, by the total number of Massachusetts Medicaid days as determined in 101 CMR 206.10(18)(c)5.

7. For each eligible nursing facility meeting the higher of the two thresholds in 101 CMR 206.10(18)(c)2., multiply the quotient calculated in 101 CMR 206.10(18)(c)6. by the eligible nursing facility's Massachusetts Medicaid days, as calculated in 101 CMR 206.10(18)(c)3.

8. For each eligible nursing facility meeting the lower of the two thresholds in 101 CMR 206.10(18)(c)2., multiply the quotient calculated in 101 CMR 206.10(18)(c)6. by the eligible nursing facility's Massachusetts Medicaid days, as they appear in 101 CMR 206.10(18)(c)4.

9. If the product in 101 CMR 206.10(18)(c)7. is greater than $700,000, cap the total calculated for each eligible nursing facility at $700,000; otherwise keep the total as is.

10. If the product in 101 CMR 206.10(18)(c)8. is greater than $300,000, cap the total calculated for each eligible nursing facility at $300,000; otherwise keep the total as is.

11. Sum up the amounts calculated in 101 CMR 206.10(18)(c)9. and 101 CMR 206.10(18)(c)10.

12. Subtract the sum calculated in 101 CMR 206.10(18)(c)11. from $16,550,000.

13. Sum up Massachusetts Medicaid days for eligible nursing facilities in 101 CMR 206.10(18)(c)4. whose amounts calculated in 101 CMR 206.10(18)(c)10. are less than $300,000.

14. Divide the amount calculated in 101 CMR 206.10(18)(c)12. by the number calculated in 101 CMR 206.10(18)(c)13.

15. For each eligible nursing facility in 101 CMR 206.10(18)(c)4. whose amounts calculated in 101 CMR 206.10(18)(c)10. are less than $300,000, multiply the quotient calculated in 101 CMR 206.10(18)(c)14. by the eligible nursing facility's Massachusetts Medicaid days, as calculated in 101 CMR 206.10(18)(c)4.

16. For each eligible nursing facility in 101 CMR 206.10(18)(c)4. whose amounts calculated in 101 CMR 206.10(18)(c)10. are less than $300,000, sum up the amount in 101 CMR 206.10(18)(c)10. and the product calculated in 101 CMR 206.10(18)(c)15.

17. If the amount calculated in 101 CMR 206.10(18)(c)16. is greater than $300,000, cap the total calculated for each eligible nursing facility at $300,000; otherwise keep the total as is.

18. Sum up the amounts calculated in 101 CMR 206.10(18)(c)9. and 101 CMR 206.10(18)(c)10. for eligible facilities that reached the $300,000 cap, and in 101 CMR 206.10(18)(c)17.

19. Subtract the sum calculated in 101 CMR 206.10(18)(c)18. from $16,550,000.

20. Repeat the above steps for eligible facilities in 101 CMR 206.10(18)(c)4. whose amounts are less than $300,000 until the remaining funds are fully distributed.

206.10: continued

21. The COVID-19 preparedness payments, for each eligible nursing facility, will equal the total calculated in 101 CMR 206.10(18)(c)9., 101 CMR 206.10(18)(c)10., 101 CMR 206.10(18)(c)17., or 101 CMR 206.10(18)(c)20., depending on whether an eligible facility was above or below the allowable cap.

(d) Overpayments. A nursing facility that fails to meet the criteria under 101 CMR 206.10(18)(b)1. and/or remain in compliance with all infection control requirements during the period of December 1, 2022, through June 30, 2023, under 101 CMR 206.10(18)(b)4. may be subject to overpayment action under 130 CMR 450.237: *Overpayments: Determination*.

(e) Correction of Material Error. EOHHS may adjust any supplemental payment upon EOHHS's determination that there was a material error in the calculation of the payment. EOHHS will not adjust any supplemental payment solely because a facility under-reported Massachusetts Medicaid days in its Quarterly User Fee Assessment Form.

(f) Additional Guidance. EOHHS may issue, *via* administrative bulletin or other written issuance, additional guidance regarding this add-on.

(21) Bariatric Add-on.

(a) For dates of service beginning on February 2, 2024, nursing facilities may receive a member-based rate add-on of $300 per member per day for each member residing in a facility for whom MassHealth is the primary payer and all of the following conditions are met:

1. prior to the member's admission, the facility must receive approval from MassHealth to bill the add-on based on the clinical profile of the member;
2. the member has a Body Mass Index (BMI) greater than 40 that can be supported by an ICD-10 code after admission;
3. the member is dependent, as defined by MDS, for at least one activity of daily living that requires a service listed in 130 CMR 456.409(B); and
4. the member requires a minimum of two staff members to assist with transfers, personal care and/or bed mobility.

