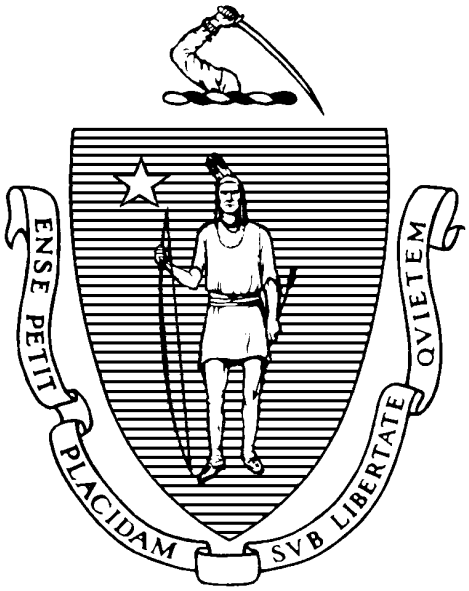
Issue: 1579, Date: July 31, 2026



The Massachusetts Register

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The Secretary of the Commonwealth,
William Francis Galvin, Secretary

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THE COMMONWEALTH OF MASSACHUSETTS

Secretary of the Commonwealth - William Francis Galvin

The Massachusetts Register

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Notices of Emergency Expiration

There Are No Notices of Emergency Expiration

Emergency Regulations

There Are No Emergency Regulations

Permanent Regulations

Acts 2026

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129	H 4805	Amending the Town Charter of the Town of Plainville.	7/7/2026
130	H 4782	Amending the Charter of the Town of Hudson.	7/7/2026
131	H 4254	Directing the City of Boston Police to Waive the Maximum Age Requirement for Police Officers for Rodney Alcindor.	7/7/2026
132	H 4255	Directing the City of Boston Police Department to Waive the Maximum Age Requirement for Police Officers for Jonathan Telfort.	7/7/2026
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135	H 4781	Authorizing the City Known as the Town of Bridgewater to Amend its Charter to Include Gender Neutral Language.	7/7/2026
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140	H 4231	Relative to Parking Enforcement in the City of Cambridge.	7/14/2026
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142	H 4359	Authorizing the Town of Milford to Convert a License for the Sale of Wine and Malt Beverages into a License for the Sale of All Alcoholic Beverages Not to Be Consumed on the Premises.	7/14/2026
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CHAPTER NUMBER	BILL NUMBER	TITLE	DATE
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Administrative Bulletin 26-02

957 CMR 4.00: Standard Quality Measure Set
Effective July 17, 2026

2027-2028 Standard Quality Measure Set Establishment

The Center for Health Information and Analysis ("CHIA") is issuing this Administrative Bulletin in accordance with 957 CMR 4.04(2) and 4.03(1) to notify Payers and Providers, including Provider Organizations and Accountable Care Organizations, of the establishment of the Standard Quality Measure Set (SQMS) for calendar years 2027-2028.

Pursuant to M.G.L. c. 12C, § 14, CHIA, in consultation with the Statewide Quality Advisory Committee (SQAC), is required to establish a SQMS in each even-numbered year for use in contracts between Payers, including the Commonwealth and Carriers, and health care Providers, Provider Organizations and Accountable Care Organizations, which incorporate quality measures into payment terms, including the designation of a set of Core Measures and a set of Non-Core Measures.

As the 2027-2028 cycle is the first under the revised M.G.L. c. 12C, § 14, CHIA worked with the reconstituted SQAC to establish the SQMS as expeditiously as practicable. The SQAC recommended the 2027-2028 SQMS to CHIA at a meeting on April 30, 2026. The SQAC's recommendations were approved by CHIA's Executive Director on June 5, 2026. The 2027-2028 SQMS is defined in Appendix A. The SQMS is also known as the Massachusetts Aligned Measure Set.

The SQMS consists of two categories of measures: the Core Measures (also known as the "Core Set") and the Non-Core Measures (also known as the "Menu Set"). The SQAC has also recommended additional Non-Core Measures that MassHealth may use to meet Medicaid-specific program needs, identified in Appendix A as "Non-Core (MassHealth Specific)."

This Administrative Bulletin only establishes the measure set; CHIA will issue a separate Data Submission Manual defining the SQMS reporting requirements for 2027-2028.

501 BOYLSTON STREET
BOSTON, MA 02116

T 617.701.8100
www.chiamass.gov

APPENDIX A

2027-2028 Massachusetts Aligned Measure Set

Set	Measure Name	Steward[i]
Core	CG-CAHPS (MHQP Version)	MHQP[ii,iii]
Core	Childhood Immunization Status (Combo 10)	NCQA[iv]
Core	Controlling High Blood Pressure	NCQA
Core	Depression Screening and Follow-Up for Adolescents and Adults	NCQA
Core	Glycemic Status Assessment for Patients with Diabetes: Glycemic Status Poor Control (>9.0%)	NCQA
Non-Core	Adult Immunization Status[v]	NCQA
Non-Core	Blood Pressure Control for Patients with Diabetes	NCQA
Non-Core	Breast Cancer Screening[vi]	NCQA
Non-Core	Cervical Cancer Screening	NCQA
Non-Core	Child and Adolescent Well-Care Visits	NCQA
Non-Core	Chlamydia Screening	NCQA
Non-Core	Colorectal Cancer Screening[vii]	NCQA
Non-Core	Developmental Screening in the First Three Years of Life	Oregon Health & Science University[viii]
Non-Core	Eye Exam for Patients with Diabetes	NCQA
Non-Core	Follow-Up After Acute and Urgent Care Visits for Asthma	NCQA
Non-Core	Health-Related Social Needs Screening[ix]	MassHealth
Non-Core	Immunizations for Adolescents (Combo 2)	NCQA
Non-Core	Initiation and Engagement of Substance Use Treatment[x]	NCQA
Non-Core	Kidney Health Evaluation for Patients with Diabetes	NCQA

Set	Measure Name	Steward[i]
Non-Core	Lead Screening in Children	NCQA
Non-Core	Prenatal & Postpartum Care	NCQA
Non-Core	Race, Ethnicity, Language and Disability Data Collection[xi]	MassHealth
Non-Core	Race, Ethnicity, and Language Stratification	Massachusetts QMAT[xii]
Non-Core	Well-Child Visits in the First 30 Months of Life	NCQA
Non-Core (MassHealth Specific)	Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA
Non-Core (MassHealth Specific)	Follow-Up After Emergency Department Visit for Mental Illness (7-day)	NCQA
Non-Core (MassHealth Specific)	Follow-Up After Hospitalization for Mental Illness (7-day)	NCQA
Non-Core (MassHealth Specific)	Follow-Up After Emergency Department Visit for Substance Use	NCQA
Non-Core (MassHealth Specific)	Topical Fluoride for Children	American Dental Association
Non-Core (MassHealth Specific)	Quality Performance Disparities Reduction	MassHealth

[i] A measure steward is responsible for the oversight, quality and maintenance of a measure throughout its lifecycle. The measure steward grants permission for measure use and application by others, approves any updates, and communicates such information to interested parties. For more information, see CMS *Roles in Measure Development*: https://mmshub.cms.gov/about-quality/new-to-measures/roles.
[ii] Massachusetts Health Quality Partners. See https://www.mhqp.org/
[iii] There is no requirement to use all measure domains or to weight domains equally in contracts. CHIA encourages a focus on domains where there is the greatest opportunity for performance improvement.

[iv] National Committee for Quality Assurance. See https://www.ncqa.org/.
[v] Payer and Provider dyads may use any of the immunization rates included in the measure.
[vi] Payer and Provider dyads may use any of the age stratifications included in the measure.
[vii] Electronic clinical quality measure (eCQM) reporting only.
[viii] See https://oregon-pip.org/
[ix] Providers should not be held accountable for the rate at which health-related social needs are identified by the Health-Related Social Needs Screening.
[x]Payer and Provider dyads may use the initiation and/or the engagement phase.
[xi]Payer and Provider dyads may optionally also include collection of sexual orientation, gender identity, and/or sex data.
[xii] See EOHHS Quality Measure Alignment Taskforce | Mass.gov

THE COMMONWEALTH OF MASSACHUSETTS

Secretary of the Commonwealth - William Francis Galvin

NOTICES OF PUBLIC REVIEW OF PROSPECTIVE REGULATIONS PUBLISHED IN COMPLIANCE WITH M.G.L. c. 30A, §§ 2 AND 3

July 31, 2026

Energy Resources, Department of	225 CMR 26.00	9/1/26 @ 6:00 P.M. & 9/2/26 @ 1:00 P.M. Written comments accepted until 9/4/26 by 5:00 P.M.
Environmental Protection, Department of	310 CMR 9.00	9/9/26 @ 1:00 P.M. & 6:00 P.M. Written comments accepted through 9/23/26 by 5:00 P.M.
	310 CMR 10.00	8/10/26 @ 1:00 P.M. & 6:00 P.M. Written comments accepted until 8/20/26 by 5:00 P.M.
Gaming Commission, Massachusetts	205 CMR 146.00	8/18/26 @ 9:30 A.M. Written comments accepted until 8/17/26 by 5:00 P.M.
Health and Human Services, Executive Office of	101 CMR 314.00	8/7/26 @ 3:00 P.M. Written testimony accepted through 8/7/26 by 5:00 P.M.
Water Pollution Control, Division of	314 CMR 9.00	8/10/26 @ 1:00 P.M. & 6:00 P.M. Written comments accepted until 8/20/26 by 5:00 P.M.

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF
ENERGY AND ENVIRONMENTAL AFFAIRS
DEPARTMENT OF ENERGY RESOURCES
100 CAMBRIDGE ST., 9th FLOOR
BOSTON, MA 02114
Telephone: 617-626-7300

NOTICE OF PUBLIC COMMENT AND HEARING

Notice is hereby given that the Massachusetts Department of Energy Resources (DOER), acting under Section 123 of Chapter 126 of the Acts of 2022, as codified under G.L. c. 25A, § 19, and in conformance with Chapter 30A of the General Laws, is holding two public hearings on proposed amendments to regulation 225 CMR 26.00 Massachusetts Offers Rebates for Electric Vehicles (MOR-EV). These amendments are intended to streamline the application processes and make the program more cost-effective and equitable. The amendments include a number of proposed changes, including lower vehicle price caps for the light duty new and used vehicle rebates and class 3-8 vehicle rebates. The amendments also include changes in rebate amounts for individuals acquiring pick-up trucks, class 2b vehicles, and class 3-8 vehicles, as well as the addition of an income threshold as new eligibility criteria for the MOR-EV+ adder.

One virtual public hearing and one in-person public hearing will be conducted to receive verbal and written comments on the regulation.

Public hearings will be held:

Tuesday, September 1, 2026 at 6:00 PM
Register in advance for this hearing:
https://zoom.us/webinar/register/WN_qDoKYA-qTBGzfdlxO6Gc4w

Wednesday, September 2, 2026 at 1:00 PM.
Location: 2nd Floor Conference Room, 100 Cambridge Street, Boston, MA 02114
Register in advance for this hearing to Morgan Bowler at morgan.bowler@mass.gov

Verbal testimony will be accepted at the hearings; however, parties may also provide written copies of their testimony. Written comments will be accepted beginning July 31, 2026 and ending at 5:00 PM on September 4, 2026. DOER requests that written comments be submitted as attached pdf files to morgan.bowler@mass.gov with the words 2026 MOR EV RULEMAKING COMMENTS in the subject line. Alternatively, comments can be submitted via mail to Morgan Bowler at the Department of Energy Resources, 100 Cambridge Street, 9th Floor, Boston, MA 02114. Copies of the proposed regulations may be obtained from the DOER website,

https://www.mass.gov/info-details/mor-ev-rebate-program, or by contacting Morgan Bowler at morgan.bowler@mass.gov.

Language interpretation services are available upon request. To request this service, please email morgan.bowler@mass.gov at least four (4) business days prior to the respective hearing. Please include your name, the event name and date, the language requested, and your phone number should we have any questions.

BY ORDER OF: Elizabeth Mahony, Commissioner
Department of Energy Resources

Small Business Impact Statement

(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No.: 225 CMR 26.00

Estimate of the Number of Small Businesses Impacted by the Regulation: None

Participation in 225 CMR 26.00 by a small business is voluntary. The number of small businesses that participated in the MOR-EV program in 2024 was less than 200.

Select Yes or No and Briefly Explain		
Yes ☐	**No** ☒	Will small businesses have to create, file, or issue additional reports? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Will small businesses have to implement additional recordkeeping procedures? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Will small businesses have to provide additional administrative oversight? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Do any other regulations duplicate or conflict with the proposed regulation? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? No, the regulations is not likely to deter the formation of small businesses in Massachusetts.

Yes ☐	**No** ☒	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? No, the regulation is not likely to have any impact on the formation of small businesses in Massachusetts.
Yes ☐	**No** ☒	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? No, the regulation does not provide for less stringent compliance or reporting requirements for small businesses.
Yes ☐	**No** ☒	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? No, participation in the program by small businesses is voluntary.
Yes ☐	**No** ☒	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No, participation in the program by small businesses is voluntary.

Commonwealth of Massachusetts
Executive Office of Energy and Environmental Affairs
Department of Environmental Protection
Address: 100 Cambridge Street, Suite 900, Boston MA 02114 | **Phone**: 617-292-5500

Maura T. Healey	**Kim Driscoll**	**Rebecca Tepper**	**Bonnie Heiple**
Governor	Lieutenant Governor	Secretary	Commissioner

PUBLIC HEARING NOTICE

This Public Hearing Notice is available in alternative languages (Español -- Tiếng Việt -- Chinese -- Kreyòl Ayisyen -- Português -- Khmer) on MassDEP's website at: https://www.mass.gov/service-details/massdep-public-hearings-comment-opportunities

Notice is hereby given that the Massachusetts Department of Environmental Protection (MassDEP), pursuant to M.G.L. c. 91, § 18 and M.G.L. Chapter 30A, is proposing regulatory amendments to 310 CMR 9.00, *The Massachusetts Waterways Regulation*. The amendments are intended to streamline the permitting and licensing processes to allow for concurrent review of applications under review with the Massachusetts Environmental Policy Act (MEPA) Office and allow the Department to begin review of a Waterways license or permit application before the filing of a Wetlands Notice of Intent.

The proposed regulatory text and a background document are available with a copy of this Public Hearing Notice on MassDEP's website at: https://www.mass.gov/service-details/massdep-public-hearings-comment-opportunities

MassDEP will hold two virtual public hearings via Zoom at the following dates and times to receive comments on the proposed changes. **Advance registration is required**.

Wednesday, September 9, 2026 at 1:00 PM
Please use this link to register in advance for this hearing:
https://us06web.zoom.us/meeting/register/_1PyDk1AQ6erQ_nsGTrbQQ

Wednesday, September 9, 2026 at 6:00 PM
Please use this link to register in advance for this hearing:
https://us06web.zoom.us/meeting/register/3QPAeH5gQ_OId-ksWgDuWw

Testimony may be presented orally at the public hearing. Written comments will be accepted through 5:00pm on **September 23, 2026.** The Department encourages electronic submission by email to dep.waterways@mass.gov and must include *Waterways Streamline Comments* in the subject line. Written comments may also be mailed to Daniel Padien, Attn: *Waterways Streamline Comments*, MassDEP-BWR, 100 Cambridge Street, Suite 900, Boston, MA 02114.

For special accommodations, please call the MassDEP Diversity Office at 617-292-1282.
TTY# MassRelay Service 1-800-439-2370. This information is available in alternate format upon request. MassDEP provides language access interpreter/translation services to limited English proficient individuals free of charge. If you need an interpreter to participate in this meeting, translation services can be found at the following link: https://www.mass.gov/info-details/massdep-language-translation-assistance.

By Order of the Department of Environmental Protection
Bonnie Heiple, Commissioner

Small Business Impact Statement

(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No.: 310 CMR 9.00: Waterways

Estimate of the Number of Small Businesses Impacted by the Regulation: 1,800 to 3,500

Yes	No	Select Yes or No and Briefly Explain
☐	☒	Will small businesses have to create, file, or issue additional reports? No, the proposed regulations will not require additional reporting.
☐	☒	Will small businesses have to implement additional recordkeeping procedures? No, the proposed regulations will not require additional recordkeeping.
☐	☒	Will small businesses have to provide additional administrative oversight? No, the proposed regulations will not require additional administrative oversight.
☐	☒	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No, the proposed regulations will not require hiring additional employees.
☐	☒	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No, the proposed regulations will not require hiring other professionals.
☐	☒	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No, the proposed regulations will not require the purchase of products or capital investments.
☐	☒	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.) No, the proposed regulations do not have design/operational standards.
☐	☒	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with the proposed regulations.
☐	☒	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? No, the proposed regulations do not require audits, inspections or other regulatory enforcement activities.
☐	☒	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No, the proposed regulations do not require the provision of educational services.

Yes ☐	No ☒	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The proposed regulation is not likely to deter the formation of small businesses.
Yes ☐	No ☒	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The proposed regulation is not likely to encourage the formation of small businesses.
Yes ☐	No ☒	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? No, the proposed regulation does not provide less stringent compliance or reporting requirements for small businesses.
Yes	No ☒	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? No, the proposed regulations does not establish less stringent schedules or deadlines for small businesses.
Yes ☒	No ☐	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? The proposed changes will simplify compliance for all regulated entities, not just small business.
Yes ☐	No ☒	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? No, the proposed regulations do not involve design or operational standards.
Yes ☐	No ☒	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No, there is no adverse impact on small businesses.

Commonwealth of Massachusetts
Executive Office of Energy and Environmental Affairs
Department of Environmental Protection
Address: 100 Cambridge Street, Suite 900, Boston MA 02114 | **Phone**: 617-292-5500

Maura T. Healey	**Kim Driscoll**	**Rebecca Tepper**	**Bonnie Heiple**
Governor	Lieutenant Governor	Secretary	Commissioner

PUBLIC HEARING NOTICE

This Public Hearing Notice is available in alternative languages (Español -- Tiếng Việt -- Chinese -- Kreyòl Ayisyen -- Português -- Khmer) on MassDEP's website at: https://www.mass.gov/service-details/massdep-public-hearings-comment-opportunities

Notice is hereby given that the Massachusetts Department of Environmental Protection (MassDEP) is proposing amendments to: 310 CMR 10.00, *Wetlands Protection*, pursuant to M.G.L. c. 131, § 40, and 314 CMR 9.00: *401 Water Quality Certification for Discharges of Dredged or Fill Material, Dredging, and Dredged Material Disposal in Waters of the United States Within the Commonwealth*, pursuant to §27 of the Massachusetts Clean Waters Act, M.G.L. c. 21, §§ 26 – 53, M.G.L. c. 21A, § 14, M.G.L. c. 21C, M.G.L c. 21E, M.G.L., c. 21H, M.G.L. c. 91, §§ 52 through 56, and M.G.L. c. 111, §§ 150A through 150A1/2. The amendments are primarily intended to streamline permitting for beneficial wetland restoration and other projects, including invasive plant management, damaged tree removal, and limited maintenance and construction of unpaved paths.

The proposed regulatory text and a background document are available with a copy of this Public Hearing Notice on MassDEP's website at: https://www.mass.gov/service-details/massdep-public-hearings-comment-opportunities

MassDEP will hold two virtual public hearings via Zoom at the following dates and times to receive comments on the proposed changes. **Advance registration is required**.

Monday, August 10, 2026 at 1:00 PM – Public Hearing
Please use this link to register in advance for this hearing:
https://us06web.zoom.us/meeting/register/y_5Y5cg6TBG41Qwc437kVQ

Monday, August 10, 2026 at 6:00 PM – Public Hearing
Please use this link to register in advance for this hearing:
https://us06web.zoom.us/meeting/register/uXlfkUaqRJ67lplAggERVA

Testimony may be presented orally at the public hearing. Written comments will be accepted through 5:00 pm on **August 20, 2026.** The Department encourages electronic submission by email to dep.wetlands@mass.gov and must include *Wetlands-401 Ecological Restoration Comments* in the subject line. Written comments may also be mailed to Lisa Rhodes, Attn: *Wetlands-401 Ecological Restoration Comments*, MassDEP-BWR, 100 Cambridge Street, Suite 900, Boston, MA 02114.

For special accommodations, please call the MassDEP Diversity Office at 617-292-1282. TTY# MassRelay Service 1-800-439-2370. This information is available in alternate format upon request. MassDEP provides language access interpreter/translation services to limited English proficient individuals free of charge. If you need an interpreter to participate in this meeting, translation services

can be found at the following link: https://www.mass.gov/info-details/massdep-language-translation-assistance.

By Order of the Department of Environmental Protection
Bonnie Heiple, Commissioner

Small Business Impact Statement

(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No: 310 CMR 10.00

Estimate of the Number of Small Businesses Impacted by the Regulation: 500 (estimated number of businesses proposing work in resource areas annually).

Yes	No	Select Yes or No and Briefly Explain
☐	☒	**Will small businesses have to create, file, or issue additional reports?** No, the proposed amendments do not increase the number of reports.
☐	☒	**Will small businesses have to implement additional recordkeeping procedures?** No, the proposed amendments do not require additional recordkeeping procedures.
☐	☒	**Will small businesses have to provide additional administrative oversight?** No, the proposed amendments do not require additional administrative oversight.
☐	☒	**Will small businesses have to hire additional employees in order to comply with the proposed regulation?** No, the proposed amendments do not require hiring additional employees.
☐	☒	**Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)?** No, the proposed amendments do not require hiring additional professionals to ensure compliance. Under the existing regulations, hiring an engineer or scientist may be necessary when filing a Notice of Intent; however, the proposed amendments would not result in requirements greater than the existing regulations.
☐	☒	**Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation?** No, the proposed amendments do not require the purchase of products or specific capital investments.
☐	☒	**Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.)** The proposed ecological restoration amendments provide flexibility by relying on performance standards to accomplish objectives. The proposed amendments to the bordering vegetated wetland boundary determination methodology include specific actions (operational standards) to ensure technical accuracy and consistency to achieve regulatory objectives. Performance standards would not ensure the regulatory objective of technical accuracy and consistency.
☐	☒	**Do any other regulations duplicate or conflict with the proposed regulation**? No, other regulations do not duplicate or conflict with the proposed amendments.
☐	☒	**Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities?** The proposed amendments do not add any new requirements to cooperate with audits, inspections or other regulatory enforcement activities. Under the existing regulations, MassDEP has the ability to perform inspections to ensure compliance with permit conditions and may conduct enforcement as needed. No additional requirements are anticipated with the proposed amendments.

Yes ☐	No ☒	**Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements?** No, the proposed amendments do not require the provision of educational services.
Yes ☐	No ☒	**Is the regulation likely to *deter* the formation of small businesses in Massachusetts?** No, the proposed amendments are not likely to deter the formation of small businesses.
Yes ☐	No ☒	**Is the regulation likely to *encourage* the formation of small businesses in Massachusetts?** No, the proposed amendments are not likely to encourage the formation of small businesses.
Yes ☐	No ☒	**Does the regulation provide for less stringent compliance or reporting requirements for small businesses?** No, the proposed amendments do not provide less stringent compliance and reporting requirements for small businesses.
Yes	No ☒	**Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses?** No, the proposed amendments do not establish less stringent schedules or deadlines for small businesses.
Yes ☐	No ☒	**Did the agency consolidate or simplify compliance or reporting requirements for small businesses?** The proposed amendments do not specifically consolidate or simplify requirements for small businesses; however, the proposed amendments do include streamlined permitting options for four ecological restoration projects. The proposed amendments also provide a minor activity (exemption) for trail construction and maintenance activities, the removal of invasive plant species, and the removal of hazardous trees, in accordance with specific requirements.
Yes ☒	No ☐	**Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective**? The proposed amendments for ecological restoration projects are currently written as performance standards. For projects proposed in wetland resource areas, the use of performance standards has proven to work best for applicants, including small businesses. The proposed amendments to the bordering vegetated wetlands boundary determination methodology should be "operational" standards to achieve the regulatory objective of technical accuracy and consistency.
Yes ☐	No ☒	**Are there alternative regulatory methods that would minimize the adverse impact on small businesses?** MassDEP does not anticipate any adverse impacts on small businesses as a result of the proposed amendments.

Legal Division

Notice of Public Hearing

Notice is hereby provided that in accordance with G.L. c. 30A § 2, the Massachusetts Gaming Commission ("Commission") will convene a public hearing for purposes of gathering comments, ideas, and information relative to the proposed adoption of regulations. The regulations were promulgated pursuant to G.L. c. 23K §§ 4 and 5, as part of the Commission's regulatory process, and concern the following regulations:

205 CMR 146.00 specifically, 205 CMR 146.18 Baccarat, Midi-baccarat, Mini-baccarat, and Baccarat-chemin de Fer Tables; Physical Characteristics. This regulation is being amended to increase clarity surrounding game play and wagering for specific game variations. Additionally, a subsection detailing payout odds for additional wagers at a gaming table has been added to this section in accordance with the authorized Rules.

Scheduled hearing date and time:

Tuesday, August 18, 2026, at 9:30 AM EST

Pursuant to Chapter 2 of the Session Acts of 2025, Governor Healey extended a limited relief from certain provisions of the Open Meeting Law which was first implemented to protect the health and safety of the public and individuals interested in attending public meetings during the global Coronavirus pandemic. In keeping with the guidance provided, the Commission will conduct this hearing utilizing remote collaboration technology.

MICROSOFT TEAMS MEETING ID: 244 636 090 631 919 PASSCODE: Xh9Gg64M

DIAL IN BY PHONE: (213) 631-9908 PHONE CONFERENCE ID: 191 944 468#

A complete copy of the draft regulations referenced above may be downloaded by visiting www.massgaming.com, clicking on 'Regulations and Compliance' and selecting the 'Proposed Rulemaking' Section. Anyone wishing to offer comments on these regulations can email Judith.Young@massgaming.gov and request the virtual hearing link to appear and speak. Alternatively, written comments may also be submitted to the same email address with 'Regulation Comment' in the subject line.

Written comments must be received by 5:00 PM EST on August 17, 2026.
Additionally, please find the accompanying Small Business Impact Statements in accordance with M.G.L. c. 30A, § 2 attached.

Massachusetts Gaming Commission
101 Federal Street, 12th Floor, Boston, Massachusetts 02110 | TEL 617.979.8400 | FAX 617.725.0258 | www.massgaming.com

Legal Division

SMALL BUSINESS IMPACT STATEMENT

The Massachusetts Gaming Commission ("Commission") hereby files this Small Business Impact Statement in accordance with G.L. c. 30A, §2, relative to the proposed adoption of **205 CMR 146.00:** *Gaming Equipment*, specifically **205 CMR 146.18:** *Baccarat, Midi-baccarat, Mini-baccarat, and Baccarat-chemin de Fer Tables; Physical Characteristics*.

This regulation concerns the operation of gaming establishments in the Commonwealth, and the gaming equipment used therein. The regulation is primarily governed by G.L. c. 23K, §§ 2, 4(37), and 5.

The proposed amendments to the section are intended to add language for clarity, remove outdated language and references to layouts that are no longer in use and also provide clearer requirements to licensees regarding what is necessary to include on Midi and Mini Baccarat layouts.

Under G.L. c. 30A, §2, the Commission offers the following responses to the statutory questions:

1. Estimate of the number of small businesses subject to the proposed regulation:

   As this regulation pertains to gaming licensees, small businesses are unlikely to be subject to this regulation.

2. State the projected reporting, recordkeeping, and other administrative costs required for compliance with the proposed regulation:

   There are no projected reporting, recordkeeping, or other administrative costs required for small businesses to comply with this regulation.

3. State the appropriateness of performance standards versus design standards:

   The standards set forth in 205 CMR 146.18 neither impose nor create new standards. The changes simplify the existing content in the regulation and constitute corrections to the existing language.

4. Identify regulations of the promulgating agency, or of another agency or department of the Commonwealth, which may duplicate or conflict with the proposed regulation:

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There appears to be no conflicting regulations in 205 CMR, and the Commission is unaware of any conflicting or duplicating regulations of any other agency or department of the Commonwealth.

5. State whether the proposed regulation is likely to deter or encourage the formation of new businesses in the Commonwealth:

   This regulation is unlikely to deter nor encourage the formation of new businesses within the Commonwealth.

Massachusetts Gaming Commission
By:

/s/ _____
Jenna Hentoff, Deputy General Counsel

Dated: July 1, 2026

★★★★★
Massachusetts Gaming Commission
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Commonwealth of Massachusetts

Executive Office of Health and Human Services

NOTICE OF PUBLIC HEARING

Under the authority of M.G.L. c. 118E and in accordance with M.G.L. c. 30A, the Executive Office of Health and Human Services (EOHHS) will hold a remote public hearing on August 7, 2026, at 3:00 PM, relative to the adoption of amendments to the following regulation.

101 CMR 314.00: Rates for Dental Services

Regulation 101 CMR 314.00 governs the rates used by all governmental units to make payments to eligible providers for dental services rendered to publicly aided individuals.

Effective for dates of service on or after January 1, 2027, EOHHS proposes establishing bundled rates for certain limited orthodontic treatment services to streamline the provision of these services for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) members. EOHHS proposes to establish a bundled rate incorporating the rate for the base visit ($250 per visit) and five follow-up visits ($270) for each of the service codes D8010, D8020, D8030, and D8040 that relate to limited orthodontic treatment of primary, transitional, adolescent, and adult dentition services, respectively. The proposed bundled rate for each code is $520 per member. All other adult and EPSDT rates, including code D8999, will remain at their current levels.

EOHHS also proposes updating frequency limitations for two preventative and diagnostic services. The proposed amendments revise the frequency limitation for limited oral evaluation services (code D0140) for adults and EPSDT members from two units per member per year to two units per provider per member per year, allowing members to receive more than two units of the limited oral evaluations rendered by multiple providers. The proposed amendments also revise the frequency limitation for silver diamine fluoride services (code D1354) for adults and EPSDT members from two units per tooth per member per lifetime to two units per tooth per member per year.

While the proposed updates to frequency limitations are updates to Subchapter 6 of the Dental Manual and do not require amendments to 101 CMR 314.00, these updates will have a fiscal impact and are therefore described herein.

Finally, the proposed amendments also update terminology and incorporate coding updates to 101 CMR 314.00 previously issued via administrative bulletins.

The estimated aggregate annual fiscal impact associated with the proposed amendments to 101 CMR 314.00 and the proposed updates to Subchapter 6 of the

Dental Manual is $233,000, or a 0.04% increase over SFY 2025 base spending of approximately $553 million. There is no fiscal impact on cities and towns.

EOHHS is proposing these amendments, subject to federal approval and in accordance with M.G.L. c. 118E, §13C, to ensure that payments are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.

To register to testify at the hearing and to get instructions on how to join the hearing online, go to www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings. To join the hearing by phone, call (646) 558-8656 and enter meeting ID 935 397 8200# when prompted.

You may also submit written testimony instead of, or in addition to, live testimony. To submit written testimony, please email your testimony to ehs-regulations@mass.gov as an attached Word or PDF document or as text within the body of the email with the name of the regulation in the subject line. All written testimony must include the sender's full name, mailing address, and organization or affiliation, if any. Individuals who are unable to submit testimony by email should mail written testimony to EOHHS, c/o D. Briggs, 100 Hancock Street, 6th Floor, Quincy, MA 02171. Written testimony will be accepted through 5:00 p.m. on August 7, 2026. EOHHS specifically invites comments as to how the amendments may affect beneficiary access to care for MassHealth-covered services.

To review the current draft of the proposed regulation, go to www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings or request a copy in writing from MassHealth Publications, 100 Hancock Street, 6th Floor, Quincy, MA 02171.

Special accommodation requests may be directed to the Disability Accommodations Ombudsman by email at ADAAccommodations@mass.gov or by phone at (617) 847-3468 (TTY: (617) 847-3788). Please allow two weeks to schedule sign language interpreters.

EOHHS may adopt a revised version of the proposed regulation taking into account relevant comments and any other practical alternatives that come to its attention.

In case of inclement weather or other emergency, hearing cancellation announcements will be posted on the MassHealth website at www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings.

Date of Newspaper Ad: July 17, 2026

Small Business Impact Statement

(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No. and Title: 101 CMR 314.00: Rates for Dental Services

Estimate of the Number of Small Businesses Impacted by the Regulation:
Approximately 2,100 eligible dental providers.

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? No. Small businesses will not have to create, file, or issue additional reports.
No	Will small businesses have to implement additional recordkeeping procedures? No. Small businesses will not have to implement additional recordkeeping procedures.
No	Will small businesses have to provide additional administrative oversight? No. Small businesses will not have to provide additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? No. Small businesses will not have to hire additional employees in order to comply with the proposed regulation.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? No. Small businesses are not required to hire other professionals to comply with the regulation.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? No. Small businesses are not required to purchase a product or make any other capital investments in order to comply with the regulation.
No	Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.) No. The regulation is required by statute under M.G.L. Chapter 118E Section 13C, and establishes the rates to be paid by governmental units to providers of non-institutional health care services, including dental services.
No	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with the proposed regulation.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? Yes. The regulation continues to require providers to periodically comply with audits, inspections, and other regulatory activities.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? No. The regulation does not require small businesses to provide educational services to keep up with regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? No. The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts, as this regulation governs payments for dental services provided to publicly aided individuals and is applied uniformly among providers.

Write Yes or No	Explain Briefly
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? No. The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts, as this regulation governs payments for dental services provided to publicly aided individuals and is applied uniformly among providers.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? No. The regulation does not distinguish between small and other businesses.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? No. This regulation requires providers to submit documentation requested by the Commonwealth for purposes of utilization and provider review to ensure compliance with requirements, including the timelines for reporting, and the regulation is applied uniformly regardless of whether the provider is a small business.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? No. This regulation requires providers to submit documentation requested by the Commonwealth for purposes of utilization and provider review to ensure compliance with requirements, including the timelines for reporting, and the regulation is applied uniformly regardless of whether the provider is a small business.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? No. The regulation establishes uniform conditions of payment for the provision of dental services to publicly aided individuals. These requirements are applied uniformly, regardless of the size of the provider's business, to maintain consistency in the care provided to publicly aided individuals.
No	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? No. The regulation does not have an adverse impact on small businesses and governs payments for dental services to publicly aided individuals and is applied uniformly regardless of whether the provider is a small business.

Commonwealth of Massachusetts
Executive Office of Energy and Environmental Affairs
Department of Environmental Protection
Address: 100 Cambridge Street, Suite 900, Boston MA 02114 | **Phone**: 617-292-5500

Maura T. Healey	**Kim Driscoll**	**Rebecca Tepper**	**Bonnie Heiple**
Governor	Lieutenant Governor	Secretary	Commissioner

Division of Water Pollution Control

PUBLIC HEARING NOTICE

This Public Hearing Notice is available in alternative languages (Español -- Tiếng Việt -- Chinese -- Kreyòl Ayisyen -- Português -- Khmer) on MassDEP's website at: https://www.mass.gov/service-details/massdep-public-hearings-comment-opportunities

Notice is hereby given that the Massachusetts Department of Environmental Protection (MassDEP) is proposing amendments to: 310 CMR 10.00, *Wetlands Protection*, pursuant to M.G.L. c. 131, § 40, and through the Division of Water Pollution Control for 314 CMR 9.00: *401 Water Quality Certification for Discharges of Dredged or Fill Material, Dredging, and Dredged Material Disposal in Waters of the United States Within the Commonwealth*, pursuant to §27 of the Massachusetts Clean Waters Act, M.G.L. c. 21, §§ 26 – 53, M.G.L. c. 21A, § 14, M.G.L. c. 21C, M.G.L c. 21E, M.G.L., c. 21H, M.G.L. c. 91, §§ 52 through 56, and M.G.L. c. 111, §§ 150A through 150A1/2. The amendments are primarily intended to streamline permitting for beneficial wetland restoration and other projects, including invasive plant management, damaged tree removal, and limited maintenance and construction of unpaved paths.

The proposed regulatory text and a background document are available with a copy of this Public Hearing Notice on MassDEP's website at: https://www.mass.gov/service-details/massdep-public-hearings-comment-opportunities

MassDEP will hold two virtual public hearings via Zoom at the following dates and times to receive comments on the proposed changes. **Advance registration is required**.

Monday, August 10, 2026 at 1:00 PM – Public Hearing
Please use this link to register in advance for this hearing:
https://us06web.zoom.us/meeting/register/y_5Y5cg6TBG41Qwc437kVQ

Monday, August 10, 2026 at 6:00 PM – Public Hearing
Please use this link to register in advance for this hearing:
https://us06web.zoom.us/meeting/register/uXlfkUaqRJ67lplAggERVA

Testimony may be presented orally at the public hearing. Written comments will be accepted through 5:00 pm on **August 20, 2026.** The Department encourages electronic submission by email to dep.wetlands@mass.gov and must include *Wetlands-401 Ecological Restoration Comments* in the subject line. Written comments may also be mailed to Lisa Rhodes, Attn: *Wetlands-401 Ecological Restoration Comments*, MassDEP-BWR, 100 Cambridge Street, Suite 900, Boston, MA 02114.

For special accommodations, please call the MassDEP Diversity Office at 617-292-1282.
TTY# MassRelay Service 1-800-439-2370. This information is available in alternate format upon

request. MassDEP provides language access interpreter/translation services to limited English proficient individuals free of charge. If you need an interpreter to participate in this meeting, translation services can be found at the following link: https://www.mass.gov/info-details/massdep-language-translation-assistance.

By Order of the Department of Environmental Protection
Bonnie Heiple, Commissioner

Small Business Impact Statement

(As required by M.G.L. c. 30A §§ 2, 3 & 5)

CMR No: 314 CMR 9.00

Estimate of the Number of Small Businesses Impacted by the Regulation: 500 (estimated number of businesses proposing work in resource areas annually).

Yes	No	Select Yes or No and Briefly Explain
☐	☒	**Will small businesses have to create, file, or issue additional reports?** No, the proposed amendments do not increase the number of reports.
☐	☒	**Will small businesses have to implement additional recordkeeping procedures?** No, the proposed amendments do not require additional recordkeeping procedures.
☐	☒	**Will small businesses have to provide additional administrative oversight?** No, the proposed amendments do not require additional administrative oversight.
☐	☒	**Will small businesses have to hire additional employees in order to comply with the proposed regulation?** No, the proposed amendments do not require hiring additional employees.
☐	☒	**Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)?** No, the proposed amendments do not require hiring additional professionals to ensure compliance. Under the existing regulations, hiring an engineer or scientist may be necessary when filing an application for a 401 water quality certification; however, the proposed amendments would not result in requirements greater than the existing regulations.
☐	☒	**Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation?** No, the proposed amendments do not require the purchase of products or specific capital investments.
☐	☒	**Are performance standards more appropriate than design/operational standards to accomplish the regulatory objective? (Performance standards express requirements in terms of outcomes, giving the regulated party flexibility to achieve regulatory objectives and design/operational standards specify exactly what actions regulated parties must take.)** The proposed amendments include the addition of both a performance standard and an operation standard to accomplish the objective of improving culvert replacement projects for climate resiliency (operational standards) and to improve aquatic organism passage (performance standard). The operational standard is necessary to ensure a minimum baseline design to accommodate anticipated streamflows.
☐	☒	**Do any other regulations duplicate or conflict with the proposed regulation**? No, other regulations do not duplicate or conflict with the proposed amendments.
☐	☒	**Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities?** The proposed amendments do not add any new requirements to cooperate with audits, inspections or other regulatory enforcement activities. No additional requirements are anticipated with the proposed amendments.

Yes ☐	No ☒	**Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements?** No, the proposed amendments do not require the provision of educational services.
Yes ☐	No ☒	**Is the regulation likely to *deter* the formation of small businesses in Massachusetts?** No, the proposed amendments are not likely to deter the formation of small businesses.
Yes ☐	No ☒	**Is the regulation likely to *encourage* the formation of small businesses in Massachusetts?** No, the proposed amendments are not likely to encourage the formation of small businesses.
Yes ☐	No ☒	**Does the regulation provide for less stringent compliance or reporting requirements for small businesses?** No, the proposed amendments do not provide less stringent compliance and reporting requirements for small businesses.
Yes	No ☒	**Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses?** No, the proposed amendments do not establish less stringent schedules or deadlines for small businesses.
Yes ☐	No ☒	**Did the agency consolidate or simplify compliance or reporting requirements for small businesses?** The proposed amendments do not specifically consolidate or simplify requirements for small businesses; however, the proposed amendments add ecological restoration limited projects as an activity not requiring an application and clarify that hand pulling aquatic plants is not considered dredging.
Yes ☒	No ☐	**Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective**? The proposed amendments include an operational standard to ensure a minimum baseline design for culvert replacement projects that will accommodate anticipated streamflow and minimize potential flood impacts. The requirement for a minimum baseline standard is best written as an operational standard to achieve the regulatory objective of climate resiliency.
Yes ☐	No ☒	**Are there alternative regulatory methods that would minimize the adverse impact on small businesses?** MassDEP does not anticipate any adverse impacts on small businesses as a result of the proposed amendments.

THE COMMONWEALTH OF MASSACHUSETTS

Secretary of the Commonwealth - William Francis Galvin

2026 CUMULATIVE TABLE TO THE MASSACHUSETTS REGISTER
1565 - 1579

The Cumulative Tables lists all regulations and amendments thereto published in the Massachusetts Register during the current year. The Table is published in each Register.

State agencies are listed in the Table as they appear in the Code of Massachusetts Regulations (CMR or Code) in CMR numerical order which is based on the cabinet structure. For example, all Human Service agencies are prefaced by the number "1" and are designated as 101 CMR through 130 CMR.

The Cumulative Tables published in the last issue of previous years will have a listing of all regulations published for that year. These Registers are:

April 6, 1976 - 1977	Register:	# 88	Date: 2004	Register:	#1016
1978		138	2005		1042
1979		193	2006		1068
1980		241	2007		1094
1981		292	2008		1120
1982		344	2009		1146
1983		396	2010		1172
1984		448	2011		1198
1985		500	2012		1224
1986		546	2013		1250
1987		572	2014		1276
1988		598	2015		1302
1989		624	2016		1329
1990		650	2017		1355
1991		676	2018		1381
1992		702	2019		1407
1993		729	2020		1433
1994		755	2021		1459
1995		871	2022		1485
1996	Supp. # 2	807	2023		1511
1997		833	2024		1537
1998		859	2025		1563
1999		885			
2000		911			
2001		937			
2002		963			
2003		989			

		Issue	*Effective Date*
101 CMR	**Executive Office of Health and Human Services**		
204.00	Rates of Payment to Resident Care Facilities		
	- *Emergency Refile* (MA Reg. # 1563)	1569	12/5/25
	- *Compliance* (MA Reg. # 1563)	1572	12/5/25
206.00	Standard Payments to Nursing Facilities		
	- *Emergency Refile* (MA Reg. # 1559)	1564	10/1/25
		1567	2/13/26
307.00	Rates for Psychiatric Day Treatment Center Services	1569	3/13/26
317.00	Rates for Medicine Services - *Emergency Refile* (MA Reg. # 1561)	1567	11/7/25
		1573	5/8/26
322.00	Rates for Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment	1568	3/1/26
327.00	Rates for Ambulance and Wheelchair Van Services		
	- *Emergency Refile* (MA Reg. # 1557)	1564	9/26/25
	- *Compliance* (MA Reg. # 1557)	1570	9/26/25
	- *Correction* (MA Reg. # 1557)	1571	9/26/25
330.00	Rates for Team Evaluation Services	1577	7/3/26
334.00	Rates for Prostheses, Prosthetic Devices, and Orthotic Devices	1576	6/19/26
337.00	Rates for Dialysis Treatments and Home Dialysis Supplies	1578	7/17/26
343.00	Rates for Hospice Services	1576	6/19/26
346.00	Rates for Certain Substance-related and Addictive Disorders Programs	1578	7/17/26
347.00	Rates for Freestanding Ambulatory Surgery Center Services	1572	4/24/26
349.00	Rates for Early Intervention Program Services		
	- *Future Effective Regulation*	1565	7/1/26
		1576	7/1/26
355.00	Rates for Freestanding Birth Center Services	1567	2/13/26
413.00	Payments for Youth Intermediate-term Stabilization Services	1576	6/19/26
414.00	Rates for Family Stabilization Services	1574	5/22/26
416.00	Rates for Clubhouse Services	1574	5/22/26
417.00	Rates for Certain Elder Care Services	1570	3/27/26
420.00	Rates for Adult Long-term Residential Services	1577	7/3/26
422.00	Rates for General Programs Disability Services	1574	5/22/26
423.00	Rates for Certain In-home Basic Living Supports	1577	7/3/26
425.00	Rates for Certain Young Parent Support Programs	1578	7/17/26
514.00	Hospital Assessment - *Emergency*	1578	7/7/26
614.00	Health Safety Net Payments and Funding		
	- *Emergency Refile* (MA Reg. # 1559)	1564	9/30/25
		1569	3/13/26
		1576	6/19/26

		Issue	Effective Date
322 CMR	**Division of Marine Fisheries**		
4.00	Fishing and Shellfishing Equipment	1566	1/30/26
		1573	5/8/26
6.00	Regulation of Catches - *Emergency*	1573	4/24/26
		1573	5/8/26
	- *Correction* (MA Reg. # 1573)	1578	5/8/26
7.00	Permits	1566	1/30/26
		1567	2/13/26
		1573	5/8/26
	- *Correction* (MA Reg. # 1573	1578	5/8/26
15.00	Management of Marine Aquaculture	1566	1/30/26
400 CMR	**Executive Office of Economic Development**		
9.00	Qualified Data Centers	1570	3/27/26
527 CMR	**Board of Fire Prevention Regulations**		
12.00	Massachusetts Electrical Code	1572	4/24/26
	- *Correction* (MA Reg. # 1572)	1575	4/24/26
603 CMR	**Department of Elementary and Secondary Education**		
7.00	Educator Licensure and Preparation Program Approval	1574	5/22/26
23.00	Student Records	1568	2/27/26
28.00	Regulations on Special Education	1579	7/31/26
31.00	Certificate of Mastery and State Seal of Biliteracy	1568	2/27/26
57.00	Standards for Interpretation and Translation Services in Schools	1579	7/31/26
606 CMR	**Department of Early Education and Care**		
10.00	Child Care Financial Assistance	1566	1/30/26
610 CMR	**Board of Higher Education**		
16.00	Degree Granting Regulation for Pilot Proposals on Innovation	1568	2/27/26
651 CMR	**Executive Office of Aging and Independence**		
12.00	Certification Procedures and Standards for Assisted Living Residences	1579	7/31/26
760 CMR	**Executive Office of Housing and Livable Communities**		
69.00	Starter Home Zoning Districts	1569	3/13/26
76.00	Seasonal Communities	1568	2/27/26
77.00	Surplus Real Property	1578	7/17/26

Docket # 1184

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 409.000**

CHAPTER TITLE: **Durable Medical Equipment Services**

AGENCY: **Division of Medical Assistance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

130 CMR 409.000 governs MassHealth providers of services related to durable medical equipment and supplies (DME) and provides program requirements and conditions of payment for providing DME to MassHealth members.

REGULATORY AUTHORITY: **M.G.L. c. 118E, §§ 7 and 12**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-847-3302**

ADDRESS: **100 Hancock Street, 6th Floor, Quincy, MA 02171**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Order 145 notifications: 08-28-25
Regulatory Review approval: 08-28-25

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **10-03-25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year:

For the first five years:

No fiscal effect: **No fiscal effect**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **07-14-26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amends 130 CMR 409.000.

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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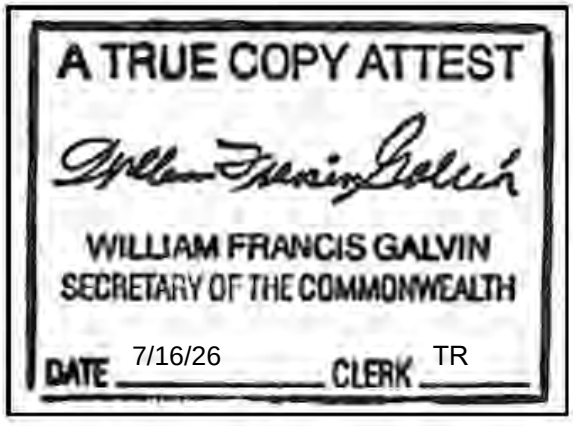

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(C) Prescription or LOMN Formats. The MassHealth agency accepts either written prescriptions or letters of medical necessity for DME in the following formats, provided the requirements of 130 CMR 409.416(B) are met.

(1) If the MassHealth agency has published a MassHealth Medical Necessity Review form for specific DME, providers may use the MassHealth Medical Necessity Review form as the prescription and letter of medical necessity specific to the DME being furnished. These forms can be found on the MassHealth website.

(2) If the forms described in 130 CMR 409.416(C)(1) are not used by the DME provider, the MassHealth agency accepts prescriptions and letters of medical necessity written on one of the following, if the form and format include all requirements in 130 CMR 409.416(B); and comply with MassHealth administrative and billing regulations and instructions; and state and federal law and regulations:

(a) the ordering practitioner's prescription pad;

(b) the ordering practitioner's letterhead stationery;

(c) the hospital prescription pad, if the member is being discharged from a hospital;

(d) electronic prescriptions (escripts) that comply with state and federal requirements;

(e) the MassHealth agency's Durable Medical Equipment and Medical Supplies General Prescription and Medical Necessity Review Form (DME-2), unless there is a product-specific Medical Necessity Review form as stated in 130 CMR 409.416(C)(1); or

(f) the Region A Durable Medical Equipment Carrier (DME Medicare Administrative Contractor (MAC)) Certificate of Medical Necessity (CMN) completed in accordance with the instructions established by the Region A DME MAC and in compliance with 130 CMR 409.416(A).

(3) For prescription and letter of medical necessity requirements for members residing in nursing facilities (*see* 130 CMR 409.416(E)).

(D) Electronic Transmission of Prescriptions. Prescriptions may be transmitted electronically to the DME provider by the member's ordering practitioner in accordance with the MassHealth agency's administrative and billing instructions and applicable state and federal laws.

(E) Documentation for Prescriptions for Members in Nursing Facilities. For members residing in nursing facilities, the prescription is the actual order in the member's medical record. The prescription must include a copy of the current month's order sheet that is signed and dated by the ordering practitioner, a copy of the medical justification from the member's nursing facility record, and must include any additional documentation necessary to support medical necessity. Additional documentation may include physician progress notes; relevant laboratory or diagnostic test results; nursing, nutrition, or therapy assessments and notes; or wound assessments with pictures done with specialized wound photography.

(F) Refills of DME.

(1) The MassHealth agency may allow payment of refills of DME prescribed up to a maximum of 12 months.

(2) The absence of an indication to refill by the prescriber renders the prescription nonrefillable.

(3) The MassHealth agency does not pay for any refill without approval from a member or member's authorized representative, provided at the time the prescription is to be refilled. The possession by a provider of a prescription with remaining refills does not constitute approval from the member to refill the prescription.

(4) The DME provider must keep records of all member or authorized representative approval of refills in accordance with 130 CMR 409.430(L).

409.417: Medical Necessity Criteria

(A) All DME covered by MassHealth must meet the medical necessity requirements set forth in 130 CMR 409.000 and in 130 CMR 450.204: *Medical Necessity*, and any applicable medical necessity guidelines for specific DME published on the MassHealth website.

(B) For items covered by MassHealth for which there is no MassHealth item-specific medical necessity guideline, and for which there is a Medicare Local Coverage Determination (LCD)

409.417: continued

indicating Medicare coverage of the item under at least some circumstances, the provider must demonstrate medical necessity of the item consistent with the Medicare LCD. However, if the provider believes the durable medical equipment is medically necessary even though it does not meet the criteria established by the local coverage determination, the provider must demonstrate medical necessity under 130 CMR 450.204: *Medical Necessity*.

(C) For an item covered by MassHealth for which there is no MassHealth item-specific medical necessity guideline, and for which there is a Medicare LCD indicating that the item is not covered by Medicare under any circumstance, the provider must demonstrate medical necessity under 130 CMR 450.204: *Medical Necessity*.

409.418: Prior Authorization

(A) Prior Authorization. The DME provider must obtain prior authorization from the MassHealth agency or its designee as a prerequisite for payment of DME identified in the DME and Oxygen Payment and Coverage Guideline Tool or other guidance specified by the MassHealth agency or its designee as requiring prior authorization, or pursuant to 130 CMR 409.413(B), for service codes not listed in Subchapter 6 or in the DME and Oxygen Payment and Coverage Guideline Tool.

(B) Prior Authorization for MassHealth Covered Services. Prior authorization for MassHealth-covered services is a determination of medical necessity only and does not establish or waive any other prerequisites for payment, such as member eligibility or requirements to seek payment from other liable parties, including Medicare.

(C) Documentation of Medical Necessity.
Prior authorization requests submitted by the provider for DME must include

(1) a completed MassHealth Prior Authorization Request (PA-1) form (if request is submitted on paper);

(2) a prescription or letter of medical necessity that meets the requirements of 130 CMR 409.416, including any additional documentation as required by 42 CFR 440.70 or other state or federal law; and

(3) if diagnostic test results are used as a means to document medical necessity, the test results must be interpreted, signed, and dated by a physician, or include documentation that supports the need for DME from an appropriate health care professional other than the DME provider, including, but not limited to, physical therapists, speech language pathologists, nurses, respiratory therapists, and occupational therapists who have expertise in the applicable area.

(D) Documentation for Prior Authorization Items Requiring Individual Consideration (IC) or Adjusted Acquisition Cost (AAC). For DME that is identified in the DME and Oxygen Payment and Coverage Guideline Tool or in other guidance issued by the MassHealth agency or its designee as requiring IC or AAC, a copy of the original invoice that reflects the provider's adjusted acquisition costs as set forth in 101 CMR 322.00: *Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment*.

(1) The MassHealth agency will accept a quote from a MassHealth provider for an item that does not have a rate established by EOHHS if the equipment has not been purchased by the provider at the time of the prior authorization request, and when the item being purchased is not an item that the provider normally purchases for its scope of business. The quote must be on the manufacturer's letterhead or form and must be addressed to the provider.

(2) At the time of a claim submission for items requiring a one-time claim submission, or, at initial claim submission for the authorized period for recurring (monthly) claims, the provider must attach the actual manufacturer’s invoice and quote used for MassHealth PA purposes. The provider must keep a copy of the quote and the invoice on file. The MassHealth agency reserves the right to deny claims if a claim is submitted without the appropriate documentation attached.

(3) For disposable medical supplies, the invoice must be dated within six months of the prior authorization request.

(4) The MassHealth agency will not accept a printed invoice or order from a manufacturer's website.

409.418: continued

(E) 90-day Requirement for Submission of Prior Authorization Requests. The provider must submit the request for prior authorization to the MassHealth agency no later than 90 calendar days from the date of the prescription. Failure to submit the request within the 90-day period will result in a denial of the prior authorization request.

(F) Prior Authorization Requests for DME Units in Excess of the Maximum Allowable Units. The MassHealth agency requires prior authorization for certain DME provided to the member if the number of units requested exceeds the maximum units described in the DME and Oxygen Payment and Coverage Guideline Tool or in other guidance issued by the MassHealth agency or its designee.

(1) The provider must include documentation that supports the medical necessity of the additional units, including requirements under 130 CMR 409.417 and 409.418.

(2) If the PA request is authorized by the MassHealth agency, or its designee, the provider must submit a separate claim with a different date of service other than the date of service for the initial maximum number of units and only for the number of excess units actually provided to the member.

(G) Additional Assessments or Other Information. In making its prior authorization determination, the MassHealth agency or its designee may require additional assessments of the member or require other necessary information in support of the request for prior authorization.

(H) Prior Authorization Requests for Members Who Have Other Insurance. For members for whom MassHealth is not the primary insurer, a provider must make diligent efforts to first identify and obtain payment from all other liable parties, including Medicare, before seeking payment from MassHealth in accordance with 130 CMR 450.316: *Third-party Liability: Requirements*. The MassHealth agency, or its designee, may request documentation of a provider's diligent efforts to collect payment from Medicare or other liable parties, including documentation of compliance with Medicare's billing and authorization requirements. If documentation requested by the MassHealth agency, or its designee, is not received within the timeframe specified by the MassHealth agency or its designee, or the documentation is incomplete or does not support coverage by MassHealth, the associated claims will be denied.

(I) Prior Authorization for Repairs of Durable Medical Equipment. Providers must submit a prior authorization request for repairs, including repairs of a member's serviceable backup power wheelchair, in accordance with 130 CMR 409.420.

(J) Notice of Approval, Denial, or Modification of a Standard or Expedited Prior-authorization Request

(1) The MassHealth agency or its designee acts on prior authorization requests in accordance with 130 CMR 450.303: *Prior Authorization*.

(2) Notice of Approval. If the MassHealth agency or its designee approves a prior authorization request for DME, the MassHealth agency will send notice of its decision to the member and the DME provider, within the timeframe specified at 130 CMR 450.303: *Prior Authorization*.

(3) Notice of Denial or Modification. If the MassHealth agency or its designee denies or approves with a modification a prior authorization request for DME, the MassHealth agency or its designee will notify the member and the DME provider, within the timeframe specified at 130 CMR 450.303: *Prior Authorization*. The notice will state the reason for the denial or modification and will inform the member of the right to appeal and of the appeal procedure in accordance with 130 CMR 610.000: MassHealth: *Fair Hearing Rules*.

(4) Right of Appeal. A member may appeal a service denial or modification by requesting a fair hearing in accordance with 130 CMR 610.000: MassHealth: *Fair Hearing Rules*.

(5) Notice of Deferral. If the MassHealth agency or its designee defers a prior authorization request due to an incomplete submission or lack of documentation to support medical necessity, the MassHealth agency or its designee will notify the member and the DME provider of the deferral and the reason for the deferral and will give the provider an opportunity to submit the incomplete or missing documentation. If the provider does not submit the required information within the timeframe specified at 130 CMR 450.303: *Prior Authorization*, the MassHealth agency or its designee will make a decision on the prior authorization request using all documentation and forms submitted to the MassHealth agency and will send notice of its decision to the provider and the member in accordance with 130 CMR 409.418(J).

409.419: Delivery of Durable Medical Equipment

(A) Delivery of Durable Medical Equipment to a Member's Home.

(1) The DME provider must ensure that DME orders are delivered within a reasonable time after DME provider receipt of a prescription or LOMN and any required documentation or prior approval for the item. Providers must make alternate arrangements such as contracting with subcontractors, or referring the member to another DME provider, when timely delivery cannot be made by the DME provider. The MassHealth agency, reserves the right to issue additional subregulatory guidance on reasonableness of delivery times for specific DME.

(2) Except as provided in 130 CMR 409.419(D), the DME provider must maintain in the member's record a copy of its delivery slip signed by the member or the member's designee accepting delivery on behalf of the member, and dated at the time of delivery. The date of the signature on the delivery slip must be the same as the date of delivery.

(3) The MassHealth agency accepts the member's mark or a signature stamp as proof of delivery on behalf of a member whose disability inhibits the member's ability to write. A signature stamp may be used only by the member or the member's designee. A signature stamp may not be used by anyone associated with either the provider or the delivery service.

(B) Delivery of Durable Medical Equipment to a Nursing Facility or ICF/IID. The provider must obtain and maintain in the member's record documentation as required in 130 CMR 409.430, including documentation from the facility that the equipment will be used only for the member to whom the equipment was delivered. The DME provider's delivery slip must be signed by the member, the member's designee or a designee from the nursing facility or ICF/IID, and otherwise meet the requirements of 130 CMR 409.430(D).

(C) Delivery of Durable Medical Equipment to a Hospital, a Nursing Facility, or an ICF/IID in Anticipation of Discharge. A provider may deliver DME to a facility for a member who is being discharged from a hospital, a nursing facility, or ICF/IID for the purpose of fitting or training the member in its proper use up to ten business days prior to the member's discharge date. The DME provider's delivery slip must be signed by the member, or the member's designee or a designee from the facility, and otherwise meet the requirements of 130 CMR 409.430(D). The DME must be solely for use in the member's home or community. The provider may not bill for DME for the days that the member was receiving training or fitting in the facility. The provider must use the date of the member's discharge from the facility as the date of service on the claim.

(D) Delivery by a Shipping Service.

(1) For medical supplies delivered to a member by a shipping service, the DME provider is responsible for maintaining in the member's record a copy of the delivery services tracking slip attached to the provider's shipping invoice. The shipping invoice must include:

(a) the name of the member;

(b) the quantity of the supply delivered;

(c) a detailed description of the items delivered including the brand name and, if applicable, the serial number; and

(d) the delivery service's package identification number.

(2) The shipping service's tracking slip must refer to each package delivered, the delivery address, and the corresponding package identification number assigned by the shipping service. The date of service on the claim must match the shipping date.

(3) A shipping service tracking slip that meets the above requirements is an acceptable form of a delivery ticket (s*ee* 130 CMR 409.430).

(E) Refills. For DME provided as refills to an original prescription, the provider must contact the member or the member's designee up to seven business days before shipping or delivering the refill to ensure that the refill is necessary and to confirm any changes to the order. If the member or designee declines a delivery, the provider must not make the delivery and must not submit a claim to the MassHealth agency for the items.

(F) Automatic Deliveries. MassHealth does not allow automatic deliveries. DME that is delivered to a member on a recurring basis must meet 130 CMR 409.419(E).

(G) DME Adjustments. The DME provider responsible for the delivery of the DME is also responsible for providing adjustments needed for proper fit and function and instructing the member on the use of the DME.

Docket # 1185

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 428.000**

CHAPTER TITLE: **Prosthetics Services**

AGENCY: **Division of Medical Assistance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

130 CMR 428.000 governs MassHealth providers of services related to prosthetics (PRT) and provides program requirements and conditions of payment for providing PRT to MassHealth members.

REGULATORY AUTHORITY: **M.G.L. c. 118E, §§ 7 and 12**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-847-3302**

ADDRESS: **100 Hancock Street, 6th Floor, Quincy, MA 02171**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Order 145 notifications: 08-28-25
Regulatory Review approval: 08-28-25

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **10-03-25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year:

For the first five years:

No fiscal effect: **No fiscal effect**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **07-14-26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amends 130 CMR 428.000.

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

DATE 7/16/26 CLERK KCR

130 CMR 428.000: PROSTHETICS SERVICES

Section

428.401: Introduction

130 CMR 428.000 states the requirements and procedures for the purchase and repair of prosthetic devices, customized equipment, and supplies under MassHealth. All providers of prosthetic services participating in MassHealth must comply with the regulations governing MassHealth, including, but not limited to MassHealth regulations set forth in 130 CMR 428.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

428.402: Definitions

The following terms used in 130 CMR 428.000 have the meanings given in 130 CMR 428.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 428.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 428.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

Accessory Equipment. Equipment that is fabricated primarily and customarily to modify or enhance the usefulness or functional capability of another piece of prosthetic equipment and that is generally not useful in the absence of such prosthetic equipment.

Adjusted Acquisition Cost. Except where the manufacturer is the provider, the price paid by the provider to the manufacturer or any other supplier for prosthetic devices, customized equipment, or supplies, excluding all associated costs such as shipping, handling, and insurance costs in accordance with 130 CMR 428.422. Where the manufacturer is the provider, the adjusted acquisition cost is the actual cost of manufacturing such prosthetic devices, customized equipment, or supplies.

American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc. (ABC). The national certifying and accrediting body for the orthotic, prosthetic, and pedorthic professions.

Board of Certification/Accreditation, International (BOC). A credentialing entity for practitioners and suppliers of comprehensive orthotic and prosthetic care.

Certified Mastectomy Fitter (CMF). A health care professional with current certification through the ABC or BOC who is specifically educated and trained in the provision of breast prostheses and post-mastectomy services, including patient assessment, formulation of a treatment plan, implementation of the treatment plan and follow-up, and practice management.

428.402: continued

Date of Service. The date the prosthesis is delivered and fitted to the MassHealth member. If the prosthetic service involves a series of fittings and adjustments, the date of service is the date on which the final adjustment is made. If the prosthetic service involves only the provision of a service (for example, a repair), then the date of service is the date on which the service was completed.

Discount. Any remuneration or reduction of payment of any kind, whether direct or indirect, received by the provider.

Nursing Facility. A licensed facility that meets the provider-eligibility and certification requirements of 130 CMR 456.404: *Requirements for Provider Participation: In-state* or 130 CMR 456.405: *Requirements for Provider Participation: Out-of-state* and whose members meet the medical eligibility criteria under 130 CMR 456.409: *Services Requirement for Medical Eligibility*. Nursing facilities do not include facilities such as rest homes, state schools, and state hospitals.

Nursing Facility Visit. A visit by a provider to a nursing facility for the purpose of providing prosthetic services.

Prior Authorization (PA) Request. A request submitted by the orthotics provider to the MassHealth agency to determine medical necessity in accordance with 130 CMR 442.412: *Prior Authorization*, 130 CMR 450.204: *Medical Necessity*, and 130 CMR 450.303: *Prior Authorization*.

Prosthesis (or Prosthetic Equipment). An artificial replacement for a missing body part, such as an artificial limb or total joint replacement.

Prosthetics Provider. An organization or individual that has enrolled with MassHealth and has signed a provider contract with the MassHealth agency who meets all applicable requirements of 130 CMR 428.404 and 130 CMR 450.000: *Administrative and Billing Regulations*. Prosthetics providers may include providers also enrolled as MassHealth participating durable medical equipment (DME) and supplies providers, oxygen and respiratory therapy equipment and supplies (OXY) providers, or orthotics services providers, who meet all program-specific requirements.

Prosthetic Service. The purchase, customization, fitting, repair, replacement, or adjustment of a prosthesis or component part, or other activity performed or equipment provided in accordance with 130 CMR 428.000.

Prosthetic Supplies. Products that are:
(1) fabricated primarily and customarily to fulfill a medical purpose;
(2) used in conjunction with a prosthesis or prosthetic equipment;
(3) generally not useful in the absence of a prosthesis; and
(4) non-reusable and disposable.

Prosthetics. The design, fitting, and attachment of an artificial replacement of a missing body part.

Service Facility. The place of business, physically accessible to MassHealth members, where prosthetic services, especially those involving fitting, adjustment, repair, and replacement of prostheses, are performed. A service facility does not include a MassHealth member's place of residence.

428.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers prosthetic services only when provided to eligible MassHealth members, subject to the restrictions and limitations in 130 CMR 428.000 and 450.000: *Administrative and Billing Regulations*. 130 CMR 450.105: *Coverage Types* specifically states, for each coverage type, which services are covered and which members are eligible to receive those services.

428.403: continued

(2) Age Limitations. In addition to any other restrictions and limitations set forth in 130 CMR 428.000 and 450.000: *Administrative and Billing Regulations*, MassHealth covers prosthetic services only when provided to eligible MassHealth members, subject to the age limitations set forth in Subchapter 6 of the *Prosthetics Manual*.

(3) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

428.404: Provider Eligibility

(A) Provider Participation Requirements. Payment for services described in 130 CMR 428.000 is made to providers who are participating in MassHealth as prosthetic providers; to providers also enrolled as MassHealth participating DME providers; OXY providers, or orthotic services providers and who meet all program-specific requirements. Applicants must meet the requirements in 130 CMR 450.000: *Administrative and Billing Regulations* as well as the requirements in 130 CMR 428.000. Participating prosthetic providers must continue to meet provider eligibility participation requirements throughout the period of their provider contract with the MassHealth agency.

(B) In State. To participate in MassHealth, a provider with a service facility in Massachusetts must:

(1) primarily engage in the business of providing prosthetic and repair services to the public;

(2) meet all state and local requirements for engaging in such business;

(3) be or employ a prosthetist currently certified by the American Board for Certification in Orthotics, Prosthetics, and Pedorthics Inc. (ABC), or the Board of Certification/ Accreditation, International (BOC), unless the provider intends to solely provide breast prostheses and accessories, in which case the provider must employ, for each service facility location, at least one full-time certified mastectomy fitter, who is currently certified by the ABC or BOC.

(4) be a Medicare provider;

(5) have a service facility that is physically accessible to MassHealth members during reasonable business hours;

(6) maintain a visible sign identifying the business and hours of operation;

(7) maintain a primary business telephone listed under the name of the business in a local directory. The exclusive use of a pager, answering machine, or cell phone is prohibited; and

(8) obtain a provider number from MassHealth and, if the provider intends to solely provide breast prostheses and accessories, be designated by the MassHealth agency as a specialty provider of certified mastectomy fitter services.

(C) Out of State. A provider with no service facility in Massachusetts may participate in MassHealth only if the provider participates in the Medicaid program of the state in which the provider primarily conducts business and otherwise meets the requirements of 130 CMR 428.404(A). Such a provider may receive payment for MassHealth services only as set forth in 130 CMR 450.109: *Out-of-state Services*.

428.405: Provider Responsibility

(A) The provider must ensure that all prosthetic equipment and supplies are:

(1) clean (sterilized when appropriate);

(2) in proper working condition;

(3) functional;

(4) free from defects; and

(5) new and unused at the time of purchase.

428.405: continued

(B) The provider must ensure that all prosthetic services are the most cost effective, given the medical need for which they are prescribed and the member's physical limitations.

(C) The provider must make a reasonable effort to purchase the item from the least costly reliable source by comparing prices charged by different suppliers for comparable items.

428.406: Covered Services

The MassHealth agency pays for only those prosthetic services listed in, and subject to the service limitations set forth in, Subchapter 6 of the *Prosthetics Manual*.

428.407: Service Limitations

The service limitations set forth in Subchapter 6 of the *Prosthetics Manual* apply, subject to the Early and Periodic Screening, Diagnosis, and Treatment provisions set forth in 130 CMR 450.144: *EPSDT Services: Diagnosis and Treatment*(A).

428.408: Noncovered Services

The MassHealth agency does not pay for any of the following:

(A) any prosthetic services for which, under comparable circumstances, the provider does not customarily bill private patients who do not have health insurance;

(B) nonmedical prosthetic services. Equipment that is used primarily and customarily for a nonmedical purpose is not considered medical equipment, even if such equipment has a medically related use;

(C) storage of prosthetic equipment or associated items; and

(D) prosthetic services that are not both medically necessary in accordance with 130 CMR 450.204: *Medical Necessity* and reasonable for the treatment of a member's condition. This includes services that:

(1) cannot reasonably be expected to make a meaningful contribution to the treatment of a member's condition or the performance of the member's activities of daily living; and

(2) are more costly than a medically comparable and suitable alternative or that serve essentially the same purpose as equipment already available to the member.

428.409: Prescription Requirements

(A) The purchase of prosthetic equipment requires a written prescription signed by a licensed physician or an independent nurse practitioner. The prescription must be written on the prescriber's prescription form and must include the following information:

(1) the member's name and address;
(2) the member's MassHealth identification number;
(3) specific identification of the prescribed item;
(4) medical justification for the use of the item, including the member's diagnosis;
(5) the prescriber's address and telephone number; and
(6) the date on which the prescription was signed by the prescriber.

(B) The provider must keep the prescription on file for the period of time required by 130 CMR 450.205: *Recordkeeping and Disclosure*.

428.410: Prosthetic Equipment Provided to Institutionalized Members

(A) Nursing Facilities. The MassHealth agency pays prosthetic providers for:

(1) the purchase and repair of prosthetic equipment; and

(2) prosthetic supplies provided for the personal full-time use of a member residing in a nursing facility.

428.410: continued

(B) Institutions Licensed as Hospitals, Chronic Disease Hospitals, and Rehabilitation Hospitals. The MassHealth agency does not pay prosthetic providers for the purchase or repair of prosthetic equipment or for supplies provided to a hospitalized member, except for prosthetic equipment that is prescribed for home use after discharge. The hospital record must document the member's discharge plan and that the date of discharge was before the purchase or repair of the prescribed item.

(C) Intermediate Care Facilities for the Mentally Retarded with 16 Beds or More (State Schools).

(1) The MassHealth agency pays prosthetic providers or the purchase and repair of customized prosthetic equipment provided for the personal full-time use of a member residing in an ICF/MR with 16 beds or more (a state school) only if the customization precludes the use of the equipment by subsequent residents in that institution.

(2) The MassHealth agency does not pay prosthetic providers for noncustomized equipment or supplies provided to a member residing in a state school.

(D) Rest Homes. The MassHealth agency pays prosthetic providers for the purchase and repair of prosthetic equipment and for associated supplies provided for the personal full-time use of a member residing in a rest home.

428.411: Repairs of Prosthetic Equipment

(A) The MassHealth agency pays for all repair services on an individual-consideration basis as described in 130 CMR 428.421.

(B) The provider of repair services is liable for the quality of the workmanship and parts, and for ensuring that repaired equipment is in proper working condition.

(C) The provider of repair services must exhaust all manufacturer warrantees before submitting claims for repairs to prosthetic equipment to the MassHealth agency.

428.412: Prior Authorization

(A) Services that require prior authorization as a prerequisite for payment are identified in 130 CMR 428.000 or are listed in Subchapter 6 of the *Prosthetics Manual* with the designation (P.A.) appearing after the service description. To determine if prior authorization is required, the provider should review both 130 CMR 428.000 and Subchapter 6. Prior authorization determines only the medical necessity of the prescribed item or service and does not waive any other prerequisites to payment such as member eligibility or resort to health-insurance payment.

(B) The provider must request prior authorization in accordance with the billing instructions in Subchapter 5 of the *Prosthetics Manual*. Before determining the medical necessity of an item or service for which prior authorization is requested, the MassHealth agency may, at its discretion, require the prescriber to submit an assessment of the member's condition and the objectives of the requested service. The MassHealth agency may also, at its discretion, require an evaluation by a licensed prosthetist to determine whether the requested prosthetic service is useful to the member, given the member's physical condition and physical environment.

(C) Notice of Approval, Denial, or Modification of a Standard or Expedited Prior-authorization Request

(1) The MassHealth agency or its designee acts on prior authorization requests in accordance with 130 CMR 450.303: *Prior Authorization*.

(2) Notice of Approval. If the MassHealth agency or its designee approves a prior authorization request for DME, the MassHealth agency will send notice of its decision to the member and the DME provider, within the timeframe specified at 130 CMR 450.303: *Prior Authorization*.

(3) Notice of Denial or Modification. If the MassHealth agency or its designee denies or approves with a modification a prior authorization request for DME, the MassHealth agency or its designee will notify the member and the DME provider, within the timeframe specified at 130 CMR 450.303: *Prior Authorization*. The notice will state the reason for the denial or modification and will inform the member of the right to appeal and of the appeal procedure in accordance with 130 CMR 610.000: MassHealth: *Fair Hearing Rules*.

428.412: continued

(4) Right of Appeal. A member may appeal a service denial or modification by requesting a fair hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(5) Notice of Deferral. If the MassHealth agency or its designee defers a prior authorization request due to an incomplete submission or lack of documentation to support medical necessity, the MassHealth agency or its designee will notify the member and the DME provider of the deferral and the reason for the deferral and will give the provider an opportunity to submit the incomplete or missing documentation. If the provider does not submit the required information within the timeframe specified at 130 CMR 450.303: *Prior Authorization*, the MassHealth agency or its designee will make a decision on the prior authorization request using all documentation and forms submitted to the MassHealth agency and will send notice of its decision to the provider and the member in accordance with 130 CMR 428.412(C).

428.413: Procedure for Requesting Prior Authorization

(A) The provider must obtain prior authorization from the MassHealth agency before providing any service that requires prior authorization. The provider must submit the Request for Prior Authorization within 90 days of the date of service requested on the prescription.

(B) The Request for Prior Authorization must document the adjusted acquisition cost (*see* 130 CMR 428.422) and the medical necessity of the requested service. The Request for Prior Authorization must contain the following documentation:

(1) a copy of the invoice or invoices from the manufacturer for the equipment, disclosing all discounts;

(2) a copy of a current prescription that must not be older than 90 days from the requested date of service (*see* 130 CMR 428.409 for information that must be included in the prescription);

(3) if requested by the MassHealth agency, a current prosthetic evaluation for the equipment, performed independently of the provider by a licensed physician or prosthetist;

(4) the date or projected date of service;

(5) the projected duration of need for the equipment; and

(6) if replacing existing equipment, the date the existing equipment was purchased.

428.414: Medicare Coverage

(A) For Medicare and third-party-liability coverage, *see* 130 CMR 450.316 through 450.318.

(B) For Medicare-covered services that are provided to members who receive Medicare Part B benefits, the MassHealth agency does not require prior authorization.

(C) When Medicare denies a claim for prosthetic services or considers the services uncovered, the MassHealth agency requires prior authorization for those services that would require prior authorization for members without Medicare.

428.415: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary prosthetics services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 428.000, and with prior authorization.

428.420: Payment for Prosthetic Services

(A) Payment to a provider for prosthetic equipment and supplies is subject to the conditions and limitations in 130 CMR 428.000 and 450.000: *Administrative and Billing Regulations*, and will be the lower of:

(1) the provider's usual and customary charge to the general public; or

(2) the fee set forth in the schedule of maximum allowable fees established by the Massachusetts Executive Office of Health and Human Services.

428.420: continued

(B) Payment for the following services is included in the provider payment under 130 CMR 428.420(A). No separate payment is allowed for:

(1) the fitting of the prosthesis;
(2) instructing the member in the use of the prosthesis;
(3) the cost of the component parts and accessory equipment;
(4) repairs due to normal wear and tear within 90 days of the date of delivery; and
(5) adjustments to the prosthesis and any prosthetic component made when fitting the prosthesis and for 90 days from the date of delivery, when the adjustments are not necessitated by changes in the member's functional abilities.

428.421: Individual Consideration

When the rate of payment for the purchase or repair of certain prosthetic equipment has not been established by the Executive Office of Health and Human Services, the MassHealth agency pays for the service based on individual consideration, subject to all other conditions of payment. Such items are identified in Subchapter 6 of the *Prosthetics Manual* by the designation (I.C.) next to the description of the item or service. The MassHealth agency determines the rate of payment for an individual-consideration item or service based on the provider's report of services and a current invoice that indicates the provider's adjusted acquisition cost as defined in 130 CMR 428.421 and 428.422. Payment for the fitting of a prosthesis is included in the adjusted acquisition cost. Providers must maintain adequate records to document the individual consideration claim and must provide these documents to the MassHealth agency and the Attorney General's Medicaid Fraud Control Unit upon demand (*see* 130 CMR 450.205: *Recordkeeping and Disclosure*). Payment to a provider for an individual consideration claim is the lower of:

(A) the provider's usual and customary charge to the general public; or

(B) the adjusted acquisition cost of the item plus a markup not to exceed:

(1) 70% for any item whose adjusted acquisition cost is less than $100;
(2) 50% for any item whose adjusted acquisition cost is $100 or greater and less than $200;
(3) 45% for any item whose adjusted acquisition cost is $200 or greater and less than $300; or
(4) 40% for any item whose adjusted acquisition cost is $300 or greater.

428.422: Adjusted Acquisition Cost

(A) The provider must disclose all discounts, as defined in 130 CMR 428.402, and must reflect such discounts in the provider's claim for payment pursuant to M.G.L. c. 118E, § 41, and U.S.C. § 1320a-7b(b)(3)(A). Any provider who fails to disclose and pass on any discounts to the MassHealth agency may be subject to civil and criminal penalties, including imprisonment, in accordance with state and federal laws.

(B)(1) Except where the manufacturer is the provider, the adjusted acquisition cost must not exceed the manufacturer's current wholesale price and must be evidenced by the purchase price of the equipment or goods listed on a copy of the supplier's invoice.

(2) Where the manufacturer is the provider, the adjusted acquisition cost must not exceed the actual cost of manufacturing the items.

(C) Where the manufacturer is the provider of any item covered under 130 CMR 428.000, the manufacturer must submit documentation that demonstrates to the MassHealth agency's satisfaction the actual cost of manufacturing the item, as set forth in 130 CMR 428.422(B).

(D) The provider must maintain the actual receipted invoice in the member's record, and make it available to the Division and the Attorney General's Medicaid Fraud Control Unit pursuant to 130 CMR 428.423 and 450.205: *Recordkeeping and Disclosure*.

(E) The provider may group together low-cost items (those with an adjusted acquisition cost of less than $5 each) to equal $5 or less, and bill the total adjusted acquisition cost plus the allowable markup listed in 130 CMR 428.421(B).

428.423: Recordkeeping Requirements

The provider must keep a record of all prosthetic services, nursing facility visits, and the medical necessity of such services provided to a member for the period of time required by 130 CMR 450.205: *Recordkeeping and Disclosure*. This record must include the following:

(A) a prescription for all purchases;

(B) a copy of the approved prior-authorization request for all prosthetic services requiring prior authorization;

(C) an acknowledgment of receipt, signed by the member or the member's representative, of prescribed equipment or supplies, including:

(1) the date of receipt of equipment or supplies;

(2) the condition of the equipment or supplies (for example, whether it is in proper working order or is damaged);

(3) the manufacturer, brand name, model number, and serial number of the equipment or supplies;

(4) for repair services, a complete description of the service, including the manufacturer, brand name, model number, and serial number of the repaired item; and

(5) next to the signature, an explanation of the representative's relationship to the member by the individual acknowledging receipt. This individual cannot be associated with either the provider or the delivery service.

(a) For routine delivery of supplies, the member must acknowledge receipt at least monthly.

(b) A signature stamp may be used by or on behalf of a MassHealth member whose disability inhibits the member's ability to write. A signature stamp may only be used by a member or the member's representative, provided that the stamp is used by the member in his or her normal course of conducting business. A signature stamp cannot be used by anyone associated with either the provider or the delivery service;

(D) the actual invoice showing the cost to the provider of the materials (if the provider is not the manufacturer of the materials);

(E) documentation demonstrating the cost of manufacturing the item provided (if the provider is the manufacturer);

(F) copies of written warranties; and

(G) documentation demonstrating efforts under 130 CMR 428.405(C) to purchase the item from the least costly reliable source.

REGULATORY AUTHORITY

130 CMR 428.000: M.G.L. c. 118E, §§ 7 and 12.

Docket # 1186

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 432.000**

CHAPTER TITLE: **Therapist Services**

AGENCY: **Division of Medical Assistance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

130 CMR 432.000 governs MassHealth Therapy providers of therapist services (occupational therapy, speech language therapy, physical therapy) and provides program requirements and conditions of payment for the provision of therapist services to MassHealth members.

REGULATORY AUTHORITY: **M.G.L. c. 118E, §§ 7 and 12**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **6178473302**

ADDRESS: **100 Hancock Street, 6th Floor, Quincy, MA 02171**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Order 145 notifications: Jul 18, 2025
Regulatory Review approval: Jul 18, 2025

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **Aug 22, 2025**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year:

For the first five years:

No fiscal effect: **No fiscal effect**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **7/15/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amends 130 CMR 432.000.

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
429 - 434.6	**429 - 434.6**

A TRUE COPY ATTEST

WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

DATE 7/16/26 CLERK MG

130 CMR 432.000: THERAPIST SERVICES

Section

432.401: Introduction

All therapists participating in MassHealth must comply with MassHealth regulations, including but not limited to 130 CMR 432.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

432.402: Definitions

The following terms used in 130 CMR 432.000 have the meanings given in 130 CMR 432.402, unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 432.000 is not determined by these definitions, but by application of regulations elsewhere in 101 CMR 339.00: *Rates for Restorative Services*, 130 CMR 432.000, and in 130 CMR 450.000: *Administrative and Billing Regulations*.

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

Capitated Program. An ICO, SCO, ACO, or PACE organization, or any other entity that, according to a contract with EOHHS, covers home health and other medical services for members on a capitated basis.

Co-treatment. Therapy performed by two therapy providers, who work together as a team to treat one member, when appropriate. The providers may only bill for a maximum of four units per member treatment session.

Group Therapy. Simultaneous therapy services provided to two to six patients who may or may not be doing the same activities.

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

432.402: continued

Maintenance Program. Repetitive services, required to maintain or prevent the worsening of function, that do not require the judgment of a licensed therapist for safety and effectiveness.

Managed Care Organization (MCO). Any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services.

Marketing. Any communication from a therapy provider, or its agent, to a member, or their family or caregivers, that can reasonably be interpreted as intended to influence the member's choice of therapy provider, whether by inducing that member

(1) to retain that therapy provider to provide therapy services to the member;
(2) not to retain therapy services from another therapy provider; or
(3) to cease receiving therapy services from another therapy provider.

Occupational Therapy. Therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of functions that affect the activities of daily living that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Occupational therapy programs are designed to improve quality of life by recovering competence, preventing further injury or disability, and to improve the individual's ability to perform tasks required for independent functioning, so that the individual can engage in activities of daily living.

Physical Therapy. Therapy services, including diagnostic evaluation and therapeutic intervention, designed to improve, develop, correct, rehabilitate, or prevent the worsening of physical functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Physical therapy emphasizes a form of rehabilitation focused on treatment of dysfunctions involving neuromuscular, musculoskeletal, cardiovascular/pulmonary, or integumentary systems through the use of therapeutic interventions to optimize functioning levels.

Prescribing Provider. The member's physician, nurse practitioner, or physician assistant who prescribes and writes the prescription for therapy services in accordance with 130 CMR 432.415.

Programs of All-inclusive Care for the Elderly (PACE). The Programs of All-inclusive Care for the Elderly (PACE), as described in 42 CFR 460 and 130 CMR 519.007(C): *Program of All-inclusive Care for the Elderly (PACE)*.

Provider Portal. The online site by which LTSS providers, as applicable, submit all MassHealth LTSS prior-authorization requests to a MassHealth designated vendor.

Senior Care Organization (SCO). A managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-covered services, and for dual eligible members, the full continuum of MassHealth and Medicare-covered services.

Speech/Language Therapy. Therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing functions that have been lost, impaired, or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries. Speech and language disorders are those that affect articulation of speech, sounds, fluency, voice, swallowing (regardless of presence of a communication disability), and those that impair comprehension, spoken, written, or other symbol systems used for communication.

432.402: continued

Therapy Provider (Therapist). A MassHealth enrolled provider of physical therapy, occupational therapy, or speech/language therapy. Therapy Provider may refer to an individual practitioner or a group practice consisting of therapy providers.

Therapy Visit. A personal contact with a member provided by a licensed physical therapist, licensed physical therapy assistant, licensed occupational therapist, licensed occupational therapy assistant, licensed speech/language pathologist, or licensed speech/language pathologist assistant for the purpose of providing a covered service.

Unfair or Deceptive Acts or Practices. Any unfair or deceptive acts or practices, as that term is referred to in M.G.L. c. 93A, § 2 and in 940 CMR: *Office of the Attorney General*.

432.403: Eligible Members

(A) (1) MassHealth Members. MassHealth covers therapist services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. 130 CMR 450.105: *Coverage Types* specifically states for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.
(2) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

432.404: Provider Eligibility: In State

Payment for the services described in 130 CMR 432.000 will be made only to therapists who are participating in MassHealth on the date of service, for services personally rendered by therapists or for services rendered by licensed therapy assistants, subject to the supervision requirements of 130 CMR 432.404(D). To participate in MassHealth as an in-state MassHealth provider, the provider must

(A) obtain a MassHealth Provider number before providing therapy services;

(B) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, and addition or deletion of a branch office;

(C) meet all applicable state and federal regulatory requirements including, but not limited to, 101 CMR 339.00: *Rates for Restorative Services*, 130 CMR 432.000, and 130 CMR 450.000: *Administrative and Billing Regulations*; and

(D) meet the applicable requirements below.
(1) Physical Therapist. A physical therapist must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as a physical therapist.
(2) Physical Therapist Assistant (PTA). A PTA must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as a PTA. PTAs must work under the supervision of a licensed physical therapist. Supervision of PTAs must be performed following state regulatory guidance. For physical therapy, *see* 259 CMR 5.00: *Physical Therapist*.
(3) Occupational Therapist. An occupational therapist must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as an occupational therapist.

432.404: continued

(4) Occupational Therapy Assistant (OTA). An OTA must be currently licensed by and in good standing with the Massachusetts Division of Professional Licensure, Board of Allied Health Professionals as an OTA. OTAs must work under the supervision of a licensed occupational therapist. Supervision of OTAs must be performed following state regulatory guidance. For occupational therapy, *see* 259 CMR 3.00: *Occupational Therapists*.

(5) Speech/Language Therapist (Speech/Language Pathologist). A speech/language pathologist must be currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-language Pathology and Audiology as a speech/language therapist or speech/language pathologist.

(6) Speech/Language Therapist Assistant (Speech/Language Pathologist Assistant (SLPA)). An SLPA must be currently licensed by and in good standing with the Massachusetts Board of Registration in Speech-language Pathology and Audiology as an SLPA. An SLPA must work under the supervision of a licensed Speech/Language pathologist. Supervision of SLPAs must be performed following state regulatory guidance. For speech/language pathology, *see* 260 CMR 10.00: *Use and Supervision of Speech-language Pathology and Audiology Assistant*.

(E) Therapy Group Practice. To participate in MassHealth as a Therapy Group Practice, a group practice

(1) must have a MassHealth provider number;

(2) must be composed of physical, occupational, or speech/language therapists (or any combination of the three), each of whom has an individual provider number;

(3) must have a physical location that meets the requirements of 130 CMR 432.406(B);

(4) must be financially viable and must at all times be able to have adequate resources to finance the provision of services; and

(5) may include PTAs, OTAs, and SLPAs who provide services subject to the supervision requirements of 130 CMR 432.404(D).

432.405: Provider Eligibility: Out of State

To participate in MassHealth, an out-of-state therapy provider must

(A) participate in the Medicaid program in the state in which it is located;

(B) be licensed by and be in good standing with their state's licensing authority;

(C) provide therapy services consistent with the provisions of 130 CMR 450.109: *Out-of-state Services*;

(D) obtain a MassHealth provider number before providing therapy services;

(E) provide services in accordance with 130 CMR 432.411: *Payable Services*; and

(F) notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the provider application in accordance with 130 CMR 450.223(B): *Provider Contract: Execution of Contract* including, but not limited to, change of ownership, change of address, and addition or deletion of a branch office.

As set forth at 130 CMR 432.411(E) and (F), the MassHealth agency pays for services provided by out-of-state therapists or by out-of-state PTAs, OTAs, and SLPAs when consistent with Medicaid requirements regarding therapy assistants in the state in which they are located, subject to the supervision requirements of 130 CMR 432.000.

432.406: Provider Responsibilities

(A) Therapy Provider Service Location Site Visits. An unscheduled therapy service location site visit may be conducted by MassHealth or its designee, to assess compliance with MassHealth rules and regulations including, but not limited to, those described in 130 CMR 432.406(B) and (C), under the following circumstances:

432.406: continued

(1) for a physical therapy services group practice or individual physical therapist who is not a Medicare provider and is newly enrolled in MassHealth; or

(2) for any MassHealth enrolled therapy provider at the sole discretion of the MassHealth agency or its designee. *See* 130 CMR 450.212: *Provider Eligibility: Eligibility Criteria*.

(B) Therapy Provider Service Location Requirements. A therapy provider service location must meet all of the following requirements:

(1) there must be a sign posted identifying the business name and hours that the service location is open;

(2) the location must be staffed with an employee during posted business hours;

(3) the location must be available to members during regular, posted business hours;

(4) all licenses, certifications, accreditations, and permits are active and visible in areas accessible to members at each provider service location;

(5) the therapy provider service location must be physically accessible to all members receiving therapy services at the service location;

(6) there must be a business telephone line with a voice message system that members are able to call;

(7) there must be written procedures and policies for maintaining and ensuring that equipment is inspected annually and is in a safe operating condition;

(8) the therapy provider service location must provide privacy to members during any therapy visit, as requested, and also offer a private space for a member and therapy provider to discuss the member's needs; and

(9) the therapy provider service location must be in compliance with applicable federal, local, and state regulations.

(C) Policy and Procedure Manual. Each therapy provider must develop, maintain, review, and comply with a comprehensive policies and procedures manual governing the delivery of therapy services, which at a minimum must address the following:

(1) human resources and personnel;

(2) a plan for ascertaining that all therapy assistants and group therapy practice health care providers have current, valid licenses;

(3) therapy group practice staff and staffing requirements;

(4) the methods for providing initial and ongoing training of personnel regarding the group therapy practice's standards, procedures, and policies including, but not limited to, standard hazardous waste disposal, emergency procedures, proper documentation, members' rights, and proper billing;

(5) staff evaluation and supervision;

(6) the mechanisms used to report and respond to violations, incident reporting, accident reports, or complaints in an appropriate manner;

(7) recognizing and reporting abuse (physical, sexual, emotional, psychological), neglect, self-neglect, and financial exploitation;

(8) Health Insurance Portability and Accountability Act (HIPAA);

(9) privacy and confidentiality;

(10) infection control and communicable disease control; and

(11) first aid and cardiopulmonary resuscitation requirements.

(D) Financial Viability Documentation. A therapy provider must, upon request, submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the therapy provider, supported by documentation to demonstrate that the therapy provider has adequate resources to finance the provision of services in accordance with 130 CMR 432.000.

432.411: Payable Services

The MassHealth agency pays for the following therapist services subject to the conditions and limitations of 130 CMR 432.000 and 130 CMR 450.000: *Administrative and Billing Regulations*:

432.411: continued

(A) individual treatment;

(B) initial therapy evaluation and reevaluations;

(C) co-treatment; and

(D) group therapy.

The MassHealth agency pays for services set forth at 130 CMR 432.411(A) through (D) when provided by therapists or by PTAs, OTAs, and SLPAs subject to the supervision requirements of 130 CMR 432.000. Service provided by supervised PTAs, OTAs, or SLPAs must be billed using the MassHealth provider ID of the supervising MassHealth-enrolled therapist.

432.412: Nonpayable Services

The MassHealth agency does not pay a therapy provider for any of the following services:

(A) indirect services such as staff meetings, staff supervision, member screening, and development or use of instructional texts and reusable treatment materials;

(B) nonmedical services such as vocational, social, and recreational services;

(C) unproven or experimental treatment, as described in 130 CMR 450.204(E);

(D) mental health services; and

(E) services provided by unlicensed persons including, but not limited to, aides and students, even if under the supervision of a licensed therapy provider.

432.413: Nonpayable Circumstances

The MassHealth agency does not pay a therapist for services provided under any of the following circumstances.

(A) The therapist provided the service in an inpatient or long-term care facility and is paid by the inpatient or long-term care facility to provide that service, whether or not the cost of the service is included in the MassHealth agency's or other payer's rate of payment for that facility.

(B) The therapist receives compensation from the state, county, or municipality, unless they are supplementing their income by providing services during off-duty hours.

(C) Under comparable circumstances, the therapist does not customarily bill private patients who do not have health insurance.

432.414: Service Limitations

(A) The MassHealth agency pays a therapist for no more than one individual treatment and one group therapy session per member per day. For further description of payable service codes and modifiers, *see* Subchapter 6 - Service Codes and Descriptions of the *Therapist Services Manual*.

(B) The MassHealth agency does not pay for a treatment claimed for the same date of service as an evaluation or reevaluation, since the evaluation or reevaluation fee includes payment both for a written report and for any treatment provided at the time of the evaluation or reevaluation.

(C) The MassHealth agency pays a therapist for providing services in a Medicare-certified long-term-care facility subject to 130 CMR 432.413(A) and only in the following circumstances:

(1) the member is not covered for therapy services under Medicare Part A or B; or

432.414: continued

(2) (a) the member is covered for therapy services under Medicare, but the facility or the therapist has submitted the claim to Medicare, and Medicare has denied payment; and
(b) the therapist has obtained prior authorization as necessary in accordance with 130 CMR 432.417.

(D) The MassHealth agency pays for the establishment of a maintenance program and the training of the member, member's family, or other persons to carry it out, as part of a regular treatment visit, not as a separate service.

(1) The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 432.414(D)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed therapist may be required to perform services that are part of a maintenance program, to ensure safety or effectiveness that may otherwise be compromised due to the member's medical condition. At the time the decision is made that the services must be performed by a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed therapist, rather than a non-therapist, must be documented in the medical record.

432.415: Prescription Requirements

(A) The MassHealth agency pays for only those treatments and evaluations for which the therapist has obtained written prescriptions from the member's prescribing provider. Electronic prescriptions (escripts) are allowable if they comply with state and federal requirements and are transmitted by the member's prescribing provider in accordance with the MassHealth agency's administrative and billing instructions.

(B) Initial Prescription. The initial prescription must be written on the prescribing provider's letterhead, must be dated prior to the initiation of the prescribed services, and must contain the following information:

(1) the member's name;
(2) the member's diagnosis that requires therapy services;
(3) the reason for the prescription;
(4) the date of the prescription; and
(5) the prescribing provider's signature and contact information, including name, NPI, and telephone number.

(C) Prescription Renewal. The MassHealth agency pays for continuing physical, occupational, or speech/language therapy only when the prescription or plan of care is signed by the member's prescribing provider every 60 days, and the therapist has obtained prior authorization from the MassHealth agency, as applicable, in accordance with 130 CMR 432.417.

(D) A prescription from the prescribing provider does not authorize payment. The therapy performed by a therapist pursuant to the evaluation described in 130 CMR 432.416 must constitute medically necessary and appropriate and effective treatment, within accepted medical standards for the member's condition.

432.416: Evaluations and Plan of Care Requirements

(A) Initial Evaluation. An initial evaluation is an in-depth assessment of a member's medical condition or disability, or both, and level of functioning to determine the need for therapy. When therapy is indicated, it is used to develop a plan of care. The evaluation is conducted by a licensed therapist in response to the prescribing provider's initial prescription for therapy services and must occur prior to the start of therapy care. The MassHealth agency will only pay for one initial evaluation relative to an initial prescription. Documentation of the therapy initial evaluation must include a written report for the member's medical record that contains at least the following information:

(1) the member's name and address;
(2) the member's diagnosis (specific and relevant to the medical condition requiring therapy services);

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(3) a list of precautions, if applicable, relevant to the member's illness, injury, or disability requiring therapy services;
(4) a medication list;
(5) a detailed treatment plan describing the type, amount, frequency, and duration of therapy and indicating the diagnosis, prognosis, anticipated goals, and location where therapy will take place, or the reason treatment is not indicated;
(6) additional health care evaluations, as indicated;
(7) a description of the member's psychosocial and health status that includes:
(a) the present effects of the member's current condition, disability, or injury/illness requiring therapy services;
(b) a brief history, the date of onset, and any past treatment of the condition, disability, or injury/illness;
(c) the member's level of functioning, including physical and functional limitations, both current and before onset of the current condition, disability or illness/injury, if applicable;
(d) any other significant physical or mental disability that may affect therapy;
(e) sensory and cognitive status, if applicable; and
(f) social supports, if applicable.
(8) identification of any current durable medical equipment (DME) used by the member;
(9) identification of any other medical/health services concurrently being provided to the member;
(10) a description of any conferences with the member, member's family, member's clinician, or other interested persons;
(11) a detailed plan of care, which must meet the conditions at 130 CMR 432.416(C);
(12) the therapist's signature and the date of the evaluation; and
(13) for speech/language therapy only:
(a) assessments of speech production skills; stimulability; receptive and expressive language skills; augmentative and alternative communication skills; fluency; and voice or swallowing;
(b) documentation of the member's cognitive linguistic functioning; and
(c) a description of the member's communication needs and motivation for therapy.

(B) Reevaluation. A reevaluation is an evaluation conducted by a licensed therapist focused on determining the member's progress toward goals identified in the plan of care, as well as making a professional judgment about continuing care, modifying goals and/or treatment, or terminating therapy services. A reevaluation is needed when there are new clinical findings, a rapid change in the individual's status, or a member's inability to respond to therapy interventions. Routine, ongoing progress notes that are part of each therapy visit are not considered reevaluations.

(C) Plan of Care. All therapy services must be provided under a plan of care established individually for the member. The plan of care must include the following:
(1) a description of the type of therapy, location where therapy will take place, anticipated frequency, length of each visit, and an estimate of the duration of the therapy services;
(2) documentation of the diagnosis, prognosis, anticipated goals, functional and measurable short- and long-term goals, and the reason therapy is needed; and
(3) dated signature of the licensed therapist who developed the plan of care.

The plan of care must be reviewed and updated at least every 60 days with the renewal of the prescription for therapy services, and more frequently as the member's condition or needs require, including any significant change that may alter the type, frequency, or duration of therapy services.

432.417: Prior Authorization

(A) General Terms.

(1) Prior authorization (PA) must be obtained from the MassHealth agency or its designee as a prerequisite to payment for visits in excess of the number of visits described in 130 CMR 432.417(B). Without such prior authorization, the MassHealth agency will not pay therapy providers for services in excess of the number of visits described in 130 CMR 432.417(B).

(2) Prior authorization determines only the medical necessity of the authorized service, and does not establish or waive any other prerequisites for payment such as member eligibility or resort to third party health insurance payment, including Medicare. The MassHealth agency or its designee acts on prior-authorization requests in accordance with 130 CMR 450.303. *See* 130 CMR 450.303: *Prior Authorization* for additional information.

(3) Approvals for prior authorization specify the number of hours, visits, or units for each service that are medically necessary and payable each calendar week and the duration of the prior authorization period. The authorization is issued in the member's name and specifies the frequency and duration of care for each service approved per calendar week.

(4) The therapy provider must submit all prior-authorization requests in accordance with 130 CMR 450.303: *Prior Authorization* and any relevant MassHealth agency instructions.

(5) In conducting prior authorization review, the MassHealth agency or its designee will apply any applicable MassHealth medical necessity guidelines and may refer the member for an independent clinical assessment to inform the determination of medical necessity for therapy services.

(6) If the number of prior-authorized services needs to be adjusted because the member's medical needs have changed, the therapy provider must request a prior authorization adjustment from the MassHealth agency or its designee.

(B) Services that Require Prior Authorization. The MassHealth agency requires that the therapist obtain prior authorization as a prerequisite to payment for the following services to eligible MassHealth members:

(1) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits but not including evaluations, for a member in a 12-month period;

(2) more than 35 speech/language therapy visits, including group-therapy visits but not including evaluations, for a member in a 12-month period; and

(3) more than two evaluations in a 12-month period.

(C) Submission Requirement. For all prior-authorization requests, the therapist must include the prescription for services that identifies the member's diagnosis, frequency, and duration of therapy services, and a description of the intended therapy intervention, as well as all forms and documentation as designated by the MassHealth agency. The therapy provider should complete a prior-authorization request for therapy services through the LTSS Provider Portal in accordance with 130 CMR 432.417(B), as applicable.

(D) Members in Capitated Programs. For those members who are enrolled in MassHealth capitated programs, the therapy provider must follow the capitated program's specific prior authorization procedures, where applicable, for therapy services.

(E) Notice of Approval, Deferral, or Denial of Prior Authorization.

(1) Notice of Approval. For all approved prior-authorization requests for therapy services, the MassHealth agency or its designee sends written notice to the member and the therapist about the frequency, duration, and intensity of care authorized, and the effective date of authorization.

(2) Notice of Denial or Modification and Right of Appeal.

(a) For all denied or modified prior-authorization requests, the MassHealth agency or its designee notifies both the member and the therapy provider of the denial or modification and the reason. In addition, the member will receive information about the member's right to appeal and the appeal procedure.

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(b) A member may request a fair hearing if the MassHealth agency or its designee denies or modifies a prior-authorization request. The member must request a fair hearing in writing within 30 days after the date of receipt of the notice of denial or modification. The Office of Medicaid Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(3) Notice of Deferral. If the MassHealth agency or its designee defers a prior-authorization request due to an incomplete submission or lack of documentation to support medical necessity, the MassHealth agency or its designee will notify the member and therapy provider of the deferral, the reason for the deferral, and provide an opportunity for the provider to submit the incomplete or missing documentation.

If the provider does not submit the required information within the timeframe specified at 130 CMR 450.303: *Prior Authorization*, the MassHealth agency or its designee will make a decision on the prior-authorization request using all documentation and forms submitted to the MassHealth agency and will send notice of its decision to the provider and the member in accordance with 130 CMR 432.417(E). *See* 130 CMR 450.303.

432.418: Recordkeeping Requirements

Payment for any service listed in 130 CMR 432.000 is conditioned upon its full and complete documentation by the provider in the member's medical record. Records must be retained by the provider in accordance with 130 CMR 450.205(G) and any other guidance provided by the MassHealth agency. The therapist is responsible for the complete documentation of therapy services provided, including therapy services provided under the therapist's supervision. The record must include the following:

(A) the prescribing provider's initial written prescription, and, if applicable, prescription renewals every 60 days (*see* 130 CMR 432.415);

(B) the written initial evaluation report and, if applicable, any subsequent reevaluation (*see* 130 CMR 432.416);

(C) the name, NPI, and telephone number of the member's prescribing provider;

(D) the written documentation for each date on which therapy was provided, including the following:

(1) the date therapy was provided;
(2) the amount of time spent in therapy;
(3) the specific therapeutic procedures and methods used;
(4) the teaching tools provided to the member, their family, or other persons;
(5) the member's response to treatment;
(6) any changes in the member's condition;
(7) the problems encountered or changes in the plan of care or goals, if any;
(8) the location where the service was provided, if different from that in the evaluation or reevaluation report;
(9) the therapist's signature and, if applicable, the signature of the licensed physical therapy assistant, the licensed occupational therapy assistant, or licensed speech/language therapy assistant; and
(10) written documentation demonstrating measurable, objective, and functional progress as a direct result of treatment, excluding those who meet criteria in 130 CMR 432.414(D).

(E) as applicable, a copy of the prior-authorization request(s), including a copy of any prior authorization forms, as designated by the MassHealth agency, and the MassHealth agency's response; and

432.418: continued

(F) documentation on the teaching provided to the member, member's family, or caregiver by the therapist on how to manage the member's treatment regimen, any ongoing teaching required due to a change in the treatment or the member's condition, and the response to the teaching; or, as applicable, documentation indicating that teaching was unsuccessful or unnecessary and why further teaching is not reasonable.

432.419: Payment for Therapy Services

The Executive Office of Health and Human Services establishes the rates payable for therapy services. *See* 101 CMR 339.00: *Rates for Restorative Services*. Payment is always subject to the conditions, exclusions, and limitations set forth in 130 CMR 432.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

432.420: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary therapy services for EPSDT-eligible members in accordance with 130 CMR 450.140 through 130 CMR 450.150, without regard to service limitations described in 130 CMR 432.000, and with prior authorization.

432.421: Quality Management and Utilization Review

(A) A therapy provider must participate in any quality management and program integrity processes as required by the MassHealth agency, including making any necessary data available and providing access to visit the therapy provider's place of business upon request by MassHealth or its designee.

(B) A therapy provider must submit requested documentation to the MassHealth agency or its designee for purposes of utilization review and provider review and audit, within the MassHealth agency's or its designee's time specifications. The MassHealth agency or its designee may periodically review a member's plan of care and other records to determine if services are medically necessary in accordance with 130 CMR 450.204: *Medical Necessity*. The therapy provider must provide the MassHealth agency or its designee with any supporting documentation the MassHealth agency or its designee requests, in accordance with M.G.L. c. 118E, § 38 and 130 CMR 450.000: *Administrative and Billing Regulations*.

432.422: Prohibited Marketing Activities

A therapy provider must not

(A) with the knowledge that a member is enrolled in a MassHealth capitated program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the MassHealth capitated program in order to retain the therapy provider to provide therapy services on a fee-for-service basis;

(B) offer to a member, or their family or caregivers, in person or through marketing, any inducement to retain the therapy provider to provide therapy services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

(C) pay a "finder's fee" to any third party in exchange for referring a member to the therapy provider; or

(D) engage in any unfair or deceptive acts or practices in connection with any marketing.

432.423: Severability

The provisions of 130 CMR 432.000 are severable. If any provision of 130 CMR 432.000 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 130 CMR 432.000 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

130 CMR 432.000: M.G.L. c. 118E, §§ 7 and 12.

Docket # 1187

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 442.000**

CHAPTER TITLE: **Orthotics Services**

AGENCY: **Division of Medical Assistance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

130 CMR 442.000 governs MassHealth providers of services related to orthotics (ORT) and provides program requirements and conditions of payment for providing ORT to MassHealth members.

REGULATORY AUTHORITY: **M.G.L. c. 118E, §§ 7 and 12**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-847-3302**

ADDRESS: **100 Hancock Street, 6th Floor, Quincy, MA 02171**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Order 145 notifications: 08-28-25
Regulatory Review approval: 08-28-25

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **10-03-25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year:

For the first five years:

No fiscal effect: **No fiscal effect**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **07-14-26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amends 130 CMR 442.000.

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

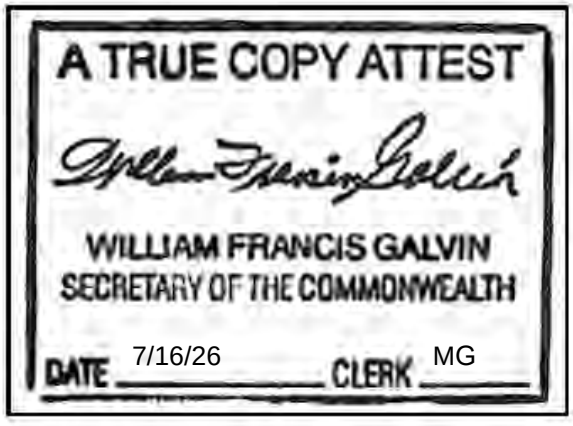
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
526.11 - 526.18	**526.11 - 526.18**



442.410: continued

(B) Hospitals. MassHealth does not pay orthotics providers for the purchase or repair of orthotics provided to a hospitalized member, except for orthotics that are prescribed for home use after discharge. The orthotics provider must document the member's discharge plan in the member's record. Documentation must indicate that the date of discharge was the date the claim was submitted for the purchase or repair of the prescribed item.

(C) Intermediate Care Facilities for the Intellectually Disabled (ICF/IID).
(1) MassHealth pays orthotics providers for the purchase and repair of custom-fabricated orthotics provided for the personal exclusive use of a member residing in an ICF/IID only if the customization precludes the use of the item by subsequent residents in that institution.
(2) MassHealth does not pay orthotic providers for the purchase or repair of orthotics that are not custom-fabricated provided to a member residing in an ICF/IID, except for therapeutic shoes for diabetics, modifications and inserts, and associated repairs, provided for the personal exclusive use of a member residing in the ICF/IID.

(D) Date of Service for Delivery to Facilities. 130 CMR 442.424 governs the date of service to be used for claims for orthotics delivered to members in facilities.

442.411: Repairs of Orthotic Products

(A) MassHealth covers repairs subject to prior authorization under 130 CMR 442.412(F). MassHealth may cover, at its discretion, repair of an item only if the repair is less than the cost to replace the item.

(B) The provider of orthotics is liable for the quality of the workmanship and parts, and for ensuring that repaired item is in proper working condition.

(C) The provider of orthotics must exhaust all manufacturer warrantees before submitting claims for repairs to orthotics to the MassHealth agency.

442.412: Prior Authorization

The orthotics provider must obtain prior-authorization (PA) from the MassHealth agency or its designee for all orthotics or orthotic services identified as subject to PA in the MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool or other guidance specified by MassHealth or its designee, or as otherwise required by 130 CMR 442.000 and 130 CMR 450.303: *Prior Authorization*. Prior authorization is a determination of medical necessity only, and does not establish or waive any other prerequisites for payment, such as member eligibility or requirements to seek payment from other liable parties.

(A) Documentation of Medical Necessity.
(1) PA requests must include:
(a) a completed MassHealth Prior Authorization Request form (the MassHealth PA-1 form adopted by MassHealth or its designee);
(b) a detailed written order that meets the requirements of 130 CMR 442.409(B);
(c) for all orthotics that are identified as requiring individual consideration (IC) in the pricing regulation, 101 CMR 334.00: *Protheses, Prosthetic Devices and Orthotic Devices* and which are also identified as subject to prior authorization in *the Orthotics and Prosthetics Payment and Guidelines Tool*, Subchapter 6, or in other guidance issued by MassHealth or its designee:
1. a copy of the original invoice, if applicable, that reflects all discounts to be applied to determine the provider's adjusted acquisition cost as defined in 101 CMR 334.02: *Prostheses, Prosthetic Devices and Orthotic Devices*; or
2. if the item has not been purchased by the provider at the time of the prior authorization request, or when the item being purchased is not an item that the provider normally purchases within its scope of business, MassHealth will accept a quote from the provider's supplier. The quote must be on the supplier's letterhead or form and must be addressed to the provider; and

442.412: continued

3. any additional assessments of the member or other necessary information requested by the MassHealth agency or its designee, in support of the request for prior authorization.

(B) 90-day Requirement for Submission of Prior Authorization Requests. The provider must submit the request for PA to MassHealth or its designee no later than 90 calendar days from the date the prescribing provider signed the detailed written order. Failure to submit the PA request within the 90-day period will result in a denial of the prior authorization request.

(C) Prior Authorization Requests for Units in Excess of the Maximum Allowable Units. MassHealth requires PA for orthotics provided to the member if the number of units requested exceeds the maximum units described in the Orthotics and Prosthetics Payment and Coverage Guidelines Tool.

(1) The provider must include documentation that supports the medical necessity of the additional units;

(2) If the PA request is authorized by MassHealth or its designee, the provider must submit a separate claim with a different date of service than the date of service for the initial maximum number of units only for the number of excess units actually provided to the member, but in no case for a number of units that exceeds the excess units for which a PA has been authorized.

(D) Prior Authorization Required before Delivery of Product. Orthotics providers must obtain prior authorization from MassHealth or its designee before delivery of a product to a MassHealth member.

(E) Prior Authorization Requests for Members Who Have Other Insurance. For members for whom MassHealth is not the primary insurer and for whom the provider is seeking payment from another insurer, the provider must make diligent efforts to first identify and obtain payment from all other liable parties, including Medicare, before seeking payment from MassHealth in accordance with 130 CMR 450.316: *Third-party Liability: Requirements*.

(F) Repairs of Orthotics. Providers must consult the Orthotics and Prosthetics Payment and Coverage Guidelines Tool, or other guidance as issued by MassHealth or its designee, to determine when PA is required for the repair of orthotics.

(1) PA is required for repairs as indicated in the Orthotics and Prosthetics Payment and Coverage Guidelines Tool, including, but not limited to, repairs exceeding $1,000:

(2) The orthotics provider must submit the following documentation with the PA request:

(a) a completed MassHealth Prior Authorization Request (the MassHealth PA-1 form, adopted by MassHealth);

(b) a detailed written order (only required if the provider requesting the repair is not the provider who initially supplied the item);

(c) an invoice or quote for the repaired or replaced item;

(d) a work order log with the estimated number of hours the repair will take;

(e) a detailed description of the circumstances that made the repair necessary; and

(f) an explanation as to why the repaired or replaced item is not covered under any warranty.

(G) Assessment. The MassHealth agency may, at its discretion, require the provider of orthotics to submit an assessment of the member's condition and the objectives of the requested service in support of a PA request. The MassHealth agency may also, at its discretion, require an evaluation by the requesting provider's ABC- or BOC-certified orthotist or pedorthist to determine whether the requested orthotic is useful to the member, given the member's physical condition and physical environment.

(H) Recordkeeping. The provider must keep the PA request on file for the period of time required by 130 CMR 450.205: *Recordkeeping and Disclosure*.

(I) Notice of Approval, Denial, or Modification of a Standard or Expedited Prior-authorization Request.

442.412: continued

(1) The MassHealth agency or its designee acts on prior authorization requests in accordance with 130 CMR 450.303: *Prior Authorization*.

(2) Notice of Approval. If the MassHealth agency, or its designee, approves a prior authorization request for orthotics, the MassHealth agency or its designee will send notice of its decision to the member and the orthotics provider, within the timeframe specified at 130 CMR 450.303: *Prior Authorization*.

(3) Notice of Denial or Modification. If the MassHealth agency, or its designee, denies or approves with a modification, a prior authorization request for orthotics, the MassHealth agency, or its designee, will notify the member and the orthotics provider, within the timeframe specified at 130 CMR 450.303: *Prior Authorization*. The notice will state the reason for the denial or modification, and will inform the member of the right to appeal and of the appeal procedure in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(4) Right of Appeal. A member may appeal a service denial or modification by requesting a fair hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(5) Notice of Deferral. If the MassHealth agency, or its designee defers a prior authorization request due to an incomplete submission or lack of documentation to support medical necessity, the MassHealth agency, or its designee will notify the orthotics provider of the deferral, and the reason for the deferral and provide an opportunity for the provider to submit the incomplete or missing documentation. If the provider does not submit the required information within the timeframe specified at 130 CMR 450.303: *Prior Authorization*, the MassHealth agency, or its designee will make a decision on the prior authorization request using all documentation and forms submitted to the MassHealth agency, and will send notice of its decision to the provider and the member in accordance with 130 CMR 442.412 (I).

442.413: Medical Necessity Criteria

(A) All orthotics covered by MassHealth must meet the medical necessity requirements set forth in 130 CMR 442.000, and 450.204: *Medical Necessity*, in the Orthotics and Prosthetics Payment and Coverage Guidelines Tool, and in any other medical necessity guidelines for specific orthotics issued by MassHealth or its designee.

(B) For items covered by MassHealth, for which there is no MassHealth item-specific medical necessity guideline and for which there is a Medicare LCD policy developed by CMS indicating Medicare coverage of the item under at least some circumstances, the provider must demonstrate medical necessity of the item consistent with the Medicare LCD. However, if the provider believes the orthotic is medically necessary even though it does not meet the criteria established by the LCD, the provider must demonstrate medical necessity under 130 CMR 450.204: *Medical Necessity*.

(C) For an item covered by MassHealth, for which there is no MassHealth item-specific medical necessity guideline and for which there is a Medicare LCD indicating that the item is not covered by Medicare, the provider must demonstrate medical necessity under 130 CMR 450.204: *Medical Necessity*.

442.414: Medicare and Other Third-party Coverage

(A) For members with Medicare and other third-party-liability coverage, *see* 130 CMR 450.316 through 450.318.

(B) When Medicare or another third-party payer denies a claim for orthotic services, the provider is required to have a MassHealth prior authorization (PA) in place for all orthotics the MassHealth agency, or its designee identifies as subject to PA in the MassHealth Orthotics and Prosthetics Payment and Coverage Guidelines Tool or other guidance specified by MassHealth or its designee, or as otherwise required by 130 CMR 442.000 or 130 CMR 450.303: *Prior Authorization*.

442.414: continued

(C) The MassHealth agency, or its designee, may request documentation of a provider's diligent efforts to collect payment from Medicare or other liable parties, including documentation of compliance with Medicare's billing and authorization requirements. If documentation requested by the MassHealth agency, or its designee is not received within the timeframe specified, or the documentation is incomplete or does not support payment by MassHealth, the associated claims will be denied. If the MassHealth agency determines that a provider did not make diligent efforts to bill other insurances and that other liable parties should have been billed, the provider will be subject to audits.

442.416: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

The MassHealth agency pays for all medically necessary orthotics or orthotic services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 442.000, and with prior authorization pursuant to 130 CMR 442.412.

442.419: Quality Management and Program Integrity

Orthotics providers shall comply with applicable CMS and MassHealth quality standards and participate in any quality measurement program requirements established by the MassHealth agency, including making any necessary data available and providing access to the provider's place of business upon request by MassHealth or its designee.

442.420: Conditions of Payment

(A) The MassHealth agency pays for orthotics in accordance with the applicable payment methodology and rate schedule established by EOHHS at 101 CMR 334.00: *Prostheses, Prosthetic Devices and Orthotic Devices*.

(B) Providers of orthotics must accept MassHealth payment as payment in full for orthotics and orthotic services according to the rates established by EOHHS at 101 CMR 334.00: *Prostheses, Prosthetic Devices and Orthotic Devices*.

(C) Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 442.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(D) An Initial Order is not a condition of payment. As set forth in 130 CMR 442.420(D)(1) through (5), a Detailed Written Order is a condition of payment. MassHealth pays for orthotics only if:

(1) the MassHealth agency, or its designee determines that the orthotics are medically necessary;
(2) the member meets the clinical eligibility criteria for the orthotics;
(3) the provider has obtained a detailed written order in accordance with 130 CMR 442.409;
(4) the provider has obtained prior authorization, if necessary, in accordance with the requirements set forth in 130 CMR 442.412; and
(5) the provider has diligently sought payment from all other liable parties in accordance with 130 CMR 442.405(I) and 130 CMR 450.000: *Administrative and Billing Regulations*.

442.421: Claims for Items Priced at Individual Consideration

The MassHealth agency will not accept a quote attached to a claim for orthotics that are identified in 101 CMR 334.00: *Prostheses, Prosthetic Devices and Orthotic Devices*; the Orthotics and Prosthetics Payment and Guidelines Tool; or in other guidance issued by MassHealth, as requiring individual consideration (I.C.). For items designated as I.C., the provider must:

(A) attach the actual manufacturer's invoice dated within six months of the prior authorization request to the claim submission;

442.421: continued

(B) not accept a printed invoice or order from a manufacturer's web site; and

(C) keep a copy of the quote and the invoice on file.

442.423: Recordkeeping Requirements

The orthotics provider must keep a record at the service facility for each member for all orthotics and orthotic services provided to a member. The record must include documentation of all purchases and repairs of all orthotics provided for each member in accordance with the recordkeeping requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. The orthotics provider must make all records retained in accordance with 130 CMR 450.205 and 130 CMR 442.000 available to the MassHealth agency or its designee upon request. Payment for services is conditioned upon the complete documentation in the member's record. In addition to fulfilling the requirements of 130 CMR 450.205, the provider must ensure that each member's record includes the following:

(A) a copy of the initial order if applicable (or written documentation of a verbal initial order) that meets the requirements set forth in 130 CMR 442.409(A) and a completed, signed, and dated detailed written order that meets the requirements set forth in 130 CMR 442.409(B) and any other applicable state or federal law or regulation;

(B) a copy of each prior authorization request submitted to the MassHealth agency or its designee on behalf of the member, including all related documentation submitted with the request, and all correspondence with the MassHealth agency or its designee and the MassHealth agency decision related to each such request;

(C) if the member has third-party liability, the provider must also maintain a copy of all documentation of their efforts to diligently seek prior authorization and payment from other liable parties;

(D) the actual invoice showing the cost to the provider of the orthotic (if the provider is not the manufacturer of the orthotic); and

(E) an acknowledgement of receipt, signed by the member or the member's representative, of the prescribed orthotics or orthotic service, including:

(1) the date of receipt of the item(s) and location of delivery;

(2) a sufficiently detailed description to identify the item(s) being delivered (such as, brand name, HCPCS code and narrative description);

(3) for repair services, a complete description of the service, including the manufacturer, and if applicable, brand name, model number, and serial number of the repaired item; and

(4) if the member's representative signs, next to the signature, an explanation of the representative's relationship to the member by the individual acknowledging receipt. This individual cannot be associated with the provider.