(b) Non-applicability with Other Payments. A nursing facility may not receive this payment for a member for whom the facility is receiving on the same dates of service a homelessness rate add-on under 101 CMR 206.10(13), a severe mental and neurological disorder add-on under 101 CMR 206.11, or a complicated high-cost care need add-on under 101 CMR 206.15.

(22) Supplemental Payment for Qualified Nursing Facilities Located near North Adams.

(a) Beginning October 1, 2024, a nursing facility located within 17 miles of 71 Hospital Avenue in North Adams, Massachusetts will qualify for a supplemental payment to support additional allowable costs. Each qualified nursing facility will receive a proportional payment of the total amount available of $2,973,456.

(b) Qualified nursing facilities will receive a supplemental payment, which will be calculated and determined as follows.

1. Calculate the total of all qualified nursing facilities' Massachusetts Medicaid days, as reported on quarterly User Fee Assessment Forms for the period April 1, 2023, through March 31, 2024.
2. Determine each qualified nursing facility's proportion of Massachusetts Medicaid days as a total of all qualified nursing facility Massachusetts Medicaid days.
3. Multiply the proportion of each facility's Medicaid User Fee days by the total amount available of $2,973,456.

206.11: Rates for Severe Mental and Neurological Disorder Services

(1) Qualifying Nursing Facility. For dates of service beginning January 15, 2022, qualifying nursing facilities will be able to receive a member-based *per diem* rate for residents with severe mental or neurological disorders who are receiving specialized rehabilitation services for such disorders. In order to qualify for this member-based *per diem* rate, a nursing facility must

(a) as of August 1, 2020, operate to provide nursing facility services, including the specialized rehabilitative services described in 101 CMR 206.11(1)(c), to residents with mental or neurological disorders, including residents with acquired brain injuries;

206.11: continued

(b) demonstrate, in the form and manner requested by EOHHS, that the percentage of the facility's annual resident days for residents with mental or neurological disorders, including residents with acquired or traumatic brain injuries, is at least 50% of its total annual resident days;

(c) provide the following specialized rehabilitation services for its residents:

1. an individualized therapeutic skill development plan for each member;
2. individual counseling;
3. group counseling (therapeutic and life skills groups), with group sessions offered multiple times each week to ensure access based on member needs and preferences;
4. sensory modulation and cognitive rehabilitation;
5. neuropsychological testing, evaluation, and intervention;
6. alcohol and substance use disorder counseling and prevention;
7. all mental health services as indicated by each resident's Pre-admission Screening and Resident Review (PASRR) Level II evaluation, or coordinate with additional providers and practitioners, who may separately bill or be paid under the appropriate provider regulations, for services designated as specialized services under the PASRR program and therefore are services that are not included in standard nursing facility services;
8. vocational programming; and
9. community reintegration.

(d) Maintain a program staff of specially trained professionals including, but not limited to, a neuropsychiatrist, a neuropsychologist, licensed mental health counselors, vocational specialists, life skills counselors, certified brain injury specialists, substance abuse counselors, and therapeutic technicians. All such staff must be trained in behavior modification and de-escalation techniques.

(2) *Per Diem* Rate for Approved Admitted Members. For dates of service beginning October 1, 2023, qualifying nursing facilities may receive a flat member-based *per diem* rate of $486 for members with a mental or neurological disorder that severely affects the member's behavior who are admitted on or after August 1, 2020, provided that the qualifying nursing facility receives approval from MassHealth prior to the member's admission that the member requires specialized rehabilitative services described in 101 CMR 206.11(1) and is therefore eligible for this enhanced rate. The specialized rehabilitative services program is designed to transition the member back to community-based care or less-restrictive placement, and such rate applies only during the time that the member has been approved by MassHealth for the enhanced rate. Qualifying nursing facilities receiving this *per diem* rate are not eligible for any other *per diem* rates or payments established under 101 CMR 206.00 with respect to such approved members, except as provided in 101 CMR 206.11(3) or, if applicable, 101 CMR 206.10. Qualifying facilities may also admit members without seeking approval from the MassHealth agency. In such circumstances, qualifying nursing facilities will receive the standard nursing facility rate established under 101 CMR 206.00 with respect to those members.