(a) a signature stamp and/or member's mark may be used by a MassHealth member whose disability inhibits the member's ability to write.

(b) a signature stamp may only be used by a member or the member's representative, provided that the stamp is used by the member in his or her normal course of conducting business. A signature stamp cannot be used by anyone associated with the provider.

(F) documentation demonstrating the cost of manufacturing the orthotic provided, including all raw materials (if the provider is the manufacturer);

(G) for repair services, a complete description of all repair services, including the manufacturer, brand name, and model number of the repaired item;

(H) documentation of a member's other insurance and any documentation submitted to and received from other insurers;

442.423: continued

(I) documentation of any oral or written complaints received from the member or submitted on behalf of the member in accordance with 130 CMR 442.405(Q). The documentation must include, at a minimum:

(1) the name, address, and telephone number of the member;

(2) the name, address, and telephone number of the person filing the complaint (if not the member);

(3) a summary of the complaint;

(4) the date the complaint was received by the provider;

(5) the name of the person receiving the complaint; and

(6) a summary of any investigation or actions taken by the provider of orthotics to resolve the complaint.

442.424: Delivery of Orthotics

(A) Proof of Delivery. Orthotics providers must maintain proof of delivery (POD) in the member's medical record. POD documentation must be made available to the MassHealth agency upon request. Orthotic providers may use one of three methods to deliver orthotics to the member: direct delivery; delivery *via* shipping; or delivery in anticipation of hospital discharge. The orthotics provider, in conjunction with the member or their designee, will determine the method of delivery.

(B) Timelines of Delivery. The orthotics provider must ensure that orthotics are delivered within a reasonable time after receipt of the detailed written order and any required documentation or approval for the item. This includes referring the member to another orthotics provider, when timely delivery cannot be made by the current orthotics provider. The MassHealth agency, or its designee, reserves the right to issue additional subregulatory guidance on reasonableness of delivery times for customized orthotics and specific orthotic items.

(C) Direct Delivery. The orthotics provider may deliver the orthotic product directly to the member or dispense the product to the member at the provider's service location. In this case the POD must be a signed and dated delivery slip. The POD documentation must include:

(1) member's name;

(2) sufficiently detailed description to identify the item(s) being delivered (such as, brand name, HCPCS code, narrative description);

(3) quantity delivered;

(4) date delivered; and

(5) member (or member's designee) signature and date of signature. The date of signature on the delivery slip must be the date that the orthotic product was received by the member or member's designee.

(6) In instances of direct delivery, for purposes of filing a claim for payment, the date of service on the claim must be the date the member received the orthotics, as evidenced by the date of the member's (or member's designee) signature on the delivery slip.

(D) Delivery *via* Shipping Service.

(1) Providers of orthotics may use a shipping service to deliver orthotic products;

(2) If the provider of orthotics utilizes a shipping service, the POD documentation must include a complete tracking record. An example of acceptable POD would include both the provider's own detailed shipping invoice and the shipping service's tracking information. Providers may also utilize a return postage-paid signed shipping invoice from the member or the member's designee as evidence of POD. The POD record must include:

(a) member's name;

(b) delivery address;

(c) shipping service's package identification number, provider of orthotics' invoice number or alternative method that links the provider of orthotics' delivery documents with the shipping service's records;

(d) sufficiently detailed description to identify the item(s) being delivered (*e.g.*, brand name, serial number, narrative description);

(e) quantity delivered;

442.424: continued

(f) date delivered; and
(g) evidence of delivery.

(3) If a provider of orthotics utilizes a shipping service, for purposes of filing a claim for payment, the date of service is the date the orthotics was shipped to the member.

(E) Delivery to Members in a Facility. Delivery to members in facilities and to members being discharged from facilities to a community dwelling;

(1) Delivery of orthotics products to a nursing facility or ICF/IID on behalf of a member:
(a) Providers of orthotics may deliver orthotics for a member directly to a nursing facility or ICF/IID. When the provider of orthotics delivers items directly to a nursing facility or ICF/IID, the documentation described in 130 CMR 442.424(C) is required. When a shipping service is used to deliver the item to a nursing facility or ICF/IID, the documentation described in 130 CMR 442.424(D) is required.
(b) The date of service on the claim must be the date as specified in 130 CMR 442.424(C)(2) or 130 CMR 442.424(D)(2), as applicable.

(2) Delivery in anticipation of discharge from a hospital:
(a) A provider of orthotics may deliver an orthotic product to a patient in a hospital for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's anticipated discharge.
(b) The date of service for purposes of filing a claim for payment is the date of discharge with the member's home as the place of service (POS).
(c) The provider of orthotics may not bill MassHealth for days prior to discharge, such as days the patient was receiving training or fitting in the hospital.

442.425: Prohibited Marketing Activities

An orthotic provider shall not:

(A) with the knowledge that a member is enrolled in a MassHealth capitated program, engage in any practice that would reasonably be expected to have the effect of steering or encouraging the member to disenroll from the MassHealth capitated program in order to retain the provider to provide services on a fee-for-service basis; or

(B) offer to a member, or his or her family or caregivers, in-person or through marketing, any inducement to retain the provider to provide orthotic services, such as a financial incentive, reward, gift, meal, discount, rebate, giveaway, or special opportunity;

(C) pay a "finder's fee" to any third-party in exchange for referring a member to the orthotic provider; or

(D) engage in any unfair or deceptive acts or practices in connection with any marketing.

REGULATORY AUTHORITY

130 CMR 442.000: M.G.L. c. 118E, §§ 7 and 12.

NON-TEXT PAGE

Docket # 1188

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 450.000**

CHAPTER TITLE: **Administrative and Billing Regulations**

AGENCY: **Division of Medical Assistance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

130 CMR 450.000: Administrative and Billing Regulations sets forth the administrative and billing regulations that apply to MassHealth providers and services.

REGULATORY AUTHORITY: **M.G.L. c. 118E, §§ 7 and 12**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-847-3302**

ADDRESS: **100 Hancock Street, 6th Floor, Quincy, MA 02171**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Order 145 notifications: 10-20-25
Regulatory Review approval: 07-13-26

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **12-01-25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year:

For the first five years:

No fiscal effect: **No fiscal effect**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **07-14-26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amends 130 CMR 450.000.

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
529 - 588.6	**529 - 588.6**
----------	**588.7 - 588.12**

A TRUE COPY ATTEST

WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

DATE 7/16/26 CLERK MG

130 CMR 450.000: ADMINISTRATIVE AND BILLING REGULATIONS

Section

Section: continued

450.101: Definitions

A number of common words and expressions are specifically defined here. Whenever one of them is used in 130 CMR 450.000, or in a provider contract, it will have the meaning given in the definition, unless the context clearly requires a different meaning. When appropriate, definitions may include a reference to federal and state laws and regulations.

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

Accountable Care Partnership Plan. A type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO) and is organized primarily for the purpose of providing health care services.

Administrative Action. A measure taken by the MassHealth agency to correct or prevent the recurrence of an unacceptable course of action by a provider, including but not limited to the imposition of an administrative fine or other sanction.

450.101: continued

Applicant. A person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Audit. An examination by the MassHealth agency of a provider's practices by means of an on-site visit, a review of the MassHealth agency's claim and payment records, a review of a provider's financial, medical, and other records such as prior authorizations, invoices, and cost reports. The MassHealth agency conducts audits to ensure provider and member compliance with laws and regulations governing MassHealth.

Behavioral Health Contractor. The entity contracted with EOHHS to provide, arrange for, and coordinate behavioral health care and other services to members on a capitated basis.

Behavioral Health Services. Mental health and substance use disorder services.

Billing Agent. Any individual or entity that contracts with a provider to act as the provider's representative for the preparation and submission of claims.

Board of Hearings (BOH). The designated hearing unit within the Executive Office of Health and Human Services Office of Medicaid.

Claim. A request by a provider for payment for a medical service or product, identified in a format approved by the MassHealth agency, that contains information including member and provider information, date of service, and description of service provided.

Coverage Type. A scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria.

Day. A calendar day unless a business day is specified.

Eligibility Verification System (EVS). The member eligibility verification system accessible to providers. EVS also may be referred to as the Recipient Eligibility Verification System (REVS).

Emergency Aid to the Elderly, Disabled and Children Program (EAEDC). A cash assistance program administered by the Department of Transitional Assistance for certain residents of Massachusetts that also covers certain medical services. The medical services component of the program is administered by the MassHealth agency.

Emergency Medical Condition. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services. Medical services that are provided by a provider that is qualified to provide such services, and are needed to evaluate or stabilize an emergency medical condition.

Expedited Prior Authorization Decision. If the MassHealth agency receives an appropriately submitted and completed prior authorization request and determines that following the prior authorization request decision time periods in 130 CMR 450.303(A) could seriously jeopardize the member's life or health, or if an expedited prior authorization decision is required by law, the MassHealth agency shall issue a prior authorization decision within 72 hours after receiving the prior authorization request.

Final Disposition. A written response by a health insurer to a request for payment, such as a rejection notice, an explanation of benefits (EOB), or a similar letter, form, or other notice, by which the insurer either denies coverage, or acknowledges coverage and indicates the amount that the health insurer will pay.

450.101: continued

Group Practice. A legal entity that employs or contracts with individual practitioners who have arranged for the joint use of facilities, and for payment into a common account of proceeds from the delivery of medical services by individual practitioners within the group. A sole proprietorship is not a group practice. An entity that qualifies under the MassHealth agency's program regulations as another discreet provider type, such as a community health center, is not a group practice. A "participant" in a group practice is any owner, employee, contractor, or provider delivering services through the group practice.

Health Insurer. A private or public entity (including Medicare) that has issued a health insurance plan or policy under which it has agreed to pay for medical services provided to a member.

Individual Practitioners. Physicians, dentists, psychologists, certified nurse practitioners, certified nurse midwives, physician assistants, certified registered nurse anesthetists, psychiatric clinical nurse specialists, clinical nurse specialists, and certain other licensed, registered, or certified medical practitioners.

Managed Care. A system of primary care and other medical services that are provided and coordinated by a MassHealth managed care provider, a One Care Plan, a SCO Plan, or the behavioral health contractor in accordance with the provisions of 130 CMR 450.117 and 130 CMR 508.000: MassHealth: *Managed Care Requirements*.

Managed Care Organization (MCO). Any entity with which the MassHealth agency contracts under its MCO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO), and is organized primarily for the purpose of providing health care services.

MassHealth. The medical assistance and benefit programs administered by the MassHealth agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396a), Title XXI of the Social Security Act (42 U.S.C. 1397aa), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Agency. The Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

MassHealth Enrollment Center (MEC). A regional office of the MassHealth agency that determines MassHealth eligibility of individuals and families who do not receive cash assistance (TAFDC, EAEDC, SSI).

MassHealth Managed Care Provider. An MCO, Accountable Care Partnership Plan, Primary Care ACO, or the Primary Care Clinician Plan.

MCO-administered ACO. A type of ACO with which the MassHealth agency contracts under its ACO program and which is administered through an MCO.

Medicaid. *See* MassHealth.

Medical Services. Medical care or related goods and services, including behavioral health services and long-term services and supports (LTSS) provided to members, paid or payable by the MassHealth agency.

Medicare. A federally administered health insurance program for persons eligible under the Health Insurance for the Aged Act, Title XVIII of the Social Security Act.

Member. A person determined by the MassHealth agency to be eligible for MassHealth.

450.101: continued

One Care Plan. An entity with which the MassHealth agency contracts under its One Care Program to provide care coordination and integrated medical care, behavioral health care, and long-term services and supports through a comprehensive provider network to dual eligible members ages 21 to 64 at the time of enrollment. One Care Plans are responsible for providing enrolled members with the full continuum of MassHealth and Medicare covered services. One Care Plans were previously referred to as integrated care organizations (ICOs).

Overpayment. A payment made by the MassHealth agency to or for the use of a provider to which the provider was not entitled under applicable federal or state law or regulation.

Over-the-counter Drug. Any drug for which no prescription is required by federal or state law. These drugs are sometimes referred to as nonlegend drugs.

Party in Interest. A person with an ownership or control interest.

Peer Review. An evaluation of the quality, necessity, and appropriateness of medical services provided by a provider, to determine compliance with professionally recognized standards of health care or compliance with laws, rules, and regulations under which MassHealth is administered.

Prescription Drug. Any drug for which a prescription is required by applicable federal or state law or regulation, other than MassHealth regulations. These drugs are sometimes referred to as legend drugs.

Primary Care. The provision of coordinated, comprehensive medical services, on both a first-contact and a continuous basis, to members enrolled in managed care. Services include an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

Primary Care ACO. A type of ACO with which the MassHealth agency contracts under its ACO program.

Primary Care Clinician (PCC) Plan. A managed care option administered by the MassHealth agency through which enrolled members receive primary care and certain other medical services.

Provider. An individual, group, facility, agency, institution, organization, or business that furnishes medical services and participates in MassHealth under a provider contract with the MassHealth agency. For purposes of applying 130 CMR 450.235 through 450.240, the term "provider" includes formerly participating providers.

Provider Contract (Also Referred to as "Provider Agreement"). A contract for medical services between the MassHealth agency and a provider.

Provider Service Restrictions. Sanctions placed by the MassHealth agency on a provider that include, but are not limited to, restrictions on services for which a provider may submit claims to and receive payment from the MassHealth agency, and restrictions on the number or particular members to whom a provider may provide services.

Provider Type. A provider classification specifying and limiting the kinds of medical services for which the provider may be paid by the MassHealth agency.

Provider under Common Ownership. Two or more providers in which a person or corporation has or had, at any time, an ownership or control interest, whether concurrently, sequentially, or otherwise. (*See* 130 CMR 450.221(A)(9)(a) and (b).)

Sanction. An administrative penalty imposed by the MassHealth agency pursuant to M.G.L. c. 118E, § 37 against a provider found to have violated MassHealth laws, regulations, or contract requirements. Sanctions include, but are not limited to, administrative fines, provider service restrictions, suspension, and termination from participation in MassHealth.

450.101: continued

Senior Care Options (SCO) Plan. An entity with which the MassHealth agency contracts under the SCO Program to provide coordinated care and medical services, behavioral health care, and long-term services and supports through a comprehensive network to dual eligible members 65 years of age or older. SCO Plans are responsible for providing enrolled members with the full continuum of MassHealth and Medicare covered services.

Standard Prior Authorization Decision. A prior authorization decision that is not an expedited prior authorization decision. For standard prior authorization decisions, the MassHealth agency acts on appropriately completed and submitted prior authorization requests within the times specified in 130 CMR 450.303(A). Except where an expedited prior authorization decision is required by law, incomplete or inappropriately submitted prior authorization requests will be acted on in accordance with 130 CMR 450.303(C)(2).

Statutory Prerequisite. Any license, certificate, permit, or other requirement imposed by state or federal law or regulation as a precondition to the practice of any profession or to the operation of any business or institution in or by which medical services are provided. Statutory pre-requisites include, but are not limited to, licenses required by the Massachusetts Department of Public Health or the Massachusetts Department of Mental Health, licenses and certificates issued by the Massachusetts boards of registration, and certificates required by the Massachusetts Department of Public Safety.

Third Party. Any individual, entity, or program other than the MassHealth agency that is or may be liable to pay for the provision of medical services in whole or in part.

Transitional Aid to Families with Dependent Children (TAFDC). A federally funded program administered by the Massachusetts Department of Transitional Assistance that provides cash assistance to certain low-income families.

Urgent Care. Medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition.

450.102: Purpose of 130 CMR 400.000 through 499.000

130 CMR 400.000 through 499.000 contain the MassHealth agency's regulations specific to provider participation in, and the medical services and benefits available under, MassHealth and the Emergency Aid to the Elderly, Disabled and Children Program. 130 CMR 450.000 applies to all MassHealth providers and services. The MassHealth agency also promulgates other regulations, and publishes other documents affecting these programs, including other chapters in 130 CMR, statements of policy and procedure, conditions of participation, guidelines, billing and claims submission instructions, provider bulletins, and other documents referenced in 130 CMR. In addition, the regulations in 130 CMR frequently refer to federal regulations, to regulations of the Massachusetts Department of Public Health and other agencies, and to rates and fee schedules established by the Massachusetts Executive Office of Health and Human Services.

450.103: Promulgation of Regulations

(A) All regulations of the MassHealth agency are promulgated in accordance with M.G.L. c. 30A. In the event of any conflict between the MassHealth agency's regulations and applicable federal laws and regulations, the MassHealth agency's regulations will be construed so far as possible to make them consistent with such federal laws and regulations.

(B) Without limiting the generality of 130 CMR 450.103(A), the MassHealth agency's regulations will be construed so far as possible to make them consistent with the federal Health Insurance Portability and Accountability Act (HIPAA), including federal regulations promulgated thereunder. To implement and comply with HIPAA, the MassHealth agency may issue billing and claims submission instructions, provider bulletins, companion guides, or other materials, which will be effective and controlling notwithstanding any MassHealth agency regulations to the contrary.

450.105: Coverage Types

A member is eligible for services and benefits according to the member's coverage type. Each coverage type is described in 130 CMR 450.105(A) through (H). Payment for the covered services listed in 130 CMR 450.105 is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment. *See* individual program regulations and managed care contracts and performance specifications for information on covered services and specific service limitations, including age restrictions applicable to certain services.

(A) MassHealth Standard.

(1) Covered Services. The following services are covered for MassHealth Standard members (*see* 130 CMR 505.002: *MassHealth Standard* and 130 CMR 519.002: *MassHealth Standard*):

(a) abortion services;
(b) acupuncture services;
(c) adult day health services;
(d) adult foster care/group adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health services;
(i) certified nurse midwife services;
(j) certified nurse practitioner services;
(k) certified registered nurse anesthetist services;
(l) Chapter 766: home assessments and participation in team meetings;
(m) chiropractor services;
(n) clinical nurse specialist services;
(o) community health center services;
(p) day habilitation services;
(q) dental services;
(r) doula services;
(s) durable medical equipment and supplies;
(t) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services in accordance with 130 CMR 450.140;
(u) early intervention services;
(v) family planning services;
(w) freestanding birth center services;
(x) hearing aid services;
(y) home health services;
(z) homeless medical respite services;
(aa) hospice services;
(bb) independent nurse (private duty nursing) and continuous skilled nursing agency services;
(cc) inpatient hospital services;
(dd) laboratory services;
(ee) nursing facility services;
(ff) orthotic services;
(gg) outpatient hospital services;
(hh) oxygen and respiratory therapy equipment;
(ii) personal care services;
(jj) pharmacy services;
(kk) physician services;
(ll) physician assistant services;
(mm) podiatrist services;
(nn) prosthetic services;
(oo) psychiatric clinical nurse specialist services;
(pp) rehabilitation services;
(qq) renal dialysis services;
(rr) speech and hearing services;
(ss) therapy services: physical, occupational, and speech/language;

450.105: continued

(tt) transportation services;
(uu) urgent care clinic services;
(vv) vision care; and
(ww) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth Standard members may be enrolled in managed care in accordance with 130 CMR 508.001: *MassHealth Member Participation in Managed Care*. (*See* also 130 CMR 450.117.)

(3) MCOs, Accountable Care Partnership Plans, One Care Plans, and SCO Plans. For MassHealth Standard members who are enrolled in an MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan, 130 CMR 450.105(A)(3)(a) and (b) apply.

(a) The MassHealth agency does not pay a provider other than the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan for any services that are covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan except for family planning services that were not provided or arranged for by the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan. It is the provider's responsibility to determine whether a MassHealth member is enrolled in an MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan and to verify the scope of services covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan. Payment for such services is subject to the terms of the managed care contracts, including but not limited to provisions governing service authorization, performance specifications, provider networks, and billing requirements.

(b) The MassHealth agency pays providers for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan in accordance with applicable MassHealth regulations. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral Health Services.

(a) MassHealth Standard members enrolled in the PCC Plan or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor, in accordance with the MassHealth agency's contract with the behavioral health contractor. (*See* 130 CMR 450.124.)

(b) MassHealth Standard members enrolled in an MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan receive behavioral health services only through the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan, in accordance with the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan. (*See* 130 CMR 450.117.)

(c) MassHealth Standard members who are not enrolled in an MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services in accordance with applicable MassHealth regulations.

(d) MassHealth Standard members who are enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E) receive behavioral health services only through the MassHealth behavioral health contractor, in accordance with the MassHealth agency's contract with the behavioral health contractor. (*See* 130 CMR 450.124.)

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth Standard members, with the exception of members described at 130 CMR 505.002(F): *Individuals with Breast or Cervical Cancer*, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(A)(1) that are not available through the member's third-party health insurer.

(B) MassHealth CarePlus.

(1) Covered Services. The following services are covered for MassHealth CarePlus members (*see* 130 CMR 505.008: *MassHealth CarePlus*):

(a) abortion services;
(b) acupuncture services;
(c) ambulance services;
(d) ambulatory surgery services;

450.105: continued

(e) audiologist services;
(f) behavioral health services;
(g) certified nurse midwife services;
(h) certified nurse practitioner services;
(i) certified registered nurse anesthetist services;
(j) chiropractor services;
(k) clinical nurse specialist services;
(l) community health center services;
(m) dental services;
(n) doula services;
(o) durable medical equipment and supplies;
(p) family planning services;
(q) freestanding birth center services;
(r) hearing aid services;
(s) home health services;
(t) homeless medical respite services;
(u) hospice services;
(v) inpatient hospital services;
(w) laboratory services;
(x) nursing facility services;
(y) orthotic services;
(z) outpatient hospital services;
(aa) oxygen and respiratory therapy equipment;
(bb) pharmacy services;
(cc) physician services;
(dd) physician assistant services;
(ee) podiatrist services;
(ff) prosthetic services;
(gg) psychiatric clinical nurse specialist services;
(hh) rehabilitation services;
(ii) renal dialysis services;
(jj) speech and hearing services;
(kk) therapy services: physical, occupational, and speech/language;
(ll) transportation services;
(mm) urgent care clinic services;
(nn) vision care; and
(oo) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth CarePlus members may be enrolled in managed care in accordance with 130 CMR 508.001: *MassHealth Member Participation in Managed Care*. (*See* also 130 CMR 450.117.)

(3) MCOs and Accountable Care Partnership Plans. For MassHealth CarePlus members who are enrolled in an MCO or Accountable Care Partnership Plan, the following rules apply.

(a) The MassHealth agency does not pay a provider other than the MCO or Accountable Care Partnership Plan for any services that are covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan, except for family planning services that were not provided or arranged for by the MCO or Accountable Care Partnership Plan. It is the provider's responsibility to determine whether a MassHealth member is enrolled in an MCO or Accountable Care Partnership Plan and to verify the scope of services covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan. Payment for such services is subject to the terms of the managed care contracts, including but not limited to provisions governing service authorization, performance specifications, provider networks, and billing requirements.

(b) The MassHealth agency pays providers other than the MCO or Accountable Care Partnership Plan for those services listed in 130 CMR 450.105(B)(1) that are not covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan in accordance with applicable MassHealth regulations. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

450.105: continued

(4) Behavioral Health Services.

(a) MassHealth CarePlus members enrolled in the PCC Plan or Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor, in accordance with the MassHealth agency's contract with the behavioral health contractor. (*See* 130 CMR 450.124.)

(b) MassHealth CarePlus members enrolled in an MCO or Accountable Care Partnership Plan receive behavioral health services only through the MCO or Accountable Care Partnership Plan, in accordance with the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan. (*See* 130 CMR 450.117.)

(c) MassHealth CarePlus members who are not enrolled in an MCO, Accountable Care Partnership Plan, or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services, in accordance with applicable MassHealth regulations.

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for MassHealth CarePlus members, with the exception of members described at 130 CMR 505.002(F): *Individuals with Breast or Cervical Cancer*, if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(B)(1) that are not available through the member's third-party health insurer.

(C) MassHealth Buy-In.

(1) For a MassHealth Buy-In member who is 65 years of age or older or is institutionalized (*see* 130 CMR 519.011*: MassHealth Buy-In*), the MassHealth agency pays all of the member's Medicare Part B premium. The MassHealth agency does not pay for any other benefit for these members.

(2) MassHealth Buy-In members are responsible for payment of copayments, coinsurance, and deductibles. MassHealth Buy-In members are also responsible for payment for any services that are not covered by the member's insurance.

(3) The MassHealth agency does not pay providers directly for any services provided to any MassHealth Buy-In member, and therefore does not issue a MassHealth card to MassHealth Buy-In members.

(4) MassHealth Buy-In members are excluded from participation with any MassHealth managed care provider pursuant to 130 CMR 508.002(A): *MassHealth Managed Care Provider*.

(D) MassHealth Senior Buy-In.

(1) Covered Services. For MassHealth Senior Buy-In members (*see* 130 CMR 519.010: *MassHealth Senior Buy-In*), the MassHealth agency pays the member's Medicare Part B premiums, and where applicable, Medicare Part A premiums. The MassHealth agency also pays for coinsurance and deductibles under Medicare Parts A and B.

(2) Managed Care Member Participation. MassHealth Senior Buy-In members are excluded from participation with a MassHealth managed care provider pursuant to 130 CMR 508.002(A): *MassHealth Managed Care Provider*.

(E) MassHealth CommonHealth.

(1) Covered Services. The following services are covered for MassHealth CommonHealth members (*see* 130 CMR 505.004: *MassHealth CommonHealth* and 130 CMR 519.012: *MassHealth CommonHealth*):

(a) abortion services;
(b) acupuncture services;
(c) adult day health services;
(d) adult foster care/group adult foster care services;
(e) ambulance services;
(f) ambulatory surgery services;
(g) audiologist services;
(h) behavioral health services;
(i) certified nurse midwife services;
(j) certified nurse practitioner services;
(k) certified registered nurse anesthetist services;

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(l) Chapter 766: home assessments and participation in team meetings;
(m) chiropractor services;
(n) clinical nurse specialist services;
(o) community health center services;
(p) day habilitation services;
(q) dental services;
(r) doula services;
(s) durable medical equipment and supplies;
(t) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services in accordance with 130 CMR 450.140;
(u) early intervention services;
(v) freestanding birth center services;
(w) family planning services;
(x) hearing aid services;
(y) home health services;
(z) homeless medical respite services;
(aa) hospice services;
(bb) independent nurse (private duty nursing) and continuous skilled nursing agency services;
(cc) inpatient hospital services;
(dd) laboratory services;
(ee) nursing facility services;
(ff) orthotic services;
(gg) outpatient hospital services;
(hh) oxygen and respiratory therapy equipment;
(ii) personal care services;
(jj) pharmacy services;
(kk) physician services;
(ll) physician assistant services;
(mm) podiatrist services;
(nn) prosthetic services;
(oo) psychiatric clinical nurse specialist services;
(pp) rehabilitation services;
(qq) renal dialysis services;
(rr) speech and hearing services;
(ss) therapy services: physical, occupational, and speech/language;
(tt) transportation services;
(uu) urgent care clinic services;
(vv) vision care; and
(ww) X-ray/radiology services.

(2) Managed Care Member Participation. MassHealth CommonHealth members may be enrolled in managed care in accordance with 130 CMR 508.001: *MassHealth Member Participation in Managed Care*. (*See* also 130 CMR 450.117.)

(3) MCOs, Accountable Care Partnership Plans, and One Care Plans. For MassHealth CommonHealth members who are enrolled in an MCO, Accountable Care Partnership Plan, or One Care Plan, 130 CMR 450.105(E)(3)(a) and (b) apply.

(a) The MassHealth agency does not pay a provider other than the MCO, Accountable Care Partnership Plan, or One Care Plan for any services that are covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or One Care Plan, except for family planning services that were not provided or arranged for by the MCO, Accountable Care Partnership Plan, or One Care Plan. It is the provider's responsibility to determine whether a MassHealth member is enrolled in an MCO, Accountable Care Partnership Plan, or One Care Plan and to verify the scope of services covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or One Care Plan. Payment for such services is subject to the terms of the managed care contracts, including but not limited to provisions governing service authorization, performance specifications, provider networks, and billing requirements.

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(b) The MassHealth agency pays providers other than the MCO, Accountable Care Partnership Plan, or One Care Plan for those services listed in 130 CMR 450.105(E)(1) that are not covered by the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or One Care Plan in accordance with applicable MassHealth regulations. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(4) Behavioral Health Services.

(a) MassHealth CommonHealth members enrolled in the PCC Plan or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor, in accordance with the MassHealth agency's contract with the behavioral health contractor. (*See* 130 CMR 450.124.)

(b) MassHealth CommonHealth members enrolled in an MCO, Accountable Care Partnership Plan, or One Care Plan receive behavioral health services only through the MCO, Accountable Care Partnership Plan, or One Care Plan, in accordance with the MassHealth agency's contract with the MCO, Accountable Care Partnership Plan, or One Care Plan. (*See* 130 CMR 450.117.)

(c) MassHealth CommonHealth members who are not enrolled in an MCO, Accountable Care Partnership Plan, or One Care Plan or with the behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services in accordance with applicable MassHealth regulations.

(d) MassHealth CommonHealth members who are enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E) receive behavioral health services only through the MassHealth behavioral health contractor, in accordance with the MassHealth agency's contract with the behavioral health contractor. (*See* 130 CMR 450.124.)

(5) Purchase of Health Insurance. The MassHealth agency may purchase third-party health insurance for any MassHealth CommonHealth member if the MassHealth agency determines such premium payment is cost effective. Under such circumstances, the MassHealth agency pays a provider only for those services listed in 130 CMR 450.105(E)(1) that are not available through the member's third-party health insurer.

(F) MassHealth Limited.

(1) Covered Services. For MassHealth Limited members (*see* 130 CMR 505.006: *MassHealth Limited* and 130 CMR 519.009: *MassHealth Limited*), the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in

(a) placing the member's health in serious jeopardy;

(b) serious impairment to bodily functions; or

(c) serious dysfunction of any bodily organ or part.

(2) Organ Transplants. Pursuant to 42 U.S.C. 1396b(v)(2), the MassHealth agency does not pay for an organ transplant procedure, or for care and services related to that procedure, for MassHealth Limited members, regardless of whether such procedure would otherwise meet the requirements of 130 CMR 450.105(F)(1).

(3) Managed Care Member Participation. MassHealth Limited members are excluded from participation in managed care pursuant to 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care*.

(G) MassHealth Family Assistance.

(1) Premium Assistance. The MassHealth agency provides benefits for MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B), (C), or (D).

(a) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B) and (C), the only benefit the MassHealth agency provides is partial payment of the member's employer-sponsored health insurance, except as provided in 130 CMR 450.105(H).

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(b) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 and Less than or Equal to 300% of the Federal Poverty Level*, the MassHealth agency provides dental services as described in 130 CMR 420.000: *Dental Services*.

(c) For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(D): *Eligibility Requirements for Adults and Young Adults Aged 19 and 20 Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300% of the Federal Poverty Level,* the MassHealth agency issues a MassHealth card and provides

1. full payment of the member's private health insurance premium; and
2. coverage of any services listed in 130 CMR 450.105(H) not covered by the member's private health insurance. Coverage includes payment of copayments, coinsurance, and deductibles required by the member's private health insurance.

(2) Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance.

(a) For children who meet the requirements of 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 and Less than or Equal to 300% of the Federal Poverty Level*, the MassHealth agency pays providers directly, or reimburses the member, for

1. copayments, coinsurance, and deductibles relating to well-baby and well-child care; and
2. copayments, coinsurance, and deductibles for services covered under the member's employer-sponsored health insurance once the member's family has incurred and paid copayments, coinsurance, and deductibles for eligible members that equal or exceed 5% of the family group's annual gross income.

(b) Providers should check the Eligibility Verification System (EVS) to determine whether the MassHealth agency will pay a provider directly for a copayment, coinsurance, or deductible for a specific MassHealth Family Assistance member.

(3) Covered Services for Members Who Are Not Receiving Premium Assistance. For MassHealth Family Assistance members who meet the eligibility requirements of 130 CMR 505.005(B), (E), (F), or (G), the following services are covered:

(a) abortion services;
(b) acupuncture services;
(c) ambulance services (emergency only);
(d) ambulatory surgery services;
(e) audiologist services;
(f) behavioral health services;
(g) certified nurse midwife services;
(h) certified nurse practitioner services;
(i) certified registered nurse anesthetist services;
(j) Chapter 766: home assessments and participation in team meetings;
(k) chiropractor services;
(l) chronic disease and rehabilitation hospital services;
(m) clinical nurse specialist services;
(n) community health center services;
(o) dental services;
(p) doula services;
(q) durable medical equipment and supplies;
(r) preventive pediatric health care screening and diagnosis (PPHSD) in accordance with 130 CMR 450.150;
(s) early intervention services;
(t) freestanding birth center services;
(u) family planning services;
(v) hearing aid services;
(w) home health services;
(x) homeless medical respite services;
(y) hospice services;

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(z) inpatient hospital services;
(aa) laboratory services;
(bb) nursing facility services;
(cc) orthotic services;
(dd) outpatient hospital services;
(ee) oxygen and respiratory therapy equipment;
(ff) pharmacy services;
(gg) physician services;
(hh) physician assistant services;
(ii) podiatrist services;
(jj) prosthetic services;
(kk) psychiatric clinical nurse specialist services;
(ll) rehabilitation services;
(mm) renal dialysis services;
(nn) speech and hearing services;
(oo) therapy services: physical, occupational, and speech/language;
(pp) urgent care clinic services;
(qq) vision care; and
(rr) X-ray/radiology services.

(4) Managed Care Participation. MassHealth Family Assistance members may be enrolled in managed care in accordance with 130 CMR 508.001: *MassHealth Member Participation in Managed Care*. (*See* also 130 CMR 450.117.)

(5) MCOs and Accountable Care Partnership Plans. For MassHealth Family Assistance members who are enrolled in an MCO or Accountable Care Partnership Plan, 130 CMR 450.105(G)(5)(a) and (b) apply.

(a) The MassHealth agency does not pay a provider other than the MCO or Accountable Care Partnership Plan for any services that are covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan, except for family planning services that were not provided or arranged for by the MCO or Accountable Care Partnership Plan. It is the provider's responsibility to determine whether a MassHealth member is enrolled in an MCO or Accountable Care Partnership Plan and to verify the scope of services covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan. Payment for such services is subject to the terms of the managed care contracts including, but not limited to, provisions governing service authorization, performance specifications, provider networks, and billing requirements.

(b) The MassHealth agency pays providers other than the MCO or Accountable Care Partnership Plan for those services listed in 130 CMR 450.105(H) that are not covered by the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan in accordance with applicable MassHealth regulations. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(6) Behavioral Health Services.

(a) MassHealth Family Assistance members enrolled in the PCC Plan or a Primary Care ACO receive behavioral health services only through the MassHealth behavioral health contractor, in accordance with the MassHealth agency's contract with the behavioral health contractor. (*See* 130 CMR 450.124.)

(b) MassHealth Family Assistance members enrolled in an MCO or Accountable Care Partnership Plan receive behavioral health services only through the MCO or Accountable Care Partnership Plan, in accordance with the MassHealth agency's contract with the MCO or Accountable Care Partnership Plan. (*See* 130 CMR 450.117.)

(c) MassHealth Family Assistance members who are not receiving premium assistance, and are not enrolled in an MCO, Accountable Care Partnership Plan, or with the MassHealth behavioral health contractor may receive behavioral health services from any participating MassHealth provider of such services in accordance with applicable MassHealth regulations.

(H) Children's Medical Security Plan. Children determined to be eligible for the Children's Medical Security Plan (CMSP) receive benefits described in 130 CMR 522.004(G): *Benefits Provided*.

450.107: Eligible Members and the MassHealth Card

(A) Eligibility Determination. MassHealth eligibility is determined in accordance with 130 CMR 501.000: *MassHealth: General Policies* through 130 CMR 522.000: *MassHealth: Other Division Programs*. Eligibility for the EAEDC Program is determined pursuant to 106 CMR 320.000 through 321.000, 701.000 through 701.600, 705.000 through 705.950, and 706.000 through 706.710.

(B) Eligibility Verification System. The MassHealth agency uses the Eligibility Verification System (EVS) for day-specific eligibility verification, and to communicate a member's MassHealth eligibility, coverage type, managed care status, restrictions, and other insurance information to health-care providers.

(C) MassHealth Card. The MassHealth agency issues a plastic identification card for most MassHealth members. The MassHealth card contains information necessary to access EVS. Members for whom the MassHealth agency pays health insurance premiums only may not have a MassHealth card.

(D) Temporary MassHealth Eligibility Card. When necessary, the MassHealth agency or the Department of Transitional Assistance will issue a temporary MassHealth card to the cardholder for use until a plastic MassHealth card is issued. The temporary MassHealth card shows dates of eligibility, service restrictions, and other insurance information. If a discrepancy occurs between information given on a temporary MassHealth card and by EVS, the information on the temporary card prevails. To be paid for a covered service that was provided based on information given on a temporary card, a provider must produce a copy of the temporary card, and have otherwise met all other prerequisites for payment.

(E) Provisional Eligibility. The MassHealth agency will provide eligibility while the applicant provides to the MassHealth agency any outstanding verification, in accordance with 130 CMR 502.003: *Verification of Eligibility Factors*.

450.108: Selective Contracting

(A) Use of Selective Contracts. The MassHealth agency may provide some services through selective contracts where such contracts are permitted by federal and state law.

(B) Termination of Provider Contracts. The MassHealth agency may terminate, in whole or in part, existing provider contracts where selective contracts are in effect. In the event of any such termination, the MassHealth agency notifies the affected providers in writing, at least 30 days prior to termination. Such termination does not affect payments to providers for services provided prior to the date of termination.

450.109: Out-of-state Services

(A) MassHealth covers services provided in another state to a MassHealth member, subject to all applicable limitations, including service coverage, prior authorization, and provider enrollment, only in the following circumstances:

(1) medical services are needed because of a medical emergency;

(2) medical services are needed and the member's health would be endangered if the member were required to travel to Massachusetts;

(3) it is the general practice for members in a particular locality to use medical resources in another state; or

(4) the MassHealth agency determines on the basis of medical advice that the needed medical services, or necessary supplementary resources, are more readily available in the other state.

(B) MassHealth does not cover services provided outside the United States and its territories.

450.110: Hospital-determined Presumptive Eligibility

(A) The MassHealth agency provides coverage for certain individuals for a limited period of time, in accordance with 130 CMR 502.003(H): *Hospital-determined Presumptive Eligibility* if, on the basis of attested information, a qualified hospital determines that the individual is presumptively eligible. Coverage for members with time-limited presumptive eligibility begins on the date on which a qualified hospital makes a determination regarding presumptive eligibility and continues until

(1) the end of the month following the month in which the hospital-determined presumptive eligibility, if the individual has not submitted a complete application as described in 130 CMR 502.001: *Application for Benefits* by that date, or

(2) an eligibility determination is made based upon the individual's submission of a complete application as described in 130 CMR 502.001: *Application for Benefits* if the complete application was submitted prior to the end of the month following the month of the hospital presumptive eligibility determination.

(B) A qualified hospital, for purposes of 130 CMR 450.110, is a hospital that satisfies the following requirements, as more fully described in provider bulletins and other guidance that may be issued by the MassHealth agency:

(1) participates as a MassHealth provider;

(2) notifies the MassHealth agency of its election to make presumptive eligibility determinations;

(3) agrees to make presumptive eligibility determinations consistent with MassHealth policies and procedures;

(4) has Certified Application Counselors on-site and available to assist individuals with the application process, including submitting the full application and understanding any documentation requirements; and

(5) has not been disqualified from making presumptive eligibility determinations.

450.112: Advance Directives

(A) Provider Participation. All hospitals, nursing facilities, MCOs, Accountable Care Partnership Plans, One Care Plans, SCO Plans, home health agencies, personal care agencies, hospices, and the MassHealth behavioral health contractor must

(1) provide to all adults 18 years of age or older, who are receiving medical care from the provider, the following written information concerning their rights, which information must reflect changes in state law as soon as possible, but no later than 90 days after the effective date of the change to

(a) make decisions concerning their medical care;

(b) accept or refuse medical or surgical treatment; and

(c) formulate advance directives (for example, living wills or durable powers of attorney for health care, or health-care proxy designations);

(2) provide written information to all adults about the provider's policies concerning implementation of these rights;

(3) document in the patient's medical record whether the patient has executed an advance directive;

(4) not condition the provision of care or otherwise discriminate against a patient based on whether that patient has executed an advance directive;

(5) ensure compliance with requirements of state law concerning advance directives; and

(6) educate staff and the community on advance directives.

(B) When Providers Must Give Written Information to Adults.

(1) A hospital must give written information at the time of the person's admission as an inpatient.

(2) A nursing facility must give information at the time of the person's admission as a resident.

(3) A provider of home health care or personal care services must give information to the person before services are provided.

(4) A hospice program must give information to the person before services are provided.

450.112: continued

(5) An MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan must give information at the time the person enrolls or reenrolls with the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan.

(C) Incapacitated Persons. If a person is admitted to a facility in an incapacitated state and is unable to receive information or articulate whether he or she has executed an advance directive, the facility must include materials about advance directives in the information to the families or to the legal representatives, surrogates, or other concerned persons of the incapacitated patient to the extent it does so in accordance with state law. This does not relieve the facility of its obligation to provide this information to the patient once the patient is no longer incapacitated.

(D) Previously Executed Advance Directives. When the patient or a relative, surrogate, or other concerned or related person presents the provider with a copy of the person's advance directive, the provider must comply with the advance directive, including recognition of the power of attorney, to the extent allowed under state law. Unless contrary to state law, if no one comes forward with a previously executed advance directive and the patient is incapacitated or otherwise unable to receive information or articulate whether he or she has executed an advance directive, the provider must note in the medical record that the person was not able to receive information and was unable to communicate whether an advance directive existed.

(E) Religious Objections. No private provider will be required to implement an advance directive if such action is contrary to the formally adopted policy of such provider that is expressly based on religious beliefs, provided

(1) the provider has informed the person or, if the person is incapacitated at the time of admission and unable to receive information due to the incapacitated condition or mental disorder, the person's family or surrogate, of such policy prior to or upon admission, if reasonably possible; and

(2) the person is transferred to another equivalent facility that is reasonably accessible to the person's family and willing to honor the advance directive. If the provider or the health care agent is unable to arrange such a transfer, the provider must seek judicial guidance or honor the advance directive.

450.117: Managed Care

(A) MassHealth members participate in managed care pursuant to 130 CMR 508.001: *MassHealth Member Participation in Managed Care*. MassHealth members may be excluded from participating in managed care pursuant to 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care*.

(B) MassHealth managed care provides for the management of medical care, including primary care, behavioral health services, and other medical services. MassHealth members who participate in managed care obtain services as follows:

(1) Members who enroll with an MCO obtain services in accordance with 130 CMR 508.004(B): *Obtaining Services when Enrolled in an MCO*.

(2) Members who enroll with the PCC Plan obtain services in accordance with 130 CMR 508.005(B): *Obtaining Services when Enrolled with the PCC Plan*.

(3) Members who enroll with an Accountable Care Partnership Plan obtain services in accordance with 130 CMR 508.006(A)(2): *Obtaining Services when Enrolled in an Accountable Care Partnership Plan*.

(4) Members who enroll with a Primary Care ACO obtain services in accordance with 130 CMR 508.006(B)(2): *Obtaining Services when Enrolled in a Primary Care ACO*.

(5) Members who enroll with a One Care Plan obtain services in accordance with 130 CMR 508.007(C): *Obtaining Services when Enrolled in an ICO*.

(6) Members who enroll with a SCO Plan obtain services in accordance with 130 CMR 508.008(C): *Obtaining Services when Enrolled in a SCO*.

450.117: continued

(7) Members who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives and who participate in managed care may choose to receive covered services from an Indian health-care provider. All participating MCOs, Accountable Care Partnership Plans, One Care Plans, and SCO Plans must provide payment for such covered services in accordance with the provisions of 42 U.S.C. 1396u-2(h) and comply with all other provisions of 42 U.S.C. 1396u-2(h). For the purposes of 130 CMR 450.117(B)(7), the term Indian health-care provider means a health care program, including contracted health services, operated by the Indian Health Service or by an Indian tribe, Tribal Organization, or Urban Indian Organization as those terms are defined in § 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(C) Members who participate in managed care are identified on EVS. (*See* 130 CMR 450.107.) For members who participate in managed care, this system will give the name and telephone number of the MassHealth managed care provider, the behavioral health contractor, the One Care Plan, or the SCO Plan, as applicable. The MassHealth agency pays for services provided to MassHealth members who participate in managed care as described in 130 CMR 450.105, 450.118, and 450.119.

(D) The MassHealth agency may impose sanctions on MassHealth managed care providers, the behavioral health contractor, One Care Plans, and SCO Plans pursuant to the terms of the MassHealth agency's contracts with those entities. If EOHHS is required to provide a pre-termination hearing pursuant to 42 CFR Part 438, EOHHS shall provide the contractor with such hearing in accordance with 42 CFR 438.710 and 130 CMR 450.241 through 247.

450.118: Primary Care Clinician (PCC) Plan

(A) Role of Primary Care Clinician. The PCC is the principal source of care for members who are enrolled in the PCC Plan. All services for which such a member is eligible, except those listed in 130 CMR 450.118(J), are payable only when provided by the member's PCC, or when the PCC has referred the member to another MassHealth provider.

(B) Provider Eligibility. Providers who wish to enroll as PCCs must be participating providers in MassHealth, or physician assistants participating pursuant to 130 CMR 433.434; must complete a PCC provider application, which is subject to approval by the MassHealth agency; must meet the requirements of the PCC provider contract; and must operate in a physical location conducive to providing services and care to enrollees in person. The following provider types may apply to the MassHealth agency to become PCCs:

(1) individual physicians who:

(a) are board eligible or board certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, or meet the requirements of 130 CMR 450.118(F)(2). A physician specialist must agree to provide primary care services to PCC Plan enrollees; and

(b) have current medical staff privileges in at least one MassHealth-participating acute hospital or meet 130 CMR 450.118(F)(1).

(2) independent certified nurse practitioners who specialize in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology and have medical staff hospital affiliation for the purposes of hospital admissions and as needed to satisfy scope of practice requirements. An independent certified nurse practitioner specialist must agree to provide primary care services to PCC Plan enrollees;

(3) community health centers (freestanding or hospital-licensed) with at least one physician on staff who meets the criteria of 130 CMR 450.118(B)(1);

(4) acute hospital outpatient departments with at least one physician on staff who meets the criteria of 130 CMR 450.118(B)(1); and

(5) group practices with at least one physician or independent certified nurse practitioner who

(a) is enrolled and approved by the MassHealth agency as a participating provider in that group in accordance with 130 CMR 450.212(A)(8);

(b) meets the requirements of 130 CMR 450.118(B)(1) or (2); and

(c) has signed the PCC contract.

450.118: continued

(6) physician assistants employed by a group practice, if the group practice also employs at least one physician who supervises the physician assistant and meets the requirements of 130 CMR 450.118(B)(5). The supervisory arrangement must comply with 130 CMR 433.434(D) and 263 CMR 5.00: *Scope of Practice, Employment of Physician Assistants and Standards of Conduct*.

(C) Community Health Center Participation. When a community health center participates as a PCC, it must assign each enrolled member to an individual practitioner who meets the requirements of 130 CMR 450.118(B)(1) or (2), or to a physician assistant who is supervised by a physician who meets the requirements of 130 CMR 450.118(B)(1).

(D) Hospital Outpatient Department Participation. When a hospital outpatient department participates as a PCC, it must assign each enrolled member to an attending physician who meets the requirements of 130 CMR 450.118(B)(1) or (2).

(E) Group Practice Participation. When a group practice participates as a PCC, the group practice

(1) may claim an enhanced fee only for services provided by those individual practitioners within the group who meet the requirements of 130 CMR 450.118(B)(1) or (2); and

(2) must assign each enrolled member to an individual practitioner who meets the criteria under 130 CMR 450.118(B)(1), (2), or (6).

(F) Waiver of Eligibility Requirements. The MassHealth agency may, if necessary to ensure adequate member access to services, and under the following circumstances, allow an individual physician to enroll as a PCC or as a physician in a group practice PCC notwithstanding the physician's inability to meet certain eligibility requirements set forth in 130 CMR 450.118(B)(1).

(1) Upon written request from a physician, the MassHealth agency may waive the requirement that an individual physician or a physician in a group practice have current medical staff privileges in at least one MassHealth-participating acute hospital, if the physician demonstrates to the MassHealth agency's satisfaction that the physician:

(a) practices in an area that is too distant to adequately respond to emergencies at the nearest acute hospital or where lack of current medical staff privileges is common for physicians practicing in that area;

(b) admits exclusively to acute hospitals that employ one or more physicians to care for their inpatient census, provided that the hospital's medical director agrees to admit and care for the physician's patients through the use of such physicians employed by the hospital; or

(c) establishes a collaborative relationship with a physician participating in MassHealth who has current medical staff privileges at the acute hospital closest to the requesting physician's office and who will assume responsibility for admitting the requesting physician's managed care members to that hospital when necessary.

(2) Upon written request from a physician, the MassHealth agency may waive the requirement that the individual physician or physician in a group practice is board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/ gynecology, if the physician is board-eligible or board-certified in another medical specialty, and otherwise meets the requirements of 130 CMR 450.118.

(G) PCC Provider Qualifications Grandfathering Provision. Notwithstanding the generality of the provisions of 130 CMR 450.118, any provider who is continuously enrolled as a PCC before April 1, 2003, is subject to the PCC provider eligibility requirements in effect on and before March 31, 2003.

(H) Rate of Payment. The MassHealth agency pays PCCs an enhanced fee for primary care services, in accordance with the terms of the PCC provider contract.

450.118: continued

(I) Termination.

(1) If the MassHealth agency determines that a PCC fails to fulfill any of the obligations stated in the MassHealth agency's regulations or PCC contract, the MassHealth agency may terminate the PCC contract in accordance with its terms. To the extent required by law, a pretermination hearing will be held in substantial conformity with the procedures set forth in 130 CMR 450.238 through 450.248.

(2) If the MassHealth agency determines that an individual practitioner within a PCC group practice fails to fulfill any of the obligations stated in the MassHealth agency's regulations or the PCC contract, the MassHealth agency may terminate the PCC contract pursuant to 130 CMR 450.118(I)(1), or require the group practice to stop assigning enrolled members to such practitioner and to reassign existing enrolled members to other practitioners in the group who meet the requirements of 130 CMR 450.118(B)(1) or (2).

(J) Referral for Services.

(1) Referral Requirement. All services provided by a clinician or provider other than the PCC Plan member's PCC require referral from the member's PCC in order to be payable, unless the service is exempted under 130 CMR 450.118(J)(5). In order to make a referral, PCCs must follow the processes described in the PCC provider contract and must include the individual national provider identifier (NPI) number of an individual practitioner who meets the criteria of 130 CMR 450.118(B)(1), (2), or (6). Please refer to 130 CMR 450.231: *General Conditions of Payments* for additional requirements regarding referrals.

(2) Time Frames for Referral. Whenever possible, the PCC should make the referral before the member's receipt of the service. However, the PCC may issue a referral retroactively if the PCC determines that the service was medically necessary at the time of receipt.

(3) Payment for Services Requiring Referral. The MassHealth agency pays a provider other than the member's PCC for services that require a PCC referral only when a referral has been submitted by the member's PCC and includes the individual NPI number of an individual practitioner who meets the criteria of 130 CMR 450.118(B)(1), (2), or (6).

(4) Services Requiring Referrals. *See* 130 CMR 450.105 for a list of the services covered for each MassHealth coverage type and applicable program regulations for descriptions of covered services and specific service limitations. Prior-authorization requirements are described in 130 CMR 450.303, 450.144(A)(2), and applicable program regulations and subregulatory publications. Payment for services is subject to all conditions and restrictions of MassHealth, including, but not limited to, the scope of covered services for a member's coverage type, service limitations, and prior-authorization requirements.

(5) Exceptions to Services Requiring Referrals. Notwithstanding 130 CMR 450.118(J)(4), the following services provided by a provider other than the member's PCC do not require a referral from the member's PCC in order to be payable (these services may be subject to other referral requirements under their respective program regulations).

(a) abortion services;
(b) adult day health services;
(c) adult foster care/group adult foster care services;
(d) annual gynecological exams;
(e) clinical laboratory services;
(f) day habilitation services;
(g) diabetic supplies;
(h) doula services;
(i) durable medical equipment (items, supplies, and equipment) described in 130 CMR 409.000: *Durable Medical Equipment Services*;
(j) early intervention services;
(k) fluoride varnish administered by a physician or other qualified medical professional;
(l) personal care services under 130 CMR 422.000: *Personal Care Attendant Services*, which includes functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B): *Functional Skills Training*, as well as fiscal intermediary functions provided by a fiscal intermediary as described in 130 CMR 422.419(B): *The Fiscal Intermediary*;
(m) HIV pre- and post-test counseling services;
(n) HIV testing;

450.118: continued

(o) homeless medical respite services;
(p) hospitalization
1. Elective Admissions. All elective admissions are exempt from the PCC referral requirement and are subject to the MassHealth agency's admission screening requirements at 130 CMR 450.208(A). The hospital must notify the member's PCC within 48 hours following an elective admission;
2. Nonelective Admissions. Nonelective admissions are exempt from the PCC referral requirement. The hospital must notify the member's PCC within 48 hours following a nonelective admission;
(q) obstetric services for pregnant and postpartum members provided up to one year after the end of the pregnancy;
(r) oxygen and respiratory therapy equipment;
(s) pharmacy services (prescription and over-the-counter drugs);
(t) radiology and other imaging services with the exception of magnetic resonance imaging (MRI), computed tomography (CT) scans, and positron emission tomography (PET) scans, and imaging services conducted at an independent diagnostic testing facility (IDTF), which do require a referral;
(u) services delivered by a behavioral health provider (including inpatient and outpatient psychiatric services);
(v) services delivered by a dentist;
(w) services delivered by a family planning service provider, for members of child-bearing age;
(x) services delivered by a hospice provider;
(y) services delivered by a limited service clinic;
(z) services delivered in a nursing facility;
(aa) services delivered by an orthotic provider described in 130 CMR 442.000: *Orthotics Services*;
(bb) services delivered by a prosthetic provider described in 130 CMR 428.000: *Prosthetics Services*;
(cc) urgent care services;
(dd) services delivered by an anesthesiologist or a certified registered nurse anesthetist;
(ee) services delivered in an intermediate care facility for individuals with intellectual disabilities (ICF/ID);
(ff) services delivered to a homeless member in a location other than the PCC office pursuant to 130 CMR 450.118(K);
(gg) services delivered to diagnose and treat sexually transmitted infections;
(hh) services delivered to treat an emergency condition;
(ii) services provided under a home- and community-based waiver;
(jj) sterilization services when performed for family planning services;
(kk) surgical pathology services;
(ll) tobacco-cessation counseling services;
(mm) transportation to covered care;
(nn) vaccine administration and injectable material for such vaccines;
(oo) vision care in the following categories (*See* Subchapter 6 of the *Vision Care Manual*.): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs;
(pp) medication assisted treatment (MAT) for opioid use disorder;
(qq) services delivered by home health agencies described in 130 CMR 403.000: *Home Health Agency*;
(rr) services provided by continuous skilled nursing agencies described in 130 CMR 438.000: *Continuous Skilled Nursing Agency*;
(ss) restorative services, including physical, occupational, and speech/language therapy;
(tt) rehabilitation center services described in 130 CMR 430.000: *Rehabilitation Center Services*;
(uu) speech and hearing center services described in 130 CMR 413.000: *Speech and Hearing Center Services*; and
(vv) independent nursing services described in 130 CMR 414.000: *Independent Nurse*.

450.118: continued

(K) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.118(J)(5)(ff), the provider must furnish written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the MassHealth agency that the PCC is approved to provide services to homeless members. The MassHealth agency retains the right to approve or disapprove such a request or revoke an approval of such a request at any time.

(L) Recordkeeping and Reporting.

(1) PCC Recordkeeping Requirement. The PCC must document all referrals in the member's medical record by recording the following:

(a) the date of the referral;
(b) the name of the provider to whom the member was referred;
(c) the reason for the referral;
(d) number of visits authorized; and
(e) copies of the reports required by 130 CMR 450.118(L)(2).

(2) Reporting Requirements. The PCC who made the referral must obtain from the provider who furnished the service the results of the referred visit by telephone and in writing whenever legally possible.

(M) Other Program Requirements. Payment for services provided to members enrolled with a MassHealth managed care provider is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(N) PCC Contracts. Providers that are PCCs are bound by and liable for compliance with the terms of the most recent PCC contract issued by the MassHealth agency, including amendments to the contract, as of the effective date specified in the PCC contract or amendment.

450.119: Primary Care ACOs

(A)(1) Role of Primary Care ACO. Each Primary Care ACO is contracted with the MassHealth agency to coordinate and manage care for enrolled members.

(2) Role of Primary Care ACO's Participating Primary Care Provider (participating PCP). The participating PCPs are the principal source of care for members who are enrolled in a Primary Care ACO. All services for which such a member is eligible, except those listed in 130 CMR 450.119(I), are payable only when provided by the member's participating PCP, or when the participating PCP has referred the member to another MassHealth provider.

(3) Role of Primary Care ACO's Referral Circle. Each Primary Care ACO may establish a referral circle of providers pursuant to its contract with the MassHealth agency.

(B) Provider Eligibility. Providers who wish to enroll as participating PCPs must be participating providers in MassHealth, must complete a participating PCP application, which is subject to approval by the MassHealth agency, and must meet the requirements of the participating PCP contract. The following provider types may apply to the MassHealth agency to become participating PCPs:

(1) individual physicians who:

(a) are board eligible or board certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, or meeting the requirements of 130 CMR 450.118(F)(2). A physician specialist must agree to provide primary care services to Primary Care ACO enrollees; and;

(b) have current medical staff privileges in at least one MassHealth-participating acute hospital or who meet 130 CMR 450.118(F)(1).

(2) independent nurse practitioners who specialize in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/ gynecology and have medical staff hospital affiliation for the purposes of hospital admissions and as needed to satisfy scope of practice requirements. An independent nurse practitioner specialist must agree to provide primary care services to Primary Care ACO enrollees;

(3) community health centers (freestanding or hospital-licensed) with at least one physician on staff who meets the criteria of 130 CMR 450.119(B)(1);

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(4) acute hospital outpatient departments with at least one physician on staff who meets the criteria of 130 CMR 450.119(B)(1);
(5) group practices with at least one physician or nurse practitioner who
(a) is enrolled and approved by the MassHealth agency as a participating provider in that group;
(b) meets the requirements of 130 CMR 450.119(B)(1) or (2); and
(c) has signed the participating PCP contract; and
(6) providers who are enrolled as PCCs pursuant to 130 CMR 450.118(G).

(C) Community Health Center Participation. When a community health center is a participating PCP, it must assign each enrollee to an individual practitioner who meets the requirements of 130 CMR 450.119(B)(1) or (2).

(D) Hospital Outpatient Department Participation. When a hospital outpatient department is a participating PCP, it must assign each enrollee to an attending physician who meets the requirements of 130 CMR 450.119(B)(1) or (2).

(E) Group Practice Participation. When a group practice participates as a participating PCP, the group practice
(1) may claim an enhanced fee only for services provided by those individual practitioners within the group who meet the requirements of 130 CMR 450.119(B)(1) or (2); and
(2) must assign each enrollee to an individual practitioner who meets the criteria under 130 CMR 450.119(B)(1) or (2).

(F) Waiver of Eligibility Requirements. The MassHealth agency may, if necessary to ensure adequate member access to services, and under the following circumstances, allow an individual physician to enroll as a participating PCP or as a physician in a group practice participating PCP notwithstanding the physician's inability to meet certain eligibility requirements set forth in 130 CMR 450.119(B)(1).
(1) Upon written request from a physician, the MassHealth agency may waive the requirement that an individual physician or a physician in a group practice have admitting privileges to at least one MassHealth-participating acute hospital, if the physician demonstrates to the MassHealth agency's satisfaction that the physician
(a) practices in an area that is too distant to adequately respond to emergencies at the nearest acute hospital or where lack of current medical staff privileges is common for physicians practicing in that area;
(b) admits exclusively to acute hospitals that employ one or more physicians to care for their inpatient census, provided that the hospital's medical director agrees to admit and care for the physician's patients through the use of such physicians employed by the hospital; or
(c) establishes a collaborative relationship with a physician participating in MassHealth who has current medical staff privileges at the acute hospital closest to the requesting physician's office and who will assume responsibility for admitting the requesting physician's managed care members to that hospital when necessary.
(2) Upon written request from a physician, the MassHealth agency may waive the requirement that the individual physician or physician in a group practice is board-eligible or board-certified in family practice, pediatrics, internal medicine, obstetrics, gynecology, or obstetrics/gynecology, if the physician is board-eligible or board-certified in another medical specialty, and otherwise meets the requirements of 130 CMR 450.119.

(G) Rate of Payment. The MassHealth agency pays participating PCPs an enhanced fee for primary care services, in accordance with the terms of the participating PCP contract.

(H) Termination.
(1) If the MassHealth agency determines that a participating PCP has failed to fulfill any of the obligations stated in the MassHealth agency's regulations or participating PCP contract, the MassHealth agency may terminate the participating PCP contract in accordance with its terms. To the extent required by law, a pretermination hearing will be held in substantial conformity with the procedures set forth in 130 CMR 450.238 through 450.248.

450.119: continued

(2) If the MassHealth agency determines that an individual practitioner within a participating PCP group practice has failed to fulfill any of the obligations stated in the MassHealth agency's regulations or the participating PCP contract, the MassHealth agency may terminate the participating PCP contract pursuant to 130 CMR 450.119(H)(1), or require the group practice to stop assigning enrollees to such practitioner and to reassign existing enrollees to other practitioners in the group who meet the requirements of 130 CMR 450.119(B)(1) or (2).

(I) Referral for Services.

(1) Referral Requirement. All services provided by a clinician or provider other than the Primary Care ACO member's participating PCP require referral from the member's participating PCP in order to be payable, unless the service is exempted under 130 CMR 450.119(I)(5). This referral requirement also applies to services delivered by individual practitioners who are part of a group practice participating PCP and who have not been identified by the group practice as providers who may be assigned Primary Care ACO members under 130 CMR 450.119(E). In order to make a referral, participating PCPs must follow the processes described in the participating PCP contract.

(2) Time Frames for Referral. Whenever possible, the participating PCP should make the referral before the member's receipt of the service. However, the participating PCP may issue a referral retroactively if the participating PCP determines that the service was medically necessary at the time of receipt.

(3) Payment for Services Requiring Referral. The MassHealth agency pays a provider other than the member's participating PCP for services that require a participating PCP referral only when a referral has been submitted by the member's participating PCP.

(4) Services Requiring Referrals. *See* 130 CMR 450.105 for a list of the services covered for each MassHealth coverage type and applicable program regulations for descriptions of covered services and specific service limitations. Prior-authorization requirements are described in 130 CMR 450.303, 450.144(A)(2), and applicable program regulations and subregulatory publications. Payment for services is subject to all conditions and restrictions of MassHealth, including, but not limited to, the scope of covered services for a member's coverage type, service limitations, and prior-authorization requirements.

(5) Exceptions to Services Requiring Referrals. Notwithstanding 130 CMR 450.119(I)(4), the following services provided by a clinician or other provider other than the member's participating PCP do not require a referral from the member's participating PCP in order to be payable (these services may be subject to other referral requirements under their respective program regulations).

(a) abortion services;
(b) adult day health services;
(c) adult foster care/group adult foster care services;
(d) annual gynecological exams;
(e) clinical laboratory services;
(f) day habilitation services;
(g) diabetic supplies;
(h) doula services;
(i) durable medical equipment (items, supplies, and equipment) described in 130 CMR 409.000: *Durable Medical Equipment Services*;
(j) early intervention;
(k) fluoride varnish administered by a physician or other qualified medical professional;
(l) personal care services under 130 CMR 422.000: *Personal Care Attendant Services*, which includes functional skills training provided by a MassHealth personal care management agency as described in 130 CMR 422.421(B): *Functional Skills Training*, as well as fiscal intermediary functions provided by a fiscal intermediary as described in 130 CMR 422.419(B): *The Fiscal Intermediary*;
(m) HIV pre- and post-test counseling services;
(n) HIV testing;
(o) homeless medical respite services;

450.119: continued

(p) hospitalization

1. Elective Admissions. All elective admissions are exempt from the PCC referral requirement and are subject to the MassHealth agency's admission screening requirements at 130 CMR 450.208(A). The hospital must notify the member's PCC within 48 hours following an elective admission;

2. Nonelective Admissions. Nonelective admissions are exempt from the PCC referral requirement. The hospital must notify the member's PCC within 48 hours following a nonelective admission;

(q) obstetric services for pregnant and postpartum members are provided up to one year after the end of the pregnancy;

(r) oxygen and respiratory therapy equipment;

(s) pharmacy services (prescription and over-the-counter drugs);

(t) radiology and other imaging services with the exception of magnetic resonance imaging (MRI), computed tomography (CT) scans, positron emission tomography (PET) scans, and imaging services conducted at an independent diagnostic testing facility (IDTF), which do require a referral;

(u) services delivered by a behavioral health provider (including inpatient and outpatient psychiatric services);

(v) services delivered by a dentist;

(w) services delivered by a family planning service provider, for members of child-bearing age;

(x) services delivered by a hospice provider;

(y) services delivered by a limited service clinic;

(z) services delivered in a nursing facility;

(aa) services delivered by an orthotic provider described in 130 CMR 442.000: *Orthotics Services*;

(bb) services delivered by a prosthetic provider described in 130 CMR 428.000: *Prosthetics Services*;

(cc) urgent care services;

(dd) services delivered by an anesthesiologist or a certified registered nurse anesthetist;

(ee) services delivered in an intermediate care facility for individuals with intellectual disabilities (ICF/ID);

(ff) services delivered to a homeless member in a location other than the PCC office pursuant to 130 CMR 450.118(K);

(gg) services delivered to diagnose and treat sexually transmitted infections;

(hh) services delivered to treat an emergency condition;

(ii) services provided under a home- and community-based waiver;

(jj) sterilization services when performed for family planning services;

(kk) surgical pathology services;

(ll) tobacco-cessation counseling services;

(mm) transportation to covered care;

(nn) vaccine administration and injectable material for such vaccines;

(oo) vision care in the following categories (*see* Subchapter 6 of the *Vision Care Manual*): visual analysis frames, single-vision prescriptions, bifocal prescriptions, and repairs;

(pp) medication assisted treatment (MAT) for opioid use disorder;

(qq) additional services provided to members by providers in the member's Primary Care ACO's referral circle pursuant to the MassHealth agency's contract with the Primacy Care ACO;

(rr) services delivered by home health agencies described in 130 CMR 403.000: *Home Health Agency*;

(ss) services provided by continuous skilled nursing agencies described in 130 CMR 438.000: *Continuous Skilled Nursing Agency*;

(tt) restorative services, including physical, occupational, and speech/language therapy;

(uu) rehabilitation center services described in 130 CMR 430.000*: Rehabilitation Center Services*;

(vv) speech and hearing center services described in 130 CMR 413.000: *Speech and Hearing Center Services*; and

(ww) independent nursing services described in 130 CMR 414.000: *Independent Nurse*.

450.119: continued

(J) Services to Homeless Members. To provide services to homeless members according to 130 CMR 450.119(I)(5)(ff), the provider must furnish written evidence of demonstrated experience in delivering medical care in a nonmedical setting, and request, in writing, designation from the MassHealth agency that the participating PCP is approved to provide services to homeless members. The MassHealth agency retains the right to approve or disapprove such a request or revoke an approval of such a request at any time.

(K) Recordkeeping and Reporting.

(1) Participating PCP Recordkeeping Requirement. The participating PCP must document all referrals in the member's medical record by recording the following:

(a) the date of the referral;
(b) the name of the provider to whom the member was referred;
(c) the reason for the referral;
(d) number of visits authorized; and
(e) copies of the reports required by 130 CMR 450.119(K)(2).

(2) Reporting Requirements. The participating PCP who made the referral must obtain from the provider who furnished the service the results of the referred visit by telephone and in writing whenever legally possible.

(L) Other Program Requirements. Payment for services provided to members enrolled with a MassHealth managed care provider is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.

(M) Participating PCP Contracts. Providers that are participating PCPs are bound by and liable for compliance with the terms of the most recent participating PCP contract issued by the MassHealth agency, including amendments to the contract, as of the effective date specified in the participating PCP contract or amendment.

450.123: Managed Care Compliance with Mental Health Parity

(A) MCOs, Accountable Care Partnership Plans, One Care Plans, and SCO Plans, and their behavioral health subcontractors or third-party administrators, if any, must comply with and implement relevant provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Federal Mental Health Parity Law), and implementing regulations and federal guidance, which requires parity between mental health or substance use disorder benefits and medical/surgical benefits with respect to financial requirements and treatment limitations.

(B) Annual Certification of Compliance with Federal Mental Health Parity Law. Each MCO, Accountable Care Partnership Plan, One Care Plan, and SCO Plan must annually review its administrative and other practices, including the administrative and other practices of any behavioral health subcontractors or third party administrators, for compliance with the relevant provisions Federal Mental Health Parity Law, regulations, and guidance.

(1) Each MCO, Accountable Care Partnership Plan, One Care Plan, and SCO Plan must submit a certification signed by the chief executive officer and chief medical officer stating that the entity has completed a comprehensive review of the administrative practices of the entity for compliance with the necessary provisions of State Mental Health Parity Laws and Federal Mental Health Parity Law.

(2) If the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan determines that all administrative and other practices were in compliance with relevant requirements of the Federal Mental Health Parity Law, the annual certification will affirmatively state that all relevant administrative and other practices were in compliance with Federal Mental Health Parity Law.

(3) If the MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan determines that any administrative or other practices were not in compliance with relevant requirements of the Federal Mental Health Parity Law, the annual certification will state that not all practices were in compliance with Federal Mental Health Parity Law, and will include a list of the practices not in compliance, and the steps the entity has taken to bring these practices into compliance.

450.123: continued

(C) A member enrolled in an MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan may file a grievance with MassHealth if the member believes that services are provided in a way that is not consistent with applicable Federal Mental Health Parity laws, regulations, or federal guidance. Member grievances may be communicated for resolution verbally or in writing to MassHealth's customer service contractor.

450.124: Behavioral Health Services

(A) Behavioral Health Contractor. Except as provided in 130 CMR 450.124(B) and (C), all behavioral health services covered by the MassHealth agency's contract with the behavioral health contractor (the Contractor) are authorized, provided, and paid solely by the Contractor. Payment for such services is subject to the terms of the Contractor's provider contracts including, but not limited to, provisions governing service authorization, performance specifications, and billing requirements. Any provider seeking a contract with the Contractor should contact the Contractor directly.

(B) Emergency Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the Contractor. Providers should refer to MassHealth bulletins for information and guidance on submission of claims for emergency department behavioral health visits.

(C) Services to Exempt Members. Services provided to the following MassHealth members are not subject to 130 CMR 450.124:

(1) members who are enrolled in an MCO, Accountable Care Partnership Plan, One Care Plan, or SCO Plan; and

(2) members who are excluded from participating in managed care under 130 CMR 508.002: *MassHealth Members Excluded from Participation in Managed Care* unless such member is enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E).

450.130: Copayments Required by the MassHealth Agency

The MassHealth agency does not require its members to make any copayments.

450.140: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction

(A) Legal Basis.

(1) In accordance with federal law at 42 U.S.C. 1396d(a)(4)(b) and 1396d(r), and 42 CFR 441.50, and notwithstanding any limitations implied or expressed elsewhere in MassHealth regulations or other publications, the MassHealth agency has established a program of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for MassHealth Standard and MassHealth CommonHealth members younger than 21 years old, including those who are parents.

(2) Any qualified MassHealth provider may deliver EPSDT services. However, in delivering well-child care, providers must follow the EPSDT Medical Protocol and Periodicity Schedule.

(3) EPSDT screening services include among other things, health, vision, dental, hearing, behavioral health, developmental and immunization status screening services.

(4) The regulations governing the EPSDT program are set forth in 130 CMR 450.140 through 450.149.

(B) Program Objectives. The objectives of the EPSDT program are

(1) to provide comprehensive and continuous health care designed to prevent illness and disability;

(2) to foster early detection and prompt treatment of health problems before they become chronic or cause irreversible damage;

(3) to create an awareness of the availability and value of preventive well-child care services; and

(4) to create an awareness of the services available under the EPSDT program, and where and how to obtain those services.

450.141: EPSDT Services: Definitions

Dental Care. Dental services customarily furnished by or through dental providers as defined in 130 CMR 420.000: *Dental Services*, to the extent the furnishing of those services is authorized by the MassHealth agency.

EPSDT Dental Protocol and Periodicity Schedule (the Dental Schedule). A schedule (*see* Appendix W: *EPSDT Services: Medical and Dental Protocols and Periodicity Schedules* of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Dental Schedule consists of screening and treatment procedures arranged according to the intervals or age levels at which each procedure is to be provided.

EPSDT Medical Protocol and Periodicity Schedule (the Medical Schedule). A schedule (*see* Appendix W: *EPSDT Services: Medical and Dental Protocols and Periodicity Schedules* of all MassHealth provider manuals) developed and periodically updated by the MassHealth agency in consultation with recognized medical and dental organizations involved in child health care. The Medical Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Interperiodic Visit. The provision of screening procedures or treatment services at an age other than those indicated on the Medical or the Dental Schedule. Interperiodic visits may be:

(1) screenings that are medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition;

(2) the provision of the full-range of EPSDT screening or treatment services delivered at an age other than one listed on the Medical or Dental Schedule to update the member's care according to the Medical or Dental Schedule; or

(3) additional screening or treatment services provided to a member whose care is already up to date according to the Medical or Dental Schedule.

Periodic Visit. The provision of screening procedures appropriate to the member's age and medical history, as prescribed by the Medical Schedule or the Dental Schedule.

Primary Care. Health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, certified nurse practitioner, or certified nurse midwife, or physician assistant to the extent the furnishing of those services is legally authorized in the Commonwealth. Primary care does not include emergency or post stabilization services provided in a hospital or other setting.

Primary Care Provider. A general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, certified nurse practitioner, certified nurse midwife, or physician assistant.

450.142: EPSDT Services: Medical Protocol and Periodicity Schedule and Dental Protocol and Periodicity Schedule

(A) Providers of Periodic and Interperiodic Visits.

(1) Primary care providers must offer to conduct periodic and medically necessary interperiodic visits to screen all members younger than 21 years old (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

(2) Acute outpatient hospitals, hospital licensed health centers, and community health centers that provide primary care services must offer to conduct periodic and medically necessary interperiodic visits to screen all members younger than 21 years old (except members enrolled in MassHealth Limited) in accordance with the Medical Schedule and must provide or refer such members to assessment, diagnosis, and treatment services.

(3) The screening services described in the Medical Schedule are payable when provided by a physician, certified nurse practitioner, certified nurse midwife, certified clinical nurse specialist, acute outpatient hospital, hospital licensed health center, community health center, or physician assistant.

450.142: continued

(B) Providers of Dental Services.

(1) Dental care providers must offer to provide services listed in Appendix W: *EPSDT Services: Medical and Dental Protocols and Periodicity Schedules* of all MassHealth provider manuals to all members younger than 21 years old (except members enrolled in MassHealth Limited) in accordance with the Dental Schedule, and must provide or refer such members to assessment, diagnosis, and treatment services.

(2) The dental services described in the Dental Schedule are payable when provided by dental providers as described in 130 CMR 420.000: *Dental Services*.

(C) Explanation of Procedures.

(1) The Medical Schedule outlines the procedures for comprehensive preventive care that help to identify members who may require further diagnosis of suspected or actual health problems, treatment of these problems, or both.

(2) The Medical Schedule explains procedures that must be documented in the medical record.

(3) The Dental Schedule is a tool to help dental providers identify members with suspected or actual dental problems that may require additional investigations, diagnosis, or treatment.

(4) The Dental Schedule explains procedures that must be documented in the dental record.

450.143: EPSDT Services: Description of Medical Protocol and Periodicity Schedule Visits (EPSDT Visits)

(A) Initial EPSDT Visit.

(1) An initial EPSDT visit must be provided for every

(a) new member;

(b) member previously seen only for sick care; and

(c) newborn previously seen only in the hospital.

(2) An initial EPSDT visit includes the recording of

(a) family, medical, behavioral health, developmental, and immunization history;

(b) a review of all systems;

(c) a comprehensive physical examination; and

(d) all exams, assessments, screening, and laboratory work indicated on the Medical Schedule as appropriate for the member's age.

(B) EPSDT Periodic Visit.

(1) An EPSDT periodic visit consists of all exams, assessments, screenings, and laboratory work indicated on the Medical Schedule as appropriate for the member's age.

(2) A provider may claim payment for an EPSDT periodic visit only when all the screening procedures on the Medical Schedule that correspond to the member's age have been delivered to the member.

(a) While the screening procedures are based upon a presumption of regular contact with health-care providers, many members will need additional screening procedures to bring them up to date.

(b) It is the provider's responsibility to provide those additional screening procedures necessary to bring the member up to date with his or her preventive health care according to the Medical Schedule.

(3) If the provider is unequipped to perform a test (for example, if he or she does not have an audiometer and an audiometric test is required), the provider must make a screening referral to another provider. However, in every case, for the referring provider to claim payment for an EPSDT periodic visit

(a) all required screening procedures must be performed; and

(b) the referring provider must receive and document all results in the member's medical record.

(C) EPSDT Interperiodic Visit. An EPSDT interperiodic visit is any visit not indicated on the Medical Schedule. Such visits may be either

(1) preventive health-care visits provided at an age or age interval not indicated on the Medical Schedule; or

(2) a screening that is medically necessary to determine the existence of a suspected illness or condition, or a change in or complication of a preexisting condition.

450.144: EPSDT Services: Diagnosis and Treatment

(A)(1) EPSDT diagnosis and treatment services consist of all medically necessary services listed in 1905(a) of the Social Security Act (42 U.S.C. 1396d(a) and (r)) that are

(a) needed to correct or ameliorate physical or mental illnesses and conditions discovered by a screening, whether or not such services are covered under the State Plan; and

(b) payable for MassHealth Standard and MassHealth CommonHealth members younger than 21 years old, if the service is determined by the MassHealth agency to be medically necessary.

(2) To receive payment for any service described in 130 CMR 450.144(A)(1) that is not specifically included as a covered service under any MassHealth regulation, service code list, or contract, the requester must submit a request for prior authorization in accordance with 130 CMR 450.303. This request must include, without limitation, a letter and supporting documentation from a MassHealth-enrolled physician, physician assistant, certified nurse practitioner, certified nurse midwife, or certified clinical nurse specialist documenting the medical need for the requested service. If the MassHealth agency approves such a request for service for which there is no established payment rate, the MassHealth agency will establish the appropriate payment rate for such service on an individual-consideration basis in accordance with 130 CMR 450.271. If the request is for a member who is enrolled in an MCO or Accountable Care Partnership Plan, as defined in 130 CMR 450.000, the requestor must submit the request to the MCO or Accountable Care Partnership Plan according to the MCO's or Accountable Care Partnership Plan's prior-authorization process. If the request is for a behavioral health service for a member who is enrolled with MassHealth's behavioral health contractor, as defined in 130 CMR 508.000, the requestor must submit the request to the behavioral health contractor according to the behavioral health contractor's prior authorization process.

(B) For any condition that requires further assessment, diagnosis, or treatment after the periodic or interperiodic visit, the provider must inform the member how and where to obtain further assessment, diagnosis, or treatment, and must either

(1) request that the member return for another appointment as soon as possible; or

(2) make a referral to another provider who can provide the appropriate assessment, diagnosis, or treatment as soon as the referring provider determines that a referral is needed.

(C) When making a referral to another provider, the referring provider must give the name and address of an appropriate provider to the member or to the member's parent or guardian.

(D) The referring provider must obtain a report of the results of assessment, diagnosis, and treatment from the provider of the referred service and document this information in the member's medical record.

450.145: EPSDT Services: Claims for Visits

(A) Initial EPSDT Visit. A provider may bill for only one initial EPSDT visit per member.

(B) Periodic Visits. For each member, a provider may bill for only one periodic visit per age level listed in the Medical Schedule.

(C) Interperiodic Visits. There is no limit on the number of medically necessary interperiodic visits that may be billed. Only interperiodic visits, at which the full range of EPSDT screening services are delivered, are payable as EPSDT periodic visits, subject to the limitations in 130 CMR 450.145(B). Any other interperiodic visit is payable according to the visit service codes and descriptions in Subchapter 6 of the screening provider's MassHealth provider manual.

(D) Newborn Visits. (Physician, physician assistant, certified nurse practitioner, certified nurse midwife, and community health center providers only)

(1) To be paid for an EPSDT periodic visit of a newborn, the provider must have visited the newborn at least twice before the newborn leaves the hospital.

(a) The first visit, for an initial history and physical examination, is payable as newborn care and not as an EPSDT periodic visit.

450.145: continued

(b) The second visit, for a discharge history, physical examination, and all other screens required for the newborn, is payable as an EPSDT periodic visit.

(2) Additional hospital visits for ill newborns are payable according to the service codes and descriptions for hospital visits.

(3) The newborn EPSDT periodic visit may occur at the provider's office if the infant's length of stay in the hospital is not long enough for the provider to visit the infant twice before the infant is discharged from the hospital.

(E) Reporting Requirement. To claim payment for an EPSDT initial, periodic, or interperiodic visit, a provider must submit a completed claim according to the MassHealth agency's billing and claims submission requirements.

450.146: EPSDT Services: Claims for Screening Services (Physician, Physician Assistant, Certified Nurse Practitioner, Certified Nurse Midwife, Certified Clinical Nurse Specialist, Acute Outpatient Hospital, Hospital Licensed Health Center, and Community Health Center Providers Only)

The services listed in Appendix Z: *EPSDT/PPHSD Screening Services Codes* of all MassHealth provider manuals and included in the Medical Schedule are payable, in addition to the initial, periodic or interperiodic visit, when they are performed and interpreted in the office of the provider who performed the initial, periodic or interperiodic visit, unless such additional payment is not permitted pursuant to the particular provider type's MassHealth provider manual.

450.148: EPSDT Services: Payment for Transportation

Transportation may be available to members accessing EPSDT services. Providers must ask members if they need transportation assistance, and refer those members who do to MassHealth Customer Service for additional information about transportation.

450.149: EPSDT Services: Recordkeeping Requirements

(A) Medical Records.

(1) A provider must create and maintain a record for every member receiving EPSDT services, in accordance with MassHealth regulations governing medical records at 130 CMR 450.205.

(2) In addition, the medical record for each member receiving EPSDT services must contain documentation of the screening procedures listed in Appendix W: *EPSDT Services: Medical and Dental Protocols and Periodicity Schedules* as well as the following:

(a) the results of all laboratory tests;

(b) the name of each referral provider; and

(c) the results of any component of the Medical Schedule that was delivered by another provider.

(B) Determination of Compliance with Medical Standards. The MassHealth agency may review the medical records of members receiving EPSDT services to determine the necessity and quality of the medical services provided. Any such determinations will be made in accordance with 130 CMR 450.204 and 130 CMR 450.206.

450.150: Preventive Pediatric Health Care Screening and Diagnosis (PPHSD) Services for Certain MassHealth Members

(A) MassHealth has established a program of preventive pediatric health care screening and diagnosis (PPHSD) services for MassHealth members younger than 21 years old who are enrolled in MassHealth Family Assistance. MassHealth Standard and MassHealth CommonHealth members are entitled to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services in accordance with 130 CMR 450.140.

450.150: continued

(B) Any qualified MassHealth provider may deliver PPHSD services.

(1) In delivering PPHSD services, providers must

(a) follow the procedures listed in the Medical Schedule; and

(b) comply with 130 CMR 450.140 through 450.143 and 130 CMR 450.145 through 450.150.

(2) PPHSD services include health, vision, dental, hearing, behavioral health, developmental, and immunization status screening services. PPHSD services do not include services that are not otherwise covered for MassHealth members enrolled in MassHealth Family Assistance.

(3) To interpret 130 CMR 450.140 through 450.143 and 130 CMR 450.145 through 450.150 for MassHealth members younger than 21 years old who are enrolled in MassHealth Family Assistance, providers should substitute the term "preventive pediatric health-care screening and diagnosis (PPHSD) services" for the term "Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services" wherever it appears.

(C) Providers delivering PPHSD services should provide members with, or refer members for, additional diagnosis and treatment services according to 130 CMR 450.105.

450.200: Conflict between Regulations and Contracts

If the MassHealth regulations about payment methods and conditions of provider participation conflict with a provider or managed care contract, such contract supersedes the regulation, unless the contract expressly states otherwise.

450.201: Choice of Provider

Pursuant to federal regulations set forth in 42 CFR 431.51, members have the right to choose providers from whom they may obtain medical services with certain exceptions that are specified in the MassHealth regulations, including, but not limited to, 130 CMR 450.117(B) and 450.316. However, a member's right to choose a provider does not permit or require payment by the MassHealth agency to any person or institution not eligible for such payment under the MassHealth regulations in effect at the time a medical service is provided.

450.202: Nondiscrimination

(A) M.G.L. c. 151B, § 4, clause 10 prohibits discrimination against any individual who is a recipient of federal, state, or local public assistance, including MassHealth, because the individual is such a recipient or because of any requirement of such an assistance program. Accordingly, except as specifically permitted or required by law, no provider may deny any medical service to a member eligible for such service unless the provider would, at the same time and under similar circumstances, deny the same service to a patient who is not a MassHealth member (for example, no new patients are being accepted, or the provider does not provide the desired service to any patient). A provider may not specify a particular setting for the provision of services to a member that is not also specified for nonmembers in similar circumstances.

(B) No provider may engage in any practice, with respect to any member, that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of § 1557 of the Affordable Care Act prohibiting discrimination on the basis of race, color, national origin, sex (including pregnancy, gender identity and sex stereotyping), age, or disability; Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; § 504 of the Rehabilitation Act of 1973; and the Age Discrimination Act of 1975.

450.202: continued

(C) Pursuant to 42 U.S.C. 1396u-2 and 42 CFR 438.3(d), MCOs, Accountable Care Partnership Plans, Primary Care ACO's participating primary care providers (participating PCPs), PCCs, the behavioral health contractor, One Care Plans, and SCO Plans may not unlawfully discriminate and will not use any policy or practice that has the effect of unlawfully discriminating against a MassHealth member eligible to enroll in the contractor's MassHealth plan on the basis of health status, need for health-care services, race, color, national origin, sex, sexual orientation, gender identity, or disability. MCOs, Accountable Care Partnership Plans, Primary Care ACO's participating primary care providers (participating PCPs), PCCs, the behavioral health contractor, One Care Plans, and SCO Plans will accept for enrollment and reenrollment all members referred by the MassHealth agency in the order in which they are referred without restriction, provided that PCCs and participating PCPs will accept members for enrollment and reenrollment up to the limits for PCC panel capacity set under the contract between EOHHS and PCCs and the limits for participating PCP panel capacity set under the contract between EOHHS and participating PCPs.

(D) Violations of 130 CMR 450.202(A), (B), and (C) may result in administrative action, referral to the Massachusetts Commission Against Discrimination, or referral to the U.S. Department of Health and Human Services, or any combination of these.

450.203: Payment in Full

(A) Federal and state laws require that participation in MassHealth be limited to providers who agree to accept, as payment in full, the amounts paid in accordance with the applicable fees and rates or amounts established under a provider contract or regulations applicable to MassHealth payment. (*See* 42 CFR 447.15 and M.G.L. c. 118E, § 36.) No provider may solicit, charge, receive, or accept any money, gift, or other consideration from a member, or from any other person, for any item or medical service for which payment is available under MassHealth, in addition to, instead of, or as an advance or deposit against the amounts paid or payable by the MassHealth agency for such item or service, except to the extent that the MassHealth regulations specifically require or permit contribution or supplementation by the member or by a health insurer.

(B) If the provider receives payment from a member for any service payable under MassHealth without knowing that the member was a MassHealth member at the time the service was provided, the provider must, upon learning that the individual is a MassHealth member, immediately return all sums solicited, charged, received, or accepted with respect to such service.

450.204: Medical Necessity

The MassHealth agency does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) A service is medically necessary if

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007: *Potential Sources of Health Care*, or 517.007: *Utilization of Potential Benefits*.

450.204: continued

(B) Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to the MassHealth agency upon request. (*See* 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

(D) Additional requirements about the medical necessity of MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

450.205: Recordkeeping and Disclosure

(A) The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members and must provide to the MassHealth agency and the Attorney General's Medicaid Fraud Division, the State Auditor and the United States Department of Health and Human Services on request such information and any other information about payments claimed by the provider for providing services or otherwise described in 130 CMR 450.205. (*See e.g.*, 42 U.S.C. 1396a(a)(27).) All providers must also disclose such records and information to any other state and federal agency to which disclosure is required by law.

(B) All providers must maintain complete patient account records. Patient account records must include complete documentation of charges, indicate the date and amount of all debit and credit transactions, and support the appropriateness of the amounts billed and paid. Institutional providers must, in addition, provide on request all records maintained by or within the institution about services provided to members by other providers. Pharmacy providers must, in addition, keep photocopies of the temporary MassHealth cards referenced when filling prescriptions, if applicable, and must produce a copy of the card on request.

(C) A provider must maintain and disclose any and all financial, statistical, and other information as may be required by the MassHealth agency, the Center for Health Information and Analysis, or any other agency described in 130 CMR 450.205(A). The required information must include, but is not limited to, ownership and licensure information, cost reports, charge books, audited financial statements, financial records, federal and state tax returns, invoices, general ledgers, trial balances, remittance advices, and explanations of benefits from health insurers and managed care organizations. Such records and documents must be provided within the time period specified by the requesting agency.

(D) All records, including but not limited to those containing signatures of medical professionals authorizing services, such as prescriptions, must, at a minimum, be legible and comply with generally accepted standards for recordkeeping within the applicable provider type as they may be found in laws, rules, and regulations of the relevant board of registration, professional treatises, and guidelines and other information published, adopted, or promulgated by state or national professional organizations and societies. All accounting records must be maintained in accordance with generally accepted accounting principles. In those instances where MassHealth regulations identify specific recordkeeping requirements for particular types of providers, such regulations constitute an additional standard against which the adequacy of records will be measured for the purposes of 130 CMR 450.205. In no instance will the completion of the appropriate MassHealth claim, the maintenance of a copy of such claim, or the simple notation of service codes constitute sufficient documentation for the purpose of 130 CMR 450.205.

450.205: continued

(E) Except as provided in 130 CMR 450.205(F), the records and information required to be maintained or disclosed under 130 CMR 450.000 include only those that relate in any manner to services provided to or prescribed for members, provided, however, that disclosure may not be refused on the ground that such records are commingled with records related to persons who are not members. Such records and information must be made available to the MassHealth agency and any other agency described in 130 CMR 450.205(A) for examination or copying during reasonable office hours at the provider's place of business or record depository. Alternatively, the requesting agency may require that the provider submit copies of such records and information.

(F) (1) Providers subject to the federal requirements for employee education about false claims laws under 42 U.S.C. 1396a(a)(68) must:

(a) provide written certification, on or before June 30th of each year, or such other date as specified by the MassHealth agency, signed under the pains and penalties of perjury, of compliance with the federal requirements;

(b) make available to the MassHealth agency, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. 1396a(a)(68), any employee handbook, and other information as the MassHealth agency may deem necessary to determine compliance; and

(c) initiate corrective actions necessary to comply with such federal requirements.

(2) The MassHealth agency may recover as overpayments any payments made to a provider that the MassHealth agency determines failed to comply with the requirements of 130 CMR 450.205(F)(1) or 42 U.S.C. 1396a(a)(68), and impose sanctions against a provider in accordance with the provisions of 130 CMR 450.000.

(G) Notwithstanding any regulatory or contractual provisions that may provide for a shorter retention period, all records described in 130 CMR 450.204 and 450.205 must be kept for at least six years after the date of medical services for which claims are made or the date services were prescribed, or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer. Providers must retain records to substantiate costs listed on a cost report for at least six years following the date of filing of the cost report or for such length of time as may be required by regulations of the Centers for Health Information and Analysis or other governing agency, whichever period is longer. In no event may any provider destroy any records while any review, audit, or administrative or judicial action involving such records is pending.

(H) In cases where audits or other reviews reveal provider noncompliance with 130 CMR 450.204 or 450.205, the MassHealth agency may seek to pursue recovery of overpayments and to impose sanctions in accordance with the provisions of 130 CMR 450.000.

(I)(1) The provider, as holder of personal data under M.G.L. c. 66A, must comply with all regulatory and statutory requirements applicable to such a holder, including those set forth in M.G.L. c. 66A, and must inform each of its employees having access to such personal data of such requirements and ensure compliance by each employee with such requirements.

(2) The provider must take reasonable steps to ensure the physical security of personal data under its control including, but not limited to:

(a) fire protection;

(b) protection against smoke and water damage;

(c) alarm systems;

(d) locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data;

(e) passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; and

(f) limited access to input and output documents.

450.206: Determination of Compliance with Medical Standards

Violations of 130 CMR 450.204 may be determined by peer review. Except as otherwise required by law, the MassHealth agency will decide the level and manner of peer review in each instance. Such peer review may be conducted by a qualified MassHealth agency employee or consultant or by one or more qualified persons provided by health-care foundations, professional societies, or such other professional organizations as the MassHealth agency may select. In appropriate cases, the MassHealth agency may rely in part or in whole upon reviews conducted by a utilization and quality-control review organization or a board of registration. In the event that the MassHealth agency decides to pursue any sanction or recovery of overpayment as a result of a peer-review recommendation, the provisions of 130 CMR 450.235 through 450.260 apply.

450.207: Utilization Management Program for Acute Inpatient Hospitals

(A) Introduction. 130 CMR 450.207 through 450.209 describes the Utilization Management Program for acute inpatient hospitals. The purpose of this program is to ensure that certain medical services for which the MassHealth agency pays are medically necessary and provided in the appropriate setting. To this end, the MassHealth agency conducts reviews before elective admissions (admission screening) and after discharge but before payment (prepayment review). The MassHealth agency also conducts utilization reviews of inpatient admissions and outpatient services on a postpayment basis pursuant to 130 CMR 450.237. The term "admitting provider" as used in 130 CMR 450.207 through 450.209 refers to the provider (for example, physician or dentist) who admits the member to the facility and who assumes primary responsibility for the member's care and the admitting provider's designee, where appropriate. The requirements of the Utilization Management Program detailed in 130 CMR 450.207 through 450.209 apply to both in-state and out-of-state hospitals.

(B) General Provisions

(1) Appendix. The MassHealth agency has issued an appendix to the provider manual for each facility and admitting provider affected by the Utilization Management Program. This appendix contains a list of information the admitting provider must provide for each review, and the name, address, and telephone number of the MassHealth agency's agent for the Utilization Management Program.

(2) Stipulations. The Utilization Management Program does not waive or replace any other MassHealth agency requirements, such as prior-authorization or consent-form requirements.

(3) Payment Restrictions.

(a) The MassHealth agency will pay the acute inpatient hospital for services subject to the Utilization Management Program only if the admitting provider has complied with the requirements in 130 CMR 450.207 through 450.209 and the service is medically or administratively necessary.

(b) Payments are subject to all general conditions and restrictions of the MassHealth agency.

(c) A provider may not bill the member for any medical care for which the MassHealth agency has denied payment due to the provider's failure to comply with the requirements of the Utilization Management Program.

(4) Exceptions. Proposed admissions of the following members, are exempt from the requirements of the Utilization Management Program, regardless of admitting diagnosis:

(a) members whose hospitalization is court-ordered;

(b) members of the EAEDC Program; and

(c) members for whom MassHealth is not the primary payer of the acute inpatient admission, including but not limited to members covered by an MCO, Accountable Care Partnership Plan, One Care Plan, SCO Plan, commercial insurance, or Medicare. However, if the primary payer denies coverage before the member is admitted or if the member has Medicare Part B only, the admission of the member is not exempt from the requirements of the Utilization Management Program.

450.208: Utilization Management: Admission Screening for Acute Inpatient Hospitals

(A) Requirements.

(1) The MassHealth agency conducts admission screening on elective admissions only. The admitting provider must notify the MassHealth agency, *via* telephone, fax, or the MassHealth Provider Online Service Center (POSC), at least seven calendar days before a proposed elective admission and provide the information specified in the appendix described in 130 CMR 450.207(B). When the admitting provider cannot notify the MassHealth agency within seven calendar days, the admitting provider must notify the MassHealth agency prior to the elective admission, and no later than 5:00 P.M. on the first day after the decision to admit. The provider must explain to the MassHealth agency why the seven-calendar-day notice requirement was not met. If the MassHealth agency cannot complete the admission-screening process before the scheduled elective admission, when neither the admitting provider nor the acute inpatient hospital has informed the MassHealth agency at least seven calendar days before the admission was scheduled, the provider may be required to reschedule the admission.

(2) Providers must notify the MassHealth agency of any changes in an approved elective admission as soon as those changes are known, but in any event, before the admission occurs. The MassHealth agency will deny payment if a service or procedure that is provided is not what was proposed and approved, and such procedure, service, or admission is not medically necessary.

(3) For postponed admissions, the admitting provider must contact the MassHealth agency and provide updated information no later than 5:00 P.M. on the second business day following the originally planned admission date.

(B) Notice of Admission Screening Decisions. The MassHealth agency sends written notice of its decisions to the admitting provider, PCC (if applicable), acute inpatient hospital, and member.

(C) Appeal of Admission Screening Decisions.

(1) If the MassHealth agency determines that an acute inpatient hospital admission is not medically necessary, the admitting provider or the PCC may request a review of the determination. Such a request must be made in writing and received by the MassHealth agency within seven calendar days after the date of the determination notice. This written request must include all documentation that the provider believes is pertinent for a second review.

(2) Providers or members may appeal the MassHealth agency's decision to deny an elective admission by requesting a hearing before the MassHealth agency's Board of Hearings. Provider hearings are governed by 130 CMR 450.241 through 450.248. Member hearings are governed by the MassHealth agency's regulations at 130 CMR 610.000: *MassHealth: Fair Hearing Rules*. Neither providers nor members are required to exhaust any other appeal rights before requesting a hearing on an admission screening decision; however, providers and members do not have a right to judicial review of an admission screening decision if they fail to exhaust their administrative remedies.

(D) Requesting Reconsideration. If the MassHealth agency denies payment for a claim because the admitting provider did not comply with the requirements of 130 CMR 450.208(A), the admitting provider or hospital may request reconsideration of the MassHealth agency's decision by contacting the MassHealth agency in writing within 30 calendar days after the date of the remittance advice on which the claim is denied. The MassHealth agency will process the claim only if the admitting provider or acute inpatient hospital demonstrates that

(1) the admission was exempt for one of the reasons described in 130 CMR 450.207(B)(4);

(2) the admitting provider, despite reasonable, good-faith efforts to identify all third-party payment sources, was unaware that the patient was a MassHealth member; or

(3) the admitting provider complied with all requirements of 130 CMR 450.208(A).

450.209: Utilization Management: Prepayment Review for Acute Inpatient Hospitals

(A) Introduction

(1) The MassHealth agency conducts prepayment reviews to evaluate acute inpatient hospital admissions for

(a) medical necessity, including, but not limited to, the appropriateness of the inpatient admission and any services;

(b) the stability of the member at the time of discharge;

(c) the quality of care provided; and

(d) compliance with the MassHealth agency's billing procedures and requirements.

(2) The MassHealth agency will identify each admission to be reviewed by mailing to the acute inpatient hospital a request for selected medical records.

(B) Submission Requirements and Time Frames.

(1) The acute inpatient hospital must submit the requested medical records to the MassHealth agency. Such medical records must be received by the MassHealth agency within 17 calendar days of the date appearing on the request. If the hospital fails to timely submit the records, the MassHealth agency will deny payment for the admission.

(2) If the MassHealth agency concludes that the records submitted are incomplete, it will inform the acute inpatient hospital in writing. The hospital must submit the documents that were missing from the medical record or records to the MassHealth agency. Such documents must be received by the MassHealth agency within 17 calendar days of the date appearing on the MassHealth agency's notice requesting such information. If the hospital fails to timely submit the documents to complete the medical record, the MassHealth agency will deny payment for the admission.

(3) The acute inpatient hospital may request reconsideration of any denials issued in accordance with 130 CMR 450.209(B)(1) or (2). Such a request must be made in writing and received by the MassHealth agency within 33 calendar days of the date appearing on the denial notice, and must include the complete medical record or records. If the hospital requests reconsideration pursuant to 130 CMR 450.209(B)(3), the MassHealth agency will review the medical record or records and notify the hospital of the determination. If the hospital does not timely request reconsideration, the denial issued pursuant to 130 CMR 450.209(B)(1) or (2) constitutes the MassHealth agency's final action, and the hospital will have no right to an adjudicatory hearing pursuant to 130 CMR 450.209(C)(3), because of its failure to exhaust its administrative remedies.

(C) Determination of Noncompliance.

(1) MassHealth Agency's Determination. If, based on its review of the information submitted in accordance with 130 CMR 450.209(B), the MassHealth agency determines that an acute hospital inpatient admission was not medically necessary, the MassHealth agency will deny payment for the admission. The hospital may rebill for medically necessary services as an outpatient claim pursuant to 130 CMR 415.414: *Utilization Review*. If, based on its review, the MassHealth agency determines that the admission was medically necessary but the hospital has failed to comply with the MassHealth agency's billing procedures and requirements, the MassHealth agency will deny the claim. In such a case, the hospital may rebill the claim pursuant to the proper billing requirements.

(2) Requesting Reconsideration.

(a) The acute inpatient hospital must request reconsideration of any denial issued in accordance with 130 CMR 450.209(C)(1) in order to be entitled to file a claim for an adjudicatory hearing pursuant to 130 CMR 450.241. Such reconsideration request must be made in writing and received by the MassHealth agency within 33 calendar days of the date appearing on the denial notice, and must include the following:

1. a written statement from a physician explaining why the MassHealth agency's denial was in error. Such explanation must specifically address all clinical issues cited in the MassHealth agency's denial and must not consist solely of the resubmission of previously submitted documents;

2. a certification from the acute inpatient hospital's Utilization Review Department (URD) that it has reviewed the medical record or records and believes that both the treatment delivered and the inpatient admission were in compliance with all MassHealth agency regulations about the medical or administrative necessity of the admission, treatment, and continued stay of that patient; and

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3. if the MassHealth agency's denial indicates that any service should have been delivered as an outpatient service, the physician statement and URD certification must explain why this would have been contrary to accepted standards of medical practice.

(b) If the hospital does not submit a request for reconsideration, the denial issued pursuant to 130 CMR 450.209(C)(1) constitutes the MassHealth agency's final action. If the hospital requests reconsideration but fails to timely comply with the requirements of 130 CMR 450.209(C)(2)(a), the reconsideration request will be summarily denied. In either case, the MassHealth agency's denial constitutes the MassHealth agency's final action, and the hospital has no right to an adjudicatory hearing pursuant to 130 CMR 450.209(C)(3) or judicial review because of its failure to exhaust its administrative remedies.

(3) MassHealth Agency's Final Determination. The MassHealth agency will review a request for reconsideration and accompanying material submitted in compliance with the requirements of 130 CMR 450.209(C)(2) and will issue a final determination based on such review. The determination will be in writing, state the reasons for the determination, and inform the acute inpatient hospital of its right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241. The claim will be decided by the Office of Medicaid's Board of Hearings in accordance with 130 CMR 450.241 through 450.248.

(D) Resubmission of Claim after Denial or Pending Review. If the acute inpatient hospital resubmits an inpatient claim for payment that, pursuant to 130 CMR 450.209, has either been denied or is pending review, and if that resubmitted claim is paid by the MassHealth agency, the MassHealth agency will void the payment of the claim when it becomes aware of the resubmission. The hospital may file a claim for an adjudicatory hearing pursuant to 130 CMR 450.241 and 450.243 through 450.248 to contest the voiding of the payment.

450.210: Performance Incentive Payments: MassHealth Agency Review

(A) Applicability. The provisions set forth in 130 CMR 450.210 establish the MassHealth agency's review process for provider disputes concerning MassHealth performance incentive payment amounts. For purposes of 130 CMR 450.210, "performance incentive" means a value-based purchasing program implemented by the MassHealth agency to pay providers to perform activities related to improving the quality of care delivered to MassHealth members.

(B) MassHealth Pay-for-performance Payment Notice. The MassHealth agency will notify the provider in writing of the agency's determination of the provider's performance incentive payment amount for the time period specified in the notice. The notice will identify the aggregate performance incentive payment amount calculated for the provider, and may separately identify the amount calculated for components of such payment amount. The MassHealth agency will notify the provider by letter, report, computer printout, electronic transmission, or other format.

(C) Requesting MassHealth Agency Review of Performance Incentive Amounts.

(1) To preserve its right to an adjudicatory hearing and judicial review, a provider must request MassHealth agency review of the provider's performance incentive payment amounts specified in the notice issued to the provider by MassHealth as described in 130 CMR 450.210(B). The request for agency review must be made in writing and be received by the MassHealth agency within 30 calendar days of the date appearing on said notice. Only those payment amounts specifically identified as in dispute by the provider in its request for agency review are subject to review.

(2) Any request for agency review submitted pursuant to 130 CMR 450.210(C)(1) must

(a) identify with specificity all payment amounts and components of such payment amounts in dispute;

(b) specify in sufficient detail the basis of the provider's disagreement with those amounts as calculated;

(c) identify and address all issues in said notice with which the provider disagrees; and

(d) include any documentary evidence and information it wants the MassHealth agency to consider.

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(D) MassHealth Agency's Final Determination.

(1) The MassHealth agency will review a provider's request for agency review only if it is submitted in compliance with the requirements of 130 CMR 450.210(C)(1) and (2). The MassHealth agency is not obligated to consider any information or documents that the provider failed to timely submit under time deadlines previously imposed by the MassHealth agency. The MassHealth agency will issue a final written determination of contested payment amounts based on its review, which will state the reasons for the determination, and inform the provider of the provider's right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241.

(2) Payment amounts and components of payment amounts specified in the notice issued to the provider by MassHealth as described in 130 CMR 450.210(B) that are not specifically identified as in dispute in a provider's request for agency review will, without further notice, constitute the MassHealth agency's final determination of those amounts. The provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review of such amounts because of the failure to exhaust its administrative remedies.

(3) If the provider does not submit a request for agency review, the notice issued to the provider by MassHealth as described in 130 CMR 450.210(B) constitutes the MassHealth agency's final determination of the provider's performance incentive payment amounts. If a provider requests agency review but fails to timely comply with the requirements of 130 CMR 450.210(C)(1) and (2), the request for agency review may be denied. In either case, said notice constitutes the MassHealth agency's final determination, and the provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review because of the failure to exhaust its administrative remedies.

450.212: Provider Eligibility: Eligibility Criteria

(A) To be eligible to participate in MassHealth as any provider type, a provider must

(1) meet all statutory requirements applicable to such provider type;

(2) meet all conditions of participation applicable to such provider type under Titles XVIII and XIX of the Social Security Act and regulations promulgated thereunder;

(3) meet all conditions of participation applicable to such provider type. Program regulations applicable to specific provider types appear in 130 CMR 400.000 through 499.000. This requirement does not apply to providers participating pursuant to 130 CMR 450.212(D) and (E);

(4) be fully licensed, certified, or registered as an active practitioner by the agency or board overseeing the specific provider type, and where the regulations define "specialist" credentials or require other credentials, providers must possess those credentials;

(5) be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for medications and biologicals;

(6) never have been subject and never have had common parties in interest with any provider subject to any disciplinary action, sanction, receivership, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency, authority, or board, including MassHealth or any other state's Medicaid program. These include, but are not limited to, revocation, suspension, termination, reprimand, censure, admonishment, fine, probation agreement, agreements not to practice or other practice limitation, practice monitoring, or remedial training or other educational or public service activities;

(7) not have purchased or otherwise obtained its practice or business entity from any provider suspended or terminated from MassHealth participation due to violations of applicable laws, rules, or regulations; or from a provider that is currently subject to a withholding of payments for a credible allegation of fraud under 130 CMR 450.249 or who terminates or has its participation terminated while subject to such a withholding of payments;

450.212: continued

(8) cooperate with the MassHealth agency during any application, revalidation of enrollment, or other review process, which may include, but not be limited to, permitting and facilitating site visits, as determined by the MassHealth agency. In addition, applicants and providers must, within 30 days upon request from CMS or the MassHealth agency, complete any requisite forms authorizing a criminal offender record check and ensure that the applicant or provider, or any person with a 5% or more direct or indirect ownership interest (as defined under 130 CMR 450.221) in the applicant or provider, submits a set of fingerprints in a form and manner determined by the MassHealth agency. Such applicants, providers, or persons may be required to pay costs associated with fingerprinting;

(9) not be subject to a moratorium on enrollment imposed in accordance with 42 CFR 455.470; and

(10) if the provider is a group practice, ensure that all individual practitioners in the group who provide services to MassHealth members and for whom the group practice bills MassHealth obtain an individual MassHealth provider number by completing a fully participating application, and meet all the requirements of 130 CMR 450.212(A)(1) through (9). Such practitioners may not enroll as nonbilling providers under 130 CMR 450.212(E). In addition, for a group practice to participate in MassHealth, it must file a group practice provider application with the MassHealth agency, and meet all of the following requirements.

(a) It must be a recognized legal entity (for example, partnership, corporation, or trust). A sole proprietorship may not be a group practice.

(b) It must satisfy at least one of the following:

1. all of the beneficial interest in the group practice must be held by individual practitioners who are members of the group practice serviced by the group practice; or

2. all members of the group practice must be employees or contractors of the group practice.

(c) It must not be currently or have previously been suspended from MassHealth participation due to violations of applicable laws, rules, or regulations or have common parties in interest with any provider that is currently under suspension or has been suspended.

(B) A provider who does not meet the requirements of 130 CMR 450.212(A)(6) through (9) or (10)(c) may, at the MassHealth agency's discretion, participate in MassHealth only if, in the judgment of the MassHealth agency, such participation would neither

(1) threaten the health, welfare, or safety of members; nor

(2) compromise the integrity of MassHealth.

(C) A provider who does not meet the requirements of 130 CMR 450.212(A) is not entitled to a hearing on the issue of eligibility.

(D) A Qualified Medicare Beneficiaries (QMB)-only provider is a provider who provides medical services only to MassHealth Senior Buy-In members described in 130 CMR 519.010: *MassHealth Senior Buy-In* and 130 CMR 505.007: *MassHealth Senior Buy-In and Buy-In* and certain MassHealth Standard members who are eligible for QMB benefits described in 130 CMR 519.002(A)(4)(c) and 130 CMR 505.002(O): *Medicare Premium Payment*. QMB-only providers are subject to all regulations pertaining to providers participating in MassHealth except as otherwise specified in 130 CMR 450.000. QMB-only providers may bill only for medical services for QMB members and Standard members eligible for QMB benefits, whether or not the associated medical services are specified in 130 CMR 400.000 through 499.000.

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(E) A nonbilling provider is an individual provider who enrolls with MassHealth because his or her information (*e.g.*, National Provider Identifier (NPI)) is required on a claim submitted by a billing provider to MassHealth pursuant to state or federal statute, regulation, billing instruction or other subregulatory guidance or is included on a claim because of a billing provider's own billing procedures, or is otherwise required or permitted by state or federal law to enroll with MassHealth for a limited purpose. A nonbilling provider must include his or her individual NPI on all orders, referrals, and prescriptions for services to MassHealth members, and must provide his or her individual NPI to a billing provider upon request in other circumstances in which the billing provider must include the nonbilling provider's NPI on MassHealth claims. *See* also 130 CMR 450.231(F).

(1) Nonbilling providers may enroll through a streamlined application process determined by the MassHealth agency.

(2) Nonbilling providers may not submit claims to or receive payments from the MassHealth agency.

(3) Nonbilling providers are not subject to certain provisions of the provider regulations relating to payments and claims processing. However, nonbilling providers are subject to all other applicable regulations pertaining to MassHealth billing providers, including but not limited to those relating to ordering, prescribing, referring, screening, prior authorization, medical necessity, utilization management and recordkeeping and disclosure with respect to services ordered, referred, prescribed or provided to MassHealth members.

(4) An individual who provides services to MassHealth members as part of a group practice, which bills on behalf of the individual, must enroll as a fully participating provider and may not enroll as a nonbilling provider under 130 CMR 450.212(E).

(F) All individual practitioners comprising the group and the group practice entity are jointly and severally liable for any overpayments owed and are subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

450.213: Provider Eligibility: Termination of Participation for Ineligibility

When a provider fails or ceases to meet any one or more of the eligibility criteria applicable to such provider, the provider's participation in MassHealth may be terminated, subject to 130 CMR 450.212(B) and 450.216. If such termination is based upon a finding, ruling, conviction, decision, order, notification, or statement of any nature (including an agreement with the provider) by any federal, state, or quasi-public board, department (other than the MassHealth agency), or other agency or another state's Medicaid program that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, or that takes any action of the nature set forth in 130 CMR 450.212(A)(6), the correctness or validity of the action taken by the issuing agency will be presumed, the termination will be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and the MassHealth agency will not afford a hearing as to the correctness or validity of such action. If such termination is based solely upon a determination of ineligibility by the MassHealth agency, the provider will be afforded notice and an opportunity for hearing in substantially the manner set forth in 130 CMR 450.241 through 450.248, and any termination will be effective as of the date of receipt of notice thereof.

450.214: Provider Eligibility: Suspension of Participation Pursuant to United States Department of Health and Human Services Order

When a provider is the subject of a notice by the United States Department of Health and Human Services (HHS) requiring the provider's suspension or the denial, termination, or refusal to renew a provider contract pursuant to § 1902(a)(39) (42 U.S.C. 1396a(a)(39)) or any other section of the Social Security Act, the provider's participation in MassHealth will be suspended or its provider contract will be denied, terminated, or not renewed in accordance with the HHS notice, subject, however, to the provisions of 130 CMR 450.216. The MassHealth agency will not afford a hearing to the provider as to the correctness or validity of the action taken by HHS.

450.215: Provider Eligibility: Notification of Potential Changes in Eligibility

(A) The provider must notify the MassHealth agency in writing, within 14 calendar days of receipt, of any written communication or electronic notification from an issuing federal or state agency, board, quasi-public board department (other than the MassHealth agency) or another state's Medicaid program that expresses an intention, conditionally or otherwise, to alter, revoke, void, suspend, or deny the issuance, renewal, or extension of any license, certificate, or other statement of qualification that constitutes a provider eligibility criterion, or take any action of the nature set forth in 130 CMR 450.212(A)(6).

(B) The provider must notify the MassHealth agency in writing, within 14 calendar days of sending to an issuing agency, of any communication that expresses an intention or desire to register as an inactive practitioner, resign, surrender, terminate, or substantially modify the conditions of any such license, certificate, or other statement of qualification that constitutes a provider eligibility criterion.

(C) Without limiting the generality of 130 CMR 450.215(A), the provider must notify the MassHealth agency in accordance with 130 CMR 450.215(A) and (B) whenever the provider

(1) has received notice of denial of Medicare or Medicaid certification from the Massachusetts Department of Public Health;
(2) has received notice of a denial of an application for renewal of a license;
(3) has filed application with the Department of Public Health to convert from nursing facility to rest home status;
(4) has received an order to show cause from a board of registration;
(5) becomes subject to any action of the nature set forth in 130 CMR 450.212(A)(6); or
(6) has been terminated or suspended from participation in Medicare or another state's Medicaid program.

450.216: Provider Eligibility: Limitations on Participation

If termination or suspension of a provider's participation in MassHealth has occurred or is imminent, the MassHealth agency will take such action as may be reasonably necessary or appropriate to prevent or to mitigate injury to members or MassHealth or both, resulting from such termination or suspension. Such action may be taken immediately upon notice to the provider notwithstanding the exercise of such rights as the provider may have to secure administrative or judicial review of the action of the issuing agency, or of the U.S. Department of Health and Human Services, or of the MassHealth agency, or any combination of them. With respect to chronic disease and rehabilitation hospitals and other long-term-care facilities, such action may include an order barring further admissions of members pending final resolution of the issues that prompted such action, or an order that the institution will continue to be paid by the MassHealth agency, for a period specified in the order, for services to members admitted to the facility prior to an order barring new admissions, or prior to such termination. Such action will be reasonably calculated to achieve, so far as possible, the following goals:

(A) protecting the health and safety of members, including present and prospective patients of the provider; and

(B) maximizing federal financial participation in the cost of medical assistance.

450.217: Provider Eligibility: Ineligibility of Suspended Providers

A provider suspended from participation in MassHealth is not eligible to participate during the period of such suspension, cannot receive payments for any services rendered to members during the period of such suspension, and is not eligible to participate until such time as a new application is filed, reviewed, and approved, and the provider contract is effective. If the violations resulted in overpayments, the MassHealth agency may deny the participation of such provider until such time as arrangements satisfactory to the MassHealth agency have been made for the restitution of all overpayments. The MassHealth agency has discretion to deny a new application after review of the any prior for cause suspensions, if in the judgment of the MassHealth agency, such participation would

450.217: continued

(A) threaten the health, welfare, or safety of members; or

(B) compromise the integrity of the MassHealth agency.

450.221: Provider Contract: Definitions

(A) Defined Terms. For the purposes of 130 CMR 450.222 through 450.228, the following words and expressions have the indicated definitions. These definitions as they are applied in 130 CMR 450.222 through 450.228 are adopted pursuant to the provisions of 42 U.S.C. §§ 1320a-3, 1320a-5, 1396a(a)(38), 1396b(i)(2), and regulations at 42 CFR 455.100.

Agent. Any person who has been delegated the authority to obligate or act on behalf of a provider.

Convicted. A judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

Disclosing Entity. A provider or fiscal agent.

Other Disclosing Entity. Any other disclosing entity and any entity that does not participate in MassHealth, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act. This includes

(1) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or managed care organization that participates in Medicare;

(2) any Medicare intermediary or carrier; and

(3) any entity (other than an individual practitioner or group practice that provides, or arranges for the provision of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Social Security Act).

Fiscal Agent. A contractor that processes or pays for provider claims on behalf of the MassHealth agency.

Indirect Ownership Interest. An ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managing Employee. A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

Ownership Interest. The possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an Ownership or Control Interest.

(1) a person or corporation that

(a) has an ownership interest totaling 5% or more in a disclosing entity;

(b) has an indirect ownership interest equal to 5% or more in a disclosing entity;

(c) has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;

(d) owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;

(e) is an officer or director of a disclosing entity that is organized as a corporation;

(f) is a partner in a disclosing entity that is organized as a partnership; or

(g) owns directly or indirectly an interest of 5% or more in any real property leased to a disclosing entity for use as a nursing facility, rest home, or hospital.

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(2) For the purpose of 130 CMR 450.221: *Person with an Ownership or Control Interest*, an individual is deemed to own any beneficial interest owned directly or indirectly by or for his or her minor children or spouse.

Significant Business Transaction. Any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or 5% of a provider's total operating expenses.

Secretary. The Secretary of the U.S. Department of Health and Human Services.

Subcontractor.

(1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the MassHealth agreement.

Supplier. An individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under MassHealth (for example, a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly Owned Supplier. A supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

(B) Determination of Ownership or Control Percentages. For the purposes of the definitions in 130 CMR 450.221(A), ownership or control percentages will be determined as follows.

(1) Indirect Ownership Interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10% of the stock in a corporation that owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation that owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported.

(2) Person with an Ownership or Control Interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10% of a note secured by 60% of the provider's assets, A's interest in the provider's assets equates to 6% and must be reported. Conversely, if B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported.

450.222: Provider Contract: Application for Contract

A person or entity may become a participating provider only by submitting an Application for Provider Contract. If approved by the MassHealth agency, the application will be part of any subsequent provider contract between the applicant and the MassHealth agency. Any omission or misstatement in the application will (without limiting any other penalties or sanctions resulting therefrom) render such contract voidable by the MassHealth agency.

450.223: Provider Contract: Execution of Contract

(A) If the provider applicant has filed a complete and properly executed application and meets all applicable provider eligibility criteria and nothing in the application or any other information in the possession of the MassHealth agency reveals any bar or hindrance to the participation of the provider applicant, the MassHealth agency will prepare and furnish a provider contract. When fully executed by the provider and the MassHealth agency, the contract will take effect as of the date determined by the MassHealth agency.

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(B) Each MassHealth provider must notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the application. Failure to do so constitutes a breach of the provider contract. In no event may a group practice file a claim for services provided by an individual practitioner until the individual practitioner is enrolled and approved by the MassHealth agency as a member of the group. At its discretion, the MassHealth agency may require a provider to recertify, at reasonable intervals, the continued accuracy and completeness of the information contained in the provider's application. Failure to complete such recertification upon request by the MassHealth agency may result in termination of the provider contract.

(C) The following provisions are a part of every provider contract whether or not they are included verbatim or specifically incorporated by reference. By executing any such contract, the provider agrees

(1) to comply with all laws, rules, and regulations governing MassHealth (*see* M.G.L. c. 118E, § 36);

(2) that the submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that

(a) the medical services for which payment is claimed were provided in accordance with 130 CMR 450.301;

(b) the medical services for which payment is claimed were actually provided to the person identified as the member at the time and in the manner stated;

(c) the payment claimed does not exceed the maximum amount payable in accordance with the applicable fees and rates or amounts established under a provider contract or regulations applicable to MassHealth payment;

(d) the payment claimed will be accepted as full payment for the medical services for which payment is claimed, except to the extent that the regulations specifically require or permit contribution or supplementation by the member;

(e) the information submitted in, with, or in support of the claim is true, accurate, and complete; and

(f) the medical services were provided in compliance with Title VI of the Civil Rights Act of 1964, § 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975;

(3) to keep for such period as may be required by 130 CMR 450.205 such records as are necessary to disclose fully the extent and medical necessity of services provided to or prescribed for members and on request to provide the MassHealth agency or the Attorney General's Medicaid Fraud Division with such information and any other information regarding payments claimed by the provider for providing services (*see* 42 U.S.C. 1396a(a)(27) and the regulations thereunder);

(4) that the contract may be terminated by the MassHealth agency if the provider fails or ceases to satisfy all applicable criteria for eligibility as a participating provider;

(5) to submit, within 35 days after the date of a request by the Secretary or the MassHealth agency, full and complete information about:

(a) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request;

(b) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request; and

(c) any information necessary to update fully and accurately any information that the provider has previously delivered to the MassHealth agency or to the Massachusetts Department of Public Health;

(6) that the MassHealth agency may recoup any sums payable by reason of a retroactive rate increase for any period during which the provider owned or operated part or all of a facility against any sums due the MassHealth agency by reason of a retroactive rate decrease for any periods;

(7) to comply with all federal requirements for employee education about false claims laws under 42 U.S.C. 1396a(a)(68) if the provider is an entity that received or made at least $5 million in Medicaid payments during the prior federal fiscal year;

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(8) to furnish to the MassHealth agency its national provider identifier (NPI), if eligible for an NPI, and include its NPI on all claims submitted under MassHealth; and

(9) to permit the Centers for Medicare & Medicaid Services (CMS) and the MassHealth agency, and their agents and designated contractors to conduct unannounced on-site inspections of any and all provider locations.