(3) High-cost Member Additional Rate. Qualifying nursing facilities may receive an additional member-based rate of $150 in addition to the *per diem* rate set by 101 CMR 206.11(2) for any member approved for admittance to the nursing facility for whom reasonable and allowable direct care costs associated with providing for such member's clinical care needs is more than 100% greater than the facility's average direct care costs per resident, provided that the facility

(a) certifies that the direct care costs associated with providing services to such member meets the requirements of 101 CMR 206.11(3);

(b) submits a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of 101 CMR 206.11(3) have been met; and

(c) receives approval from the MassHealth agency for the additional rate, to be applied prospectively from the date of approval, with respect to such member.

The MassHealth agency reserves the right to request additional documentation in support of the expected direct care costs prior to granting approval for this additional rate.

206.11: continued

(4) Non-applicability with Other Payments. A nursing facility may not receive this payment for a member for whom the facility is receiving on the same dates of service a Medicaid transitional add-on under 101 CMR 206.10(7), a homelessness rate add-on under 101 CMR 206.10(13), a substance use disorder add-on or a substance use disorder induction period add-on under 101 CMR 206.10(14), a behavioral indicator add-on under 101 CMR 206.10(16), a bariatric add-on under 101 CMR 206.10(21), or a complicated high-cost care need add-on under 101 CMR 206.15.

206.12: Direct Care Cost Quotient

(1) Beginning October 1, 2020, nursing facilities must have a Direct Care Cost Quotient (DCC-Q), as described in 101 CMR 206.12(2), of at least 75%. For the rate year beginning October 1, 2022, a nursing facility rate will be subject to a downward adjustment if the facility failed to be at or above the 75% DCC-Q threshold for the period of July 1, 2021, through June 30, 2022. For rate years beginning on or after October 1, 2023, a nursing facility rate will be subject to a downward adjustment if the facility fails to be at or above the 75% DCC-Q threshold in the previous full fiscal year.

(2) The DCC-Q will be calculated by dividing certain direct care workforce expenses, such as nursing, dietary, restorative therapy, or social worker staff expenses, by the facility's total revenue, excluding the revenue for non-nursing facility lines of business and subtracting the User Fee Assessments, certain federal and state payments, certain prescription drug expenses, and certain other ancillary costs related to services provided to Medicare residents, to be identified *via* administrative bulletin or other written issuance.

(a) A multiplier may be applied to one or more direct care workforce position types as an incentive. A multiplier must be calculated by multiplying the cost associated with a given direct care workforce position type in the numerator by 1.5 or more, but not to exceed 3.

(b) The workforce position types eligible for any multiplier described in 101 CMR 206.12(2) and the magnitude of such multiplier in calculating the DCC-Q may be established by EOHHS *via* administrative bulletin or other written issuance.

(3) All nursing facilities, including facilities in 101 CMR 206.12(5), will be required to submit an interim compliance report by March 1st of each year and a final compliance report by July 31st of each year. The interim report will be used to inform nursing facilities if they are on track to meet the 75% DCC-Q threshold set forth in 101 CMR 206.12(1). The final compliance report will be used for determining whether the facility met that threshold.

(4) The downward adjustment to the rate will be applied in the following rate year to facilities that failed to meet the 75% DCC-Q threshold. Such downward adjustment will be calculated as follows.

(a) For every 1% below the 75% DCC-Q threshold, a 0.5% downward adjustment will be applied to the facility's nursing and operating standard payments at each PDPM nursing case mix category.

(b) The maximum downward adjustment calculated in 101 CMR 206.12(3)(a) may be no more than 5% of the facility's nursing and operating standard payments at each PDPM nursing case mix. EOHHS may apply the maximum downward adjustment of 5% in the following rate year for facilities that fail to submit the final report by the due date established in 101 CMR 206.12(3).

(c) EOHHS will not adjust any downward adjustment under 101 CMR 206.12(4) solely because a facility under-reported certain direct care workforce expenses or over-reported its revenue in its final DCC-Q compliance report.

(5) Nursing facilities that had less than 5,000 Massachusetts Medicaid Days as reported on their Quarterly User Fee Assessment Forms for the period of April 1, 2023, through March 31, 2024, will be exempt from the downward adjustment set forth in 101 CMR 206.12(4).

(6) EOHHS may issue an administrative bulletin or other written issuance to clarify provisions of 101 CMR 206.12, and to provide further detail on the types of staffing and direct care expenditures that qualify towards the DCC-Q and the data reporting requirements.