(D) The provider must terminate a provider contract only by written notice to the MassHealth agency and such termination will be effective no earlier than 30 days after the date on which the MassHealth agency actually receives such notice, unless the MassHealth agency explicitly specifies or agrees to an earlier effective date. Any provision allowing for termination upon written notice does not constitute the MassHealth agency's specification of or agreement to an earlier effective date.

450.224: Provider Contract: Exclusion and Ineligibility of Convicted Parties

The MassHealth agency may terminate, or refuse to enter into or to renew a provider contract if

(A) the provider, any party in interest in such provider, an agent or managing employee of such provider, or in the case of a group practice, any individual practitioner enrolled as a member of the group, has been convicted of a criminal offense relating to that person's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act, or of a crime of such a nature that, in the judgment of the MassHealth agency, the participation of such provider will compromise the integrity of MassHealth; or

(B) the provider or an individual practitioner enrolled as a member of a group practice has been a party in interest, a managing employee, or an agent of a provider that has been convicted of a criminal offense relating to that person's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act, or of a crime of such a nature that, in the judgment of the MassHealth agency, the participation of such provider will compromise the integrity of MassHealth.

450.226: Provider Contract: Issuance of Provider ID/Service Location Numbers

(A) Upon execution of the provider contract, the MassHealth agency will issue a provider ID/service location number or numbers to be used to identify the provider that is the subject of the contract.

(B) For every case in which a provider is assigned two or more provider ID/service location numbers, the provider must use each provider ID/service location number only in conjunction with the facility or location to which the provider ID/service location number is assigned. The MassHealth agency, however, maintains its right to commence proceedings in accordance with the provisions of 130 CMR 450.235 through 450.248 against any or all of its provider ID/service location numbers, regardless of the location or facility where the violation has been alleged to have occurred or the overpayment received.

(C) The MassHealth agency may require providers to obtain separate national provider identifiers (NPIs) for each service location and may deem it necessary to issue separate provider ID/service location numbers for separate service locations. The MassHealth agency may specify such requirements through provider bulletins, billing guidance, provider enrollment instructions, or other subregulatory written issuance.

450.227: Provider Contract: Termination or Disapproval

The MassHealth agency may at its discretion disapprove a provider contract, and may terminate an existing contract, if the provider fails to disclose any information in accordance with the provisions of 130 CMR 450.222, 450.223, or 42 CFR 455.100 through 106, 42 CFR 455.436, 42 CFR 1002, or as otherwise required by state or federal law.

450.231: General Conditions of Payment

(A) Except to the extent otherwise permitted by state or federal regulations, no provider is entitled to any payment from MassHealth unless on the date of service the provider was a participating provider and the person receiving the services was a member.

(B) The "date of service" is the date on which a medical service is provided to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers to a member medical goods that had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date before the final delivery of the goods, the MassHealth agency will pay the provider for the goods only under the following circumstances:

(1) the member must have been eligible for MassHealth on the date of the member's last visit with the provider before the provider orders or fabricates the goods;

(2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit;

(3) the provider has submitted documentation with the claim to the MassHealth agency that verifies both the date of the member's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;

(4) the provider must not have accepted any payment from the member for the goods except copayments as provided in 130 CMR 450.130; and

(5) the provider must have attempted to deliver the goods to the member.

(C) For the purposes of 130 CMR 450.231, a provider who directly services the member and who also produces the goods for delivery to the member has "fabricated" an item if the provider has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary member visits.

(D) A provider is responsible for verifying a member's eligibility status on a daily basis, including but not limited to members who are hospitalized or institutionalized. In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider's failure to verify a member's MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member's MassHealth eligibility determination, *see* 130 CMR 450.309(B). For payment to out-of-state providers providing services on an emergency basis, *see* 130 CMR 450.309(c).

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) may be made upon the MassHealth agency's receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act.

(F) Payment to all providers is made in accordance with the payment methodology applicable to the provider, established by EOHHS, subject to all applicable federal payment limits.

(G) If under state or federal statute, regulation, billing instructions or other subregulatory guidance, a National Provider Identifier (NPI) of a MassHealth-enrolled provider is required on a claim submitted to MassHealth, the NPI must be included on the claim, and that provider must participate in MassHealth for the claim to be payable. If the NPI of a provider who is not a MassHealth participating provider is included on a claim for any reason or if an NPI is not provided in accordance with state or federal requirements, that claim may not be payable.

(H) When any participating MassHealth provider orders, refers, or prescribes a service for a MassHealth member, that provider must include his or her individual NPI on such orders, referrals, or prescriptions. Such provider must also provide his or her individual NPI to a servicing billing provider upon request in other circumstances in which the servicing billing provider must include the ordering, referring or prescribing provider's NPI on MassHealth claims.

450.233: Rates of Payment to Out-of-state Providers

(A) Except as provided in 130 CMR 450.233(D) and 435.405(B), payment to an out-of-state institutional provider for any medical service payable by the MassHealth agency is the lowest of

(1) the rate of payment established for the medical service under the other state's Medicaid program;

(2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or

(3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider, other than an acute hospital, must submit to the MassHealth agency a current copy of the applicable rate schedule under its state's Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable by the MassHealth agency is made in accordance with the applicable fee schedule established by EOHHS, subject to any applicable federal payment limit (*see* 42 CFR 447.304).

(D) Payment to an out-of-state acute hospital provider for any medical service payable by the MassHealth agency is made as set forth in 130 CMR 450.233(D)(1) through (3). For purposes of 130 CMR 450.233(D), a "High MassHealth Volume Hospital" means any out-of-state acute hospital provider that had at least 100 MassHealth discharges during the most recent federal fiscal year for which complete data is available as determined by the MassHealth agency at least 90 days prior to the start of each federal fiscal year.

(1) Inpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for inpatient services as specified in 130 CMR 450.233(D)(1)(a) through (d).

(a) Payment Amount per Discharge.

1. Out-of-state APAD. Out-of-state acute hospitals are paid an adjudicated payment amount per discharge ("out-of-state APAD") for inpatient services; provided that the out-of-state APAD is not paid for inpatient services that are paid on a *per diem* basis under 130 CMR 450.233(D)(1)(b) or (c) and that payment for certain APAD carve-out services is as set forth in 130 CMR 450.233(D)(1)(d) and not in 130 CMR 450.233(D)(1)(a). The out-of-state APAD is calculated using the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals on the date of admission, which is then multiplied by the MassHealth DRG Weight assigned to the discharge based on the information contained in a properly submitted inpatient acute hospital claim.

a. "MassHealth DRG Weight" for purposes of 130 CMR 450.233(D) is the MassHealth relative weight determined by the MassHealth agency for each unique combination of APR-DRG and Severity of Illness (SOI).

b. "APR-DRG" or "DRG" for purposes of 130 CMR 450.233(D) refers to the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned to a claim by the 3M APR-DRG Grouper.

2. Out-of-state Outlier Payment. If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, then the out-of-state acute hospital is also paid an outlier payment for that discharge ("out-of-state outlier payment"). The out-of-state outlier payment is equal to the marginal cost factor in effect for in-state acute hospitals on the date of admission multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The "calculated cost of the discharge" for purposes of 130 CMR 450.233(D) will be determined by the MassHealth agency by multiplying the out-of-state acute hospital's allowed charges for the discharge by the following cost-to-charge ratio:

i. For a High MassHealth Volume Hospital, the hospital's inpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.

ii. For all other out-of-state acute hospitals, the median in-state acute inpatient hospital cost-to-charge ratio in effect on the date of admission based on MassHealth discharge volume, as determined by the MassHealth agency.

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b. The "discharge-specific outlier threshold" for purposes of 130 CMR 450.233(D) is equal to the sum of the out-of-state APAD corresponding to the discharge, and the fixed outlier threshold in effect for in-state acute hospitals on the date of admission.

(b) Out-of-state Transfer *Per Diem*.

1. Out-of-state acute inpatient hospitals are paid the out-of-state transfer *per diem* for inpatient services as calculated and capped as set forth in 130 CMR 450.233(D)(1)(b)2. (the "out-of-state transfer *per diem*") in the following circumstances:

a. If an out-of-state acute inpatient hospital transfers a MassHealth patient to another acute inpatient hospital, the MassHealth agency pays the transferring hospital the out-of-state transfer *per diem* for the period during which the member was an inpatient at the transferring hospital.

b. If a MassHealth member's enrollment in a MassHealth contracted managed care organization or accountable care partnership plan changes during an out-of-state acute inpatient hospital stay, such that the MassHealth agency is responsible for payment of only a portion of the hospital stay, the hospital is paid the out-of-state transfer *per diem* for that portion of the stay.

c. The MassHealth agency will pay the out-of-state transfer *per diem* in such other circumstances as in-state acute hospitals would be paid the in-state transfer *per diem*, as determined by the MassHealth agency.

2. The out-of-state transfer *per diem* is equal to the sum of the hospital's out-of-state APAD plus, if applicable, any out-of-state outlier payment, that would have otherwise applied for the period during which the transfer *per diem* is payable as calculated by the MassHealth agency, divided by the mean in-state acute hospital all-payer length of stay for the particular DRG assigned, as determined by the MassHealth agency. Total out-of-state transfer *per diem* payments for a given hospital stay are capped at the sum of the hospital's out-of-state APAD plus, if applicable, any out-of-state outlier payment that would have otherwise applied for the transfer *per diem* period. No other payments specified in 130 CMR 450.233(D)(1) apply.

(c) Out-of-state Psychiatric *Per Diem*. If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, including psychiatric and substance use disorder services, the out-of-state acute hospital will be paid an all-inclusive psychiatric *per diem* equal to the psychiatric *per diem* most recently in effect for in-state acute hospitals on the date of service ("out-of-state psychiatric *per diem*"). No other payments specified in 130 CMR 450.233(D)(1) apply.

(d) Payment for APAD Carve-outs. The following APAD carve-out services are paid separately from the out-of-state APAD and out-of-state outlier payment, as specified in 130 CMR 450.233(d)1. and 130 CMR 450.233(d)2.

1. Long-acting Reversible Contraception (LARC) Device (LARC Device).

a. A LARC device refers specifically to intrauterine devices and contraceptive implants; it does not refer to the LARC procedure, itself.

b. An out-of-state acute inpatient hospital may be paid for a LARC device separate from the out-of-state APAD, if the following conditions are met:

i. the member requests the LARC device while admitted as an inpatient for a labor and delivery stay and, at the time of the procedure, is a clinically appropriate candidate for immediate post-labor and delivery LARC device insertion;

ii. the practitioner performing the procedure has been properly trained for immediate postpartum LARC device insertion, and performs the procedure immediately after labor and delivery during the same inpatient hospital stay; and

iii. the hospital satisfies all other conditions for such payment as set forth in regulations and other formal written issuances of the MassHealth agency.

c. If the out-of-state acute inpatient hospital qualifies for separate payment of a LARC device, the hospital will be reimbursed for the LARC device according to the fee schedule rates for such devices set forth in 101 CMR 317.00: *Rates for Medicine Services*.

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d. A hospital's charges for a LARC device are excluded in calculating any out-of-state outlier payment under 130 CMR 450.233(D)(1)(a)2.

2. APAD Carve-out Drugs.

a. The list of MassHealth-designated APAD carve-out drugs is set forth on the "MassHealth Acute Hospital Carve-out Drugs List" page of the MassHealth Drug List (MHDL) which is available on the MassHealth website (https://masshealthdruglist.ehs.state.ma.us/MHDL/). This list may be updated from time to time.

b. All APAD carve-out drugs require prior authorization, and the acute inpatient hospital stay continues to also be subject to applicable admission screening requirements of the MassHealth agency. (*See* also, *e.g.*, 130 CMR 450.208 and 450.303.)

c. An out-of-state acute inpatient hospital may be paid separate from the out-of-state APAD for an APAD carve-out drug administered to a member during an inpatient admission, if the hospital satisfies all applicable MassHealth conditions of payment set forth in regulations and other formal written issuances of the MassHealth agency.

d. If the out-of-state acute inpatient hospital qualifies for separate payment of the APAD carve-out drug, the hospital will be reimbursed for the APAD carve-out drug in accordance with the MassHealth payment method applicable to such drug as in effect for in-state acute inpatient hospitals on the date of service.

e. A hospital's charges for an APAD carve-out drug are excluded in calculating any out-of-state outlier payment under 130 CMR 450.233(D)(1)(a)2.

(2) Outpatient Services.

(a) Payment for Outpatient Services. Except as provided in 130 CMR 450.233(D)(2)(c) and 450.233(D)(3), out-of-state acute hospitals are paid for outpatient services utilizing an adjudicated payment per episode of care payment methodology ("out-of-state APEC") as described in 130 CMR 450.233(D)(2)(b), or in accordance with the applicable fee schedule established by EOHHS for outpatient services for which in-state acute hospitals are not paid the APEC. For purposes of 130 CMR 450.233(D), "APEC-covered services" are outpatient services for which in-state acute hospitals are paid an APEC, and "episode" means all APEC-covered services delivered to a MassHealth member on a single calendar day, or if the services extend past midnight in the case of emergency department or observation services, on consecutive days.

(b) Out-of-state APEC. The Out-of-state APEC for each payable episode will equal the sum of the episode-specific total EAPG payment, and the APEC outlier component (*see* 130 CMR 450.233(D)(2)(b)1. and 2.). For proper payment, out-of-state acute hospitals must include on a single claim all of the APEC-covered services that correspond to the episode, and must otherwise submit properly completed outpatient hospital claims.

1. The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC outpatient statewide standard in effect for in-state acute hospitals on the date of service, and the claim detail line's adjusted EAPG weight. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line MassHealth EAPG weights to produce the claim detail line's adjusted EAPG weight used for this calculation. For purposes of 130 CMR 450.233(D),

a. EAPG stands for Enhanced Ambulatory Patient Group. EAPG(s) are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient claim by the 3M EAPG Grouper and refer to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix.

b. 3M EAPG Grouper refers to the 3M Corporation's EAPG grouper that has been configured for the MassHealth APEC payment methodology.

c. MassHealth EAPG weight refers to the MassHealth relative weight developed by the MassHealth agency for each unique EAPG.

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2. The "APEC outlier component" is equal to the marginal cost factor in effect for in-state acute hospitals on the date of service multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold.

If the episode-specific case cost is less than the episode-specific outlier threshold, then the APEC outlier component will be $0.

a. The "episode-specific case cost" for purposes of 130 CMR 450.233(D) shall be determined by the MassHealth agency by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the following cost-to-charge ratio:

i. For a High MassHealth Volume Hospital, the hospital's outpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.

ii. For all other out-of-state acute hospitals, the median in-state acute outpatient hospital cost-to-charge ratio in effect on the date of service based on MassHealth episode volume, as determined by the MassHealth agency.

b. The "episode-specific outlier threshold" for purposes of 130 CMR 450.233(D) is equal to the sum of the episode-specific total EAPG payment corresponding to the episode, and the fixed outpatient outlier threshold in effect for in-state acute hospitals on the date of service.

c. In no case is an APEC outlier component payable if the episode-specific total EAPG payment is $0.

(c) Payment for APEC Carve-out Drugs.

1. The list of MassHealth-designated APEC carve-out drugs is set forth on the "MassHealth Acute Hospital Carve-out Drugs List" page of the MassHealth Drug List (MHDL) which is available on the MassHealth website (https://masshealthdruglist.ehs.state.ma.us/MHDL/). This list may be updated from time to time.

2. All APEC carve-out drugs require prior authorization. *See* also 130 CMR 450.303.

3. An out-of-state acute outpatient hospital may be paid separate from the out-of-state APEC for an APEC carve-out drug administered to a member during an acute outpatient hospital visit, if the hospital satisfies all applicable MassHealth conditions of payment set forth in regulations and other formal written issuances of the MassHealth agency.

4. If the out-of-state acute outpatient hospital qualifies for separate payment of the APEC carve-out drug, the hospital will be reimbursed for the APEC carve-out drug in accordance with the MassHealth payment method applicable to such drug as in effect for in-state acute outpatient hospitals on the date of service.

(3) Services Not Available in State.

(a) For medical services payable by the MassHealth agency that are not available in-state as determined by the MassHealth agency, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid the rate of payment established for the medical service under the other state's Medicaid program (or equivalent) as determined by the MassHealth agency, or such other rate as the MassHealth agency determines necessary to ensure member access to services.

(b) For an inpatient service that is not available in-state, as determined by the MassHealth agency, payment to the out-of-state acute hospital under 130 CMR 450.233(D)(3)(a) will also include acute hospital outpatient services that the MassHealth agency determines are directly related to the service that is not available in-state.

(c) In order to receive payment under 130 CMR 450.233(D)(3), an out-of-state acute hospital provider must

1. submit to the MassHealth agency a complete list of services that are to be performed, along with their corresponding charges;

2. coordinate the case with clinical staff designated by the MassHealth agency; and

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3. comply with all other applicable MassHealth admission screening and prior authorization requirements, and any other conditions of payment of the MassHealth agency.

450.234: Rates of Payment to Chronic Disease, Rehabilitation, or Similar Hospitals with Both Out-of-state Inpatient Facilities and In-state Outpatient Facilities

Payment to a chronic disease, rehabilitation, or similar hospital with both out-of-state inpatient facilities and in-state outpatient facilities, for any medical service payable by the MassHealth agency is made as follows:

(A) Inpatient Services. For inpatient services, payment is in accordance with 130 CMR 435.405(B).

(B) Outpatient Services.
(1) For outpatient services provided out-of-state, payment is in accordance with 130 CMR 450.233(A) and (B).
(2) For outpatient services provided in-state, payment is the median in-state outpatient hospital cost-to-charge ratio for similar hospitals.

450.235: Overpayments

(A) Overpayments include, but are not limited to, payments to a provider
(1) for services that were not actually provided or that were provided to a person who was not a member on the date of service;
(2) for services that were not payable under MassHealth on the date of service, including services that do not comply with applicable program regulations or managed care performance specifications, services that were payable only when provided by a different provider type, and services that were not medically necessary (as defined in 130 CMR 450.204);
(3) in excess of the maximum amount properly payable for the service provided, to the extent of such excess;
(4) for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;
(5) for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts;
(6) for services provided when, as of the date of service, the provider was not a participating provider, or was in any breach or default of the provider contract;
(7) for services billed that result in a duplicate payment; or
(8) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.

(B) A provider must report in writing and return any overpayments to the MassHealth agency within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later. A provider must include in such written report the reason for the overpayment and use such form and follow such process that may be prescribed by the MassHealth agency.

450.236: Overpayments: Calculation by Sampling

In any action or administrative proceeding to determine or recover overpayments, the MassHealth agency may ascertain the amount of overpayments by reviewing a representative sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. The MassHealth agency employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid and representative sample.

450.237: Overpayments: Determination

The existence and amount of overpayment may be determined in an action to recover the overpayment in any court having jurisdiction. The MassHealth agency may also determine the existence and amount of overpayments. The procedures described in 130 CMR 450.236 and 450.237 do not apply to overpayments resulting from rate adjustments, which are governed by methods described in 130 CMR 450.259.

(A) Overpayment Notice. When the MassHealth agency believes that an overpayment has been made, it notifies the provider in writing of the facts upon which the MassHealth agency bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), the MassHealth agency will so inform the provider. The MassHealth agency may notify the provider by letter, draft audit report, computer printout, or other format.

(B) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the overpayment notice. The reply must specifically identify and address all allegations in the overpayment notice with which the provider disagrees. With the reply, the provider may submit additional data and argument to support its claim for payment and must include any documentary evidence it wants the MassHealth agency to consider. If the MassHealth agency states in the overpayment notice that the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), a provider may contest only the factual assertion that the federal or state agency made such a determination. The provider may not contest in any proceeding before or against the MassHealth agency the amount or basis for such determination.

(C) Overpayment Determination. The MassHealth agency considers and reviews only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that the provider has been overpaid, the MassHealth agency will so notify the provider in writing of its final determination, which will state the amount of overpayment that the MassHealth agency will recover from the provider.

(D) Adjudicatory Hearing. If the provider submits a timely reply, the provider may file a claim for an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243.

(E) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing or judicial review if it fails to submit a timely reply. The MassHealth agency will take appropriate action to recover the overpayment.

450.238: Sanctions: General

(A) Introduction. All providers are subject to the rules, regulations, standards, and laws governing MassHealth. 130 CMR 450.238 through 450.240 set forth the MassHealth agency's procedures for imposing sanctions for violations of those rules, regulations, standards, and laws. Such sanctions may include, but are not limited to, administrative fines, provider service restrictions, and suspension or termination from participation in MassHealth. The MassHealth agency determines the amount of any fine and may take into account the particular circumstances of the violation. The MassHealth agency may assess an administrative fine whether or not overpayments have been identified based on the same set of facts.

(B) Instances of Violation. Instances of violation include, but are not limited to

(1) billing a member for services that are payable under MassHealth, except copayments as provided in 130 CMR 450.130;

(2) submitting claims under an individual provider's MassHealth provider number for services for which the provider is entitled to payment from an employer or under a contract or other agreement;

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(3) billing the MassHealth agency for services provided by someone other than the provider, unless expressly permitted by the applicable regulations;
(4) billing the MassHealth agency before delivery of service, unless permitted by the applicable regulations;
(5) failing to comply with recordkeeping and disclosure requirements;
(6) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more comprehensive service for which a single rate of payment is established;
(7) failing to return credit balance funds to the MassHealth agency within 60 days of their receipt;
(8) failing to obtain or provide a physician's order, prescription, or referral when required by the applicable regulations;
(9) failing to comply with MassHealth enrollment, licensure, or certification requirements; and
(10) misapplication or misappropriation of personal needs allowance funds.

450.239: Sanctions: Calculation of Administrative Fine

(A) The MassHealth agency may assess an administrative fine not to exceed the greater of
(1) $100 for each instance of violation of the rules, regulations, standards, or laws governing MassHealth;
(2) $100 for each day of violation of the rules, regulations, standards, or laws governing MassHealth; or
(3) three times the payable amount of each claim, in accordance with 130 CMR 450.239.

(B) In determining the amount of any administrative fine, the MassHealth agency considers the following factors.
(1) Nature and Circumstances of the Claim. The MassHealth agency considers the circumstances to be mitigating if the violations were of the same type and occurred within a short period of time; there were only a few such instances; there was no history of similar types of violations; and the total monetary value of these instances was less than $1,000. Conversely, the MassHealth agency considers the circumstances to be aggravating if the violations were of a single type or several types and occurred over a lengthy period of time; there were many such instances; there was a history of similar types of violations; and the total monetary value of these instances was $1,000 or more.
(2) Prior Offenses. The MassHealth agency may consider the circumstances to be aggravating if the provider previously had been held liable for criminal, civil, or administrative sanctions relating to MassHealth.
(3) Financial Condition and Member-access Considerations. The MassHealth agency considers the circumstances to be mitigating if the imposition of a full penalty will jeopardize the ability of the provider to continue as a health-care provider and if the provider's inability to continue as a health-care provider would result in a demonstrable access problem for members in the provider's geographic region. The provider has the burden of demonstrating such access problem.
(4) Other Factors. The MassHealth agency will consider other mitigating or aggravating circumstances. If there are substantial mitigating circumstances, the MassHealth agency will decrease the administrative fine to be assessed. Conversely, if there are substantial aggravating circumstances, the MassHealth agency will increase the administrative fine to be assessed.

450.240: Sanctions: Determination

(A) Sanction Notice. When the MassHealth agency believes that sanctions should be imposed, the MassHealth agency will notify the provider in writing of the alleged violations and the proposed sanctions. The notice will be sufficiently detailed to reasonably inform the provider of the acts that the MassHealth agency alleges constitute such violations.

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(B) Suspension, Termination, or Provider Service Restrictions upon Sanction Notice. If the MassHealth agency finds, on the basis of information it has before it, that a provider's continued participation in MassHealth, or in the case of provider restrictions, participation without such restrictions, during the pendency of the administrative process could reasonably be expected to endanger the health, safety, or welfare of its members or compromise the integrity of MassHealth, it may suspend or terminate the provider's MassHealth participation or impose service restrictions on the provider at the same time the sanction notice described in 130 CMR 450.240(A) is sent to the provider. Said suspension, termination, or provider service restriction will remain in effect until either the MassHealth agency, pursuant to 130 CMR 450.240(D), issues a final determination removing or revising said suspension, termination, or provider service restriction, or the Medicaid Director, pursuant to 130 CMR 450.248, issues a final agency decision removing or revising said suspension, termination, or provider service restriction.

(C) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the sanction notice. The reply must specifically identify and address all allegations in the sanction notice with which the provider disagrees and explain any objections to the proposed sanctions. The provider must also include any additional documentary evidence it wants the MassHealth agency to consider.

(D) Sanction Determination. The MassHealth agency will consider and review only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that sanctions should be imposed because the provider has committed one or more violations of any rule, regulation, standard, or law governing MassHealth, the MassHealth agency will notify the provider in writing of its final determination, which will state any sanctions that the MassHealth agency will impose against the provider.

(E) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243. The MassHealth agency may amend or supplement the sanction notice at any time before the commencement of an adjudicatory hearing as long as any additional findings have been identified in a notice or amended notice. Once an adjudicatory hearing has commenced, the hearing officer may permit amendment of the sanction determination upon proper motion by the MassHealth agency and will permit amendment, where necessary, to conform the sanction determination to the evidence.

(F) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing or judicial review if it fails to submit a timely reply. The MassHealth agency will take appropriate action to implement the proposed sanctions.

450.241: Hearings: Claim for an Adjudicatory Hearing

(A) A provider may challenge the findings set forth in the MassHealth agency's final determination, issued pursuant to

(1) regulations, including but not limited to, 130 CMR 450.208(C)(2), 450.209(C)(3), 450.209(D), 450.210(D)(1), 450.213 (as to provider termination based solely upon a determination of ineligibility by the MassHealth agency), 450.237(D), or 450.240(E); or

(2) other formal written issuances of the MassHealth agency which specify that the provider has a right to challenge the findings set forth in the MassHealth agency's final determination using the process set forth in 130 CMR 450.241 through 450.248.

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(B) To challenge the findings set forth in the MassHealth agency's final determination, the provider must file a claim for an adjudicatory hearing (claim) with the Board of Hearings and the MassHealth agency within 30 calendar days of the date on the final determination. The last day of the time period to be computed is included unless it is a Saturday, Sunday, or legal holiday or other day on which the Board of Hearings is closed, in which event the period shall run until the end of the next following business day. Pursuant to 130 CMR 450.243, in addition to filing the request for an adjudicatory hearing timely, the provider must specifically identify each issue and fact in dispute and state the provider's position, the pertinent facts to be adduced at the hearing, and the reasons supporting that position. A claim is filed on the date actually received by both the Board of Hearings and the MassHealth agency. The failure to either file a timely claim, state the basis of the claim, or file with both the Board of Hearings and the MassHealth agency in compliance with 130 CMR 450.243 will result in implementation of the action identified in the final determination.

450.242: Hearings: Stay of Suspension or Termination or Provider Service Restriction

A timely claim will stay any suspension or termination or provider service restriction described in the final determination until there has been a final agency action pursuant to 130 CMR 450.243(D) or 450.248; provided, however, that if the MassHealth agency finds on the basis of information it has before it that a provider's continued participation in MassHealth or in the case of provider service restrictions, participation without such restrictions, during the pendency of the administrative appeal could reasonably be expected to endanger the health, safety, or welfare of members or compromise the integrity of MassHealth, the suspension, termination, or provider service restrictions will not be stayed. A timely claim will not stay any withholding of payments under 130 CMR 450.249.

450.243: Hearings: Consideration of a Claim for an Adjudicatory Hearing

(A) A timely claim must specifically identify each issue and fact in dispute and state the provider's position, the pertinent facts to be adduced at the hearing, and the reasons supporting that position.

(B) If a matter has been referred to or is under investigation by the Attorney General's Medicaid Fraud Division or other criminal investigation agency, or if a question of quality of care has been referred to a professional licensing board for investigation, the Board of Hearings, upon notice from the MassHealth agency, will postpone the hearing until the conclusion of such investigation and the final disposition of any criminal complaint, indictment, or order to show cause that ensues, or until the MassHealth agency notifies the Board to schedule the hearing. A provider may not request a postponement of the hearing under 130 CMR 450.243(B).

(C) The Board of Hearings will grant a hearing only if the claimant demonstrates all of the following.

(1) The claim was filed with the Board of Hearings and the MassHealth agency within the time limits set forth in 130 CMR 450.241.

(2) There is a genuine and material issue of adjudicative fact for resolution.

(3) The factual issues can be resolved by available and specifically identified reliable evidence as set forth in M.G.L. c. 30A, § 11(2). A hearing will not be granted on the basis of general allegations or denials or general descriptions of positions and contentions.

(4) The allegations of the provider, if established, would be sufficient to resolve a factual dispute in the manner urged by the provider. A hearing will not be granted if the provider's submissions are insufficient to justify the factual determination urged, even if accurate.

(5) Resolution of the factual dispute in the way sought by the provider is relevant to and would support the relief sought.

(D) Failure to comply with the conditions of 130 CMR 450.243(C) may result in dismissal of the claim, at the discretion of the Office of Medicaid Board of Hearings. Dismissal of a claim, without a timely request to vacate, or an upheld dismissal following a timely request to vacate, is a final agency action reviewable pursuant to M.G.L. c. 30A. Dismissal of a noncompliant claim, and the request to vacate a dismissal, shall be governed as follows:

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(1) The appellant will be informed by written notice of the dismissal and of the procedures for requesting that the dismissal be vacated.
(2) A request to vacate a dismissal must be in writing, must be signed by the appellant, and must demonstrate good cause for the appellant's failure to comply with the conditions set forth in 130 CMR 450.243(C).

(E) Notwithstanding 130 CMR 450.243(C) and (D), if there is no issue of adjudicative fact, but the provider has challenged the MassHealth agency's interpretation or application of regulations or laws, argument concerning such challenges will be presented in memoranda and briefs.

450.244: Hearings: Authority of the Hearing Officer

The hearing officer does not render a decision about the legality of federal or state laws, including, but not limited to, the MassHealth regulations. If the legality of such law or regulation is raised by the provider, the hearing officer renders a decision based on the applicable law as interpreted by the MassHealth agency. Such decision includes a statement that the hearing officer cannot rule on the legality of such law or regulation and is subject to judicial review in accordance with M.G.L. c. 30A.

450.245: Hearings: Burden of Proof

The provider has the burden of establishing by a preponderance of the evidence that the provider has complied with the MassHealth requirements cited in the MassHealth agency's final determination or otherwise has correctly received, or is entitled to receive, any amounts in dispute.

450.246: Hearings: Procedure

The hearing is conducted in accordance with M.G.L. c. 30A, §§ 9, 10, and 11 and the formal rules of the Standard Rules of Practice and Procedure found at 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure*, 801 CMR 1.01: *Purpose, Application and Authority*, and 801 CMR 1.03: *General Provisions*, as modified or supplemented by 130 CMR 450.000.

450.247: Hearings: Hearing Officer's Decision

The hearing officer's decision is in the form of a proposed decision to the Medicaid director. The proposed decision may affirm, modify, or overturn the actions proposed in the MassHealth agency's final determination. The proposed decision includes a determination of the amount of overpayments, if overpayments have been alleged, and a statement of reasons for the decision, including determination of each issue of fact or law necessary to the decision. If the provider makes a written request for the proposed decision prior to its issuance, the Board of Hearings notifies the provider by mail of the proposed decision. The decision of the hearing officer is effective when and to the extent it is adopted by the Medicaid director.

450.248: Medicaid Director's Decision

If the provider has made a written request for a copy of the proposed decision prior to its issuance, the provider has seven calendar days from its receipt of the proposed decision to file written objections with the Medicaid director. The Medicaid director may adopt or modify the proposed decision, or return the matter to the hearing officer for further consideration, based on evidence already in the record or, if necessary, additional evidence to be included in the reopened record. The hearing officer will resubmit the proposed decision to the Medicaid director, as modified pursuant to 130 CMR 450.247 and 450.248. The provider is notified of the Medicaid director's action. When the Medicaid director has adopted or modified the proposed decision, the Medicaid director's decision is a final agency action reviewable pursuant to M.G.L. c. 30A.

450.249: Withholding of Payments

(A) Introduction. The term "withholding of payments" or "withholding payments" as used in 130 CMR 450.249 means the withholding of all or a portion of payments payable to a provider. While withholding payments, the MassHealth agency continues to process the provider's claims. To avoid rejection of otherwise proper claims because of late submission, a provider whose payments are being withheld must continue to submit timely claims.

(B) Withholding Payments from Providers for Overpayments or Other Violations. Upon written notice to the provider, the MassHealth agency may withhold payments to a provider, or any provider under common ownership (defined the same as "provider under common ownership" in 130 CMR 450.101), if the MassHealth agency believes that the provider has received any overpayments or committed any violations. The notice states the effective date of the withholding, the amount being withheld, and the reason for the withholding. A provider subject to a withhold may submit written evidence for consideration by the MassHealth agency as to why payments in whole or in part should not be withheld. The withholding of payments expires 90 calendar days after the date withholding begins unless the MassHealth agency has sent the provider an overpayment or sanction notice pursuant to 130 CMR 450.237 or 450.240. The withholding of payments continues until the entitlement to the withheld funds and the amount of overpayment or administrative fines has been finally adjudicated and all due amounts have been recovered.

(C) Withholding Payments for Credible Allegation of Fraud. Upon written notice to the provider, or without notice as provided for under 42 CFR 455.23(b), the MassHealth agency may withhold payments to a provider, or to any provider under common ownership (defined the same as "provider under common ownership" in 130 CMR 450.101), where there is a credible allegation of fraud under 42 CFR 455.23. The notice complies with 42 CFR 455.23(b) and informs the provider of the right to submit written evidence for consideration by the MassHealth agency as to why payments in whole or in part should not be withheld. The withholding of payments continues until such time as any investigation and associated enforcement proceedings are completed, and all due amounts have been recovered. If the Attorney General's Medicaid Fraud Division or other law enforcement agency declines to accept any fraud referral, any payments withheld under 130 CMR 450.249(C) are released and no further payments are withheld, unless within ten business days of the MassHealth agency receiving such notice from the Attorney General's Medicaid Fraud Division or other law enforcement agency, the MassHealth agency sends written notice to the provider in accordance with 130 CMR 450.249(B) that the MassHealth agency believes that the provider has received any overpayments or committed any violations.

(D) Withholding Payments to Providers Withdrawing from MassHealth.

(1) The MassHealth agency may withhold payments to a provider, or to any providers under common ownership, at any time following receipt by the MassHealth agency of notification of the provider's intention to close or to withdraw from MassHealth. The MassHealth agency may withhold such payments whenever the MassHealth agency reasonably believes that there may be an outstanding issue, claim, or adjustment in connection with or incident to any payment to the provider. Such payment may be withheld regardless of whether the outstanding issue, claim, or adjustment is related to that payment. Circumstances in which there may be an outstanding issue, claim, or adjustment include, without limitation:

(a) an outstanding provider cost report;
(b) an anticipated or pending audit or utilization review;
(c) a rate decrease or other payment adjustment; or
(d) an outstanding or incomplete payment reconciliation.

(2) The MassHealth agency notifies the provider in writing of the date of the withholding, the amount withheld, and the reason for the withholding. The withholding of payments under 130 CMR 450.249(D) continues until the provider's entitlement to the withheld funds, and all outstanding issues, claims, or adjustments in connection with or incident to the payments to the provider, have been finally adjudicated or otherwise finally resolved. During the period the MassHealth agency withholds payments under 130 CMR 450.249(D), the MassHealth agency may recoup or offset all or part of the withheld funds for repayment by the provider of any liability incurred due to a rate decrease, any recoupment account balance owed, or any other debt, liability, or account balance owed by the provider.

450.249: continued

(E) Federal Orders to Withhold Payments. If the MassHealth agency receives notice from the U.S. Department of Health and Human Services of an order for suspension of payments to a provider under 42 U.S.C. § 1396m or any other section of the Social Security Act, the MassHealth agency withholds payments otherwise due the provider in accordance with the terms of the notice. The MassHealth agency promptly notifies the provider of such action and the reason for it. The MassHealth agency takes such other action as may be necessary or appropriate to ameliorate the effect of actions taken under 130 CMR 450.249(E) on members and on MassHealth, including action similar to that described in 130 CMR 450.216. The withholding of payments continues until the underlying Department of Health and Human Services order is rescinded, or becomes final and unappealable, at which time apportionment of the withheld amounts between the MassHealth agency and the provider are made.

(F) Continued Provider Participation in the MassHealth Program.

(1) A provider subject to a withhold under 130 CMR 450.249(B), (C), and (E) must continue to provide services to MassHealth members as long as the provider continues to participate in MassHealth. Any provider terminating its participation in MassHealth must do so in accordance with 130 CMR 450.223(D) and such other statutory, regulatory, or contractual requirements as may be applicable to the particular provider or provider type.

(2) Any provider that terminates or otherwise discontinues its business operations will be deemed to be terminating its participation in MassHealth and accordingly must comply with the requirements stated in 130 CMR 450.249(F)(1).

(3) Notwithstanding 130 CMR 450.249(F)(1), the MassHealth agency may suspend or terminate the participation of or impose a service restriction on a provider subject to a withholding of payments.

450.259: Overpayments Attributable to Rate Adjustments

(A) Whenever an overpayment occurs due to a rate adjustment that is established by the MassHealth agency in accordance with applicable law, the MassHealth agency notifies the provider in writing by issuing a remittance advice identifying the impact of the rate adjustment on all previously paid claims and stating the amount of the overpayment.

(B) A provider must pay to the MassHealth agency the full amount of any overpayment attributable to a rate adjustment. The applicable recoupment account will be systematically established against all future payments until the full amount is repaid, unless the provider enters into a payment arrangement with the MassHealth agency under 130 CMR 450.260(H).

(C) If a provider disputes the MassHealth agency's computation of an overpayment attributable to a rate adjustment, the provider must submit proposed corrections, including a detailed explanation, in writing to the MassHealth agency within 30 calendar days after the date of issuance of the remittance advice under 130 CMR 450.259(A). The fact that any rate adjustment is under appeal is not considered a factor in determining the amount of liability. The fact that a provider has submitted proposed corrections to the MassHealth agency does not delay or suspend the provider's payment obligations set forth under 130 CMR 450.259(B).

(D) If proposed corrections are timely submitted in accordance with 130 CMR 450.259(C), the MassHealth agency reviews the proposed corrections and notifies the provider of its decision within 30 calendar days of receipt of the provider's corrections. If the MassHealth agency determines that corrections are required, the MassHealth agency makes any appropriate payment adjustments reflecting the corrections.

(E) A provider must pay the MassHealth agency the full amount of the overpayment stated in a remittance advice under 130 CMR 450.259(A), regardless of any pending appeal, action, or other proceeding contesting the overpayment, including but not limited to, any appeal, action, or other proceeding contesting any rate on which the overpayment is computed. If required by a final disposition of any such appeal, action, or proceeding, the MassHealth agency issues a revised remittance advice and makes any appropriate payment adjustments to effect the final disposition.

450.260: Monies Owed by Providers

(A) Provider Liability. A provider is liable for the prompt payment to the MassHealth agency of the full amount of any overpayments, or other monies owed under 130 CMR 450.000, including but not limited to 130 CMR 450.235(B), or under any other applicable law or regulation. A provider that is a group practice is liable for any overpayments owed and subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

(B) Ownership Liability. Any owner of an institutional provider is liable for the monetary liability of the institutional provider under 130 CMR 450.260(A) to the extent of the owner's ownership interest. For purposes of 130 CMR 450.260, an "owner" is a person or entity having an ownership interest in an institutional provider, as such interest is defined in 130 CMR 450.221(A)(9)(a), (b), (c), or (f). An "institutional provider" is any provider that provides nursing facility services, or acute, chronic, or rehabilitation hospital services.

(C) Common Ownership Liability. Any two or more providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, are jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260(A).

(D) Successor Liability. Any successor owner of a provider is liable for the obligation of any prior owner to pay the full amount of any monies owed by the prior owner under 130 CMR 450.260(A). For purposes of 130 CMR 450.260, a "successor owner" is any successor owner, operator, or holder of any right to operate all or a part of the prior owner's health-care business, which includes, but is not limited to, the business management, personnel, physical location, assets, or general business operations. A successor owner of a nursing facility or hospital includes any successor owner or holder of a license to operate all or some of the beds of a nursing facility or hospital.

(E) Group Practice Liability. The individual practitioner who provided the service and the group practice will be jointly and severally liable for each of their obligations to pay the full amount of any monies owed under 130 CMR 450.260.

(F) Recoupment. If a provider fails to pay the full amount of any monies owed under 130 CMR 450.260(A), the MassHealth agency may recoup up to 100% of any and all payments to the provider, without further notice or demand, until such time as the full amount of any monies owed under 130 CMR 450.260(A) is paid in full.

(G) Set-off. The MassHealth agency may apply a set-off against payments to a provider in the following circumstances.

(1) Providers under Common Ownership. Whenever any monies are owed by a provider under 130 CMR 450.260(A), the MassHealth agency may set off up to 100% of any and all payments to any providers who are or were, at any time, wholly or partly owned by the same person or entity, whether concurrently, sequentially, or otherwise, without further notice or demand, until such time as the full amount of the monies owed under 130 CMR 450.260(A) is repaid in full.

(2) Successors. Upon the sale or transfer of all or part of a provider, the MassHealth agency may set off up to 100% of any and all payments to any successor owner, without further notice or demand, until such time as the full amount of any monies owed by any prior owner under 130 CMR 450.260(A) is repaid in full.

(3) Group Practices. Whenever monies are owed by a group practice under 130 CMR 450.260(A), the MassHealth agency may set off up to 100% of any and all payments to the individual practitioner who provided the service, without further notice or demand, until such time as the full amount of any monies owed by the group practice under 130 CMR 450.260(A) is repaid in full. Whenever monies are owed by an individual practitioner who is a member of a group practice under 130 CMR 450.260(A), the MassHealth agency may set off up to 100% of any and all payments to the group practice, without further notice or demand, until such time as the full amount of any monies owed by the individual practitioner under 130 CMR 450.260(A) is repaid in full.

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(H) Payment Arrangements. If the recoupment or set-off would cause a financial hardship for a provider, the provider may submit a request in writing, with appropriate documentation, to the MassHealth agency for a payment arrangement. At its discretion, the MassHealth agency may enter into a written arrangement with a provider, its owner, any provider under common ownership, or any successor owner to establish a schedule to pay to the MassHealth agency the full amount of any monies owed, on such terms as are acceptable to the MassHealth agency. The arrangement may provide for such guarantees or collateral as may be acceptable to the MassHealth agency to secure the payment schedule.

(I) Court Action. The MassHealth agency may recover the full amount of any monies owed to the MassHealth agency under 130 CMR 450.260(A) by commencing an action in any court of competent jurisdiction. Such action may be commenced against any parties described under 130 CMR 450.260.

(J) Joint and Several Obligations. All obligations of any parties described under 130 CMR 450.260 are joint and several.

450.261: Member and Provider Fraud

All members and providers must comply with all federal and state laws and regulations prohibiting fraudulent acts and false reporting, specifically including but not limited to 42 U.S.C. 1320a-7b. Providers shall also promptly notify the MassHealth agency if it suspects a member is not eligible to receive MassHealth or someone other than the member is using the member's MassHealth card to receive or attempt to receive services or if any provider may be engaging in Medicaid fraud. The provider shall cooperate with and provide all information requested by the MassHealth agency, the Attorney General's Medicaid Fraud Division, the State Auditor's Office, or any other law enforcement entity investigating such fraud.

450.271: Individual Consideration

(A) The MassHealth agency may identify certain services as requiring individual consideration (IC) in program regulations, associated lists of service codes and service descriptions, billing instructions, provider bulletins, and other written issuances from the MassHealth agency. For services requiring individual consideration, the MassHealth agency establishes the appropriate amount of payment based on the standards and criteria set forth in 130 CMR 450.271(B). Providers claiming payment for any IC-designated service must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that must minimally include where applicable, but is not limited to, an operative report, pathology report, or in the case of a purchase, a copy of the supplier's invoice. The MassHealth agency does not pay claims for "IC" services unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim.

(B) The MassHealth agency determines the appropriate payment for an IC service in accordance with the following standards and criteria:

(1) the amount of time required to perform the service;
(2) the degree of skill required to perform the service;
(3) the severity and complexity of the member's disease, disorder, or disability;
(4) any applicable relative-value studies; and
(5) any complications or other circumstances that the MassHealth agency deems relevant.

450.275: Teaching Physicians: Documentation Requirements

In order to be paid for physician services provided in a teaching setting, physicians must comply with the following documentation requirements.

(A) Definitions. Whenever one of the following terms is used in 130 CMR 450.275, it has the meaning given in the definition, unless the context clearly requires a different meaning.

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Resident. An individual who participates in an approved Graduate Medical Education (GME) program, including interns and fellows. A medical student is never considered a resident.

Teaching Physician. A physician (not a resident) who involves residents in the care of his or her patients. Where applicable and appropriate, the use of the phrase "teaching physician" will be construed to include teaching podiatrists and teaching dentists.

Teaching Setting. A setting in which there is an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

(B) General Requirements.

(1) Under MassHealth, the MassHealth agency pays for physician services (which are otherwise payable) furnished in teaching settings only if documentation in the patient's medical record clearly substantiates that the key portions of the services are personally provided by a teaching physician, or the key portions of the services, which include decision-making processes, are provided jointly by a teaching physician and resident, or by a resident in the presence of a teaching physician. (The teaching physician must determine which portions of the service or procedure are to be considered key and require his or her presence.) Any contribution of a medical student to the performance of a service or procedure must be performed in the physical presence of a teaching physician, or jointly with a resident.

(2) The teaching physician may not bill for the supervision of residents.

(3) The teaching physician may not bill for services provided solely by residents.

(C) Documentation.

(1) The teaching physician and resident are each responsible for documenting in the medical record his or her own level of involvement in the services. Documentation by the resident alone is not acceptable. In all cases, the teaching physician must personally document his or her presence and participation in the services in the medical record. This documentation by the teaching physician may either be in writing or *via* a dictated note, and may include references to notes entered by the resident.

(2) If the teaching physician would be repeating key elements of the service components previously documented by the resident (for example, the patient's complete history and physical examination), the teaching physician need not repeat the documentation of these components in detail. In these circumstances, the teaching physician's documentation may be brief, summary comments that reflect the resident's entry and that confirm or revise the key elements identified.

(D) Covered Services. The MassHealth agency pays for medical services (including, but not limited to, evaluation and management services, surgery services, anesthesia services, and radiology services) performed in a teaching setting if the following requirements are met, in addition to the general requirements in 130 CMR 450.275(A) through (C):

(1) Exceptions to Physical-presence Requirement. For certain services (general/internal medicine, pediatric, obstetric/gynecologic, and psychiatric), the teaching physician does not have to be physically present for the key portions of the service. (Refer to Appendix K: *Teaching Physicians* of the *Physician Manual* for a listing of the service codes for which this exception to the physical presence requirement applies.)

(2) Services Paid on the Basis of Time. For services paid on the basis of time (excluding anesthesia and those psychiatric services listed in Appendix K: *Teaching Physicians* of the *Physician Manual*), the teaching physician must be present for the period of time for which the claim is made. Time spent by the resident in the absence of the teaching physician may not be added to time spent by the resident and teaching physician with the member, or time spent by the teaching physician alone with the member. For example, the MassHealth agency will pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes.

(3) Medical Services. For medical services (including, but not limited to, evaluation and management services), the teaching physician may supervise up to four residents at any given time, and he or she must direct the care from such proximity as to constitute immediate physical availability.

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(4) Surgery Services. For surgery services, the teaching physician is responsible for the preoperative, intra-operative, and postoperative care of the member. The teaching physician must be scrubbed and physically present during the key portion of the surgical procedure. During the intra-operative period in which the teaching physician is not physically present, he or she must remain immediately available to return to the procedure, if necessary. He or she must not be involved in another procedure from which he or she cannot return. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure or during the closing of the surgical site to become involved in another surgical procedure, he or she must arrange for another teaching physician to be immediately available to intervene as needed. The designee must be a physician (excluding a resident) who is not involved in or immediately available for any other surgical procedure. The following guidelines apply to specific types of surgery and related services:

(a) Concurrent Surgeries. To be paid for concurrent surgeries, the teaching physician must be present during the key portions of both operations. Therefore, the key portions must not occur simultaneously. When all of the key portions of the first procedure have been completed, the teaching physician may initiate his or her involvement in a second procedure. The teaching physician must personally document the key portions of both procedures in his or her notes to demonstrate that he or she was immediately available to return to either procedure as needed.

(b) Straightforward or Low-complexity Procedures. The teaching physician must be present for the decision-making portions of straightforward or low-complexity procedures.

(c) Endoscopy Procedures. For procedures performed through an endoscope (other than endoscopic operations, when the endoscopy performed is not the key portion of the surgical procedure), the teaching physician must be present during the entire viewing. The entire viewing includes the period of insertion through removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching-physician-presence requirement.

(d) Obstetrics. To be paid for the procedure, the teaching physician must be present for the delivery. In situations in which the teaching physician's only involvement was at the time of delivery, he or she may bill for the delivery only. To be paid for the global procedures, the teaching physician must be physically present, in accordance with the general requirements in 130 CMR 450.275(B) and applicable program requirements.

(5) Anesthesia Services. If a teaching anesthesiologist is involved in a procedure with a resident, or with a resident and a non-physician anesthetist, the teaching physician must be present for induction and emergence. For any other portion of the anesthesia service, the teaching physician must be immediately, physically available to return to the procedure, as needed. The documentation in the medical records must indicate the teaching anesthesiologist's presence and participation in the administration of the anesthesia.

(6) Radiology Services. The interpretation of diagnostic tests must be performed or reviewed by a teaching physician. If the teaching physician's signature is the only signature on the interpretation, this indicates that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed both the image and the resident's interpretation and either agrees with or edits the findings. The teaching physician's countersignature alone is not acceptable documentation.

450.301: Claims

(A) Except as provided in other program regulations, a claim for a medical service may be submitted only by the provider that provided the service. In the absence of a specific exception or qualification, 130 CMR 450.301(A) and (B) apply.

(1) An individual practitioner may not claim payment under his or her own name and provider ID/service location number for services actually provided by another individual, whether or not the individual who provided the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

450.301: continued

(2) An individual practitioner may not claim payment under his or her own name and provider ID/service location number for medical services provided by the individual practitioner and for which the practitioner is paid by another entity (for example, hospital, clinic, long-term-care facility, pharmacy, home health agency, health maintenance organization, community health center, psychiatric day treatment program, day habilitation center, and adult day care center). In such cases, payment may be claimed only by the institution or facility.

(B) A provider may submit claims only if
(1) the payment for the services claimed is not otherwise claimed by any other MassHealth provider; and
(2) payment or any other compensation for the delivery of such services is not received by any provider from any other source.

450.302: Claim Submission

(A)(1) Electronic Claims. All claims submitted to the MassHealth agency for payment must be submitted electronically in a format designated by the MassHealth agency, unless the provider has been approved for an electronic claim submission waiver.
(2) Paper Claims.
(a) Any paper claims submitted by a provider who does not have an approved electronic claim submission waiver, pursuant to 130 CMR 450.302(A)(3), are rejected.
(b) Any paper claims submitted by a provider who has an approved electronic claim submission waiver must be submitted on the claim form designated by the MassHealth agency and according to its administrative and billing instructions.
(3) Waiver Criteria. The MassHealth agency grants a provider an electronic claim submission waiver if any of the following criteria apply.
(a) The provider has submitted an average of fewer than 20 claims per month over the previous 12 months.
(b) The provider is experiencing temporary technical difficulties related to upgrading their current billing system or installing a new one.
(c) The provider is experiencing temporary technical difficulties related to testing or interfacing with the MassHealth agency's claims processing system.
(d) The provider does not have Internet access or a computer.
(e) The provider is experiencing temporary disruption in service, for at least five business days, caused by a natural disaster or utility work.
(f) The provider attests to the MassHealth agency that its staff responsible for claims submission have a disability that prevents the submission of electronic claims that cannot be easily mitigated with reasonable accommodation.
(g) The provider has an extenuating circumstance in which submitting electronic claims would impede the provider's ability to participate in MassHealth.
(4) Waiver Duration. An electronic claim submission waiver is valid for 12 months from the date of issue. Providers who continue to experience circumstances that necessitate a waiver must apply for another waiver at least 30 days before the expiration of their current waiver, in order to avoid a possible interruption in payment.
(5) Waiver Fee. There is no fee for the first electronic claim submission waiver. The MassHealth agency may assess an administrative fee based on paper claim volume for any subsequent electronic claim submission waiver granted to a provider.
(6) Waiver Request Review Process. After review of a provider's request for an electronic claim submission waiver, the MassHealth agency notifies the provider in writing of its decision. If the waiver request is incomplete, the MassHealth agency may request additional information from the provider. If the provider does not submit the requested information to the MassHealth agency within 30 days of the request date, the MassHealth agency denies the waiver request. A provider may reapply for an electronic claim submission waiver with new or additional information.

(B) All claims submitted by a group practice must clearly identify by provider ID/service location number the individual practitioner who actually provided the services being claimed.

450.302: continued

(C) A group practice may submit claims only for services provided by individual practitioners who are MassHealth providers and who have been enrolled and approved by the MassHealth agency as a participant in the group.

450.303: Prior Authorization

In certain instances, the MassHealth agency requires providers to obtain prior authorization to provide medical services. These instances are identified in the billing instructions, program regulations, associated lists of service codes and service descriptions, provider bulletins, and other written issuances from the MassHealth agency. Such information is available on the MassHealth website at https://www.mass.gov/masshealth-provider-library, and copies may be obtained upon request. The provider must submit all prior authorization requests in accordance with the MassHealth agency's instructions. Prior authorization determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment, such as member eligibility or resort to health-insurance payment.

(A) For standard prior authorization decisions, the MassHealth agency acts on appropriately completed and submitted prior authorization requests within the following time periods.

(1) For pharmacy services—by telephone or other telecommunication device within 24 hours of the prior authorization request. The MassHealth agency will authorize at least a 72-hour supply of a prescription drug to the extent required by federal law. (*See* 42 U.S.C. 1396r-8(d)(5).)

(2) For transportation to medical services—within seven calendar days after a prior authorization request, or the number of days, if less than seven, necessary to avoid any serious and imminent risk to the health or safety of the member that might arise if the MassHealth agency did not act before the full seven days had elapsed.

For nonemergency transportation between an acute care hospital and post-acute care facility-within the next business day.

(3) For all other MassHealth services—within seven calendar days after a prior authorization request.

(B) For expedited prior authorization decisions for all MassHealth services, the MassHealth agency shall issue a prior authorization decision within 72 hours after receiving an appropriately submitted and completed prior authorization request. Providers must request an expedited prior authorization decision in a manner and format specified by the MassHealth agency.

(C) The following rules apply for prior authorization requests.

(1) The date of any prior authorization request is the date the request is received by the MassHealth agency, if the request conforms to all applicable submission requirements, including but not limited to the form, the place to which the request is sent, and required documentation.

(2) For standard prior authorization decisions, if a provider submits a prior authorization request that is incomplete or does not comply with all submission requirements, the MassHealth agency informs the provider

(a) of the relevant requirements, including any applicable program regulations;

(b) that the MassHealth agency will act on the request within the time limits specified in 130 CMR 450.303 if it receives the required information within 14 calendar days after the date on the MassHealth-issued notice that identifies that the request is incomplete and/or does not comply with all submission requirements; and

(c) that if the required information is not submitted to the MassHealth agency by 14 calendar days after the date on the MassHealth-issued notice that identifies that the request is incomplete and/or does not comply with all submission requirements, the MassHealth agency will issue a prior authorization decision based on the information that has been submitted to the MassHealth agency and the applicable MassHealth rules and regulations.

(3) Unless the MassHealth prior authorization decision states otherwise, a service is authorized on the date the MassHealth agency sends a notice of its prior authorization decision to the member or someone acting on the member's behalf.

450.303: continued

(D) The MassHealth agency does not act on prior authorization requests for
(1) covered services that do not require prior authorization; or
(2) noncovered services, except to the extent that MassHealth regulations specifically allow for such prior authorization requests.

450.304: Claim Submission: Signature Requirement

Every CMS-1500 claim form submitted for payment must be signed by the provider that provided the service or the provider's agent on behalf of the provider that provided the service. A provider that accepts payment of a claim is presumed to have authorized the submission of the claim on his or her behalf.

450.307: Unacceptable Billing Practices

(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method.

(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden:
(1) duplicate billing, which includes the submission of multiple claims for the same service, for the same member, by the same provider or multiple providers;
(2) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more comprehensive service for which a single rate of payment is established; and
(3) submitting claims under an individual practitioner's provider ID/service location number for services for which the practitioner is otherwise entitled to compensation.

450.309: Time Limitation on Submission of Claims: General Requirements

(A) In accordance with M.G.L. c. 118E, § 38, all claims must be received by the MassHealth agency within 90 days from the date of service or the date of the explanation of benefits from another insurer. When a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.

(B) For claims that are not submitted within the 90-day period but that meet one of the exceptions specified in 130 CMR 450.309(B), a provider must request a waiver of the billing deadline (a 90-day waiver) pursuant to the billing instructions provided by the MassHealth agency. The exceptions are as follows:
(1) a medical service was provided to a person who was not a member on the date of service, but was later enrolled as a member for a period that includes the date of service;
(2) a medical service was provided to a member who failed to inform the provider in a timely fashion of the member's eligibility for MassHealth; and
(3) other exceptions that are expressly authorized by the MassHealth agency pursuant to a MassHealth transmittal letter or provider bulletin.

(C) When a medical service was provided to a MassHealth member in another state by a provider that is not enrolled in MassHealth, the MassHealth agency will consider a claim for such service to have been timely submitted if all of the following apply:
(1) the medical service was provided in accordance with 130 CMR 450.109;
(2) the provider submits an application to the MassHealth agency to become a participating provider within 90 days after the date of service and the MassHealth agency approves the application; and
(3) the provider submits the claim for payment within 90 days after the date of the notice from the MassHealth agency approving the provider's application.

(D) All requests for waivers of the billing deadline submitted to the MassHealth agency for review must be submitted electronically in a format designated by the MassHealth agency, unless the provider has been approved for an electronic claim submission waiver as specified in 130 CMR 450.302(A)(3).

450.313: Time Limitation on Submission of Claims: Claims for Members with Health Insurance

If a provider delays submitting a claim in order to bill a member's health insurer (*see* 130 CMR 450.316 through 450.318), the claim will have been timely submitted if it is received:

(A) no later than the 90th day after the date of the notice of final disposition by the health insurer (if more than one insurer is involved, the submission period will be measured from the latest final disposition, and the period for making requests will be measured from the date of the notice of final disposition from the previous insurer); and

(B) no later than 18 months after the date of service.

450.314: Final Deadline for Submission of Claims

(A) If the MassHealth agency has denied a claim that was initially submitted within the 90-day deadline, the provider may resubmit the claim with appropriate corrections or supporting information.

(B) The MassHealth agency, pursuant to M.G.L. c. 118E, § 38, will not pay any claim submitted or resubmitted for services provided more than 12 months before the date of submission or resubmission, except as provided in 130 CMR 450.313 and 450.323.

450.316: Third-party Liability: Requirements

All resources available to a member, including but not limited to all health and casualty insurance, must be coordinated and applied to the cost of medical services provided by MassHealth. (*See* 42 CFR Part 433, Subpart D.) Except to the extent prohibited by 42 U.S.C. § 1396a(a)25(E) or (F), all providers must make diligent efforts to obtain payment first from other resources, including casualty payer payments, so that the MassHealth agency will be the payer of last resort. The MassHealth agency will not pay a provider and will recover any payments to a provider if it determines that, among other things, the provider has not made such diligent efforts. Under no circumstances may a provider bill a member for any amount for a MassHealth-covered service, except as provided by 130 CMR 450.130.

(A) "Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, including insurers. Diligent efforts include, but are not limited to:

(1) determining the existence of health insurance by asking the member if he or she has other insurance and by using insurance databases available to the provider;

(2) verifying the member's other health insurance coverage, currently known to the MassHealth agency through the eligibility verification system (EVS) on each date of service and at the time of billing;

(3) submitting claims to all insurers with the insurer's designated service code for the service provided;

(4) complying with the insurer's billing and authorization requirements;

(5) appealing a denied claim when the service is payable in whole or in part by an insurer; and

(6) returning any payment received from the MassHealth agency after any available third-party resource has been identified. The provider must bill all available third-party resources before resubmitting a claim to the MassHealth agency.

(B) The MassHealth agency will deem that the provider did not exercise diligent efforts pursuant to 130 CMR 450.316(A) if the insurer denies payment due to the provider's

(1) noncompliance with the insurer's billing and authorization requirements, including but not limited to errors in submission, failure to obtain prior authorization, failure to submit appropriate documentation and billing, providing services outside the service network, or untimely billing;

(2) request or provocation of a denial; or

(3) appeal of an insurer's favorable coverage determination.

450.316: continued

(C) Failure to comply with the provisions of 130 CMR 450.316(A) may subject a provider to sanctions and liability for overpayments as determined by the MassHealth agency in accordance with 130 CMR 450.235 through 450.240.

(D) Unless otherwise permitted by regulation, a provider is not entitled to receive or retain any MassHealth payment for a service provided to a member, if on that date of service the member had any other health insurance, including Medicare, that may have covered the service, and the provider did not participate in the member's other health insurance plan.

(E) If at any time a provider learns of health insurance not identified by EVS, the provider must copy both sides of the member's insurance card(s), or otherwise record the member's MassHealth identification number, insurance carrier, policy number, group number, and effective date of coverage, then send this information to the MassHealth agency.

(F) If a third-party resource is identified after the provider has already billed and received payment from the MassHealth agency, the provider must promptly return any payment it received from the MassHealth agency. The provider must bill all third-party resources before resubmitting a claim to the MassHealth agency.

(G) If a member is covered by more than one health insurer, the provider must request payment from all of the insurers prior to submitting a claim to the MassHealth agency.

450.317: Third-party Liability: Payment Limitations on Other Health Insurance Claim Submissions

(A) Subject to compliance with all conditions of payment, for members who have other health insurance in addition to MassHealth, the MassHealth agency's liability is the lesser of:

(1) the member's liability, including coinsurance, deductibles, and copayments, as reported on the explanation of benefits or remittance advice from the insurer; or

(2) the provider's charges or maximum allowable amount payable under the MassHealth agency's payment methodology, whichever is less, minus the insurance payments.

(B) For the purposes of 130 CMR 450.317, if the provider has entered into an agreement with any third party to accept payment for less than the amount of charges, the member's liability will be calculated based on such payment amount.

(C) Unless specifically provided for in law or by contract or interagency service agreement with the MassHealth agency, the MassHealth agency is not liable for payment of a service for which a member is not liable, including, without limitation, services available through an agency of the local, state, or federal government, or through a legally obligated person or entity.

(D) The MassHealth agency will deny a claim for a service payable in whole or in part by one or more other insurers unless the claim is accompanied by a final disposition from each insurer.

450.318: Third-party Liability: Payment Limitations on Medicare Crossover Claim Submissions

(A) A crossover is defined as a claim for a member who has Medicare in addition to MassHealth, where Medicare has made a payment or has approved an amount that was applied to the member's deductible.

(B) To obtain crossover payment, a provider must

(1) bill the Medicare fiscal intermediary or carrier, as applicable, in accordance with their billing rules, including using the appropriate Medicare claim form and format;

(2) accept assignment according to Medicare instructions; and

(3) follow the MassHealth agency's billing instructions relating to crossover claims.

450.318: continued

(C) Unless specifically provided for in law or by contract or interagency service agreement with the MassHealth agency, the MassHealth agency is not liable for payment of a service for which a member is not liable, including, without limitation, services available through an agency of the local, state, or federal government, or through a legally obligated person or entity.

(D) The MassHealth agency's crossover liability will not exceed
(1) the member's liability including coinsurance, deductibles, and copayments as reported on the explanation of benefits or remittance advice from Medicare;
(2) the maximum allowable amount payable under the MassHealth agency's payment methodology; or
(3) the MassHealth agency's established rate for crossover payment.

450.321: Third-party Liability: Waivers

The MassHealth agency may waive any requirements of 130 CMR 450.316 through 450.318, as applied to any provider, to institute information-gathering projects and to evaluate methods of exercising the third-party liability recovery options described in 42 CFR 433.139. The MassHealth agency will grant waivers only for projects that are likely to increase the efficient and economical collection of third-party resources and will state the extent of any waiver in the documents establishing such projects.

450.323: Appeals of Erroneously Denied or Underpaid Claims

Pursuant to M.G.L. c. 118E, § 38, the MassHealth agency has established the following procedures for appealing claims that the provider believes were denied in error or underpaid. The MassHealth agency's Final Deadline Appeals Board has exclusive jurisdiction to review appeals submitted by providers of claims for payment that were, as a result of MassHealth agency error, denied or underpaid, and that cannot otherwise be timely resubmitted.

(A) Criteria for Filing an Appeal. All requests for appeals submitted to the MassHealth agency for review must be submitted electronically in a format designated by the MassHealth agency, unless the provider has been approved for an electronic claim submission waiver as specified in 130 CMR 450.302(A)(3). To file an appeal with the MassHealth agency's Final Deadline Appeals Board, the provider must meet all of the following criteria.
(1) The provider must have submitted the original claim in a timely manner, pursuant to 130 CMR 450.309 through 450.314.
(2) The provider must have exhausted all available corrective actions outlined in the billing instructions provided by the MassHealth agency.
(3) The date of service for which the appeal is submitted must exceed the filing time limit of 12 months, unless third-party insurance is involved, in which case the filing time limit is 18 months (the final billing deadline).
(4) Claims for dates of service more than 36 months after the date of service are not eligible for an appeal.
(5) The provider must file the appeal within 30 days after the date on the remittance advice that first denied the claim for exceeding the final billing deadline.
(6) The provider must demonstrate that the claim was, as a result of MassHealth agency error, denied or underpaid.

(B) Accompanying Documentation. Along with each appeal of a claim, the provider must submit the following information to substantiate the contention that the claim was, because of MassHealth agency error, denied or underpaid:
(1) a standard appeal form prescribed by the MassHealth agency or cover letter describing the nature of the MassHealth agency error that resulted in the denial or underpayment of the claim. The statement must include the provider name, provider ID/service location number, member name, member number, and date of service.
(2) evidence of the claim's original, timely submission and resubmission, if applicable;
(3) a copy of the applicable page from each remittance advice on which the claim was previously processed;

450.323: continued

(4) a copy of the remittance advice or electronic response that indicates that the final submission deadline has passed;
(5) an accurately completed electronic claim or a legible and accurately completed paper claim if the provider has received a waiver of the electronic submission requirement; and
(6) any other documentation supporting the appeal.

(C) Procedure for Deciding Appeals. All appeals are decided by the MassHealth agency's Final Deadline Appeals Board based upon written evidence submitted by the provider. The provider has the burden of establishing by a preponderance of the evidence that the claims appealed were denied or underpaid because of MassHealth agency error.

(D) Request for an Adjudicatory Hearing. A provider may submit a request for an adjudicatory hearing with a final deadline appeal if there is a dispute about a genuine issue of material fact. The request must include a statement indicating the specific reasons why a hearing should be conducted. The request must include the following information:
(1) a statement identifying the material facts in dispute;
(2) a summary of the evidence that the provider would offer at the hearing to support his or her contentions; and
(3) a statement explaining why the evidence could only be presented at a hearing.

(E) Notification of Approval or Denial of Request for an Adjudicatory Hearing.
(1) If the Final Deadline Appeals Board determines that a hearing is justified, the MassHealth agency notifies the provider of:
(a) the issues of fact for which a hearing has been justified; and
(b) the identity of the person or entity designated by the MassHealth agency to conduct the hearing.
(2) Any hearing hereunder, whether conducted by the Final Deadline Appeals Board or its designee, is conducted in accordance with the provisions of 130 CMR 450.244 through 450.248.
(3) If the Final Deadline Appeals Board determines that a hearing is not justified, the MassHealth agency notifies the provider of the reasons why it decided not to hold a hearing.

(F) Decisions of the Final Deadline Appeals Board. The Final Deadline Appeals Board reviews each appeal that is properly submitted and notifies the provider in writing of its decision. The notification includes a brief statement of the reasons for its decision. The decision is a final agency action, reviewable pursuant to M.G.L. c. 30A.

450.324: Payment of Claims

The MassHealth agency will make electronic payments payable only to the provider, except as required by law or at the MassHealth agency's discretion.

450.331: Billing Agents

(A) The MassHealth agency processes claims that are submitted by a billing agent on behalf of a provider. At the written request of a provider, the MassHealth agency may also mail payments and remittance advices to a billing agent, but such payments are payable to the provider only, and in no event are payable to the billing agent. The MassHealth agency does not make payments to a billing agent.

450.331: continued

(B) The MassHealth agency recognizes a billing agent solely and strictly as the provider's agent. A billing agent is not considered a "provider" by the MassHealth agency. A provider's use of a billing agent does not relieve the provider of any responsibility imposed elsewhere in 130 CMR 450.000 for the claims that the provider submits or that are submitted on the provider's behalf. Any provider that engages a billing agent for the preparation and submission of claims to the MassHealth agency is fully responsible to the MassHealth agency for all acts by such billing agent with actual or apparent authority to perform such acts, notwithstanding any contrary provisions in any agreement between the provider and the billing agent. In case of any violations of laws, rules, or regulations, or of the provider contract arising out of the acts of the billing agent, the provider is fully liable as though they were the provider's own acts.

REGULATORY AUTHORITY

130 CMR 450.000: M.G.L. c. 118E, §§ 7 and 12.

Docket # 31

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **262 CMR 2.00**

CHAPTER TITLE: **Requirements for Licensure as a Mental Health Counselor**

AGENCY: **Board of Registration of Allied Mental Health and Human Services Professionals**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

This regulation states the eligibility criteria for licensure as a Licensed Mental Health Counselor (LMHC). The amendments establish licensure requirements for the new license category of Licensed Supervised Mental Health Counselors (LSMHCs), in accordance with chapter 177 of the Acts of 2022, an act addressing barriers to care for mental health, enacted on August 10, 2022. The amendments also clarify eligibility requirements for LMHCs and codify protections for LMHCs and LSMHCs from Chapter 16 of the Acts of 2025, an act strengthening health care protections in the commonwealth.

REGULATORY AUTHORITY: **M.G.L. c. 112, §§ 163 through 172; c. 13, §§ 88 through 90**

AGENCY CONTACT: **Sheila York** PHONE: **781-636-7138**

ADDRESS: **250 Washington Street, 2nd Floor, Boston MA 02108**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Office of Housing and Livable Communities (formerly DHCD) on 7/25/25
Massachusetts Municipal Association on 7/25/25

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **September 19, 2025**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **Minimal for both stakeholders and the Department.**

For the first five years: **Minimal for both stakeholders and the Department.**

No fiscal effect:

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **7/10/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

Mental Health Counseling, Licensed Mental Health Counselor, Supervised Licensed Mental Health Counselor, Licensure requirements

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amend 262 CMR 2.00

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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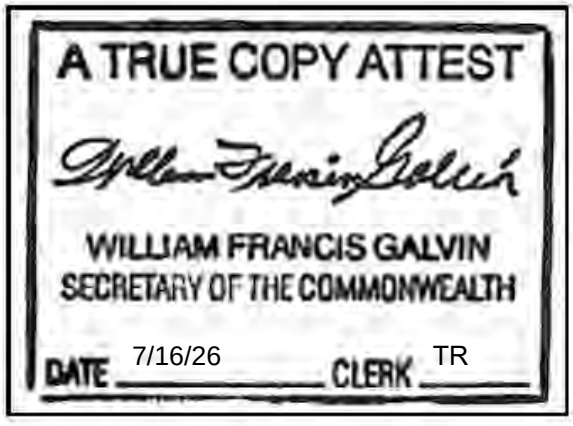

262 CMR: BOARD OF ALLIED MENTAL HEALTH AND HUMAN SERVICES PROFESSIONS

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262 CMR 2.00: REQUIREMENTS FOR LICENSURE AS A MENTAL HEALTH COUNSELOR

Section

2.01: Preface

To qualify for licensure as a mental health counselor, pursuant to the requirements of M.G.L. c. 112, § 165, an applicant must provide evidence satisfactory to the Board that the education and clinical field experience requirements listed in 262 CMR 2.05 through 2.08 have been met by the applicant.

All Licensed Mental Health Counselors are charged with having knowledge of 262 CMR and are required to practice Mental Health Counseling in accordance with its provisions.

2.02: Definitions

Approved Supervisor. An individual who is at least one of the following:

(a) A Massachusetts Licensed Mental Health Counselor or Massachusetts licensed marriage and family therapist with:

1. three years of Full Time, or the equivalent Part Time, experience as a practicing Massachusetts Licensed Mental Health Counselor or licensed Massachusetts marriage and family therapist; or
2. an approved Clinical Supervisor certification from the Massachusetts Mental Health Counselors Association (MaCCS), American Mental Health Counselors Association, American Association of Marriage and Family Therapists, National Board for Certified Counselors, or a similar certificate approved by the board; or
3. twelve continuing education hours in supervision provided by Entity-approved Sponsors, as defined in 262 CMR 7.02: *Definitions*, that cover legal and ethical issues, theories, and recordkeeping in supervision;

(b) A Massachusetts licensed independent clinical social worker with three years of Full Time, or the equivalent Part Time, experience as a practicing licensed independent clinical social worker; or

(c) A Massachusetts licensed psychologist with health service provider certification; or

(d) A Massachusetts licensed physician with a sub-specialization in psychiatry; or

(e) A Massachusetts licensed nurse practitioner with a sub-specialization in psychiatry; or

(f) If a supervisee's training and supervision occur outside of Massachusetts, an Approved Supervisor is a licensed person who, as determined by the Board, has equivalent qualifications in that state to a licensed mental health practitioner in a category listed above.

Board. The Board of Registration of Allied Mental Health and Human Services Professions established under M.G.L. c. 13, § 88.

Board Examination. The National Clinical Mental Health Counseling Examination administered by the National Board for Certified Counselors, Inc.

Clinical Field Experience Site. A site providing pre and post- Master's clinical field experience training that is a public or private Recognized Educational Institution or health or mental health institution regulated by the state, or other appropriate entity regulated by the state or otherwise exempt from regulation, that has integrated programs for the delivery of clinical Mental Health Counseling and has established provisions for appropriate supervision.

2.02: continued

Contact Hour. The unit of measurement of Direct Client Contact Experience of at least 45 minutes which may be composed of segments of at least 15 consecutive minutes.

Contract Supervisor. A Licensed Mental Health Counselor with three years of Full Time or the equivalent Part Time post-licensure clinical Mental Health Counseling experience who has a written agreement with the individual receiving supervision and the Clinical Field Experience Site where supervision is occurring regarding the supervision to be provided.

Direct Client Contact Experience. Direct, face-to-face, clinical Mental Health Counseling experience with a range of individuals, groups, couples, or families through Clinical Field Experience Sites that conforms to the Mental Health Counseling scope of practice as defined in 262 CMR 2.02: Mental Health Counseling. Such experience does not include vocational guidance services, academic school guidance counseling, industrial or organizational consulting services, teaching or conducting research.

Emergency Contact. In school settings where individuals are working as school adjustment counselors, the school principal, a guidance counselor or a licensed educational psychologist who serves as the contact in the temporary absence of an Approved Supervisor. In certain health care facilities where Mental Health Counseling is provided, a licensed rehabilitation counselor, a licensed psychologist, a psychiatric nurse practitioner or a designated clinical administrator who serves as the contact in the temporary absence of an Approved Supervisor.

Full Time. 35 hours per week, 48 weeks per year. The full time practice of clinical Mental Health Counseling must include at least ten Contact Hours per week of Direct Client Contact Experience.

Graduate Level Course. A course consisting of graduate level academic work. For required courses, a Graduate Level Course is a minimum of three semester credits or four quarter credits. For elective courses, a Graduate Level Course may be one or more semester/quarter credits.

Group Supervision. A regularly scheduled meeting of not more than ten mental health supervisees under the direction of an Approved Supervisor or Contract Supervisor for a period of at least one Supervisory Contact Hour. "Peer" supervision groups do not constitute Group Supervision.

Individual Supervision. A meeting of one supervisee with an Approved Supervisor or Contract Supervisor for at least one Supervisory Contact Hour.

Internship. A distinctly defined, post-*Practicum*, supervised curricular experience that totals a minimum of 600 clock hours. An internship enables the supervisee to enhance clinical Mental Health Counseling skills and integrate professional knowledge and skills appropriate to the supervisee's initial professional placement. An internship provides an opportunity for the individual to perform all the activities that a regularly employed staff member in the setting would be expected to perform.

Licensed Mental Health Counselor. A person licensed as a mental health counselor under M.G.L. c. 112, § 165.

Licensed Supervised Mental Health Counselor. A person licensed as a supervised mental health counselor under M.G.L. c. 112, § 165.

2.02: continued

Mental Health Counseling. The rendering of professional services to individuals, families or groups for compensation, monetary or otherwise. These professional services include: applying the principles, methods, and theories of counseling, human development, learning theory, group and family dynamics, the etiology of mental illness and dysfunctional behavior and psychotherapeutic techniques to define goals and develop a treatment plan of action aimed toward the prevention, treatment and resolution of mental and emotional dysfunction and intra or interpersonal disorders to all persons irrespective of diagnosis. The practice of Mental Health Counseling includes, but is not limited to, assessment, diagnosis and treatment, counseling and psychotherapy, of a nonmedical nature of mental and emotional disorders, psychoeducational techniques aimed at prevention of such disorders, and consultation to individuals, couples, families, groups, organizations and communities.

Post-Master's Degree Clinical Field Experience. Supervised work experience compliant with 262 CMR 2.07 and beginning after the candidate has earned all required education pursuant to 262 CMR 2.05.

Part Time. Experience gained in less than 35 hours per week for the purpose of meeting the post-graduate clinical field experience requirement.

Practicum. A distinctly defined, pre-Internship, supervised curricular experience that totals a minimum of 100 clock hours. A provides for the development of clinical Mental Health Counseling and group work skills under supervision. A may take place through the academic campus or through a Clinical Field Experience Site.

Recognized Educational Institution. An educational institution licensed or accredited by the state regional accrediting body in which it is located which meets regional standards for the granting of a Master's or Doctoral degree.

Relevant Field. Counseling, counselor education, expressive therapies, adjustment counseling, rehabilitation counseling, counseling psychology, clinical psychology, or another Mental Health Counseling field determined by the Board to be a Relevant Field.

Supervised Clinical Field Experience. Supervision compliant with 262 CMR 8.03(4) by an Approved Supervisor while in the practice of clinical Mental Health Counseling services.

Supervisory Contact Hour. The unit of measurement of Individual Supervision, Group Supervision, or Supervised Clinical Field Experience lasting a minimum of 45 consecutive minutes.

2.03: Licensure Application Requirements

(1) An applicant for licensure as a Licensed Supervised Mental Health Counselor must provide to the Board the following:

(a) a complete application for licensure as prescribed by the Board;

(b) a final transcript which demonstrates that the applicable degree and education requirements under 262 CMR 2.05 have been met;

(c) evidence which demonstrates that the applicant has completed the clinical field experience requirements under 262 CMR 2.06; and

(d) evidence of a passing score on the Board Examination. Passing scores remain valid for a period of five years from the date the examination was taken.

(2) An applicant for licensure as a Licensed Mental Health Counselor must provide to the Board the following:

(a) a complete application for licensure as prescribed by the Board;

(b) a final transcript that demonstrates the applicable degree and education requirements under 262 CMR 2.05 have been met;

(c) evidence that demonstrates the applicant has completed the clinical field experience requirements under 262 CMR 2.06 through 2.08; and

2.03: continued

(d) evidence of a passing score on the Board Examination. Passing scores will remain valid for a period of five years from the date the examination was taken unless the applicant was licensed as a Licensed Supervised Mental Health Counselor or as a mental health counselor, or the equivalent, by another state or jurisdiction after passing the Board Examination.

(e) If the applicant holds or held a license as a Licensed Supervised Mental Health Counselor, the applicant must provide only 262 CMR 2.03(2)(a) and (c).

(3) Any applicant who holds a license, certification or registration as a mental health counselor, or the equivalent thereof as determined by the Board, issued by another state or jurisdiction, may apply to the Board for licensure as a mental health counselor by reciprocal recognition. Such applicants must submit to the Board:

(a) a complete application for licensure as prescribed by the Board;

(b) a final transcript that demonstrates the applicable degree and education requirements under 262 CMR 2.05 have been met;

(c) evidence of a passing score on the Board Examination; and

(d) written proof, in a form acceptable to the Board, that the applicant's license, certification, or registration has been in good standing with the licensing authority that issued it for the three years preceding the date the applicant applied for licensure in Massachusetts.

2.05: Education and Degree Requirements

(1) Eligible applicants must have a minimum of 60 semester credit hours or 80 quarter credit hours (each semester credit equals 1.33 quarter credits) from an integrated, planned and comprehensive program from a Recognized Educational Institution, which degree/certificates includes a and Internship as defined in 262 CMR 2.02 and the Required Course Areas as defined by 262 CMR 2.05(2).

Eligible applicants must obtain the required education through the following degree programs:

(a) a Master's degree in Mental Health Counseling or a Relevant Field of at least 60 semester credits (80 quarter credits);

(b) a Master's degree in Mental Health Counseling or a Relevant Field of at least 48 semester credits (64 quarter credits) with completion of at least 12 semester credits (16 quarter credits) of additional qualifying courses listed in 262 CMR 2.05(2)(a) and (b); or

(c) a Master's degree in Mental Health Counseling or a Relevant Field with a certificate of advanced graduate studies (CAGS); or

(d) two Master's degrees in Mental Health Counseling or a Relevant Field; or

(e) a Doctoral degree in Mental Health Counseling or a Relevant Field.

Eligible applicants who hold degrees listed in 262 CMR 2.05(1)(a) through (e), but are missing credits or required courses, may supplement their degree program by taking additional qualifying courses or credits listed in 262 CMR 2.05(2)(a) and (b). No applicant shall earn credit for any supervised experience that occurs prior to the applicant's completion of all education listed in 262 CMR 2.05.

(2) As components of the degrees and certificates listed in 262 CMR 2.05(1), candidates must meet the following requirements:

(a) Required Course Areas. The successful completion of a minimum of ten Graduate Level Courses in each of the ten content areas listed in 262 CMR 2.05(2)(a) and each course may be used to fill only one requirement. All courses must focus specifically on Mental Health Counseling. The ten content areas are as follows:

1. Counseling Theory. Examination of the major theories, principles and techniques of Mental Health Counseling and their application to professional counseling settings. Understanding and applying theoretical perspectives with clients.

2. Human Growth and Development. Understanding the nature and needs of individuals at all developmental stages of life. Understanding major theories of physical, cognitive, affective and social development and their application to Mental Health Counseling practice.

2.05: continued

3. Psychopathology. Identification and diagnosis and mental health treatment planning for abnormal, deviant, or psychopathological behavior, includes assessments and treatment procedures.

4. Social and Cultural Foundations. Theories of multicultural counseling, issues and trends of a multicultural and diverse society. Foundational knowledge and skills needed to provide Mental Health Counseling services to diverse populations in a culturally competent manner.

5. Clinical Skills. Understanding of the theoretical bases of the counseling processes, Mental Health Counseling techniques, and their therapeutic applications. Understanding and practice of counseling skills necessary for the mental health counselor.

6. Group Work. Theoretical and experiential understandings of group development, purpose, dynamics, group counseling methods and skills, as well as leadership styles. Understanding of the dynamics and processes of Mental Health (therapeutic, psychosocial, psycho-educational) groups.

7. Special Treatment Issues. Areas relevant to the practice of Mental Health Counseling, *i.e*. psychopharmacology, substance abuse, school or career issues, marriage and family treatment, sexuality and lifestyle choices, treating special populations.

8. Appraisal. Individual and group educational and psychometric theories and approaches to appraisal. Examination of the various instruments and methods of psychological appraisal and assessment including, but not limited to, cognitive, affective, and personality assessment utilized by the mental health counselor. The function of measurement and evaluation, purposes of testing, reliability and validity.

9. Research and Evaluation. Understanding social science research, evaluative methodologies and strategies, types of research, program evaluation, needs assessments, ethical and legal considerations.

10. Professional Orientation. Understanding of professional roles and functions of Mental Health Counselors, with particular emphasis on legal and ethical standards. Ethical case conceptualization, analysis and decision making as it relates to clinical practice. Knowledge and understanding of the standards set by the code of ethics of the American Counseling Association and the American Mental Health Counselors Association. Understanding of licensure and regulatory practices.

(b) Electives Areas. Graduate Level Courses other than required Graduate Level Courses must be elective Graduate Level Courses which include knowledge and skills in the practice of Mental Health Counseling. Appropriate Graduate Level Courses may include, but are not limited to, any of the content areas listed under 262 CMR 2.05(2)(a) as well as:

1. best practices for maintaining and terminating counseling and psychotherapy;
2. consultation skills;
3. outreach and prevention strategies;
4. diagnosis and treatment issues;
5. working with special populations;
6. professional identity and practice issues, including historical perspectives;
7. mental health regulations and policy;
8. management of community mental health programs.

(c) a ; and

(d) an Internship.

2.06: Pre-master's Degree Clinical Field Experience Requirements

(1) Eligible applicants must demonstrate the completion of a pre-Master's degree *Practicum* that includes Supervised Clinical Field Experience and Direct Client Contact Experience. The *Practicum* must take place over a minimum period of at least seven weeks through an academic campus or through a Clinical Field Experience Site. The must include:

(a) 40 Contact Hours of Direct Client Contact Experience through Clinical Field Experience Sites conforming to the Mental Health Counseling scope of practice as defined under 262 CMR 2.02 or peer role plays and laboratory experience in individual, group, couple and family interactions;

(b) 25 Supervisory Contact Hours of supervision; of which:

1. a minimum of ten Supervisory Contact Hours must be Individual Supervision;

2.06: continued

2. a minimum of five Supervisory Contact Hours must be Group Supervision with no more than ten supervisees in a group;
3. the remaining ten Supervisory Contact Hours may be Individual or Group Supervision.

(2) Eligible applicants must demonstrate the completion of a pre-Master's degree Internship which includes Supervised Clinical Field Experience and Direct Client Contact Experience. Where the Internship is conducted through the intern's place of employment, the Internship site must provide additional activities and supervision clearly delineated from the intern's usual work activities. The Internship must include:

(a) 240 Contact Hours of Direct Client Contact Experience through Clinical Field Experience Sites conforming to the Mental Health Counseling scope of practice defined under 262 CMR 2.02;

(b) 45 Supervisory Contact Hours of supervision; of which:

1. a minimum of 15 Supervisory Contact Hours must be Individual Supervision;
2. a minimum of 15 Supervisory Contact Hours must be Group Supervision, with no more than ten supervisees in a group;
3. the remaining 15 Supervisory Contact Hours may be either Individual Supervision or Group Supervision.

(3) and Internship supervisees in a Clinical Field Experience Site may see clients only when there is an Approved Supervisor or Contract Supervisor available. In the temporary absence of either, a supervisee may see clients so long as an Emergency Contact is available.

(4) Supervisors must conduct regular evaluations of the *Practicum* and Internship supervisee's performance throughout the experience including a formal evaluation upon completion of the experience. Such evaluations shall include but not be limited to direct observation and review of process notes.

2.07: Post-master's Degree Clinical Field Experience Requirements

(1) Eligible applicants must complete, in no less than two and no more than eight years, a minimum of two years of Full Time or equivalent Part Time, post-Master's degree Supervised Clinical Field Experience and Direct Client Contact Experience. Post Master's Degree Supervised Clinical Field Experience and Direct Client Contact Experience may not begin until the applicant has completed 60 semester credits (80 quarter credits), including all requirements under 262 CMR 2.05.

(2) Eligible applicants must demonstrate the completion of the following post-Master's experience requirements:

(a) 3,360 total hours; which includes:

(b) 960 Contact Hours of Direct Client Contact Experience, of which:

1. a minimum of 610 Direct Client Contact Experience Contact Hours are in individual, couples, or family counseling; and
2. a maximum of 350 Direct Client Contact Experience Contact Hours may be in group counseling.

(3) Eligible applicants must demonstrate the completion of the following supervision hour requirements during post-Master's experience:

(a) at least 130 total hours of supervision of which at least 75 hours must be in Individual Supervision;

(b) a minimum of one Supervisory Contact Hour of supervision for every 16 Contact hours of Direct Client Contact Experience; and

(c) if working Part Time, supervision that is pro-rated no less than one Supervisory Contact Hour bi-weekly.

(4) Eligible applicants must demonstrate the following supervision conditions:

(a) the applicant must have a formal relationship with the Clinical Field Experience Site;

2.07: continued

(b) the supervisor must be a staff member of the Clinical Field Experience Site who is an Approved Supervisor or a Contract Supervisor so long as written notice of agreements with a contract supervisor are provided to and maintained on file by appropriate personnel at the Clinical Field Experience Site;
(c) annual evaluations of the supervisee must be completed by the Approved Supervisor or Contract Supervisor and reviewed and maintained on file by appropriate personnel at the site; and

(5) The provision of an Emergency Contact must be in place for all Clinical Field Experience Sites. The Emergency Contact individual shall not replace the requirement for an Approved Supervisor or Contract Supervisor.

2.08: Supervision by Licensed Mental Health Counselors

A minimum of 75 Supervisory Contact Hours of the 200 total Supervisory Contact Hours of supervision required (pre- or post-Master's degree) must be supervision by an Approved Supervisor who is a Licensed Mental Health Counselor or an equivalently licensed mental health counselor from another state or jurisdiction.

2.09: Legally Protected Health Care Activity

No person shall be denied initial licensure or denied renewal due to any complaint, criminal charge, conviction, judgment, discipline, or other sanction due to the providing or assisting in providing reproductive health care services or gender-affirming health care services, as defined at M.G.L. c. 12, § 11*I½*, so long as the services provided would have been lawful in Massachusetts and are consistent with standards for good professional practice in Massachusetts

REGULATORY AUTHORITY

262 CMR: M.G.L. c. 112, §§ 163 through 172 and M.G.L. c. 13, §§ 88 through 90.

NON-TEXT PAGE

Docket # 32

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **262 CMR 3.00**

CHAPTER TITLE: **Requirements for Licensure as a Marriage and Family Therapist**

AGENCY: **Board of Registration of Allied Mental Health and Human Services Professionals**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

This regulation states the eligibility criteria for licensure as a Licensed Marriage and Family Therapist (LMFT). The amendments clarify eligibility requirements for LMFTs and codify protections for LMFTs from Chapter 16 of the Acts of 2025, an act strengthening health care protections in the commonwealth.

REGULATORY AUTHORITY: **M.G.L. c. 112, §§ 163 through 172; c. 13, §§ 88 through 90**

AGENCY CONTACT: **Sheila York** PHONE: **781-636-7138**

ADDRESS: **250 Washington Street, 2nd Floor, Boston MA 02108**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Office of Housing and Livable Communities (formerly DHCD) on 7/25/25
Massachusetts Municipal Association on 7/25/25

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **9/19/25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **Minimal for both stakeholders and the Department.**

For the first five years: **Minimal for both stakeholders and the Department.**

No fiscal effect:

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **7/10/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*
Licensed Marriage and Family Therapy, Licensed Marriage and Family Therapist, Licensure requirements

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*
Amend 262 CMR 3.00

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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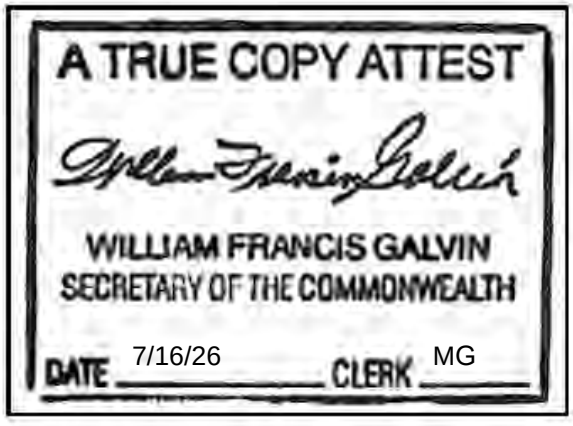
13 - 16	**13 - 16**



262 CMR 3.00: REQUIREMENTS FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST

Section

3.01: Preface

To qualify for licensure as a marriage and family therapist, pursuant to M.G.L. c. 112, § 165, an applicant must provide evidence satisfactory to the Board that the professional standards and education experience requirements of one of the Licensure Eligibility Requirements described in 262 CMR 3.03 have been met by the applicant.

All Licensed Marriage and Family Therapists are charged with having knowledge of the existence of 262 CMR and are required to practice marriage and family therapy in accordance with 262 CMR.

3.02 Definitions

AAMFT. The American Association for Marriage and Family Therapy

Approved Supervisor: An Approved Supervisor is any of the following:

(a) A Massachusetts Licensed Marriage and Family Therapist or Massachusetts licensed mental health counselor with:

1. three years of full-time, or the equivalent part-time, experience as a practicing Massachusetts Licensed Marriage and Family Therapist or Massachusetts licensed mental health counselor; or

2. an Approved Clinical Supervisor certification from the Massachusetts Mental Health Counselors Association (MaCCS), American Mental Health Counselors Association, AAMFT, or National Board for Certified Counselors, or a similar certificate approved by the Board; or

3. 12 continuing education hours in supervision provided by Entity-approved Sponsors, as defined in 262 CMR 7.02: *Definitions*, that cover legal and ethical issues, theories, and recordkeeping in supervision.

(b) A Massachusetts licensed independent clinical social worker with three years of full-time, or the equivalent part-time, experience as a practicing Massachusetts licensed independent clinical social worker; or

(c) A Massachusetts licensed psychologist with health service provider certification; or

(d) A Massachusetts licensed physician with a sub-specialization in psychiatry; or

(e) A Massachusetts licensed nurse practitioner with a sub-specialization in psychiatry; or

(f) If a supervisee's training and supervision occurred outside of Massachusetts, an Approved Supervisor is a licensed person who, as determined by the Board, has equivalent qualifications in that state to a licensed mental health practitioner in a category listed above.

Board. The Board of Registration of Allied Mental Health and Human Services Professions established under M.G.L. c. 13, § 88.

Clinical Field Experience Site: A site providing pre- and post-Master's degree clinical field experience training that is a public or private Recognized Educational Institution or health or mental health institution regulated by the state, or other appropriate entity regulated by the state or otherwise exempt from regulation, that has integrated programs for the delivery of clinical Marriage and Family Therapy and has established provisions for appropriate supervision.

3.02: continued

Clinical Internship or *Practicum*. A supervised internship or *practicum* in Marriage and Family Therapy shall be included in the Master's degree or doctoral program of study. The internship or *practicum* shall include a minimum of 300 hours of direct, face-to-face client contact with individuals, family groups, couples, groups or organizations (public or private) under the direction of an Approved Supervisor. The supervision shall consist of 100 face-to-face hours, of which 50 must be Individual Supervision.

Full-time. 35 hours per week for 48 weeks per year. The Full-time practice of Marriage and Family Therapy includes at least ten hours per week of clinical work with individuals, family groups, couples, groups or organizations (public or private).

Graduate Level Course. Three semester credit or four-quarter credit graduate credits from a Recognized Educational Institution.

Group Supervision. A regularly scheduled meeting of Marriage and Family Therapy supervision of not more than six practitioners, plus an Approved Supervisor, for a period of at least 1½ hours. "Peer" supervision does not qualify.

Individual Supervision. A regularly scheduled meeting of Marriage and Family Therapy supervision of not more than two practitioners with an Approved Supervisor for a period of at least one hour.

Licensed Marriage and Family Therapist. A person licensed as a marriage and family therapist under M.G.L. c. 112, § 165.

Licensure Examination. The Association of Marital and Family Therapy Regulatory Board's Examination in Marital and Family Therapy.

Marriage and Family Therapy. The rendering of professional mental health services to individuals, family groups, couples, groups or organizations (public or private) for compensation, monetary or otherwise. Said professional services shall include applying systemic principles, methods and therapeutic techniques to individuals, family groups, couples, groups or organizations (public or private) for the purpose of resolving emotional conflict, modifying perceptions and behavior, enhancing communication and understanding among family members and the prevention of family and individual crises. Marriage and Family Therapists may also engage in Psychotherapy of a Non-medical Nature and make appropriate referrals to psychiatric resources and other mental health professionals and organizations.

Psychotherapy of a Non-medical Nature. The utilization of psychological and interpersonal systemic theories and related practice methodologies to assess, diagnose, treat and interpret to modify conscious and unconscious processes of behavior.

Recognized Educational Institution. An educational institution licensed or accredited by the state in which it is located which meets national standards for the granting of a master's or doctoral degree. Meeting National Standards includes, but is not limited to, approval by the United States Department of Education.

Relevant Field. Psychology, social work, counselor education**,** counseling psychology, theology, law, medicine, nursing, community mental health, education with a concentration in counseling or psychology, or other field determined by the Board to be a Relevant Field.

Supervised Clinical Experience (Post-degree). A minimum of 200 hours of supervision in the clinical practice of Marriage and Family Therapy by an Approved Supervisor. A minimum of 100 hours of the required minimum 200 hours of supervision must be Individual Supervision.

3.03 Licensure Eligibility Requirements

A candidate for licensure as a Licensed Marriage and Family Therapist must meet the requirements of 262 CMR 3.03 or 262 CMR 3.04.

(1) Clinical Fellow of the AAMFT. A candidate applying under this category must provide satisfactory evidence that:

(a) the applicant is currently a clinical fellow of the AAMFT in good standing; and

(b) the applicant has achieved a passing score on the Licensure Examination, or its equivalent; or

(2) Initial Applicant. A candidate applying under this category must meet the following requirements:

(a) Education. Eligible applicants must have a minimum of 60 semester credit hours or 80 quarter credit hours (each semester credit equals 1.33 quarter credits) in Marriage and Family Therapy or a Relevant Field from an integrated, planned and comprehensive program from a Recognized Educational Institution, which degree/certificates includes an Internship or *Practicum* as defined in 262 CMR 3.02 and the Required Course Areas as defined by 262 CMR 3.03(2)(b).

Eligible applicants must have obtained the required education through the following degree programs:

1. a Master's degree in Marriage and Family Therapy or a Relevant Field of at least 60 semester credits (80 quarter credits); or
2. a Master's degree in Marriage and Family Therapy or a Relevant Field of at least 48 semester credits (64 quarter credits) with completion of at least 12 semester credits (16 quarter credits) of additional qualifying courses listed in 262 CMR 3.03(2)(b); or
3. a Master's degree in Marriage and Family Therapy or a Relevant Field with a certificate of advanced graduate studies (CAGS); or
4. two Master's degrees in Marriage and Family Therapy or a Relevant Field; or
5. a Doctoral degree in Marriage and Family Therapy or a Relevant Field.

Eligible applicants who hold degrees listed in 262 CMR 3.03(2)(a), but are missing credits or required courses, may supplement their degree program by taking additional qualifying courses or credits listed in 262 CMR 3.03(2)(b). No applicant shall earn credit for any supervised experience that occurs prior to the applicant's completion of all education listed in 262 CMR 3.03(2).

(b) The required coursework must include:

1. Three graduate level courses in each of the following content areas, for a total of nine courses:

a. Marital and Family Studies. Family life cycle; sociology of the family; families under stress; violence in the family; the contemporary family; the role of intimacy and sexuality in the family; family in a social context; consultation with families and larger systems; substance abuse and the family; the cross-cultural family; and youth/adult/aging and the family; family subsystems; individual, interpersonal relationships (marital, parental, sibling). This content area should focus on marital and family studies, not marital and family therapy as described in 262 CMR 3.03(2)(b).

b. Marital and Family Therapy. Family therapy methodology; family assessment; treatment and intervention methods; overview of major clinical theories of Marital and Family Therapy as defined in 262 CMR 3.02; couples therapy; sex therapy.

c. Human Development. Human development; personality theory; human sexuality; psychopathology; behavior-pathology. One course in this category must be in psychopathology or its equivalent.

2. One graduate level course in each of the following content areas, for a total of two courses:

a. Professional Studies. Professional socialization and the role of the professional organization; legal responsibilities and liabilities; independent practice and interprofessional cooperation; ethics; family law.

3.03: continued

b. Research. Research design; methods; statistics; research in marital and family studies and therapy;

(c) Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). In the absence of evidence to the contrary, a Master's degree or Doctoral program that is accredited by COAMFTE is presumed to meet the requirements of 262 CMR 3.03(2)(a) and (b).

(3) Experience. A candidate must complete:

(a) Clinical Internship or *Practicum* and

(b) Post-Master's Degree Experience. At least 3,360 hours of post-Master's degree experience in Marriage and Family Therapy completed at a Clinical Field Experience Site under the direction of an Approved Supervisor. The 3,360 hours must include Supervised Clinical Experience and 1,000 hours of face-to-face contact hours of clinical experience with individuals, family groups, couples, groups or organizations (public or private) under the direction of an Approved Supervisor, of which at least 500 hours must be with couples and family groups. A candidate may not earn more than 35 experience hours per week for 48 weeks a year.

(4) Examination. A candidate must pass the Licensure Examination.

3.04: Reciprocity

Any applicant who holds a license, certification or registration as a Marriage and Family Therapist, or the equivalent thereof as determined by the Board, issued by another state or jurisdiction, may apply to the Board for licensure as a Marriage and Family Therapist by reciprocal recognition.

Such applicants must submit to the Board:

(1) a complete application for licensure as prescribed by the Board;

(2) a final transcript which demonstrates that the applicable degree and education requirements under 262 CMR 3.03 have been met;

(3) evidence of a passing score on the Licensure Examination, or the equivalent; and

(4) written proof, in a form acceptable to the Board, that the applicant's license, certification, or registration has been in good standing with the licensing authority that issued it for the three years preceding the date the applicant applied for licensure.

3.05: Legally Protected Health Care Activity

No person shall be denied initial licensure or denied renewal due to any complaint, criminal charge, conviction, judgement, discipline, or other sanction due to providing or assisting in providing reproductive health or other gender-affirming care services, as defined in M.G.L. c. 12, § 11*I½*, so long as the services provided would have been lawful in Massachusetts and are consistent with the standards for good professional practice.

REGULATORY AUTHORITY

262 CMR 3.00: M.G.L. c. 112, §§ 163 through 172; M.G.L. c. 13, §§ 88 through 90.

Docket # 33

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **262 CMR 8.00**

CHAPTER TITLE: **Ethical Codes and Standards of Conduct**

AGENCY: **Board of Registration of Allied Mental Health and Human Services Professionals**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

The Board of Registration of Allied Mental Health and Human Services Professions (Board) licenses professionals in the fields of Behavioral Analysis, Educational Psychology, Marriage and Family Therapy, Mental Health Counseling, and Rehabilitation Counseling. This regulation identifies the ethical codes of national associations that the Board has adopted for each of its licensed professions and states additional Board standards for the professions. The amendments update one reference to the ethical code and apply relevant ethics rules to Licensed Supervised Mental Health Counselors. The amendments also codify protections for licensees from Chapter 16 of the Acts of 2025, an act strengthening health care protections in the commonwealth.

REGULATORY AUTHORITY: **M.G.L. c. 112, §§ 163 through 172; c. 13, §§ 88 through 90**

AGENCY CONTACT: **Sheila York** PHONE: **781-636-7138**

ADDRESS: **250 Washington Street, 2nd Floor, Boston MA 02108**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Office of Housing and Livable Communities (formerly DHCD) on 7/25/25
Massachusetts Municipal Association on 7/25/25

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **9/19/25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **Minimal for both stakeholders and the Department.**

For the first five years: **Minimal for both stakeholders and the Department.**

No fiscal effect:

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **7/10/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

Ethical Codes, Standards of Conduct, Allied Mental Health Practitioners, Behavioral Analysis, Educational Psychology, Marriage and Family Therapy, Mental Health Counseling, and Rehabilitation Counseling

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amend 262 CMR 8.00

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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A TRUE COPY ATTEST

WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

DATE 7/16/26 CLERK KCR

262 CMR 8.00: ETHICAL CODES AND STANDARDS OF CONDUCT

Section

8.01: Ethical Codes

The Board of Allied Mental Health and Human Services Professions adopts as its official guides the ethical codes and standards of conduct listed in 262 CMR 8.01(1) through (6), except as such codes deviate in any way from the provisions of 262 CMR or M.G.L. c. 112, §§ 163 through 172:

(1) For Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors:
(a) *American Counseling Association Code of Ethics*; and
(b) *American Mental Health Counselors Association Code of Ethics*;

(2) For Licensed Marriage and Family Therapists: *Code of Ethics of the American Association for Marriage and Family Therapists*;

(3) For Licensed Rehabilitation Counselors:
(a) *Code of Professional Ethics for Rehabilitation Counselors of the Commission on Rehabilitation Counselor Certification*; and
(b) *Certification of Disability Management Specialists Commission Code of Professional Conduct*;

(4) For Licensed Educational Psychologists: *Principles for Professional Ethics of the National Association of School Psychologists*; and

(5) For Licensed Applied Behavior Analysts and Licensed Assistant Applied Behavior Analysts: *The Ethics Code for Behavior Analysts of the Behavior Analyst Certification Board*.

8.02: Standards of Conduct Applicable to all Allied Mental Health Practitioners Licensed by the Board of Allied Mental Health and Human Services Professions

(1) Treatment Records.
(a) A licensee shall create and maintain a treatment record for each client which meets the standards of usual and customary practice.
(b) The licensee must maintain a client's treatment record for a minimum period of seven years from the date of the client's last professional contact with the licensee and in a manner which permits the former client or a successor licensee access to the record within the terms of 262 CMR. In the event that the client is a minor, the licensee must maintain the client's record for at least one year after the client has reached the age of majority as defined in M.G.L. c. 4, § 7, but in no event shall the record be retained for less than seven years.
(c) Upon commencing services, licensees shall notify clients in writing that treatment records will be maintained and the manner in which clients or authorized representatives may inspect treatment records. Licensees shall adhere to the following practices:
1. upon written request and within a reasonable period of time, licensees shall provide the client or authorized representative of the client a copy of such client's treatment record, pursuant to M.G.L. c. 112, § 12CC;

8.02: continued

2. licensees may decline to permit a client or the client's authorized representative to inspect or obtain a copy of his or her treatment record if the licensee, in the reasonable exercise of his or her professional judgment, believes that allowing that client or the client's authorized representative to inspect or copy his or her treatment record would adversely affect the physical or mental well-being of that client; and

3. if a licensee declines to provide a copy of a client's treatment record to that client or the client's authorized representative pursuant to 262 CMR 8.02(1)(c)2., the licensee shall provide that client with a treatment summary in lieu of the full treatment record. If after receiving the treatment summary the client continues to request a copy of the full treatment record, the licensee shall provide a copy of the full treatment record to either an attorney designated by the client or a psychotherapist, as defined in M.G.L. c. 112, § 12CC designated by that client.

(d) licensee may not require payment of any balance due for prior professional services rendered to the client as a pre-condition for making the treatment records available. A licensee may charge a reasonable fee for copying of treatment records and postage where applicable.

(e) Licensees shall protect confidentiality, in accordance with applicable regulations and laws, in the creation, maintenance, storage, transfer and disposal of client records and in the event of withdrawal from practice or death of the licensee.

(f) Licensees shall comply with all state and federal laws regarding the creation, maintenance, storage, transfer, and disposal of treatment records.

(2) Client Relationships. In matters pertaining to boundaries or to dual, personal or sexual relationships, a licensee's relationship with a client shall be presumed to extend to a minimum of five years from the date of the rendering of the last professional service within the definitions of the licensees practice pursuant to M.G.L. c. 112, § 163. Licensees shall engage in relationships that maintain appropriate boundaries, avoid dual relationship, and uphold the following standards:

(a) licensees shall not knowingly accept as clients, individuals or family members of individuals with whom the licensee has a familial, romantic, social, supervisory or professional relationship;

(b) licensees shall not engage in romantic or sexual relationships or behaviors with clients, family members of their clients, or partners of their clients;

(c) licensees shall refrain from entering into or promising a personal, professional, financial, or other relationship with any client, family members of their client, or partners of their client, provided however that 262 CMR 8.02(2) shall not prohibit a licensee from having a future professional relationship with an agency under which the client is served; and

(d) when working with multiple clients, licensees shall respect individual client rights and maintain objectivity. When a licensee agrees to provide services to two or more persons who have a relationship with each other the licensee shall disclose in writing upon commencing services the nature of the relationship the licensee will have with each person. Should conflicting roles arise, the licensee shall identify and document adjustments in roles and make referrals as necessary.

(3) Confidential Communications.

(a) Except as otherwise provided by law, all communications, including electronic communications, between any licensee and the client(s) to whom the licensee has rendered professional services shall be deemed to be treated as confidential information in perpetuity.

(b) For purposes of supervision or consultation regarding the licensee's work with a client, information which is acquired by a licensee pursuant to the professional practice, whether directly or indirectly, may be disclosed, to another appropriate licensee as part of a consultation which is designed to enhance the services provided to a client or clients.

(c) Licensees must, in their statements of confidentiality and informed consent to clients, inform clients that the licensee may seek supervision or consultation. In disclosing client information, licensees shall use their best efforts to safeguard the client's privacy by not disclosing the client's name or other identifying demographic information, or any other information by which the client might be identified by the consultant.

8.02: continued

(4) Fees and Billing. All licensees shall bill accurately and truthfully, consistent with law, and shall not misrepresent their fees. Licensees shall not bill for services that were not provided.

(5) Compliance with Other Laws. All licensees shall comply with applicable state and federal law governing their respective practice as an Allied Mental Health and Human Services Professional, including M.G.L. c. 119, § 51A.

(6) Legally Protected Health Care Activity. Notwithstanding the grounds for discipline specified in 262 CMR 8.00, no licensee shall be subject to discipline for providing or assisting in providing reproductive health services or gender-affirming health care services, as defined in M.G.L. c. 12 § 11*I*½, or for any conviction, judgment, discipline, or other sanction arising from such health care services, so long as the services provided would have been lawful in Massachusetts and are consistent with standards for good professional practice in Massachusetts.

8.03: Standards of Conduct Applicable to Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors

(1) Licensed Mental Health Counselor and Licensed Supervised Mental Health Counselor treatment records shall include, but not be limited to, at a minimum:

(a) a signed informed consent document;
(b) an intake summary;
(c) an assessment or diagnosis;
(d) a treatment plan;
(e) dates and progress notes for each treatment session;
(f) communications with collateral entities;
(g) communications with clients relating to treatment, including electronic communications; and
(h) a termination summary.

(2) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors must inform clients, in writing, of policies regarding confidentiality of information and the legal limits and exceptions to confidentiality. Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall not communicate either verbally or in writing with others about a client without the client's express written consent, including any legal proceedings, except when the limits of confidentially may legally be invoked, such as, but not limited to, cases of potential harm to the client or significant or deadly harm to others by the client, and legal proceedings under M.G.L. c. 112, § 172(a). Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall ensure the accuracy of client information shared with other parties, including any third party payers.

(3) Informed Consent and Performance of Services without Consent.

(a) A Licensed Mental Health Counselor and Licensed Supervised Mental Health Counselor shall not perform nor attempt to perform any mental health services or function without the written and signed informed consent of the client or prospective client who is to receive that service or function.

(b) Where the client or prospective client who is to receive the mental health counseling service is not mentally competent to give legally valid consent for the performance or provision of that service or function, the Licensed Mental Health Counselor and Licensed Supervised Mental Health Counselor shall not perform nor attempt to perform that service or function without the prior written consent of an individual who is legally authorized to give consent on behalf of that client or prospective client, or of a guardian appointed by a court of competent jurisdiction to act on behalf of that client or prospective client.

(c) Where the client or prospective client who is to receive the mental health service or function is a minor, the Licensed Mental Health Counselor or Licensed Supervised Mental Health Counselor shall make and document reasonable attempts to obtain informed consent from both parents when custody is held jointly, or from the minor's legal guardian(s) unless the minor:

8.03: continued

1. is emancipated by court petition and decree;
2. is married, widowed or divorced;
3. is a parent of a child himself or herself;
4. is a member of any of the armed forces of the United States of America;
5. is living separate and apart from his or her parent(s) or legal guardian and is managing his or her own financial affairs;
6. reasonably believes that he or she is suffering from, or has come in contact with, a disease defined as dangerous to the public health pursuant to M.G.L. c. 111, § 6, and the service(s) or function(s) to be performed pertain to the diagnosis or treatment of that disease;
7. will be served by not notifying his or her parent(s) or legal guardian of the performance of the proposed service(s) or function(s), and the Licensed Mental Health Counselor or Licensed Supervised Mental Health Counselor reasonably believes and documents in the treatment record that the minor fully understands the nature of the proposed service(s) or function(s) and the risks and benefits of those service(s) or function(s); or
8. would suffer a detrimental effect as a result of contact with one or more of the custodial parents. Such clinical opinion shall be documented in the treatment record.

(d) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall not knowingly withhold any information that would inhibit a client or prospective client from making an informed choice when selecting a provider of mental health services.

(e) Written and signed Informed consent shall include but is not limited to:

1. the Licensed Mental Health Counselor's or Licensed Supervised Mental Health Counselor's credentials;
2. a statement regarding Confidentiality and its limits;
3. information regarding the use of tests and inventories;
4. information regarding accurate and appropriate billing procedures;
5. an explanation of services provided and of the risks and benefits of counseling services, including an explanation of the risks and benefits of engaging in the use of distance counseling, technology, and/or social media within the counseling process; and
6. a client bill of rights which includes but is not limited to information concerning informed consent, the licensee's grievance process, client respect, and the client's right to terminate treatment;

(4) Supervision.

(a) In providing supervision services to graduate students, post-graduate individuals seeking licensure, including Licensed Supervised Mental Health Counselors, and other clinicians, Licensed Mental Health Counselors shall:

1. have an informed consent agreement with the supervisee, including an agreement for supervision that includes rights and responsibilities of both supervisor and supervisee;
2. have a process for resolving differences;
3. keep accurate and appropriate records of the supervision sessions;
4. have a responsibility to know the current 262 CMR governing licensure as a Licensed Mental Health Counselor and Licensed Supervised Mental Health Counselor;
5. regularly attend continuing education and participate in activities regarding topics and skills for both counseling and supervision;
6. maintain appropriate boundaries with supervisees;
7. make supervisees aware of professional and ethical standards and legal responsibilities of licensure; and
8. address the role of multiculturalism and diversity in the supervisory relationship.

(b) In addition, Licensed Mental Health Counselors providing supervision as an Approved Supervisor to graduate students or post-graduate individuals seeking licensure, including Licensed Supervised Mental Health Counselors, shall:

1. understand and accept their responsibilities to monitor the welfare of clients treated by their supervisees;
2. provide supervisees with ongoing performance appraisal and evaluation feedback, as well as formal evaluations; and

8.03: continued

3. refrain from endorsing supervisees who fail to meet professional standards of practice.

(5) Termination, Absences and Referral.

(a) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall not abandon or neglect their clients in counseling.

(b) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall make appropriate arrangements for any necessary treatment of their client if the Licensed Mental Health Counselor or Licensed Supervised Mental Health Counselor is on vacation or is ill for an extended period of time.

(c) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall make arrangements for emergency backup to cover expected and unexpected absences;

(d) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall make reasonable efforts to assess treatment goals and outcomes with the client and terminate a relationship when it is reasonably clear that the treatment no longer serves the needs of the client;

(e) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors may terminate counseling when:

1. he or she reasonably believes to be in jeopardy of harm by the client or by another person with whom the client has a relationship;
2. the client does not pay the fees charged; or
3. insurance denies such treatment and the Licensed Mental Health Counselor or Licensed Supervised Mental Health Counselor recommends other service providers.

(f) When transferring or referring clients to other practitioners, Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall ensure and document that appropriate clinical and administrative processes are completed for an appropriate transition.

(6) Professional Responsibilities and Conduct.

(a) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall provide services within the scope of practice for the profession and within the bounds of their particular competencies and the limitations of their expertise. When practicing new specialty areas, Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall obtain proper education, training, or supervision.

(b) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall obtain consultation and supervision when needed as clinically indicated, including but not limited to when practicing outside of an area of expertise or when treating at-risk clients.

(c) Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall not practice if they are impaired and unable to practice competently. Licensed Mental Health Counselors and Licensed Supervised Mental Health Counselors shall seek professional assistance to determine whether to limit, suspend or terminate their professional responsibilities until such time as it is determined that they may safely resume their work.

8.04: Standards of Conduct Applicable to Licensed Applied Behavior Analysts and Licensed Assistant Applied Behavior Analysts

(1) Licensed applied behavior analysts and licensed assistant applied behavior analysts may engage only in evidence-based practice. For purposes of 262 CMR 8.04, Evidence-based Practice shall mean the integration of best peer-reviewed research evidence with clinical expertise and patient characteristics.

(2) Licensed applied behavior analysts and licensed assistant applied behavior analysts may provide behavioral diagnostic, therapeutic, teaching, research, supervisory, consultative, or other behavior analytic service delivery only in the context of a defined remunerated professional role. Provided, however, that 262 CMR 8.04 shall not prohibit the provision of *pro-bono* services when performed in the context of a defined professional role.

8.04: continued

(3) Licensed applied behavior analysts and licensed assistant applied behavior analysts shall not abandon clients but may terminate a professional relationship when it becomes reasonably clear that the client no longer needs the service, is not benefiting, or is being harmed by continued service. Licensed applied behavior analysts and assistant applied behavior analysts may terminate a professional relationship with a client where a conflict arises which the licensee cannot resolve or where the client or responsible payer(s) fails to pay for services or determines services are no longer eligible for coverage.

(4) Prior to termination for whatever reason, except where precluded by the client's conduct or where the client or responsible payer(s) fails to pay for services or determines services are no longer eligible for coverage, licensed applied behavior analysts and licensed assistant applied behavior analysts shall provide clients with 30 days written notice of the termination, discuss the client's views and needs, provide appropriate pre-termination services, suggest alternative service providers as appropriate, or take other reasonable steps to facilitate transfer of responsibility to another provider if the client needs one immediately. Licensed applied behavior analysts and licensed assistant applied behavior analysts shall document all steps taken during termination.

(5) Supervision Requirements.

(a) Licensed assistant applied behavior analysts shall:

1. when engaged in the practice of applied behavior analysis, receive a minimum of one hour per month of individual face-to-face supervision in the treatment setting from a licensed applied behavior analyst, or a physician or psychologist approved by the Board in accordance with M.G.L. c. 112, § 163;
2. prior to providing treatment, obtain approval from a licensed applied behavior analyst, or a physician or psychologist approved by the Board in accordance with M.G.L. c. 112, § 163, for all treatment plans; and
3. on a form acceptable to the Board, maintain documentation of their supervision.

(b) When acting as a supervisor of licensed assistant applied behavior analysts, licensed applied behavior analysts shall:

1. provide the licensed assistant applied behavior analyst with the type, frequency, and duration of supervision that is consistent with the needs of the client and that is consistent with acceptable clinical standards and any state or federal law and includes a minimum of one hour per month of individual face-to-face supervision in the treatment setting;
2. approve treatment plans used by the assistant applied behavior analyst;
3. be professionally responsible for the clinical oversight of all clients receiving services from the licensed assistant applied behavior analyst; and
4. On a form acceptable to the Board, maintain documentation of supervision.

(c) When acting as a supervisor of any non-licensed paraprofessionals, licensed applied behavior analysts shall:

1. if the employer of the paraprofessional, conduct a criminal offender record information check prior to hiring;
2. be professionally responsible for the clinical oversight of all clients receiving services from the paraprofessionals;
3. provide the paraprofessional with the type, frequency, and duration of supervision that is consistent with the needs of the client and that is consistent with acceptable clinical standards and any state or federal law; and
4. on a form acceptable to the Board, maintain documentation of supervision.

(d) For purposes of 262 CMR 8.04(5), documentation of supervision shall include but is not limited to:

1. the date of each supervisory meeting;
2. the duration of each supervisory meeting;
3. the format of each supervisory meeting;
4. an evaluation of supervisee performance by the supervisor;
5. the total experience hours obtained during the supervision;
6. the total individual and small-group supervision hours obtained during the supervision; and
7. the signature for supervisor and supervisee.

8.04: continued

(6) Where the demands of a public agency or school district with which a licensed applied behavior analyst or licensed assistant applied behavior analyst is contracted conflict with 262 CMR 8.04(1) or (5)(a)1., (b)1., (c)2. or 3., the licensed applied behavior analyst or licensed assistant applied behavior analyst shall seek to resolve the workplace conflict in a way that permits adherence to 262 CMR 8.00 and shall document such efforts.

REGULATORY AUTHORITY

262 CMR 8.00: M.G.L. c. 112, §§ 163 through 172 and c. 13, §§ 88 through 90.

NON-TEXT PAGE

Docket # 448

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **603 CMR 28.00**

CHAPTER TITLE: **Regulations on Special Education**

AGENCY: **Department of Elementary and Secondary Education**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

The amended regulation reflects the amendments to G.L. c. 71 B, section 3 as set forth in sections 29 and 30 of Chapter 14 of the Acts of 2025. The amendments update the definition of "Individualized Education Program" and discipline procedures for students with disabilities.

REGULATORY AUTHORITY: **M.G.L. c. 69, §1B, and c. 71B**

AGENCY CONTACT: **Mary Morales** PHONE: **781-338-3429**

ADDRESS: **135 Santilli Highway, Everett, MA 02149**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Prior notification sent to the Joint Committee on Education on 3/5/26; The Executive Office of Housing and Livable Communities on 3/2/26; and the Massachusetts Municipal Association on 3/2/26.