206.13: Average Staffing Hours Incentive

(1) As of October 5, 2020, each nursing facility is required to submit information on its staffing levels, including information demonstrating the facility's average hours per patient day (HPPD) to EOHHS, in the manner and format requested by EOHHS *via* administrative bulletin or other written issuance.

(2) As of January 1, 2021, a nursing facility that fails to meet an average of at least 3.58 (HPPD) in accordance with 101 CMR 206.13(1), is subject to a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235: *Overpayments*.

(3) To determine a facility's average (HPPD) in each calendar quarter, EOHHS will divide the facility's total number of productive hours worked by nursing staff, including registered nurses, licensed practical nurses and nurses' aides, in the calendar quarter by the facility's total number of patient days in that calendar quarter.

(4) EOHHS may issue administrative bulletins or other written issuance to further clarify these provisions and to provide additional guidance regarding what qualifies as productive hours, what staff types are included in nursing staff, the reporting requirements, and the requirements for disputing the calculation described in 101 CMR 206.13(3).

206.14: Special Requirements Related to St. 2022, c. 268

Recognizing the constraints on nursing facility capacity and the intent of St. 2022, c. 268 to support economic growth and relief in the Commonwealth, nursing facilities are expected to use the incremental increases in funding resulting from the increased nursing and operating standard rates cost adjustment factor funded by St. 2022, c. 268 and implemented in 101 CMR 206.03(1)(a) and 101 CMR 206.06(7)(b), to support nursing facility workforce, direct care staffing, and capacity in order to increase capacity and the timeliness of admissions.

206.15: Add-on for Members with Complicated High-cost Care Needs

(1) Members with Complicated High-cost Care Needs. Nursing facilities may receive a member-based rate add-on, in addition to the facility's standard *per diem* rate established under 101 CMR 206.00, for any member (for example, a resident requiring 1:1 staffing), for whom reasonable and allowable direct care costs associated with providing for such member's clinical care needs are significantly greater than the standard nursing facility rate (for example, because the member's care needs necessitates the purchase or rental of specialized equipment or hiring of additional staff). The facility may receive an add-on for such member, as calculated according to 101 CMR 206.15(2), provided that all of the following conditions are met:

(a) Prior to admission, the facility certifies that the direct care costs associated or expected to be associated with providing services to such member are necessary to provide the services recommended by the member's physician and care team, and documented in the member's care plan;

(b) The facility submitted a summary of expected direct care costs associated with providing services to such member demonstrating that the requirements of 101 CMR 206.15 have been met;

(c) The facility provides the MassHealth agency with any additional or clarifying documentation in support of the actual or expected direct care costs associated with the resident's care needs; and

(d) The facility receives approval from the MassHealth agency for the add-on.

206.15: continued

(2) Complicated and High-cost Care Add-on Calculation. The add-on rate must be a daily rate equal to the total reasonable and allowable costs associated with the high-cost member as determined by EOHHS, above the standard nursing, capital, and operating costs considered and included in calculating the nursing facility's standard *per diem* rates established under 101 CMR 206.00, up to a maximum add-on of $600 per day. EOHHS must have sole discretion over what may be considered a reasonable and allowable cost for the purposes of calculating this add-on. The add-on for each resident must be effective on the later of the date the nursing facility receives MassHealth approval for the add-on or the date of the member's admission to the nursing facility. A nursing facility may not receive this add-on for a member for whom the facility is receiving on the same dates of service a Medicaid transitional add-on under 101 CMR 206.10(7), a homelessness rate add-on under 101 CMR 206.10(13), a substance use disorder add-on or a substance use disorder induction period add-on under 101 CMR 206.10(14), a behavioral indicator add-on under 101 CMR 206.10(16), a bariatric add-on under 101 CMR 206.10(21), or a *per diem* rate for severe mental or neurological disorders under 101 CMR 206.11.

(3) Periodic Recertification. A nursing facility that receives the add-on under 101 CMR 206.15 may be required periodically to recertify to MassHealth that all conditions established under 101 CMR 206.15(1)(a) continue to be met with respect to each member for whom it receives the add-on, and must submit updated direct care cost information for each member. If the facility fails to provide such certification and information, MassHealth may terminate the add-on received by the nursing facility for the member.

206.16: Severability

The provisions of 101 CMR 206.00 are severable. If any provision of 101 CMR 206.00 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 206.00 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

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