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **3/13/26-4/24/26**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **N/A**

For the first five years: **N/A**

No fiscal effect: **N/A**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **6/18/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

Special Education
Discipline Regulations
Individualized Education Program
IEP

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amendments to 603 CMR 28.00, Regulations on Special Education

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 15 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
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7 & 8	**7 & 8**
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245 - 250	**245 - 250**
271 & 272	**271 & 272**
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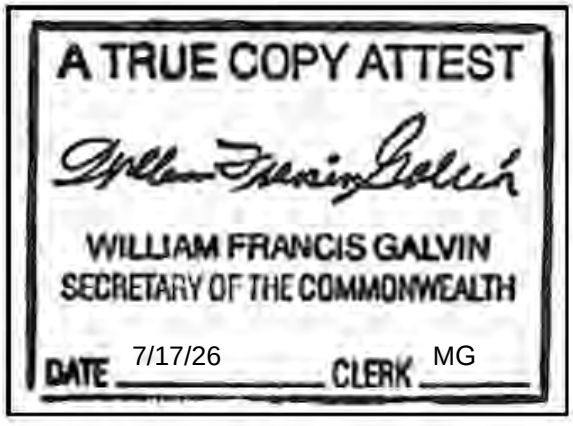

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603 CMR 28.00: SPECIAL EDUCATION

Section

28.01: Authority, Scope and Purpose

(1) 603 CMR 28.00 is promulgated pursuant to the authority of the Board of Elementary and Secondary Education under M.G.L. c. 69, § 1B, and M.G.L. c. 71B.

(2) 603 CMR 28.00 governs the provision by Massachusetts public schools of special education and related services to eligible students and the approval of public or private day and residential schools seeking to provide special education services to publicly funded eligible students. The requirements set forth in 603 CMR 28.00 are in addition to, or in some instances clarify or further elaborate, the special education rights and responsibilities set forth in state statute (M.G.L. c. 71B), federal statute (20 U.S.C. § 1400 *et seq*.), and federal regulations (34 CFR § 300 *et seq*.).

(3) The purpose of 603 CMR 28.00 is to ensure that eligible Massachusetts students receive special education services designed to develop the student's individual educational potential in the least restrictive environment in accordance with applicable state and federal laws.

28.02: Definitions

Approved Private Special Education School or Approved Program shall mean a private day or residential school, within or outside Massachusetts, that has applied to, and received approval from, the Department according to the requirements specified in 603 CMR 28.09.

Approved Public Special Education School shall mean a program operated by a public school or an educational collaborative providing full day or residential special education services to eligible students in a facility serving primarily students with disabilities. Such program shall be approved when it has applied to, and received approval from, the Department according to the requirements specified in 603 CMR 28.09.

Certified Special Educator shall mean a person with a teaching certificate or license in an area of special education or a related service provider with appropriate certification or license in his or her professional area. Licensure shall meet the requirements of the 603 CMR 7.00: *Educator Licensure and Preparation Program Approval* and the requirements for renewal of license at 603 CMR 44.00: *Recertification*, as necessary. A certified or licensed special educator may provide, design, or supervise special education services.

Consent shall mean agreement by a parent who has been fully informed of all information relevant to the activity for which consent is sought, in his or her native language or other mode of communication, understands and agrees in writing to the carrying out of the activity, and understands that the granting of consent is voluntary and may be revoked at any time. The consent describes the activity and lists the records (if any) that will be released and to whom.

Day shall mean calendar day unless 603 CMR 28.00 specifies school day, which shall mean any day, including a partial day, that students are in attendance at school for instructional purposes.

Department shall mean the Massachusetts Department of Elementary and Secondary Education.

28.02: continued

Disability shall mean one or more of the following impairments:

(a) Autism. A developmental disability significantly affecting verbal and nonverbal communication and social interaction. The term shall have the meaning given it in federal law at 34 CFR § 300.8(c)(1).

(b) Developmental Delay. The learning capacity of a young child (three through nine years old) is significantly limited, impaired, or delayed and is exhibited by difficulties in one or more of the following areas: receptive and/or expressive language; cognitive abilities; physical functioning; social, emotional, or adaptive functioning; and/or self-help skills.

(c) Intellectual Impairment. The permanent capacity for performing cognitive tasks, functions, or problem solving is significantly limited or impaired and is exhibited by more than one of the following: a slower rate of learning; disorganized patterns of learning; difficulty with adaptive behavior; and/or difficulty understanding abstract concepts. Such term shall include students with mental retardation.

(d) Sensory Impairment. The term shall include the following:

1. Hearing Impairment or Deaf. The capacity to hear, with amplification, is limited, impaired, or absent and results in one or more of the following: reduced performance in hearing acuity tasks; difficulty with oral communication; and/or difficulty in understanding auditorally-presented information in the education environment. The term includes students who are deaf and students who are hard-of-hearing.

2. Vision Impairment or Blind. The capacity to see, after correction, is limited, impaired, or absent and results in one or more of the following: reduced performance in visual acuity tasks; difficulty with written communication; and/or difficulty with understanding information presented visually in the education environment. The term includes students who are blind and students with limited vision.

3. Deafblind. Concomitant hearing and visual impairments, the combination of which causes severe communication and other developmental and educational needs.

(e) Neurological Impairment. The capacity of the nervous system is limited or impaired with difficulties exhibited in one or more of the following areas: the use of memory, the control and use of cognitive functioning, sensory and motor skills, speech, language, organizational skills, information processing, affect, social skills, or basic life functions. The term includes students who have received a traumatic brain injury.

(f) Emotional Impairment. As defined under federal law at 34 CFR § 300.8(c)(4), the student exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems. The determination of disability shall not be made solely because the student's behavior violates the school's discipline code, because the student is involved with a state court or social service agency, or because the student is socially maladjusted, unless the Team determines that the student has a serious emotional disturbance.

(g) Communication Impairment. The capacity to use expressive and/or receptive language is significantly limited, impaired, or delayed and is exhibited by difficulties in one or more of the following areas: speech, such as articulation and/or voice; conveying, understanding, or using spoken, written, or symbolic language. The term may include a student with impaired articulation, stuttering, language impairment, or voice impairment if such impairment adversely affects the student’s educational performance.

(h) Physical Impairment. The physical capacity to move, coordinate actions, or perform physical activities is significantly limited, impaired, or delayed and is exhibited by difficulties in one or more of the following areas: physical and motor tasks; independent movement; performing basic life functions. The term shall include severe orthopedic impairments or impairments caused by congenital anomaly, cerebral palsy, amputations, and fractures, if such impairment adversely affects a student’s educational performance.

28.02: continued

(i) Health Impairment. A chronic or acute health problem such that the physiological capacity to function is significantly limited or impaired and results in one or more of the following: limited strength, vitality, or alertness including a heightened alertness to environmental stimuli resulting in limited alertness with respect to the educational environment. The term shall include health impairments due to asthma, attention deficit disorder or attention deficit with hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, and sickle cell anemia, if such health impairment adversely affects a student's educational performance.

(j) Specific Learning Disability. The term means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think speak, read, write, spell, or to do mathematical calculations. Use of the term shall meet all federal requirements given in federal law at 34 CFR § § 300.8(c)(10) and 300.309.

District or School District shall mean a Massachusetts municipal school department or regional school district, acting through its school committee or superintendent of schools; a county agricultural school, acting through its board of trustees or superintendent/director; and any other Massachusetts public school established by statute, certificate, or charter, acting through its governing board or director. School districts have programmatic and financial responsibility in accordance with the procedures of 603 CMR 28.10.

Eligible Student shall mean a person three through 21 years old who has not attained a high school diploma or its equivalent, who has been determined by a Team to have a disability(ies), and as a consequence is unable to progress effectively in the general education program without specially designed instruction or is unable to access the general curriculum without a related service. An eligible student shall have the right to receive special education and any related services that are necessary for the student to benefit from special education or that are necessary for the student to access the general curriculum. In determining eligibility, the school district must thoroughly evaluate and provide a narrative description of the student's educational and developmental potential.

In-district Program shall mean a special education program operated in a public school building or other facility that provides educational services to students of comparable age, with and without disabilities.

(a) or young children ages three to five years old, the term shall include programs provided by the public school in the eligible child's home if such setting has been identified by the Team as the natural or least restrictive setting to deliver the services on the child's IEP.

(b) For students three through 21 years old, the term shall include programs provided by the district in a home or hospital setting if such setting is required by the student's physician and the student would otherwise have been served in an in-district program.

(c) For students 14 years of age or older, when the Team has determined that a vocational program is appropriate, work settings shall be considered in-district programs if such programs offer ongoing opportunities for students to interact with community members and/or other workers without disabilities engaging in similar activities.

(d) A program operated solely by an individual, not for profit corporation or agency, or proprietary corporation shall not be considered an in-district program unless it is located within a public school building.

Individualized Education Program (IEP) shall mean a written statement, developed and approved in accordance with federal and state special education law in a form established by the Department that identifies a student's special education needs and describes the services a school district shall provide to meet those needs.

Least Restrictive Environment (LRE) shall mean the educational placement that assures that, to the maximum extent appropriate, students with disabilities, including students in public or private institutions or other care facilities, are educated with students who are not disabled, and that special classes, separate schooling, or other removal of students with disabilities from the general education environment occurs only when the nature or severity of the student's disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

28.02: continued

Notice shall mean the notice and content required in accordance with the federal special education law whenever the school district proposes or refuses to initiate or change the identification, evaluation, or educational placement or the provision of special education services to the student.

Out-of-district Program shall mean a special education program located in a building or facility outside of the general education environment that provides educational services primarily to students with disabilities and shall include all programs approved under 603 CMR 28.09. Such program may be operated by a private organization or individual, a public school district, or a collaborative.

Parent shall mean father or mother. For purposes of special educational decision-making, parent shall mean father, mother, legal guardian, person acting as a parent of the child, foster parent, or an educational surrogate parent appointed in accordance with federal law. Legal authority of the parent shall transfer to the student when the student reaches 18 years of age.

Program School shall mean the school in which the student is enrolled according to the provisions of M.G.L. c. 71, § 89 (charter schools); M.G.L. c. 71, § 94 (Commonwealth of Massachusetts virtual schools); M.G.L. c. 74 (vocational schools); M.G.L. c. 76, § 12A (Metco) or M.G.L. c. 76, § 12B (school choice), and shall not include schools approved under 603 CMR 28.09 or institutional school programs as described in 603 CMR 28.06(9).

Progress Effectively in the General Education Program shall mean to make documented growth in the acquisition of knowledge and skills, including social/emotional development, within the general education program, with or without accommodations, according to chronological age and developmental expectations, the individual educational potential of the student, and the learning standards set forth in the Massachusetts Curriculum Frameworks and the curriculum of the district. The general education program includes preschool and early childhood programs offered by the district, academic and non-academic offerings of the district, and vocational programs and activities.

Related Services shall have the meaning set forth in federal special education law at 34 CFR § 300.34. Individuals providing interpreting services for students who are deaf or hard of hearing shall be registered with the Massachusetts Commission for the Deaf and Hard of Hearing.

State Agency shall mean a Massachusetts state agency.

Special Education shall mean specially designed instruction to meet the unique needs of the eligible student or related services necessary to access the general curriculum and shall include the programs and services set forth in state and federal special education law.

Team shall mean a group of persons, meeting participant requirements of federal special education law as provided at 34 CFR § § 300.321 and 300.116(a)(1), who, together, discuss evaluation results, determine eligibility, develop or modify an IEP, or determine placement.

28.03: Administration and Personnel

(1) General Responsibilities of the School District.

(a) General. Each school district shall provide or arrange for the provision of special education and related services for eligible students in accordance with the provisions of state and federal law and regulation.

1. The school district shall provide training to all school district staff, including general, English as a second language, and special educators, administrators, and paraprofessionals, on the requirements of special education.

2. The school district shall provide such staff training in analyzing and accommodating diverse learning needs of all students in the general education classroom.

3. The school district shall provide such staff training in methods of collaboration among teachers, paraprofessionals, and teacher assistants to accommodate diverse learning needs.

28.03: continued

(4) Standard Procedures and Forms. The Department may prepare standard forms to assist school districts in meeting state and federal special education requirements.

(a) The school district shall use forms that, at a minimum, contain the elements of those forms issued by the Department.

(b) School districts shall maintain required data on eligible students receiving special education services, shall ensure that such data remains current and accurate, and, on request, shall report such data in the form required by the Department and in accordance with 603 CMR 10.00: *School Finance and Accountability* and the guidelines for reporting student and financial data.

(5) Waivers. A school district, collaborative, or approved special education school program may submit in writing a proposal for approval by the Department for the satisfaction of any requirement in 603 CMR 28.00 in a manner different from that specified in 603 CMR 28.00. The Department may approve such proposal if it shows substantial promise of contributing to improvements in the methods for meeting the goals of 603 CMR 28.00 and if such proposal does not conflict with any provision of law. No such proposal shall be implemented until approved by the Department.

(6) Enforcement: Withholding of Funds. The Department may withhold funds for special education from cities, towns, school districts, or private schools or agencies that do not comply with regulations or statutes related to special education or do not carry out plans for such compliance within a reasonable period of time; provided, however, that nothing in 603 CMR 28.03(6) shall be construed to prevent the Department from withholding state and federal funds to the extent it deems necessary consistent with state and federal law, or from taking such other enforcement action as may be authorized by law.

28.04: Referral and Evaluation

(1) Referral for Initial Evaluation. A student may be referred for an evaluation by a parent or any person in a caregiving or professional position concerned with the student's development.

(a) When a student is referred for an evaluation to determine eligibility for special education, the school district shall send written notice to the student's parent(s) within five school days of receipt of the referral.

(b) The notice required by 603 CMR 28.04(1)(a) shall meet all of the content requirements set forth in M.G.L. c. 71B, § 3, and in federal law and shall seek the consent of a parent for the evaluation to occur, and provide the parents with the opportunity to express any concerns or provide information on the student's skills or abilities.

(c) School districts shall provide the student's parents with an opportunity to consult with the Special Education Administrator or his or her designee to discuss the reasons for the referral, the content of the proposed evaluation, and the evaluators used.

(d) Upon referral, school districts shall evaluate children who are 2½ years old and who may be receiving services through an early intervention program. An initial evaluation shall be conducted in order to ensure that if such child is found eligible, special education services begin promptly at age three.

(2) Initial Evaluation. Upon consent of a parent, the school district shall provide or arrange for the evaluation of the student by a multidisciplinary team within 30 school days. The assessments used shall be adapted to the age of the student and all testing shall meet the evaluation requirements set out in state and federal law, including but not limited to the requirement that when conducting an evaluation for a student who is an English learner as defined in M.G.L. c. 71A, § 2, school districts shall consider the English language proficiency of the student. Assessments and other evaluation materials used to evaluate said student shall be provided and administered in the student's primary language and in the form most likely to yield accurate information on what the student knows and can do academically, developmentally, and functionally. The school district shall ensure that appropriately credentialed and trained specialists administer all assessments.

(a) Required Assessments.

1. An assessment in all areas related to the suspected disability.
2. An educational assessment by a representative of the school district, including

28.04: continued

a. a history of the student's educational progress in the general curriculum. Such assessment shall include information provided by a teacher(s) with current knowledge regarding the student's specific abilities in relation to learning standards of the Massachusetts Curriculum Frameworks and the district curriculum; and

b. an assessment of the student's attention skills, participation behaviors, communication skills, memory, and social relations with groups, peers, and adults.

c. The school district shall also thoroughly evaluate and provide a narrative description of the student's educational and developmental potential.

d. When a child is being assessed to determine eligibility for services at age three, an observation of the child's interactions in the child's natural environment or early intervention program is strongly encouraged.

e. For children who are receiving early intervention services, school districts are encouraged to use current and appropriate assessments from early intervention teams, whenever possible, to avoid duplicate testing.

(b) Optional Assessments. The Administrator of Special Education may recommend or a parent may request one or more of the following:

1. A comprehensive health assessment by a physician that identifies medical problems or constraints that may affect the student's education. The school nurse may add additional relevant health information from the student's school health records.

2. A psychological assessment by a licensed school psychologist, licensed psychologist, or licensed educational psychologist, including an individual psychological examination.

3. A home assessment that may be conducted by a nurse, psychologist, social worker, guidance or adjustment counselor, or teacher and includes information on pertinent family history and home situation and may include a home visit, with the agreement of a parent.

(c) Reports of Assessment Results. Each person conducting an assessment shall summarize in writing the procedures employed, the results, and the diagnostic impression, and shall define in detail and in educationally relevant and common terms, the student's needs, offering explicit means of meeting them. The assessor may recommend appropriate types of placements, but shall not recommend specific classrooms or schools. Summaries of assessments shall be completed prior to discussion by the Team and, upon request, shall be made available to the parents at least two days in advance of the Team discussion at the meeting occurring pursuant to 603 CMR 28.05(1).

(3) Annual Reviews and Three-year Reevaluations. The school district shall review the IEPs and the progress of each eligible student at least annually. Additionally, every three years, or sooner if necessary, the school district shall, with parental consent, conduct a full three-year reevaluation consistent with the requirements of federal law.

(4) Unscheduled Evaluations for Medical Reasons. If, in the opinion of the student's physician, an eligible student is likely to remain at home, in a hospital, or in a pediatric nursing home for medical reasons and for more than 60 school days in any school year, the Administrator of Special Education shall, without undue delay, convene a Team to consider evaluation needs and, if appropriate, to amend the existing IEP or develop a new IEP suited to the student's unique circumstances.

(5) Independent Education Evaluations. Upon receipt of evaluation results, if a parent disagrees with an initial evaluation or reevaluation completed by the school district, then the parent may request an independent education evaluation.

(a) All independent education evaluations shall be conducted by qualified persons who are registered, certified, licensed or otherwise approved and who abide by the rates set by the state agency responsible for setting such rates. Unique circumstances of the student may justify an individual assessment rate that is higher than that normally allowed.

(b) The parent may obtain an independent education evaluation at private expense at any time.

(c) Public Funding of Independent Education Evaluations. When the parent requests public funding for an independent education evaluation, the district shall abide by the following provisions for a sliding fee scale:

28.04: continued

1. If the student is eligible for free or reduced cost lunch or is in the custody of a state agency with an Educational Surrogate Parent appointed in accordance with federal law, then the school district shall provide, at full public expense, an independent education evaluation that is equivalent to the types of assessments done by the school district. No additional documentation of family financial status is required from the parent.

2. If the family financial status is not known, the district shall offer the parent information about the sliding fee scale and the opportunity to provide family income information to determine if the family may be eligible for public funding of all or part of the costs of an independent education evaluation. Provision of financial information by the family is completely voluntary on the part of the family. The lack of financial information provided by the family will disqualify the family from such additional public funding of all or part of the costs of an independent education evaluation under 603 CMR 28.04(5)(c) but shall not limit the rights of parents to request public funding under 603 CMR 28.04(5)(d).

3. If the family agrees to provide financial information, such information shall include anticipated annual income of the family, including all sources of income and verifying documents. Financial information shall be reviewed by the district, shall be kept confidential during review by the district, shall not be copied or maintained in any form at the district except to note that information was provided and reviewed and met or did not meet sliding fee scale standards. Financial documents shall be promptly returned to the parent upon the district's determination of financial income status.

4. The district shall consider family size and family income information in relation to Federal Poverty Guidelines and shall contribute public funds to the costs of the independent education evaluation according to the following standards:

a. If the family income is equal to or less than 400% of the federal poverty guidelines, the district shall pay 100% of the costs of an independent education evaluation.

b. If the family income is between 400% and 500% of the federal poverty guidelines, the district shall pay 75% of the costs of an independent education evaluation.

c. If the family income is between 500% and 600% of the federal poverty guidelines, the district shall pay 50% of the costs of an independent education evaluation

d. If the family income is over 600% of the federal poverty guidelines, the district shall have no obligation to cost-share with the parent.

5. When the parent seeks and receives public funding for an independent education evaluation under 603 CMR 28.04(5)(c)4.a. through d., the parent may request independent assessments in one, more than one, or all of the areas assessed by the school district.

6. The right to this publicly funded independent education evaluation under 603 CMR 28.04(5)(c) continues for 16 months from the date of the evaluation with which the parent disagrees.

(d) If the parent is requesting an independent education evaluation in an area not assessed by the school district, the student does not meet income eligibility standards, or the family chooses not to provide financial documentation to the district establishing family income level, the school district shall respond in accordance with the requirements of federal law. Within five school days, the district shall either agree to pay for the independent education evaluation or proceed to the Bureau of Special Education Appeals to show that its evaluation was comprehensive and appropriate. If the Bureau of Special Education Appeals finds that the school district's evaluation was comprehensive and appropriate, then the school district shall not be obligated to pay for the independent education evaluation requested by the parent.

(e) Whenever possible, the independent education evaluation shall be completed and a written report sent no later than 30 days after the date the parent requests the independent education evaluation. If publicly funded, the report shall be sent to the parents and to the school district. The independent evaluator shall be requested to provide a report that summarizes, in writing, procedures, assessments, results, and diagnostic impressions as well as educationally relevant recommendations for meeting identified needs of the student. The independent evaluator may recommend appropriate types of placements but shall not recommend specific classrooms or schools.

28.04: continued

(f) Within ten school days from the time the school district receives the report of the independent education evaluation, the Team shall reconvene and consider the independent education evaluation and whether a new or amended IEP is appropriate.

28.05: The Team Process and Development of the IEP

(1) Convening the Team. Within 45 school working days after receipt of a parent's written consent to an initial evaluation or reevaluation, the school district shall: provide an evaluation; convene a Team meeting to review the evaluation data, determine whether the student requires special education and, if required, develop an IEP in accordance with state and federal laws; and provide the parents with two copies of the proposed IEP and proposed placement, except that the proposal of placement may be delayed according to the provisions of 603 CMR 28.06(2)(e); or, if the Team determines that the student is not eligible for special education, the school district shall send a written explanation of the finding that the student is not eligible. The evaluation assessments shall be completed within 30 school working days after receipt of parental consent for evaluation. Summaries of such assessments shall be completed so as to ensure their availability to parents at least two days prior to the Team meeting. If consent is received within 30 to 45 school working days before the end of the school year, the school district shall ensure that a Team meeting is scheduled so as to allow for the provision of a proposed IEP or written notice of the finding that the student is not eligible no later than 14 days after the end of the school year.

(2) Determinations of the Team.

(a) Eligibility Determination. The Team shall examine the evaluative data, including information provided by the parent, and make one of the following determinations:

1. The student is eligible. If the student has one or more of the disabilities defined at 603 CMR 28.02(7) and if, as a result of the disability(ies), the student is unable to progress effectively in the general education program without the provision of specially designed instruction, or is unable to access the general curriculum without the provision of one or more related services, the Team shall determine that the student is eligible.

a. Consistent with state and federal special education law, the Team shall establish whether a student has a disability(ies) as defined in 603 CMR 28.02(7), determine the type(s) of disability(ies) and shall ensure that the student's inability to progress is a result of the disability(ies) and not a result of an inability to meet the school discipline code, limited English proficiency, social maladjustment, or lack of instruction in reading or math.

b. Once eligibility has been determined, the type of disability of the student shall not be used to provide a basis for labeling or stigmatizing the student. Additionally, the type of disability shall not define the needs of the student and shall in no way limit the services, programs, or inclusion opportunities provided to the student.

c. If the Team determines that the student is an eligible student, the Team shall develop an individualized education program (IEP).

2. The student is not eligible. If the Team determines that the student is not eligible, the Team chairperson shall record the reason for such finding, list the meeting participants, and provide written notice to the parent of their rights in accordance with federal requirements within ten days of the Team meeting.

(b) Evaluation Information is Inconclusive. If the Team finds the evaluation information insufficient to develop an IEP, the Team, with parental consent, may agree to an extended evaluation period.

1. The extended evaluation period shall not be used to deny programs or services determined to be necessary by the Team. If, prior to the extended evaluation, the Team determines that sufficient information is available to identify some necessary objectives and services, the Team shall write a partial IEP that, if accepted by the parent, shall be immediately implemented by the district while the extended evaluation is occurring.

2. The extended evaluation period shall not be used to allow additional time to complete the required assessments under 603 CMR 28.04(2)(a).

3. If the parent consents to an extended evaluation, the Team shall document its findings and determine what evaluation time period is necessary and the types of information needed to develop an IEP, if appropriate. The Team may decide to meet at intervals during the extended evaluation, but in all cases shall reconvene promptly to develop or complete an IEP when the evaluation is complete.

28.05: continued

4. The extended evaluation may extend longer than one week, but shall not exceed eight school weeks.
5. The extended evaluation shall not be considered a placement.

(3) Developing the IEP. Upon determining that the student is eligible for special education, the Team shall develop an IEP using the evaluation data to guide development of goals and objectives for the student.

(a) Parent disagrees with evaluation and seeks an independent education evaluation. If a parent disagrees with the evaluation results, the Team may, with the agreement of the parent, delay writing some or all of the IEP until an independent education evaluation can be completed.

(b) If the Team writes a partial IEP, a parent may consent to the proposed partial program prior to completion of the full IEP. In such case, the partial program shall be implemented immediately.

(c) The IEP shall be completed using the standard IEP format provided by the Department. If the Team members are unable to agree on the IEP, the Team chairperson shall state the elements of the IEP proposed by the school district

(4) Contents of the IEP. Upon determining that the student requires special education and based upon the evaluative data, the Team shall write an IEP for the student and decide the student's placement. The IEP shall describe the special education and related services that the student requires and shall include all elements required under federal and state law.

(a) The IEP shall include specially designed instruction to meet the needs of the individual student and related services that are necessary to allow the student to benefit from the specially designed instruction, or may consist solely of related services that are necessary to allow the student to access the general curriculum, consistent with federal and state requirements.

(b) The Team shall carefully consider the general curriculum, the learning standards of the Massachusetts Curriculum Frameworks, the curriculum of the district, and shall include specially designed instruction or related services in the IEP designed to enable the student to progress effectively in the content areas of the general curriculum.

(c) For any student approaching graduation or 22 years old, the Team shall determine whether the student is likely to require continuing services from adult human service agencies. In such circumstances, the Administrator of Special Education shall make a referral to the Bureau of Transitional Planning in the Executive Office of Health and Human Services in accordance with the requirements of M.G.L. c. 71B, § 12A through C (known as Chapter 688).

(d) The daily duration of the student's program shall be equal to that of the regular school day, unless the Team states that a different duration is necessary to provide a free appropriate public education to the student. In such case, the Team shall specify the daily duration of the program, and the Team shall state on the IEP the reason for such different duration.

1. An extended year program may be identified if the student has demonstrated or is likely to demonstrate substantial regression in his or her learning skills and/or substantial difficulty in relearning such skills if an extended program is not provided.
2. If residential services are required, the IEP must clearly specify the reasons for such determination and how such services will be coordinated with the day education services provided to the student. Additionally, the goals and services on the student's IEP must reflect the comprehensive nature of the educational program required.
3. If a longer program is required, the student's IEP must specify why a longer program is necessary.
4. Camping or recreation programs provided solely for recreational purposes and with no corresponding IEP goals or specially designed instruction shall not be considered extended year programs.

(5) Transportation. The Team shall determine whether the student requires transportation because of his or her disability in order to benefit from special education.

(a) Regular Transportation. If the student does not require transportation as a result of his or her disability, then transportation shall be provided in the same manner as it would be provided for a student without disabilities. In such case, the IEP shall note that the student receives regular transportation, and if the school district provides transportation to similarly situated students without disabilities, the eligible student shall also receive transportation.

28.05: continued

1. If regular transportation is noted on the student's IEP and the student is placed by the school district in a program located at a school other than the school the student would have attended if not eligible for special education, the student is entitled to receive transportation services to such program.

2. If regular transportation is noted on the student's IEP and the student is enrolled by his or her parents in a private school and receiving services under 603 CMR 28.03(1)(e), such student is not entitled to transportation services unless the school district provides transportation to students without disabilities attending such private school.

(b) Special Transportation. If the Team determines that the student's disability requires transportation or specialized transportation arrangements in order to benefit from special education, the Team shall note on the student's IEP that the student requires special transportation. In such circumstances, transportation is a related service.

1. The Team shall determine necessary modifications, special equipment, assistance, need for qualified attendants on vehicles, and any particular precautions required by the student and shall document such determinations in the student's IEP. If specialized arrangements can be provided on regular transportation vehicles, the school district shall make such arrangements.

a. The district shall arrange to have eligible students who use wheelchairs transported in vehicles that do not require such students to be removed from their wheelchairs in order to enter or leave the vehicles; provided, however, 603 CMR 28.05(5)(b) shall not be applicable where a Team or the student's physician recommends that the student regularly transfer in and out of conventional vehicles to or from a wheelchair for therapeutic or for independence training reasons.

b. The Team shall specify whether the student requires assistance in or out of the home, on or off of the vehicle, and in or out of the school. If such assistance is specified, the district shall ensure that it is provided.

c. The Team shall specify if the student has a particular need or problem that may cause difficulties during transportation, such as seizures, a tendency for motion sickness, behavioral concerns, or communication disabilities.

2. If special transportation is noted on the student's IEP, the student is entitled to receive transportation services to any program provided by the public school and in which the student participates.

3. If special transportation is noted on the student's IEP and the student is enrolled by his or her parents in a private school and receiving services under 603 CMR 28.03(1)(e), the school district's obligation to provide transportation shall be limited to transportation services within the geographic boundaries of the school district.

(c) In no event shall a school district allow transportation considerations to influence, modify, or determine the educational program required by any student in need of special education.

(6) Determination of Placement. At the Team meeting, after the IEP has been fully developed, the Team shall determine the appropriate placement to deliver the services on the student's IEP. Unless the student's IEP requires some other arrangement, the student shall be educated in the school that he or she would attend if the student did not require special education.

(a) Identification by the Team of placement shall proceed in accordance with the options delineated in 603 CMR 28.06.

(b) Lack of an identified placement shall not delay the proposal of the IEP to the parent following the Team meeting.

(7) Parent Response to Proposed IEP and Proposed Placement. Immediately following the development of the IEP, and within 45 school working days after receipt of the parent's written consent to an initial evaluation or reevaluation, the district shall provide the parents with two copies of the proposed IEP and proposed placement along with the required notice, except that the proposal of placement may be delayed according to the provisions of 603 CMR 28.06(2)(e) in a limited number of cases.

(a) later than 30 days after receipt of the proposed IEP and proposed placement, the parents shall:

1. Accept or reject the IEP in whole or in part; request a meeting to discuss the rejected portions of the IEP or the overall adequacy of the IEP; or if mutually agreed upon, accept an amended proposal; and

28.10: continued

3. The request for appeal shall identify the district(s) that the appealing district claims should have been assigned responsibility; and

4. The appealing district shall include such district(s) as a party to the appeal.

(c) A party may request a decision without a hearing with the agreement of all parties.

(d) The Bureau of Special Education Appeals shall render a decision within 45 days of receipt of the hearing request. The granting of a postponement shall not extend the 45-day deadline for issuance of a decision unless the postponement is requested by a party and allowed by the hearing officer for good cause.

(e) The Bureau of Special Education Appeals may return the case to the Department of Elementary and Secondary Education based on new information presented at the hearing.

(f) The decision of the Bureau of Special Education Appeals shall be limited to a determination of the assigned school district and the effective date of such assignment.

28.11: Discipline Procedures for Eligible Students

(1) Authority of School Personnel.

(a) Case-by-case Determination. School personnel may consider any unique circumstances on a case-by-case basis when determining whether a change in placement, consistent with the other requirements of 603 CMR 28.11, is appropriate for an eligible student who violates a code of student conduct.

(b) General. School personnel under this section may remove an eligible student who violates a code of student conduct from their current placement to an appropriate interim alternative educational setting, another setting, or suspension, for not more than ten consecutive school days (to the extent those alternatives are applied to students without disabilities), and for additional removals of not more than ten consecutive school days in that same school year for separate incidents of misconduct, so long as those removals do not constitute a change in placement under 603 CMR 28.11(7).

(c) Additional Authority. For disciplinary changes in placement under 603 CMR 28.11(7), if the behavior that gave rise to the violation of the school code is determined not to be a manifestation of the eligible student's disability pursuant to 603 CMR 28.11(1)(e), school personnel may apply the relevant disciplinary procedures to the eligible student in the same manner and for the same duration as the procedures would be applied to students without disabilities, except as provided in 603 CMR 28.11(1)(d).

(d) Services.

1. An eligible student who is removed from their current placement pursuant to 603 CMR 28.11 must receive educational services during periods of removal consistent with M.G.L. c. 71, § § 37H, 37H½, and 603 CMR 53.00: *Student Discipline*.

2. An eligible student who is removed from their current placement pursuant to 603 CMR 28.11(1)(c) or (g) must:

a. Continue to receive educational services as necessary to provide a free appropriate public education, to enable the student to continue to participate in the general education curriculum, although in another setting, and to progress toward meeting the goals set out in the student's IEP; and

b. Receive, as appropriate, a functional behavioral assessment, and behavioral intervention services and modifications, that are designed to address the behavior violation so that it does not recur.

3. If the removal is a change of placement under 603 CMR 28.11(7), the student's Team determines appropriate services under 603 CMR 28.11(1)(d)2.

4. The services required by 603 CMR 28.11(1)(d) may be provided in an interim alternative educational setting.

(e) Manifestation Determination.

1. Within ten school days of any decision to change the placement of an eligible student because of a violation of a code of student conduct, the district, the parent, and relevant members of the student's Team (as determined by the parent and the district) must review all relevant information in the student's file, including the student's IEP, any teacher observations, and any relevant information provided by the parents to determine:

a. If the conduct in question was caused by, or had a direct and substantial relationship to, the student's disability; or

b. If the conduct in question was the direct result of the district's failure to implement the IEP.

28.11: continued

2. The conduct must be determined to be a manifestation of the student's disability if the school district, the parent, and relevant members of the student's Team determine that a condition in either 603 CMR 28.11(1)(e)(1)a. or b. was met.

3. If the school district, the parent, and relevant members of the student's Team determine the condition of 603 CMR 28.11(1)(e)1.b. was met, the district must take immediate steps to remedy those deficiencies.

(f) Determination That Behavior Was a Manifestation. If the school district, the parent, and relevant members of the Team make the determination that the conduct was a manifestation of the student's disability, the Team must:

1. Either:

a. Conduct a functional behavioral assessment, unless the district had conducted a functional behavioral assessment before the behavior that resulted in the change of placement occurred, and implement a behavioral intervention plan for the student; or

b. If a behavioral intervention plan already has been developed, review the behavioral intervention plan, and modify it, as necessary, to address the behavior; and

2. Except as provided in 603 CMR 28.11(1)(g), return the student to the placement from which the student was removed, unless the parent and the school district agree to a change of placement as part of the modification of the behavioral intervention plan.

(g) Special Circumstances.

1. School personnel may remove a student to an interim alternative educational setting for not more than 45 school days without regard to whether the behavior is determined to be a manifestation of the student's disability, if the student does one of the following:

a. Carries a dangerous weapon to or possesses a dangerous weapon at school, on school premises, or to or at a school function under the jurisdiction of the Department or a school district;

b. Knowingly possesses or uses illegal drugs, or sells or solicits the sale of a controlled substance while at school, on school premises, or at a school function under the jurisdiction of the Department or a school district;

c. Has inflicted serious bodily injury upon another person while at school, on school premises, or at a school function under the jurisdiction of the Department or a school district.

2. For the purposes of this section, the following definitions shall apply:

a. Controlled substance means a drug or other substance identified under schedules I, II, III, IV, or V in section 202(c) of the Controlled Substances Act (21 U.S.C. 812(c)).

b. Illegal drug means a controlled substance; but does not include a controlled substance that is legally possessed or used under the supervision of a licensed health-care professional or that is legally possessed or used under any other authority under state or federal law.

c. Serious bodily injury has the meaning given the term "serious bodily injury" under paragraph (3) of subsection (h) of section 1365 of title 18, United States Code.

d. Dangerous weapon has the meaning given the term "dangerous weapon" under paragraph (2) of the first subsection (g) of section 930 of title 18, United States Code.

(h) Notification. Not later than the date on which the decision is to take disciplinary action, as permitted by this section, is made, the school district must notify the parents of that decision and provide the parents with the procedural safeguards notice as described in 34 C.F.R. § 300.504. Such notice shall be consistent with state law requirements.

(2) Determination of Setting. The student's Team determines the interim alternative setting for services under 603 CMR 28.11(1)(c), (d)4., and (g).

(3) Appeal.

(a) General. The parent of an eligible student who disagrees with any decision regarding placement under 603 CMR 28.11(1) or (2) or the manifestation determination under 603 CMR 28.11(1)(e), or a school district that believes that maintaining the current placement of the student is substantially likely to result in injury to the student or others, may appeal the decision by requesting a hearing with the Bureau of Special Education Appeals. The hearing is requested by filing a complaint pursuant to 34 C.F.R. § § 300.507 and 300.508(a) and is conducted on an expedited basis pursuant to the Bureau of Special Education Appeals Hearing Rules.

28.11: continued

(b) Authority of Hearing Officer.

1. Consistent with 34 C.F.R. § 300.511, a hearing officer hears and makes a determination regarding the appeal.

2. In making such determination, the hearing officer may:

a. Return the eligible student to the placement from which the student was removed if the hearing officer determines that the removal was a violation of 603 CMR 28.11(1) or that the student's behavior was a manifestation of the student's disability; or

b. Order a change of placement of the eligible student to an appropriate interim educational setting for not more than 45 school days if the hearing officer determines that maintaining the current placement is substantially likely to result in injury to the student or to others.

3. The procedures in 603 CMR 28.11(3)(a) and (b) may be repeated to request continuation of an interim alternative education placement ordered under 603 CMR 28.11(3)(b)(2) if the district believes that returning the student to the original placement is substantially likely to result in injury to the student or others.

4. The hearing officer's determination may be appealed consistent with 34 C.F.R. § 300.514.

(4) Placement During Appeals.

When an appeal under 603 CMR 28.11(3) has been made by either the parent or the district, the student must remain in the interim alternative setting pending the decision of the hearing officer or until the expiration of the time period specified in 603 CMR 28.11(1)(c) or (g), whichever occurs first, unless the parent and the district agree otherwise.

(5) Protections for Students Not Determined Eligible for Special Education and Related Services.

(a) General. A student who has not been determined eligible for special education and related services and who has engaged in behavior that violated a code of student conduct, may assert any of the protections provided for in 603 CMR 28.11 if the district had knowledge, as determined in accordance with this paragraph, that the student was a student with a disability before the behavior that precipitated the disciplinary action occurred.

(b) Basis of Knowledge. A district will be deemed to have knowledge that a student is an eligible student if before the behavior that precipitated the disciplinary action occurred:

1. The parent of the student expressed concern in writing to supervisory or administrative personnel, or a teacher of the student, that the student is in need of special education and related services;

2. The parent of the student requested an evaluation of the student pursuant to 34 C.F.R. § § 300.300 through 300.311; or

3. The teacher of the student, or other district personnel, expressed specific concerns about a pattern of behavior demonstrated by the student directly to the director of special education of the district or to other school or district administrators.

(c) Exception. A district will not be deemed to have knowledge if:

1. The parent of the student:

a. Has not allowed an evaluation of the student pursuant to 34 C.F.R. § § 300.300 through 300.311 and 603 CMR 28.04; or

b. Has refused special education services; or

2. The student has been evaluated in accordance with 34 C.F.R. § § 300.300 through 300.311 and 603 CMR 28.04 and determined not to be eligible.

(d) Conditions That Apply If No Basis of Knowledge.

1. If a district does not have knowledge that a student is an eligible student prior to taking disciplinary measures against the student, the student may be subjected to the disciplinary measures applied to students without disabilities who engage in comparable behaviors.

2. If a request is made for an evaluation of a student during the time period in which the student is subjected to disciplinary measures under 603 CMR 28.11(1), the evaluation must be conducted in an expedited manner.

28.11: continued

a. Until the evaluation is completed, the student remains in the educational placement determined by the school authorities, which can include suspension or expulsion; provided however, that for disciplinary action taken pursuant to M.G.L. c. 71, § § 37H, 37H½, 37H¾ or 603 CMR 53.00: *Student Discipline*, the student shall have the opportunity to make academic progress during the period of removal consistent with state law.

b. If the student is determined to be an eligible student, taking into consideration information from the evaluation conducted by the district and information provided by the parent, the district must provide special education and related services in accordance with federal and state special education law, including 603 CMR 28.11.

(6) Referral to and Action by Law Enforcement and Judicial Authorities.

(a) Rule of Construction. Nothing in 603 CMR 28.11(6) prohibits a district from reporting a crime committed by an eligible student to appropriate authorities or prevents state or local law enforcement and judicial authorities from exercising their responsibilities with regard to the application of federal and state law to crimes committed by an eligible student.

(b) Transmittal of Records.

1. A district reporting a crime committed by an eligible student must ensure that copies of the special education and disciplinary records of the student are transmitted for consideration by the appropriate authorities to whom the district reports the crime.

2. July 23, 2026A district reporting a crime under 603 CMR 28.11 may transmit copies of the student's special education and disciplinary records only to the extent that the transmission is permitted by the Family Educational Rights and Privacy Act, M.G.L. c. 71, § 37L, and 603 CMR 23.00: *Student Records*.

(7) Change of Placement Because of Disciplinary Removals.

For purposes of removals of an eligible student from the student's current educational placement under 603 CMR 28.11(1) through (6), a change of placement occurs if:

(a) The removal is for more than ten consecutive school days; or

(b) The student has been subjected to a series of removals totaling more than ten cumulative days over the course of the school year.

REGULATORY AUTHORITY

603 CMR 28.00: M.G.L. c. 69, § 1B, and c. 71B.

(PAGES 275 THROUGH 298 ARE RESERVED FOR FUTURE USE.)

Docket # 449

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **603 CMR 57.00**

CHAPTER TITLE: **Standards for Interpretation and Translation Services in Schools**

AGENCY: **Department of Elementary and Secondary Education**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

603 CMR 57.00, Standards for Interpretation and Translation Services in Schools, reflect the amendments to G.L. c. 69, section 1B as set forth in section 25 of Chapter 140 of the Acts of 2025. The board shall promulgate regulations establishing standards for the provision of interpretation and translation services, including standards for the qualification of interpreters and translators, to limited English proficient parents and legal guardians of all public school students.

REGULATORY AUTHORITY: **MGL c. 69, §1B**

AGENCY CONTACT: **Mary Morales** PHONE: **781-338-3429**

ADDRESS: **135 Santilli Highway, Everett, MA 02149**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Prior notification sent to the Joint Committee on Education on 3/5/26; The Executive Office of Housing and Livable Communities on 3/2/26; and the Massachusetts Municipal Association on 3/2/26.

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **3/13/26-4/24/26**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **N/A**

For the first five years: **N/A**

No fiscal effect: **N/A**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **6/18/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

Translation Services in Schools
Interpretation Services in Schools

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

New regulation: 603 CMR 57.00, Standards for Interpretation and Translation Services in Schools

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 15 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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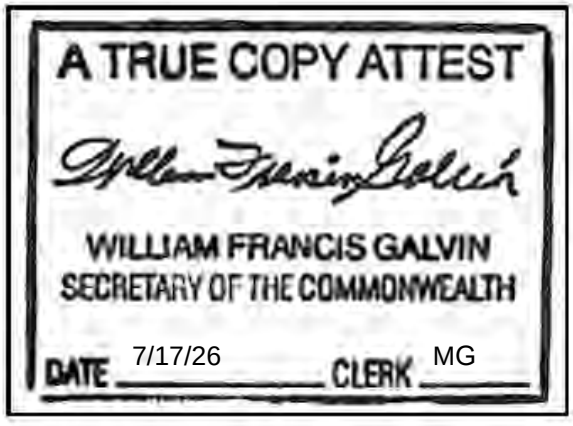

603 CMR 57.00: STANDARDS FOR INTERPRETATION AND TRANSLATION SERVICES IN SCHOOLS

Section

57.01: Scope and Purpose

603 CMR 57.00 establishes standards for the provision of interpretation and translation services to parents and legal guardians with limited English proficiency of all public school students.

57.02: Definitions

Advanced Education Interpreter. An individual who satisfies the requirements set out in 603 CMR 57.03 (2) and facilitates communication between school staff and parents and legal guardians with limited English proficiency on matters relating to special education and other specialized meetings such as meetings for safety plans, meetings for English Learner Education program placement, due process or student discipline hearings, meetings addressing bullying complaints, and meetings addressing the use of physical restraint or seclusion.

Board. The Board of Elementary and Secondary Education.

Commissioner. The Commissioner of Elementary and Secondary Education.

Department. The Department of Elementary and Secondary Education.

Education Interpreter. An individual who satisfies the requirements set out in 603 CMR 57.03(1) and facilitates communication in matters not requiring an Advanced Education Interpreter between school staff and parents and legal guardians with limited English proficiency.

Interpretation. The accurate conversion of spoken or signed language from one language to another language.

Parents and legal guardians with limited English proficiency. Parents and legal guardians of public school students who primarily communicate in a language other than English and have a limited ability to read, speak, write or understand English.

Public school student. A student who is enrolled in a Massachusetts public school, including a career technical education school, charter school, collaborative education program, recovery high school, virtual school, or the day school of a special education school approved under 603 CMR 28.09: *Approval of Public or Private Day and Residential Special Education School Programs*.

School Translator. An individual who facilitates written communication between school staff and parents and legal guardians with limited English proficiency and who satisfies the requirements set out in 603 CMR 57.04.

Translation. The accurate conversion of written text from one language into another language.

57.03: Standards for the Qualifications of Interpreters

(1) Education Interpreters shall successfully complete either
(a) a training course approved by the Department regarding the provision of interpretation services in an educational setting, or
(b) other measure approved by the Department.
The course or other measure must include information relating to knowledge of specialized terms and concepts used in schools, the role of an interpreter in school settings, ethics and the need to maintain confidentiality. To be eligible for the course or other measure approved by the Department, an applicant must demonstrate proficiency in English and another language, as determined by the Department.

(2) Advanced Education Interpreters shall successfully complete either
(a) a training course approved by the Department for Advanced Education Interpreters regarding the provision of interpretation services in a specialized educational setting, or
(b) other measure approved by the Department.
The course or other measure must include information relating to knowledge of specialized terms and concepts used in schools and specialized terms and concepts related to special education, safety plans, English Learner Education plans, discipline, bullying, and physical restraint or seclusion. The course or other measure must also include information on the role of an interpreter in school settings, ethics and the need to maintain confidentiality. To be eligible for the course or other measure, an applicant must demonstrate proficiency in English and another language, as determined by the Department.

(3) An individual whose primary job responsibilities have included serving as an interpreter in a school district for at least two years prior to September 1, 2027, may meet the requirements for an Education Interpreter by providing a letter of endorsement from the school's superintendent or executive director certifying the applicant's demonstrated proficiency in English and another language.

(4) An individual who has been employed as an interpreter in a school district prior to September 1, 2027 and whose primary job responsibility has been to provide interpretation in special settings, including interpretation services for Individualized Education Program (IEP) Team meetings or other meetings relating to special education; meetings for safety plans; meetings for English Learner Education program placement; due process or student discipline hearings; meetings addressing bullying complaints; or meetings addressing the use of physical restraint or seclusion, may meet the requirements for an Advanced Education Interpreter by providing a letter of endorsement from the school's superintendent or executive director certifying the applicant's demonstrated knowledge of specialized terms and concepts and proficiency in English and another language.

(5) The Department may develop alternative pathways that allow interpreters who have been trained and qualified in non-school settings to satisfy the training requirements for becoming an Education Interpreter or Advanced Education Interpreter.

57.04: Standards for the Qualifications of Translators

(1) A School Translator shall:
(a) Demonstrate written proficiency in English and at least one other language, including knowledge of specialized terms and concepts used in schools, through a formal assessment approved by the Department.
(b) Demonstrate an understanding of the ethics of translation in an educational setting, and the need to maintain confidentiality through successful completion of a training course or other measure approved by the Department.
(c) Successfully complete an assessment regarding the provision of translation services in an educational setting, or other measure approved by the Department. The assessment or other measure must include information relating to knowledge of specialized terms and concepts used in schools, the role of a translator in school settings, ethics and the need to maintain confidentiality.

57.04: continued

(2) An individual whose primary job responsibility has been to serve as a translator in a school district for at least one year prior to September 1, 2027, may meet the requirements for a School Translator by providing a letter of endorsement from the school's superintendent or executive director certifying the applicant's demonstrated written proficiency in English and another language.

57.05: Standards for the Provision of Interpretation and Translation Services

(1) Education Interpreters or Advanced Education Interpreters provide interpretation services for communications between school staff and parents and legal guardians with limited English proficiency related to matters that do not require a specialized vocabulary, including but not limited to spontaneous conversations, and discussions at parent/teacher conferences and open houses.

(2) Advanced Education Interpreters provide interpretation services for scheduled meetings including but not limited to Individualized Education Program (IEP) Team meetings or other meetings relating to special education; meetings for safety plans; meetings for English Learner Education program placement; due process or student discipline hearings; meetings addressing bullying complaints; or meetings addressing the use of physical restraint or seclusion.

(3) Machine translation may be used to translate a document so long as the translation is reviewed and edited as needed by a School Translator before the document is provided to a parent or legal guardian with limited English proficiency. Multilingual communication applications or tools that support translated communication between parents or legal guardians and school staff may be used without review and editing by a School Translator for informational notifications that do not include any specialized terminology.

57.06: General Requirements

(1) Implementation. 603 CMR 57.00 is implemented starting on September 1, 2027.

(2) Waiver. A public school, by its superintendent or executive director, may make a written request to the Commissioner for a waiver of any requirement in 603 CMR 57.00 based on good cause. No such waiver shall be effective until approved by the Commissioner. Waivers shall be effective for no longer than one school year. All waiver requests shall be:

a. Submitted in a manner and form prescribed by the Department;

b. Specify the provisions of 603 CMR 57.00 to be waived, the duration of the waiver (not to exceed one year), the circumstances to which the waiver applies, and the specific reason that a waiver is sought; and

c. Be accompanied by supporting documentation to support the need for relief.

57.07: Severability.

If any section or portion of a section of 603 CMR 57.00, or the applicability of 603 CMR 57.00 to any person, entity or circumstance is held invalid by a court, the remainder of 603 CMR 57.00 or the applicability of such provisions to other persons, entities or circumstances shall not be affected thereby.

REGULATORY AUTHORITY

603 CMR 57.00: M.G.L. c. 69, § 1B

NON-TEXT PAGE

Docket # 144

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **651 CMR 12.00**

CHAPTER TITLE: **Certification Procedures and Standards for Assisted Living Residences**

AGENCY: **Executive Office of Aging and Independence**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

The Executive Office of Aging & Independence (AGE) seeks to update 651 CMR 12.00 in accordance with Chapter 197 of the Acts of 2024, An Act to Improve Quality and Oversight of Long-Term Care. The primary focus is on regulating the addition of certification process and related requirements for Basic Health Services in Assisted Living Residences (ALRs). In addition, AGE has added requirements to seek to create a safer environment in ALRs. The regulatory action is necessary to ensure the health, safety, and welfare of Residents and staff.

REGULATORY AUTHORITY: **M.G.L. c. 19A, § 6; M.G.L. c. 19D, § 19**

AGENCY CONTACT: **Julian Smith** PHONE: **617-645-8661**

ADDRESS: **Executive Office of Aging & IndependenceOne Ashburton Place10th FloorBoston, MA 02108**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Approval by the Executive Office of Administration & Finance was given on 7/8/26.

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **2/26/26**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **N/A**

For the first five years: **N/A**

No fiscal effect: **There is no fiscal effect.**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **6/30/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*
Licensing and permitting, elders, healthcare

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*
This regulation will amend the current version of 651 CMR 12.00, Certification Procedures and Standards for Assisted Living Residences.

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 02 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

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CODE OF MASSACHUSETTS REGULATIONS

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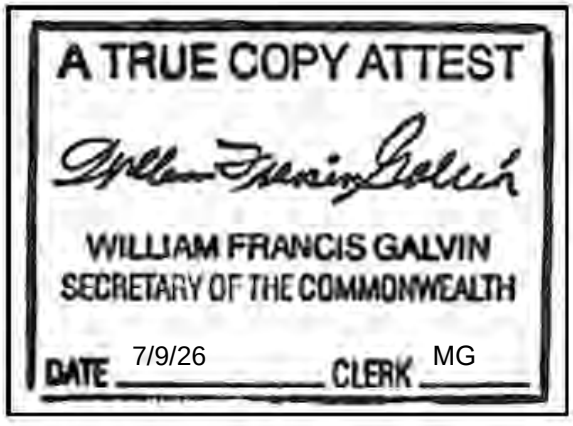

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651 CMR 12.00: CERTIFICATION PROCEDURES AND STANDARDS FOR ASSISTED LIVING RESIDENCES

Section

12.01: Scope and Purpose

(1) 651 CMR 12.00 sets forth the requirements for Certification, renewal of Certification and suitability for Applicants and Sponsors of Assisted Living Residences. The purpose of 651 CMR 12.00 is to promote the availability of services for older adults or persons with disabilities in a residential environment; to promote dignity, individuality, and privacy to support and preserve decision-making ability of such persons and to promote their health, safety, and welfare; to promote the ability of Assisted Living Residents to age in place; and to promote continued improvement of Assisted Living Residences. The Executive Office of Aging & Independence (EOAI) may clarify the substantive provisions of 651 CMR 12.00 by written guidance, instructions, bulletins, or other written issuance.

(2) Although the provisions of M.G.L. c. 19D and 651 CMR 12.00 do not apply to the following entities and premises for the original facilities and services for which said entities and premises were originally licensed or organized to provide, if any such entity seeks to have all or part of its premises advertised, operated or maintained as an Assisted Living Residence, it must apply to become Certified in accordance with 651 CMR 12.03:

(a) Convalescent homes, licensed nursing homes, licensed rest homes, charitable homes for the aged or intermediate care facilities for persons with an intellectual disability licensed pursuant to M.G.L. c. 111, § 71;

(b) Hospices licensed pursuant to the provisions of M.G.L. c. 111, § 57D;

(c) Facilities providing continuing care to residents, as those terms are defined by M.G.L. c. 93, § 76;

(d) Congregate housing authorized by M.G.L. c. 121B, § 39;

(e) Group homes or supported living programs operating under contract with the Department of Mental Health, MassAbility, or the Department of Developmental Services;

(f) Housing operated for only those duly ordained priests or for the members of the religious orders of the Roman Catholic Church in their own locations, buildings, Assisted Living Residences or headquarters to provide care, shelter, treatment and medical assistance for any of the said duly ordained priests or members of the said religious order.

(3) The provisions of M.G.L. c. 19D are not applicable to any residential premises available for lease by elderly or disabled individuals that is financed or subsidized in whole or in part by local, state, or federal housing programs established primarily to develop or operate housing rather than to provide housing and personal services in combination.

12.02: Definitions

When used in 651 CMR 12.00, unless the context otherwise requires, the following terms shall have the following meanings:

Abuse. Consistent with the Elder Protective Services regulations, 651 CMR 5.00: *Elder Abuse Reporting and Protective Services Program*, an act or omission, including but not limited to emotional abuse, financial exploitation, neglect, physical abuse, sexual abuse, and/or self-neglect.

Activities of Daily Living (ADL). Tasks related to bathing, dressing, grooming, ambulation, eating, toileting and other similar tasks related to personal care needs.

Administrative Fee. Any charge billed to and payable by a Resident as a condition of admission, excluding room, board, and services.

Alteration. Any of the following changes made after the date of the Residence's last Certification:

(a) a change in the number of Units;
(b) a substantial change in the configuration of Units;
(c) a substantial change in the premises;
(d) a substantial change in the operating plan;
(e) a new management company; and
(f) a name change of the Residence or the Residence's Sponsor.

Applicant. A person or legal entity applying to EOAI for Certification as a Sponsor of an Assisted Living Residence.

Assisted Living Residence or Residence. Any entity, however organized, whether conducted for profit or not for profit, which meets all of the following criteria:

(a) provides room and board;
(b) provides, directly by its employees or through arrangements with another organization which the entity may or may not control or own, Personal Care Services for three or more adults who are not related by consanguinity or affinity to their care provider; and
(a) collects payments or third-party reimbursements from or on behalf of Residents to pay for the provision of assistance with the Activities of Daily Living, or arranges for the same.

Basic Health Services. Certain services provided at an Assisted Living Residence certified to provide such services by employees of the Residence that are qualified to administer such services or a qualified third-party in accordance with a Medical Order issued by an Licensed Independent Provider; provided, however, that such services shall include all of the following:

(i) injections;
(ii) the application or replacement of simple non-sterile dressings;
(iii) the management of oxygen on a regular and continuing basis;
(iv) specimen collection and the completion of a home diagnostic test, including, but not limited to, COVID-19 testing, influenza testing, warfarin, prothrombin or international normalized ratio testing, and glucose testing; provided, that such home diagnostic test or monitoring is approved by the United States Food and Drug Administration for home use; and
(v) application of ointments or drops.

Bathing Facility. A room equipped with a showerhead or a bathtub to enable one person to take a shower or a bath.

Certification. EOAI's initial approval, or subsequent renewal of that approval, of the qualifications of an Applicant or Sponsor to operate and maintain an Assisted Living Residence subject to the requirements of M.G.L. c. 19D and 651 CMR 12.00.

12.02: continued

Certified Provider of Ancillary Health Services. A person or legal entity certified to provide home health care services or hospice care services under Title XVIII of the Social Security Act 49, Stat. 620 (1935) or an entity licensed under M.G.L. c. 111 that provides physician services, pharmacy services, restorative therapies, podiatry, hospice services, and/or home health aide services.

Clinical Professional. A licensed health care provider who provides health services, including Basic Health Services, within their scope of practice to Residents of an Assisted Living Residence.

Computation of Time. In computing any period of time under 651 CMR 12.00, the day of the act which initiates the running of the time period shall not be counted. The last day of the time period shall be included, unless it is a Saturday, Sunday or legal holiday or any other day on which EOAI is closed, in which case the period shall run until the end of the next business day. When the time period is less than seven days, any days when EOAI is closed shall be excluded from the computation.

Controlled Substances. For the purposes of 651 CMR 12.00, controlled substances shall include all Class II controlled substances identified by 21 U.S.C. c. 13, and any Class I controlled substances identified by 21 U.S.C. c. 13, that may be legally prescribed according to the laws of the Commonwealth.

EOAI. The Executive Office of Aging & Independence, formerly known as the Executive Office of Elder Affairs, a department within the Executive Office of Health and Human Services established pursuant to M.G.L. c. 6A, § 16.

EOHHS. The Executive Office of Health and Human Services established pursuant to M.G.L. c. 6A, § 2.

EOHHS Agency. Any department, agency, commission, office, board, division, or other body within and subject to EOHHS under M.G.L. c. 6A, § 16, including EOAI.

Evidence Informed Falls Prevention Program. The use of the best available knowledge and research to guide the design and implementation of a program to assess Resident risk for falls and establish preventive measures and situational procedures.

Floater. A staff member of the Residence who is available on an ad hoc basis to assist in times of unusually heavy workload or emergency situations and is not specifically assigned to a group of Residents or unit.

Health Care Agent. An adult to whom authority to make health care decisions is delegated under a Health Care Proxy.

Health Care Proxy. A document delegating to an agent the authority to make health care decisions, executed in accordance with the requirements of M.G.L. c. 201D.

Instrumental Activities of Daily Living (IADL). Tasks related to meal preparation, housekeeping, clothes laundering, shopping for food and other items, telephoning, use of transportation, and other similar tasks related to environmental needs.

Legal Representative. Guardian, Conservator, or attorney in-fact under a Power of Attorney, as appropriate. No entity or individual can be a legal representative unless they meet all requirements under applicable state law.

Licensed Independent Provider. Licensed Independent Provider shall have the same meaning as the term "authorized medical professional" as defined in M.G.L. c. 19D, § 1.

Lift Device. A device designed to assist in transferring a Resident between positions or locations, including, but not limited to, ceiling-based lifts, floor-based lifts, and sit-to-stand lifts.

12.02: continued

Limited Medication Administration (LMA). The administration of medication to a Resident which is not otherwise prohibited by M.G.L. c. 19D or 651 CMR 12.00. LMA may only be provided in a Residence by a practitioner as defined in M.G.L. c. 94C, or a nurse licensed under the provisions of M.G.L. c. 112, § 74 or § 74A to the extent allowed by laws, regulations and standards governing nursing practice in Massachusetts, but which may not include a nurse delegate under M.G.L. c. 112, § 80B. This definition is not intended to address or prohibit the administration of medication conducted by a family member, an individual designated in writing by the Resident, or the Resident's Legal Representative, the conducting of which is not governed by 651 CMR 12.00.

Lodging. The provision of a single or a double living Unit.

Manager. The individual who has general administrative charge of an Assisted Living Residence. A Manager may also be known as an Executive Director.

Medical Order. A care order as defined in St. 2024, c. 197, § 2 as a written order for Basic Health Services issued by an authorized medical professional.

Medication Diversion. The transfer of any legally prescribed medication from the individual for whom it was prescribed to another person for any illicit use.

Medication Error. A failure to administer a medication as prescribed, including the failure to administer the correct medication or the failure to administer the medication:

(1) Within appropriate time frames;
(2) In the correct dosage;
(3) In accordance with accepted practice;
(4) To the correct participant; or
(5) In the correct route.

Mobility Assistive Device. Any portable or fixed mechanical, electronic, or manual device (*e.g.*, a cane, walker, wheelchair, *etc*.) specifically designed, approved, and maintained for the purpose of facilitating the safe movement or ambulation of a Resident with limited mobility. The Mobility Assistive Device must conform to applicable national and local safety and quality standards.

Modification of Certification. A change to or limitation on the scope of a Sponsor's authority to operate an Assisted Living Residence.

Mutual Aid. A coordinated and collaborative effort between local Assisted Living Residences to provide support and assist with the management of evacuations and resource/asset needs, including the identification of substitute housing for use during an extended evacuation of Residents.

Newly Constructed. A building or buildings for which a person or entity received a building permit on or after June 1, 1995 and seeks Certification as an Assisted Living Residence; provided that a building or buildings for which a person or entity at any time is or was providing facilities or services other than those of an Assisted Living Residence shall not be considered newly constructed for the purpose of the physical requirements for an Assisted Living Residence under M.G.L. c. 19D, § 16 or 651 CMR 12.04(1).

Personal Care Service. Assistance with one or more of the Activities of Daily Living and Self-administered Medication Management, either through physical support or supervision. Supervision includes reminding or observing Residents while they perform activities.

Personal Care Staff. Any individual who provides Personal Care Services to a Resident.

Residency Agreement. The written contract between an Assisted Living Residence and a Resident or prospective Resident on either a temporary (*e.g.*, for respite care) or more permanent basis.

12.02: continued

Resident. An individual who resides in an Assisted Living Residence and who receives housing and Resident Services and, when the context requires or permits, such individual's Legal Representative. An individual who resides in an Assisted Living Residence or Special Care Residence for any period of time shall be entitled to all the rights and privileges accorded under 651 CMR 12.00 regardless of the anticipated length of the residency.

Resident Care Director. The individual(s) responsible for ensuring and overseeing the process for coordination of Resident Services, including the preparation and periodic review and revision of each Resident's Service Plan. A Resident Care Director may also be known as a Service Coordinator.

Resident Representative. An individual who is authorized by the Resident to help them fully participate in planning services or paying fees. The Resident Representative shall not be employed by the Residence, nor affiliated with the Sponsor unless related to the Resident by kinship or marriage. The Resident Representative shall not act on behalf of a Resident in circumstances warranting a Legal Representative. The Residence shall not treat the Resident Representative as personally liable for payment of Resident fees without having first obtained the Resident Representative's written agreement to act as a guarantor or surety.

Resident Services. Services to assist Residents with Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), Self-administered Medication Management (SAMM), or other similar services, but does not include optional services such as concierge services, recreational or leisure services. Resident Services are provided either through physical assistance or staff supervision.

Restraint. For the purposes of 651 CMR 12.00, any action taken by the Assisted Living Residence for the purpose or punishing or penalizing a Resident, or to control or manage a Resident's behavior with lesser effort by the Assisted Living Residence that is not in the Resident's best interest by means of:

(a) manual method or physical or mechanical device, material, or equipment attached or adjacent to the Resident's body that the individual cannot remove easily which restricts the Resident's freedom of movement or normal access to their body; or

(b) any drug not required to treat medical symptoms and not requested by the Resident.

Secretary. The Secretary of the Executive Office of Aging & Independence of the Commonwealth of Massachusetts.

Self-administered Medication Management (SAMM). A process which includes reminding Residents to take medication, opening containers for Residents, opening prepackaged medication for Residents, reading the medication label to Residents, and observing Residents while they take the medication.

Serious Incident. Any sudden or progressive development or event that requires immediate attention and decisive action to prevent or minimize any negative impact on the health, safety, or welfare of one or more Residents.

Service Plan. The individualized plan for each Resident developed and implemented in accordance with 651 CMR 12.04(8) and 12.04(9).

Skilled Nursing Care. Skilled services described in 130 CMR 456.409: *Clinical Eligibility Criteria* or any successor regulation.

Special Care Residence (SCR). The Residence in its entirety or any separate and distinct section or sections within the Residence that provide(s) an enhanced level of supports and services for one or more Residents to address their specialized needs due to cognitive or other impairments.

Special Care Unit. A portion of a Special Care Residence designed for and occupied pursuant to a Residency Agreement by one or two individuals as the private living quarters of such individuals.

12.02: continued

Sponsor. The person or legal entity named in the Certification of an Assisted Living Residence. A Sponsor may be the owner of the Assisted Living Residence.

Transfer Assistive Device. Any portable or fixed mechanical, electronic, or manual device (*e.g.*, a Lift Device, a bed rail that is less than half the length of the bed, *etc*.) specifically designed, approved, and maintained for the purpose of transferring a Resident with limited mobility. The Transfer Assistive Device must conform to applicable national and local safety and quality standards.

Transfer of Ownership. Transfer of a majority interest in the ownership of an Assisted Living Residence. In the case of an individual, transfer of ownership; in the case of a corporation, transfer of a majority of the stock thereof; in the case of a partnership, transfer of a majority of the partnership interest; in the case of a trust, change of the trustee, or majority of trustees shall constitute transfer of ownership. A transfer of ownership shall also be deemed to have occurred where foreclosure proceedings have been instituted and consummated by a mortgagee in possession of the premises, or when bankruptcy proceedings have been initiated.

Unanticipated Death. The death of a Resident resulting from any cause not directly related to an existing diagnosis or prognosis.

Unit. A portion of an Assisted Living Residence designed for and occupied pursuant to a Residency Agreement by one or two individuals as the private living quarters of such individuals.

12.03: Certification Process

(1) Requirements and Limitations.

(a) No person or legal entity shall advertise, operate, or maintain an Assisted Living Residence until it has been certified by EOAI.

(b) No person or legal entity shall advertise, market, or provide Basic Health Services until it has been certified by EOAI to provide such services.

(c) Notwithstanding the requirement of 651 CMR 12.03(1)(a), prior to the commencement of operations, an Applicant may advertise an uncertified Assisted Living Residence only if it first initiates the application process for Certification by notification to EOAI, and if it clearly states in all advertising and marketing materials that it has not completed the EOAI Certification process.

(d) An Applicant must have sufficient property rights, as an owner or lessee, as the Secretary or a designee finds necessary for the operation of an Assisted Living Residence.

(e) An Application for Certification shall not be approved until the Applicant and premises meet the requirements of 651 CMR 12.03(2).

(2) Application for Certification. Application for initial Certification or renewal of such Certification shall be made on forms and in the manner prescribed by EOAI. Every Application shall be notarized and signed under the pains and penalties of perjury by the Applicant. Except as set forth in 651 CMR 12.03(10), an Application for initial Certification shall be submitted to EOAI at least 90 days prior to the date the Applicant plans to commence operation of the Assisted Living Residence. EOAI shall charge a non-refundable fee set by the Secretary of Administration and Finance pursuant to M.G.L. c. 7, § 3B for the filing of the Application for Certification of an Assisted Living Residence. An Applicant shall file a separate Application for each Assisted Living Residence for which Certification is sought. In support of the Application for Certification, each Applicant shall provide:

(a) The name and address of each officer, director, and trustee; and the names and addresses of each owner, general partner, limited partner, or shareholder with a 5% or greater interest in the Assisted Living Residence. For each such individual or entity identified in 651 CMR 12.03(2), the Applicant shall provide to EOAI documentation of the history of each such individual or entity, including, but not limited to:

12.03: continued

1. all multifamily housing, Assisted Living or health care facilities in which the individual or entity has been or is an officer, director, trustee, or partner and, if applicable, evidence from the relevant regulatory authority that said individual or entity's multifamily housing, Assisted Living, or health care facility has met criteria for licensure or Certification and, if applicable, have corrected all cited deficiencies without de-licensure or de-certification being imposed;

2. documentation of any enforcement action against the individual or entity and, if applicable, evidence that the individual or entity has corrected all cited deficiencies without revocation of licensure or certification;

3. whether such individual or entity has been convicted of Medicare or Medicaid fraud;

4. whether such individual or entity has any judgments or settled any Medicare or Medicaid false claims cases;

5. whether such individual or entity has been terminated from a Medicare program or Medicaid program for any reason; and

6. any other information or documentation requested by EOAI.

(b) A copy of the conversion approval from the DPH, if an Applicant seeks to convert all or part of a premises licensed as a Long-Term Care Facility to an Assisted Living Residence or if an Applicant seeks to add Assisted Living Residences to existing premises licensed as a Long-Term Care Facility;

(c) An operating plan which shall include, at a minimum, the following information:

1. The number of single and double occupancy Units for which Certification is sought, the number of single and double occupancy Units designated as Special Care Units, and the number of Residents per Unit; The location of Units and Special Care Units, common spaces, and egresses by floor;

2. The fee structure for lodging, meals and services, and any optional services, including Basic Health Services;

3. The type, extent, daily availability, and cost of services to be offered, including optional services, such as Basic Health Services, in a format that allows Residents to understand their anticipated weekly or monthly costs; the arrangements for providing such services, including third-party contracts, and linkages with hospital and nursing facilities;

4. A Plan for Self-Administered Medication Management (SAMM) for Residents, including, but not limited to, assistance with as-necessary medication (PRN) when part of the SAMM, and, if offered, Limited Medication Administration;

5. A means for Residents to communicate urgent or emergency needs, and a plan to provide timely assistance to them;

6. Policies and procedures for the maintenance and operation of an automated external defibrillator (AED);

7. The number of staff to be employed in the operation of the Assisted Living Residence and their minimum qualifications and responsibilities;

8. A copy of the Residency Agreement and any disclosures that will be used by the Assisted Living Residence. The Residency Agreement must clearly describe the rights and responsibilities of the Resident and Sponsor, and comply with all requirements of M.G.L. c. 19D and 651 CMR 12.00;

9. A copy of all required current building, fire safety, and locally approved state sanitary code certificates and permits;

10. Procedures to notify a Resident and their Legal or Resident Representative, as appropriate, that the Assisted Living Residence is no longer an appropriate environment for the Resident. Such notice shall describe the changes in the Resident's service needs that justify such a finding, explain when those changes occurred, and describe how the Resident's needs can no longer be satisfied;

11. Procedures to ensure the advance and timely notification, of at least 60 calendar days, to a Resident and their Legal or Resident Representative, as appropriate, of any new fees or changes to existing fees, unless the Resident is assessed as needing additional services to ensure their health and safety more immediately. The Residence must establish and maintain written policies and procedures for how it handles urgent service needs and communicates fee changes, if any, with the Resident and their Legal or Resident Representative, as appropriate;

12.03: continued

12. A copy of all policies and procedures related to the design and operation of a Special Care Residence or Residences required under 651 CMR 12.04(5);
13. A copy of the quality improvement and assurance program required under 651 CMR 12.04(11);
14. A copy of the disaster and emergency preparedness plan required under 651 CMR 12.04(12);
15. A copy of the communicable disease control plan required under 651 CMR 12.04(13);
16. A copy of the Controlled Substances policies and procedures required by 651 CMR 12.04(15);
17. A statement citing the beginning and ending dates of the Residence's fiscal year;
18. Policies and procedures designed to ensure a safe environment for all Residents;
19. If the Residence accepts Residents who require the use a Lift Device, the policies and procedures regarding the training of Clinical Professionals and Personal Care Staff about all aspects of a program for safe and appropriate operation of any Lift Device used for lifting a Resident assessed to require such assistance to ensure the safe transfer of Residents;
20. Policies and procedures regarding which staff are trained and certified in cardiopulmonary resuscitation (CPR), and the use of an automated external defibrillator (AED);
21. Policies and procedures for when cardiopulmonary resuscitation (CPR) will be performed on a Resident and when an automated external defibrillator will be used on a Resident;
22. Policies and procedures regarding the storage and usage of naloxone and epinephrine;
23. Policies and procedures regarding the proper use, administration, and maintenance of oxygen, including safety protocols;
24. Policies and procedures regarding smoking on the Residence's premises and in the Residents' Units;
25. Emergency response procedures for all Residents; and
26. Other information EOAI deems necessary.

(d) Applications for Certification renewal must also include a statement that the data required by 651 CMR 12.04(14), information documenting all substantial changes to the operating plan prior to the effective date, and all other information required by EOAI, have been submitted.

(3) Application for Certification of Basic Health Services.

(a) Any Residence may apply to EOAI for Certification to provide Basic Health Services. No Residence shall offer or provide Basic Health Services without first being certified by EOAI to provide Basic Health Services.

(b) An Application to provide Basic Health Services shall be made on forms and in the manner prescribed by EOAI.

(c) An Application to be certified to provide Basic Health Services shall be submitted to EOAI at least 90 days prior to the date the Applicant plans to commence the provision of Basic Health Services.

(d) In support of the Application for Certification, each Applicant shall provide a detailed operating plan for the provision of Basic Health Services that includes, at a minimum:

1. a proposed administrative and operational structure to ensure the safe and effective provision of Basic Health Services and meet the needs of its Residents; and
2. a compliance plan to meet the requirements established under M.G.L. c. 19D and 651 CMR 12.00, which shall include, but not be limited to:
   a. staff qualifications, and initial and ongoing training and competencies;
   b. effective policies and procedures to ensure the availability of adequate supplies necessary for the provision of Basic Health Services and the safe administration and secure storage of medications;
   c. a process to determine whether the location where Basic Health Services will be provided is medically appropriate and to identify the space, equipment, and supplies necessary to provide such services in an effective and private manner;

12.03: continued

d. an organizational chart that details the roles and responsibilities of staff providing Basic Health Services, including designating the management or clinical lead charged with the creation, ongoing review and approval of all policies and procedures for each component of Basic Health Services;

e. policies and procedures for the provision of each component of Basic Health Services provided by the Residence;

f. standards for Resident assessment and evaluation to determine whether it is appropriate for the Residence to initiate or continue the provision of Basic Health Services to a Resident;

g. policies and procedures regarding the routine communication with the Resident's Licensed Independent Provider;

h. emergency response procedures for Residents receiving Basic Health Services;

i. procedures to ensure continuity of care for Residents receiving Basic Health Services who move-in or move-out of the Residence; and

j. the role, membership, and authority of an internal quality assurance and performance improvement committee. The internal quality assurance and performance improvement committee must develop and implement key quality indicators and implement key quality indicators as described or defined by EOAI.

(4) Review of Applications. The EOAI shall not review an Application for Certification unless:

(a) The Application includes all information required by EOAI;

(b) The Application includes all required attachments and statements that are required for the Certification; and

(c) The Applicant has paid all required Application fees and any outstanding fines issued in accordance with M.G.L. c. 19D and 651 CMR 12.00.

(5) Evaluation of Application. The EOAI shall not approve an Application for Certification unless:

(a) The Secretary or a designee has conducted a compliance review of the Assisted Living Residence as set forth in 651 CMR 12.09 and has reasonably determined that the premises meets the requirements of M.G.L. c. 19D and is in compliance with 651 CMR 12.00; and

(b) The Secretary or a designee has conducted a review of the Applicant and has reasonably determined that the Applicant meets the requirements of M.G.L. c. 19D and is in compliance with 651 CMR 12.00.

(c) EOAI may, in its discretion, deny Certification to any Applicant who had an ownership interest in an entity licensed under M.G.L. c. 111, a licensed medical provider, or a home health agency certified under Title XVIII of the Social Security Act, as amended, that:

1. has been the subject to a patient care receivership action;
2. has ceased to operate such an entity as a result of, or has otherwise been subject to:
   a. suspension or revocation of license or certification;
   b. receivership; or
   c. a settlement agreement arising from suspension or revocation of a license or certification;
3. has a settlement agreement in *lieu* of or as a result of receivership;
4. has been the subject of a delicensure action or involuntary termination of participation in either the Medical Assistance program or the Medicare program;
5. has been the subject of a substantiated case of patient abuse or neglect involving material failure to provide adequate protection or services for a Resident in order to prevent such abuse or neglect; or
6. has over the course of its operation been cited for repeated, serious or willful violations of rules and regulations governing the operation of said entity that indicate a disregard for resident safety and an inability to responsibly operate an Assisted Living Residence.

(6) Certification.

(a) After reviewing and evaluating an Application for Certification or renewal of Certification, if EOAI determines that all required regulatory requirements are met, EOAI will issue a Certification.

12.03: continued

(b) The Certification shall indicate whether the Residence is certified to provide Basic Health Services.
(c) Each Certification shall be for a term of two years and include a date of expiration.
(d) Each Certification shall be valid only in the possession of the Residence and the Sponsor to whom it is issued and shall not be subject to sale, assignment or other transfer, voluntary or involuntary.
(e) No Certification shall be valid for any building premises other than those for which the Certification was originally issued.
(f) Every Assisted Living Residence Certificate must be displayed in a conspicuous place in the Residence and on the Residence's website.
(g) The Certification of a Sponsor to operate an Assisted Living Residence shall be returned by registered mail to EOAI immediately upon:
1. Revocation of or refusal to renew the Certification;
2. Transfer of ownership;
3. Change of the Sponsor's or Residence's name; or
4. Closure or other termination of the Residence's operations.

(7) Certification of Basic Health Services.
(a) EOAI will review the submitted Application for Basic Health Services Certification and conduct a compliance review of the Residence as set forth in 651 CMR 12.09.
(b) Upon making a determination that the Residence is in compliance with the requirements of M.G.L. c. 19D and 651 CMR 12.00, the Residence shall be approved by EOAI to provide Basic Health Services and a Certification will be issued.
(c) A Residence certified to provide Basic Health Services shall pay a fee to EOAI in accordance with 651 CMR 12.03(8).
(d) Once approved and certified to provide Basic Health Services by EOAI, a Residence must notify Residents of the availability of such services for eligible Residents prior to initiating the provision of such services.
(e) EOAI shall make available electronic copies of the required components of Basic Health Services operating plans on its website.

(8) Certification Fee and Basic Health Services Annual Fee. Upon receiving notice of Certification, a Sponsor shall forward within ten days to EOAI a Certification fee set by the Secretary of Administration and Finance pursuant to M.G.L. c. 7, § 3B, based on the number of Units certified on the date of its most recent Application. In the event that the Applicant or Sponsor of an Assisted Living Residence alters the Residence by the addition or removal of Units, a fee adjustment may be made by EOAI. No fee for initial certification or certification renewal shall be due from any Assisted Living Residence created under the HUD Assisted Living Conversion Program. If the Residence is certified to provide Basic Health Services, the Residence shall forward within ten days of the certification, or within ten days of the anniversary of said certification as applicable, an annual Basic Health Services fee set by the Secretary of Administration and Finance pursuant to M.G.L. c. 7, § 3B. Failure to pay any of the fees required by 651 CMR 12.03 within the ten-day period shall result in a finding of non-compliance by EOAI under 651 CMR 12.09.

(9) Renewal Certification Procedures.
(a) The Application for renewal of a Certification shall be filed on a form provided by EOAI, include an Application fee as set by the Secretary for Administration and Finance and follow the procedures set forth in 651 CMR 12.03.
(b) If the Application for renewal of a Certification is filed and date-stamped at EOAI at least 30 days before the stated expiration date of the Certification, the Certification shall not expire until EOAI notifies the Sponsor that the Application for renewal has been denied.
(c) Term of Renewal Certification. EOAI will renew for a term of two years the Certification of a Residence if EOAI determines that the Sponsor and the Residence meet the requirements of M.G.L. c. 19D and 651 CMR 12.00.

12.03: continued

(10) Change of Ownership.

(a) Any person or entity who intends to acquire a 5% or greater interest in an existing Assisted Living Residence shall submit an Application for Certification to EOAI at least 30 days prior to the change of the ownership interest.

1. The Application for Certification shall include a statement on a form developed by EOAI, signed and notarized by the parties, regarding the anticipated change of ownership of the Residence.

2. If EOAI receives these documents at least 30 days prior to the effective date of the change of ownership, the new Applicant shall be considered to be deemed temporarily certified from and after the date of the change of ownership, until such time as EOAI approves or denies the Applicant's Application for Certification.

(b) Within five days after the Transfer of Ownership or change of ownership is completed:

1. The new Applicant must submit a signed and notarized statement confirming the change of ownership or Transfer of Ownership is complete. The new Applicant must notify all current Residents, Resident Representatives or Legal Representatives, if applicable, and prospective Residents that the change of ownership or Transfer of Ownership has occurred and that the Residence is awaiting EOAI's decision on the new Sponsor's Application for Certification; and

2. The previous Sponsor must return its Assisted Living Residence Certificate to EOAI.

(c) Any notice of hearing, order or decision that EOAI or the Secretary issues for a Residence prior to a Transfer of Ownership or change of ownership shall be effective against the former Sponsor prior to such change of ownership of Transfer of Ownership and, where appropriate, the new Sponsor, following such change of ownership or Transfer of Ownership unless said notice, order or decision is modified or dismissed by EOAI or by the Secretary.

(d) EOAI retains the discretion to conduct a full or partial compliance review in the event of a Transfer of Ownership or a change of ownership.

(e) Within 14 calendar days of EOAI approving the new Sponsor's Certification, the Residence must provide written notice to all Residents, their Legal Representatives and Resident Representatives (if applicable), and the Long-Term Care Ombudsman Program confirming EOAI's approval and issuance of the new Certificate.

(f) The Residence must make ownership information available to all Residents, Legal Representative and Resident Representatives (if applicable). The Residence must make ownership information available to prospective Residents, upon request.

(11) Closure. In the event a Sponsor of an Assisted Living Residence elects to permanently close or sell the Residence for any reason, compliance with the following notification procedures is required:

(a) Resident Notice. A written notice must be received by the Residents, their Legal Representatives, and their Resident Representatives (if applicable), at least 120 days prior to the date on which the Sponsor intends to close or sell the Residence and cease operations as an Assisted Living Residence. At a minimum, such notice shall include:

1. The date on which the Sponsor intends to close or sell the Residence and cease operations as an Assisted Living Residence;

2. A description of the actions the Sponsor will take to assist the Residents in securing comparable housing and services, if necessary;

3. A reference to the rights of the Residents that may be exercised under the landlord/tenant laws established under M.G.L. c. 186 or M.G.L. c. 239; and

4. The contact information for the Long-Term Care Ombudsman Program.

(b) EOAI Notice. A written notice must be received by EOAI at least 120 days prior to the date on which the Sponsor intends to close or sell the Residence and cease operations as an Assisted Living Residence. Such notice shall include a copy of the Resident notice in accordance with 651 CMR 12.03(11)(a), proof of notification of all affected Residents and their Legal Representatives and Resident Representatives (as applicable), and the identification of all Residents receiving additional services, including but not limited to, Group Adult Foster Care.

(c) Long-Term Care Ombudsman Program Notice. A written notice must be received by the Long-Term Care Ombudsman Program at least 120 days prior to the date on which the Sponsor intends to close or sell the Residence and cease operations as an Assisted Living Residence.

12.03: continued

(12) Suspension of Certification. If EOAI suspends the Certification of an Assisted Living Residence, the Sponsor shall display the notice of suspension in a prominent place in the Residence, in place of the Certification, so long as the suspension is in effect.

12.04: General Requirements for an Assisted Living Residence

An Assisted Living Residence shall meet the following requirements to obtain and maintain Certification:

(1) Physical Requirements.

(a) An Assisted Living Residence shall provide only single or double Units with lockable doors on the entry door of each Unit. Residents shall have exclusive rights to their Units with lockable doors at the entrance of their individual or shared Units, however, as part of a Resident's Service Plan, keys or access codes may be readily available to specified shift staff. This access must be noted in the Resident's Service Plan.

(b) All Newly Constructed Assisted Living Residences shall provide a private bathroom for each Unit which shall be equipped with at least one lavatory, one toilet, and one bathtub or shower stall;

(c) All other Assisted Living Residences shall provide at a minimum, a private half-bathroom (*i.e.*, equipped with one washstand and one toilet) for each living Unit and shall provide at least one Bathing Facility for every three Residents;

(d) All Assisted Living Residences shall provide at a minimum, either a kitchenette or access to a refrigerator, sink, and heating element for all Residents, however, as part of a Resident's Service Plan, such access may be limited to supervised access;

(e) Every Assisted Living Residence shall meet the requirements of all applicable federal and state laws and regulations, including, but not limited to, the state sanitary code, state building and fire safety codes and regulations, and laws and regulations governing handicapped accessibility;

(f) Every Residence shall have an automated external defibrillator (AED) and ensure its proper upkeep.

(g) Every Residence shall have unexpired naloxone that is centrally located and readily accessible to Residence staff.

(h) Every Residence shall have unexpired epinephrine that is readily accessible to Residence staff.

(i) Every Residence shall provide a living area space which allows for communal dining and social engagement opportunities within the Residence.

(j) All equipment and supplies shall be kept in sanitary and good working condition.

(k) The premises shall be free of any condition that could reasonably be determined to pose a danger to Resident safety, especially in the event of an emergency or evacuation.

(l) Fire Protection.

1. All Residences shall have an approved annual fire inspection by the local fire department.

2. At least once a year, the Residence shall obtain instruction by the head of the local fire department or their representative on the duties of the Residence's employees in case of fire, and note such instruction sought and the date and type of instruction provided in the Residence's record.

3. Fire extinguishers shall be recharged and so labeled at least once a year.

4. If applicable, emergency lights shall be checked monthly by the individual in charge of the Residence, and if deficient, repaired immediately.

5. All exits shall be clearly identified by exit signs, adequately lighted and free from obstruction.

6. Clothes dryers must be kept in good working order and shall be inspected at the time of installation and annually thereafter. The lint screen and vent in the dryer must be properly maintained.

7. Kitchen hood extinguisher systems shall be properly maintained, inspected and certified.

(m) Oxygen Use and Storage.

1. All oxygen shall be used or stored in accordance with the National Fire Protection Association Code.

12.04: continued

2. A carrier appropriate for the transportation of oxygen shall be used when delivering or transporting oxygen.
3. Signs indicating oxygen is available, currently in use, or stored shall be conspicuously posted.
4. Oxygen tanks shall be safely stored and labeled when empty.

(2) Service and Service Coordination Requirements.

(a) Each Assisted Living Residence shall designate at least one Resident Care Director. The Resident Care Director shall be qualified by training and experience, and shall be responsible for the following:

1. Reviewing with the Resident the assessment and service options available to address needs and preferences identified under 651 CMR 12.04(7) and (8);
2. Implementation of the Service Plan developed under 651 CMR 12.04(8);
3. Monitoring the Resident's needs and the services provided by the Residence to address those needs;
4. Coordinating with and participating in the Quality Improvement and Assurance program, as set forth under 651 CMR 12.04(11); and
5. Maintaining complete and accurate records of Service Plans.
6. If the Resident Care Director is not a licensed nurse, they must work with a licensed nurse to ensure that the Resident's medical needs are being addressed and that the Service Plan is signed by the licensed nurse.

(b) The Sponsor of the Assisted Living Residence shall provide or arrange for the provision of the following services by personnel meeting standards for professional qualifications and training set forth in 651 CMR 12.05, 12.07, and 12.08:

1. For all Residents whose Service Plans so specify, supervision of and assistance with Activities of Daily Living, including at a minimum bathing, dressing, and ambulation, which may include the use of a Transfer Assistive Device or Mobility Assistive Device (if applicable) and similar tasks; and supervision or assistance with Instrumental Activities of Daily Living including at a minimum laundry, housekeeping, socialization and similar tasks;
2. Self-administered Medication Management (SAMM) of prescription or over-the-counter medication, if specified by a Resident's Service Plan. When assisting a Resident to self-administer medication the individual performing SAMM must:
   a. Remind the Resident to take the medication;
   b. Check the package to ensure that the name on the package is that of the Resident;
   c. Observe the Resident take the medication; and
   d. Document in writing the observation of the Resident's actions regarding the medication (*e.g.*, whether the Resident took or refused the medication, the date and time).
   e. Allow for the following:
      i. If requested by the Resident, the individual performing SAMM may open prepackaged medication or open containers, read the name of the medication and the directions on the label to the Resident, and respond to any questions the Resident may have regarding those directions.
      ii. The Residence may assist a Resident with SAMM from a medication container that has been removed from its original pharmacy-labeled packaging or container by another person (*e.g.*, by the Resident's family). Such assistance is not required of the Residence. If this service is to be provided, the Residence and Resident shall have a full written disclosure of the risks involved and consent by the Resident.
   f. Be performed only by:
      (i) an individual who has completed Personal Care Services Provider Training as set forth in 651 CMR 12.07(7) unless a relevant exemption set forth at 651 CMR 12.07(10) applies;
      (ii) a practitioner, as defined in M.G.L. c. 94C; or
      (iii) a nurse registered or licensed under the provisions of M.G.L. c. 112, § 74 or 74A to the extent allowed by laws, regulations and standards governing nursing practice in Massachusetts, and which does not include a nurse delegate under M.G.L. c. 112, § 80B.

12.04: continued

g. Central storage of a Resident's medications in an area outside of a Resident's Unit is prohibited. Residences shall provide a refrigerator to store medication in the Resident's Unit if refrigeration is required, and may employ a locked location in which to safely store medications within a Unit.

3. Timely assistance to Residents and prompt response to urgent or emergency needs:

a. By the presence of 24 hour per day on-site staff;

b. By the provision of personal emergency response systems for each Resident if the Service Plan requires or other means for the purpose of signaling such staff. The personal emergency response system must always be active and accessible to the Resident. Emergency response system calls must be answered in a timely and appropriate manner. No response shall exceed ten minutes.

c. Any additional response systems EOAI may require in accordance with the service needs of the Residents; and

d. Documented hourly safety checks in the SCR Units for twelve hours overnight.

4. Up to three regularly scheduled meals daily (minimum of one meal per day). All Assisted Living Residences shall use daily recommended dietary allowances as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences set forth in the Title III of the Older Americans Act as amended (42 U.S.C. § 3030g) as a minimum dietary standard. In addition to the foregoing, at a minimum, an Assisted Living Residence shall provide or arrange for the availability of food selections that would permit a Resident to adhere to a diet consistent with the most recent edition of Dietary Guidelines for Americans and dietary plans that do not require complex calculations of nutrients or preparation of special food items. These dietary plans shall include sodium restricted, sugar restricted and low fat. The Residence shall have a qualified registered dietitian review the Residence's dietary plans at least every six months.

(3) Basic Health Services.

(a) The Provision of Basic Health Services.

1. Any Residence certified to provide Basic Health Services shall offer all such Basic Health Services included in 651 CMR 12.02.

2. Prior to providing Basic Health Services to a Resident, the Residence must:

a. obtain the written consent of the Resident or the Resident's Legal Representative or the Health Care Agent, as applicable, to receive Basic Health Services and document the written consent in the Resident record;

b. inform the Resident they have the option of retaining a third-party provider of their choice to provide equivalent Basic Health Services;

c. ensure that a Registered Nurse updates the Resident's Service Plan with the Resident's Medical Order and reviews with the Resident, Resident Representative, Health Care Agent, or Legal Representative, as applicable, said Service Plan;

d. provide and discuss the fees associated with the provision of Basic Health Services;

e. update the Resident's Residency Agreement to reflect the inclusion of Basic Health Services and any associated fees; and

f. include documentation in the Resident record to ensure the coordination of Basic Health Services with SAMM or LMA, as appropriate.

3. After obtaining Resident consent for the Residence to provide Basic Health Services, the Residence must update the Resident's Residency Agreement or amend it with a supplemental agreement that identifies the Basic Health Services to be provided to the Resident and any associated costs.

4. In the event a Resident retains a third-party provider of Basic Health Services, the Residence must coordinate with the third-party provider to the extent practicable and provide or obtain Resident records sufficient to ensure continuity of care and the safe provision of Basic Health Services. The Residence may not retaliate against a Resident who elects to retain a third-party provider of Basic Health Services.

5. The Residence must identify whether the Resident has a Health Care Proxy, whether the Health Care Proxy is invoked, and establish a means of contact with the Health Care Agent. If the Health Care Proxy is invoked, the Health Care Agent must be notified regarding the provision of Basic Health Services.

12.04: continued

6. Any Residence providing Basic Health Services shall comply with all state and federal standards regarding specimen collection and the completion of a home diagnostic test (*e.g.* a Certificate of Waiver for the Clinical Laboratory Improvement Amendments).

7. Medical Orders.

a. Basic Health Services may only be provided to a Resident in accordance with a valid Medical Order issued by a Licensed Independent Provider. The Medical Order shall be signed and dated by the Licensed Independent Provider.

b. Documentation of a Resident's Medical Order must be retained in the Resident record.

c. The Residence must regularly communicate with the Resident or Legal Representative or the Resident's Health Care Agent, if applicable. The Residence must maintain contact information for the Resident's Licensed Independent Provider to ensure the most recent Medical Order is on file and the Residence is aware of any potential changes to the Resident's needs.

d. In the event a new Medical Order is issued, the Residence must conduct an evaluation pursuant to 651 CMR 12.04(3)(a)8.

e. Basic Health Services may only be provided if the Resident's setting is deemed medically appropriate for such services and the proper equipment, including an automated external defibrillator (AED), medication, and supplies are readily available.

8. Before Basic Health Services are provided by the Residence, the Resident must be assessed and evaluated by a Registered Nurse to ensure:

a. the provision of Basic Health Services can be provided in a safe and effective manner that is consistent with scope of practice;

b. the Resident is properly identified and consents to such services;

c. a Resident's Medical Order is valid and up to date; and

d. any significant change in the Resident's condition is reported to the Resident's Licensed Independent Provider before the provision of Basic Health Services.

9. Service Requirements.

a. Basic Health Services must be provided by a Clinical Professional who has the training and demonstrated competency in providing such services within their scope of practice.

b. The Clinical Professional must identify the Basic Health Services provided and document each date and time such services are provided, as well as any assessment findings in the Resident's record.

c. Basic Health Services provided by the Residence must meet the standard of care for Clinical Professionals.

d. The Residence must coordinate with any licensed hospice provider for hospice care provided to a Resident pursuant to 651 CMR 12.04(4)(b)1 to ensure continuity of care.

e. All Residence staff providing care to a Resident receiving Basic Health Services must monitor the Resident's condition and notify the Clinical Professional as well as the Resident, or the Resident's Legal Representative or Health Care Agent, if applicable, and the Resident's Licensed Independent Provider, regarding any change in the Resident's condition.

10. Resident Service Plan, Resident Record, and Communication Log.

a. The Residence's Registered Nurse must develop the Resident's Service Plan in accordance with 651 CMR 12.04(8).

b. Upon the implementation of any revision to a Resident's Service Plan that includes the provision of Basic Health Services, the Residence shall review with the Resident, Resident Representative, or Legal Representative, as applicable, any changes to the fees associated with the provision of Basic Health Services established by the Resident's Residency Agreement, and shall document such review in the Resident record.

c. Documentation of all Basic Health Services provided to a Resident must be included in the Resident record.

12.04: continued

d. The provision of Basic Health Services delivered to participating Residents shall be included in the staff communication log as needed to communicate information necessary to maintain the continuity of care for Residents receiving Basic Health Services.

11. Residence Discontinuance.

a. A Residence opting to discontinue the provision of Basic Health Services must provide at least 120 days' notice to:

i. EOAI;

ii. all Residents, their Legal Representatives and Resident Representatives, as appropriate;

iii. the Residents' Licensed Independent Providers;

iv. the Residents' Health Care Agents, if applicable; and

v. the Long-Term Care Ombudsman.

b. The notice must include, at a minimum:

i. a statement of the Residence's intent to discontinue the provision of Basic Health Services and the basis for its decision;

ii. a proposed date of discontinuance not earlier than 120 days after the date of the notice; and

iii. a plan to ensure Residents are able to continue to receive Basic Health Services until other arrangements can be made.

c. The notice to be submitted to EOAI must also identify all affected Residents and include contact information for Residence staff responsible for managing the discontinuance of Basic Health Services, including the staff responsible for issuing the required notices to Residents and ensuring the continuity of care for affected Residents.

d. Upon the discontinuance of providing Basic Health Services, the Basic Health Services Certification will be amended to reflect the change in the Residence's operation.

(4) Skilled Care Services.

(a) The Sponsor may arrange for the provision of ancillary health services in the Residence. With the exception of the care included within the definition of Basic Health Services provided by Residences certified to provide Basic Health Services, the Sponsor may not use Assisted Living Residence staff for these services unless said staff is functioning as an employee of a Certified Provider of Ancillary Health Services or as an employee of a licensed hospice;

(b) No Assisted Living Residence shall admit a Resident who requires 24-hour skilled nursing supervision unless such Resident elects to receive Basic Health Services from Residences that are certified to provide such services and from qualified third parties who are capable of providing Skilled Nursing Care that is not included in Basic Health Services or the Resident elects to receive Skilled Nursing Care from a qualified third-party. No Assisted Living Residence shall provide Skilled Nursing Care or admit or retain a Resident in need of Skilled Nursing Care where such Resident receives services from qualified third parties unless the following criteria are met:

1. The Skilled Nursing Care will be provided by a Certified Provider of Ancillary Health Services or by a licensed hospice; and

2. The Certified Provider of Ancillary Health Services does not train the Assisted Living Residence staff to provide the Skilled Nursing Care.

(c) Nursing services provided by a Certified Provider of Ancillary Health Services such as injection of insulin or other drugs used routinely for maintenance therapy of a disease may be provided to Residents.

(d) Neither nurses employed by Residences nor nurses contracted by Residences shall direct any non-licensed staff to perform Skilled Nursing Care or to administer any medications to Residents, nor oversee nor supervise such practice, including as related to a nurse delegate under M.G.L. c. 112, § 80B.

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(5) Special Care. Any Residence that chooses to advertise, market, otherwise promote or provide special care for Residents shall administer such care and services in accordance with the requirements of 651 CMR 12.04(5) in addition to all other requirements of 651 CMR 12.00. A Residence may not operate a Special Care Residence without submitting an operating plan to EOAI that explains how the Special Care Residence or Residences will meet the specialized needs of its resident population, including those who may need assistance in directing their own care due to cognitive or other impairments. This includes a description of the physical design of the structure and the units, physical environment, specialized safety features, enrichment activities, and the ongoing training of staff.

(a) All Special Care Residences shall be administered in accordance with the following safeguards:

1. Entry and exit doors in the common use areas within Special Care Residences shall be alarmed and secured in accordance with local, state and federal laws and regulations. All doors must automatically unlock in the case of fire, power outage or emergency situation;
2. Staff shall be trained and assigned according to the requirements of 651 CMR 12.06 and 12.07;
3. The Residence shall develop and implement a 24-hour preparedness plan by assessing the needs of each occupant of any Special Care Residence for emergency assistance, and devise an appropriate method to provide the necessary assistance;
4. The Residence shall develop and implement policies and procedures to assess and reduce the risk of potential hazards in the physical environment related to the special characteristics of the population. Such policies and procedures must include an annual written statement describing in detail how the physical characteristics of any Special Care Residence have been or will be modified to promote the safety of its Residents;
5. The Residence shall develop Special Care Residence policies and procedures that address potentially unsafe Resident behaviors such as unsupervised wandering, and verbally or physically aggressive behavior including coercive or inappropriate sexual behavior;
6. The Residence shall develop policies and procedures governing the transition of Residents moving in or out of any Special Care Residence;
7. The Residence shall provide a multipurpose activity space; and
8. All Special Care Residences that commence an initial certification process after October 1, 2015 shall provide a secure outdoor space.

(b) Special Care Residences shall prepare a planned activity program that includes structured activities with designated staff a minimum of three times within a 24-hour period, seven days per week. The planned activity program shall address Resident needs in the following areas of Resident function, as applicable:

1. Gross motor activities;
2. Self-care activities;
3. Social activities; and
4. Sensory and memory enhancement activities.

(c) The Residence shall document and make available upon request all plans, policies and procedures required under 651 CMR 12.04(5)(a) and (b) in accordance with the disclosure requirements of 651 CMR 12.08(3).

(d) Administrative staff of the Residence qualified by training and experience shall review the operations of any Special Care Residence twice each year. The reviews may be conducted as part of the Residence Quality Improvement and Assurance program prescribed under 651 CMR 12.04(11). The Residence shall document the results of these reviews.

(6) Optional Services.

(a) The Assisted Living Residence may provide or arrange for the provision of the following optional services, including but not limited to:

1. Local transportation for medical and recreational purposes;
2. Barber or beauty services, sundries for personal consumption and other amenities;
3. Assistance to Residents with accessing telehealth services;

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4. Basic Health Services for Residents whose Service Plans include Basic Health Services, in accordance with the requirements set forth within M.G.L. c. 19D and 651 CMR 12.00, by personnel who meet the standards for professional qualifications and training set forth in regulations promulgated pursuant to M.G.L. c. 19D;

5. Ancillary services for health-related care including, but not limited to, restorative therapies, podiatry, hospice care, home health or other such services; provided, however, that such services shall be delivered by an individual licensed to provide such care;

6. Money management and other financial arrangements to be performed by an independent party for any Resident unable to manage their funds or property. The Sponsor shall not allow any employee of an Assisted Living Residence to control or manage the funds or property of a Resident; provided that the Sponsor may, at the request of the Resident or their Legal Representative, hold and disburse Resident funds, not to exceed $200, for personal use of the Resident. The Sponsor shall detail such agreements in the Resident's Service Plan; and

7. Limited Medication Administration (LMA) for Residents whose Service Plan include LMA.

a. The Residence must perform LMA from an original, pharmacy-filled and pharmacy-labeled container.

b. In addition to the requirements and limitations set forth in 651 CMR 12.04(4), a nurse with a valid Massachusetts nursing license employed by the Assisted Living Residence may administer non-injectable medications, prescribed or ordered by an authorized prescriber, by oral or other methods (*e.g.* topical, inhalers, eye and ear drops, medical patches, as necessary oxygen, suppositories). LMA performed by a licensed nurse must be completed in accordance with all applicable laws, regulations and standards governing the medication administration process by a nurse, including documentation requirements.

c. In accordance with the standards of nursing practice, a nurse may only administer medication from an original, pharmacy-filled and pharmacy-labeled container. All medication must be kept in the Resident's Unit and stored in such a manner that the nurse can adequately verify the integrity of the medication.

(b) Discontinuance of Optional Services.

1. Resident Discontinuance.

a. Planned Discontinuance or Pause in Services.

i. A Resident may pause or discontinue receiving optional services, including, but not limited to, Basic Health Services and Limited Medication Administration, from the Residence upon written notice to the Residence.

ii. For any planned pause or discontinuance of optional services, the Resident shall give the Residence at least 14 days' advance written notice of the date on which services are to be paused or discontinued.

iii. A Resident who has properly submitted written notice under 651 CMR 12.04(6)(b)1.a.ii. shall not be charged a cancellation fee or a fee for services not provided due to such planned pause or discontinuance.

b. Unplanned Discontinuance or Pause.

i. If a Resident must pause or discontinue optional services because of an unplanned or emergent event (*e.g.*, hospitalization, acute illness, or other unexpected change in condition), the Resident or their representative, if applicable, shall notify the Residence in writing as soon as reasonably practicable.

ii. Upon receipt of such written notice, the Residence shall accommodate the change immediately. The Residence may not assess a fee for the optional services not provided 24 hours after receipt of the written notice. In accordance with M.G.L. c. 19D, § 10, a Resident shall not be charged a cancellation fee or a fee for services not provided due to the discontinuation of Basic Health Services.

(7) Screening and Assessment.

(a) Prior to signing a Residency Agreement and a Resident moving in, the Residence must arrange for an in-person initial assessment conducted by a nurse shall determine:

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1. The prospective Resident's service needs and preferences and the ability of the Residence to meet those needs;
2. The Resident's physical and functional abilities;
3. The Resident's cognitive status and psychosocial condition;
4. Whether a medication program (*e.g.* SAMM or LMA) is appropriate and which medication program, based on the following:
   a. The completion of an observational assessment by a nurse to determine whether the Resident is capable of performing the particular method(s) of independent medication administration; and,
   b. A written statement by that nurse documenting the Resident's capability of performing the particular method(s) of independent medication administration;
5. Whether the Resident requires Basic Health Services;
6. Whether the Resident is at risk for elopement;
7. Whether the Resident is suitable for a Special Care Residence; and
8. Whether the Resident requires special assistance during an emergency or evacuation. The assessment must specify what type of assistance the Resident requires.
9. Whether the Resident has any special dietary needs or requirements.

(b) The nurse's assessment must validate any information provided by the Resident, their Legal Representative, or Resident Representative, if applicable. The nurse's assessment must also include an evaluation by the Resident's physician or authorized practitioner, of the prospective Resident's physical, cognitive, functional, and psychosocial condition conducted within the past 90 days. The preadmission assessment shall note the name of any Legal Representative, Health Care Agent, or any other person who has been documented as having decision-making authority for the Resident and the scope of their authority. The Residence shall collect any relevant documentation before move-in.

(c) The initial assessment findings shall be documented and disclosed to the Resident, their Legal Representative and Resident Representative, if any, prior to the Service Plan development and before the Resident moves into the Residence, and must be reviewed by a nurse employed by the Residence.

(8) Service Plan Development.

(a) The nurse and Resident Care Director shall develop an individualized Service Plan for each Resident in accordance with the findings of the initial screening described in 651 CMR 12.04(7).

1. Said Service Plan shall be developed before the Resident moves into the Residence and be based on information provided by the Resident, their Legal Representative and Resident Representative, if applicable.
2. The Residence shall ensure the Resident's participation in the development of the Service Plan to the maximum extent possible and shall include the Legal Representative, any Health Care Agent, or Resident Representative to the extent that they are authorized, willing, and able to be involved. The parties must have a thorough conversation that must be documented by the Residence. The conversation must include:
   a. the services that will be provided to the Resident, including a breakdown of associated costs;
   b. any potential or anticipated future services that may be required based on the Resident's changing needs as well as an estimated cost for such services; and
   c. any other information that may be necessary to ensure the Resident's health, safety, and welfare.
3. If the Resident's Licensed Independent Provider has issued a Medical Order for the provision of Basic Health Services, a Registered Nurse, shall consult with said Licensed Independent Provider when developing the Resident's Service Plan.

(b) The Service Plan shall include an evaluation, conducted within the past three months by the Resident's physician or authorized practitioner, of the prospective Resident's physical, cognitive, functional, and psychosocial condition. It is the responsibility of the Resident or their representative to have the physician's or authorized practitioner's evaluation completed. This evaluation may be the same evaluation that is required in 651 CMR 12.04(7)(a).

(c) The Residence shall, at a minimum, document its assessment findings for the Resident on the following:

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1. Allergies;
2. Diagnoses;
3. Medications (including dosage, method of administration and frequency);
4. Dietary needs;
5. Fall risk, especially nighttime fall risk and risk of falling from the bed during sleep;
6. The need for assistance in emergency situations or evacuations. The Service Plan must detail what type of assistance the Resident requires during an emergency or evacuation;
7. If the Resident requires a new Mobility Assistive Device or there is a change in the current use of the device, an assessment must be completed by a Massachusetts licensed occupational therapist or physical therapist. An assessment must also be completed after any significant change in condition.
8. If the Resident requires a new Transfer Assistive Device or there is a change in the current use of the device, an assessment must be completed by a Massachusetts licensed occupational therapist or physical therapist. An assessment must also be completed after any significant change in condition. For a Transfer Assistive Device that is affixed to a Resident's bed, a Massachusetts licensed occupational therapist or physical therapist must conduct an assessment every six months.
9. The need for assistance with transfers that require the use of a Lift Device, if applicable;
10. History of psychosocial issues including the presence of manifestations of distress, or behaviors which may present a risk to the health and safety of the Resident or others;
11. Level of personal care needs, including ability to perform ADLs and IADLs;
12. Ability of the Resident to manage medication, including the ability to take medication on an as-needed basis; and
13. The type and frequency of Basic Health Services to be provided, if applicable.

(d) The Resident Care Director or nurse shall review the Resident's initial Service Plan within 30 days of the commencement of residency and document the review to ensure the Resident's needs and preferences are accurately incorporated therein and that the Residence is capable of meeting the Resident's needs in accordance with 651 CMR 12.00. The initial Service Plan shall be in writing, signed and dated by the Resident or their Legal Representative, and by the Sponsor or their representative.

(9) Service Plan Requirements.

(a) Each Service Plan shall be based on a current assessment of the Resident, and indicate the following:

1. A description of all the services to be provided, along with all the fees for services;
2. The Resident's goals, and the frequency and duration of all services provided to address the Resident's particular physical, cognitive, psychological and social needs, including but not limited to the following:
   a. Details of the manner in which the Residence shall provide for the presence of a 24-hour per day, on-site staff, and the manner in which the Residence shall provide for personal emergency response devices or procedures;
   b. Details of the types of assistance with medications that the Residence shall provide, if any;
   c. Details regarding the provision of Basic Health Services, if applicable;
   d. Description of services, including the provision of Basic Health Services, if applicable, that will be provided by a person or entity not affiliated with the Assisted Living Residence or by a certified provider of ancillary health services (*e.g.* VNA services, private duty aides, adult day care) if the Resident, Resident Representative, or Legal Representative notifies the Assisted Living Residence that he or she has arranged for such services; and
   e. The need for a meal plan prescribed or ordered by a Resident's physician. The Residence shall have a qualified registered dietitian review the Resident's dietary needs, and provide the Resident with diet management counseling; and
3. The identification of staff or categories of staff who will provide the services;
4. The schedule and methods of monitoring assessments and services of the Resident;
5. The schedule and methods of monitoring staff providing services;

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6. The use of a Transfer Assistive Device or Mobility Assistive Device(s) by or for a Resident. A Transfer Assistive Device or Mobility Assistive Device may only be used for the purpose of enhancing Resident independence in mobility and transfers. The Residence must collaborate with the Resident or Legal Representative, as applicable. The Service Plan must:

a. Include the purpose and intended outcome for use of the Transfer Assistive Device or Mobility Assistive Device. The Transfer Assistive Device or Mobility Assistive Device must be assessed for proper use by the Resident.

b. Distinguish between devices that:

i. Enhance mobility;

ii. Provide positional support;

iii. Provide transfer support; or

iv. Address specific medical needs.

c. Address the circumstances under which the Transfer or Mobility Assistive Device should and should not be used.

i. The Transfer or Mobility Assistive Device must not have the effect of restricting the Resident's voluntary movement.

ii. The Resident must be able to enter and exit a bed freely and independently with no additional assistance when using a Transfer Assistive Device affixed to a Resident's bed.

iii. The use of any bed rail is limited to those that cover less than half the length of the bed. The use of full-length bed rails is prohibited.

iv. Service planning and assessment for Residents who utilize Transfer Assistive Devices or Mobility Assistive Devices shall address the Resident's physical and cognitive abilities to safely and effectively use the device and shall identify any necessary supports, supervisions, or interventions required to promote Resident safety.

d. Note the staff positions trained to assist with the use of Transfer or Mobility Assistive Devices.

e. Include the consent of the Resident or Legal Representative, as applicable.

f. Include documentation that the Residence provided written disclosure(s) and information explaining the risks associated with a Transfer Assistive Device or Mobility Assistive Device to the Resident or their Legal Representative, if applicable.

g. Include usage guidelines. The usage guidelines must be strictly followed by either trained staff or, where appropriate, the Resident, to mitigate the risks of falls or injury during movement and transfers.

7. The Service Plans for Residents residing in Special Care Units must indicate the enrichment activities provided to them as set forth in 651 CMR 12.04(5).

8. The need for assistance during an emergency or an evacuation. The Service Plan must detail what type of assistance the Resident requires during an emergency or an evacuation.

(b) All Service Plans shall be in writing, signed and dated by the Resident or their Legal Representative, and any Health Care Agent, if applicable, and by the Sponsor or their representative. A copy of the Resident's Service Plan shall be given to the Resident or their Legal Representative, as applicable.

(c) Following the Service Plan review required by 651 CMR 12.04(8)(d), the Resident Care Director or nurse shall:

1. Reassess the Service Plan not less than every six months, or

i. at any time upon identifying an improvement in the Resident's condition;

ii. at any time upon identifying a decline in the Resident's condition that will not normally resolve itself without intervention by staff, is not self-limiting, impacts more than one area of the Resident's health status, and requires interdisciplinary review and/or revision of the Service Plan; or,

iii. at any time upon receipt of a new or modified Medical Order for a Resident who receives Basic Health Services.

2. Reassess the Service Plan not less than every three months for Residents who receive Basic Health Services;

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3. Document the Service Plan review to ensure the Resident's needs and preferences are accurately incorporated therein and that the Residence is capable of meeting the Resident's needs in accordance with 651 CMR 12.00.

4. Ensure that the Service Plan has been signed by the Resident or their Legal Representative, and any Health Care Agent, if applicable, after a Service Plan review has occurred.

5. Sign the Service Plan any time a review of the Resident's Service Plan has occurred.

(d) The Service Plan shall be confidential except to the extent necessary to provide services and manage the operations of the Assisted Living Residence or to the extent the Service Plan is subject to disclosure as required by law; provided that EOAI may review the Service Plan at any time with the consent of the Resident or their Legal Representative.

(10) Ombudsman Requirements. The Applicant or Sponsor of an Assisted Living Residence is required to assist the Long-Term Care Ombudsman Program in its duties as a condition of maintaining Certification. *See* 101 CMR 30.00: *Statewide Long-Term Care Ombudsman Program*.

(11) Quality Assurance and Performance Improvement. The Residence shall establish an effective, ongoing quality improvement and assurance program to evaluate its operations and services to continuously improve services and operations, and to assure Resident health, safety, and welfare. The program should encompass oversight and monitoring of Residence services, ongoing quality improvement, and implementation of any plan that addresses improved quality of services. Residence staff shall gather, review and analyze data at least annually unless otherwise specified to evaluate its provision of services to its residents and assess the overall outcome of services and planning and Resident experience of care. The program must be based on analysis of relevant information focusing on Resident safety, well-being and satisfaction. The program shall include but not be limited to review and assessment of the following operations:

(a) Service Planning. The Residence shall review a random sample of Resident assessments, Service Plan and progress notes at least once each year to ensure that the Residents' Service Plans have been implemented and meet the Residents' general needs and any self-identified goals.

(b) Resident Safety Assurances. The Residence shall review policies and procedures designed to ensure a safe environment for all residents. Such policies and procedures shall include an Evidence Informed Falls Prevention Program. The emergency response system must be tested at a minimum quarterly. These tests must be documented. In addition, the Residence must monitor response call times and utilize a documented Quality Assurance and Performance Improvement (QAPI) process, at least quarterly, to reduce response times and immediately address and prevent extended response times. The Residence must be able to obtain and provide all response times as well as average response times by month. The Residence must perform quarterly checks to ensure that the Residence is free from conditions that could reasonably be determined to pose a danger to Resident safety, especially in the event of an emergency or evacuation.

(c) Medication Quality Plan. The Residence shall develop and implement systems that support and promote safe SAMM, and if applicable, LMA and Basic Health Services programs. The Medication quality plan shall include but need not be limited to the following components:

1. Semiannual evaluation of each Personal Care Staff that examines their awareness of SAMM and LMA regulations and applicable policies, and verifies their demonstrated ability to comply with SAMM and LMA regulations and related Residence policies and procedures;

2. A quarterly audit of a random sample of the Residence medication documentation sheets required under 651 CMR 12.04(2)(b)2. or 651 CMR 12.04(6)(a)7.b. to ensure compliance with SAMM and LMA protocols and Residence policies; and

3. A quarterly audit of all Medication Errors. All Medication Errors occurring at a Residence shall be recorded, tracked, and reviewed.

(d) A system shall be in place to facilitate the detection of issues and problems, to expedite the implementation of action, to resolve problems and communicate outcomes of actions taken or refused. Information solicited from Residents should be collected in a manner which offers anonymity (*e.g.*, suggestion box, resident satisfaction surveys, *etc.*).

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(e) Data analysis shall be used to identify and implement changes that will improve performance or reduce the risk of Resident harm. The Residence shall maintain documentation demonstrating it has collected and analyzed data, implemented appropriate actions to address identified issues and resolve problems, and shall note any recommended follow-up actions and whether or not they were performed.

(f) The result of the quality assurance and performance improvement program cannot be the sole basis for a determination of non-compliance pursuant to 651 CMR 12.09.

(g) Quality Assurance and Performance Improvement (QAPI) Committee. Residences providing Basic Health Services must establish a quality assurance and performance improvement committee, which must consist of, at a minimum, a Clinical Professional and the Executive Director of the Residence, and, as needed, a physician, advanced practice registered nurse, or a representative of the relevant pharmacy. Quality Assurance and Performance Improvement Committee meetings shall be held quarterly at a minimum and whenever a Serious Incident or Medication Error involving Basic Health Services occurs.

(12) Disaster and Emergency Preparedness Plan and Reporting Requirements. Each Residence shall have a comprehensive disaster and emergency preparedness plan to meet potential disasters and emergencies, including fire; flood; severe weather; loss of heat, electricity, or water services; and Resident-specific crises, such as a missing Resident. The plan shall be designed to reasonably ensure the continuity of operations of the Residence. The Residence must review and update the plan every year. This review of the plan must be documented in the plan.

(a) Plan Requirements.

1. The plan shall be developed in conjunction with local and state emergency planners as well as local and state fire and safety experts. The plan and any changes to the plan must include the following elements:

a. an evacuation strategy for both immediate evacuations, for such events as fires or gas leaks, as well as delayed evacuations, for such events as impending severe weather;

b. an established Mutual Aid plan that addresses essential issues, such as supplies, staff, and beds;

c. the provisions of subsistence needs for staff and Residents, whether they evacuate or shelter in place, including, but not limited to the following:

i. food, water, medical, and pharmaceutical supplies;

ii. alternate sources of energy to maintain:

1. Temperatures to protect Resident health and safety and for the safe and sanitary storage of provisions;

2. Emergency lighting;

3. Fire detection, extinguishing, and alarm systems; and

4. Sewage and waste disposal;

c. an established relationship with local public safety officials and with local Emergency Management Services (EMS) officials;

d. participation in Health and Homeland Alert Network (HHAN);

e. protocols for full participation in safety alert or notification systems or processes for missing and vulnerable persons and elopements, such as the Silver Alert System (a system to register people at risk of wandering with participating local or county law enforcement to expedite their safe recovery in the event they become lost); and

f. A documented, Residence-based and community-based risk assessment utilizing an all-hazards approach, including missing Residents.

2. The plan shall indicate the locations of alarm signals and fire extinguishers, the locations of emergency exits; the evacuation routes and the procedures for evacuating Residents; and the assignment of specific tasks and responsibilities to the personnel of each shift;

3. The plan must include protocols for regularly checking and documenting compliance with all physical building and premises requirements, including routine checks of the Residence by staff to confirm that the building is safe, accessible, and free from conditions that could reasonably be determined to pose a danger to Resident safety, especially in the event of an emergency or evacuation;

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4. The plan must specify the persons to be notified during an emergency and must include the telephone numbers of police, fire, ambulance, and emergency medical transport to be contacted in an emergency;

5. The plan shall address the physical and cognitive needs of Residents, and shall include special staff response, including the procedures needed to ensure the safety of any Resident. The plan shall include provisions related to individuals residing in a Special Care Residence, and shall be amended or revised whenever any Resident with unusual needs is admitted. The plan must provide a means for the Residence to be able to remotely access copies of the Residents' records electronically, such as during an emergency;

6. The plan shall provide for the conducting of quarterly elopement and fire drills and rehearsals for all shifts, and annual simulated evacuation drills, and rehearsals for all shifts. Each staff person must participate at least annually in each of the following drills: simulated evacuation drill, elopement drill, and fire drill. These drills shall test the effectiveness of the plan;

7. Residences must seek to include Residents who are willing and able to participate in simulated evacuation drills at least annually, and must encourage and support such participation of all such Residents;

8. The Residence shall provide every Resident with a copy of the instructions they will be given under the plan, and shall have available for their review a copy of the plan.

9. The emergency procedures and evacuation route shall be posted in conspicuous locations throughout the Residence as well as in each Unit on the back of the door.

10. Each Residence shall ensure a reliable means is available at all times, in accordance with EOAI guidelines; for:

(a) sending information to the EOAI regarding incidents and emergencies occurring on the premises;

(b) receiving information from EOAI and other state and local authorities in the event of an emergency; and

(c) activating Mutual Aid.

11. The plan must include a communications section to ensure that Residents and their Resident Representatives, Legal Representatives, and Health Care Agents, as applicable, are able to receive communications and information from the Residence in the event of a storm or power outage.

(b) Staff Training. The Residence shall ensure disaster, and emergency preparedness by orienting new employees at the time of employment to the Residence's emergency preparedness plan, performing quarterly reviews of the emergency preparedness plan with employees, and making certain that all personnel are trained to perform the tasks assigned to them. Staff must also be trained on procedures regarding elopements, including the process for using elopement notification systems, such as the Silver Alert system.

(c) Serious Incident Reporting.

1. The Executive Director or their designee must provide a report in a form and format prescribed by EOAI to the EOAI Assisted Living Residence Certification Unit for any Serious Incident as defined in 651 CMR 12.02 occurring at the Residence. The Residence additionally must perform an incident investigation which may include, but is not limited to, determining whether any Resident has been harmed or placed at risk of harm and take appropriate action to treat the Resident, which may include sending the Resident to a healthcare facility for a medical evaluation or removing the risk of harm.

2. If a Resident has been harmed or placed at risk of harm, the Residence must notify the Resident, Health Care Agent, Resident Representative, or Legal Representative, if applicable.

3. Any incident involving theft must be reported to local law enforcement.

4. A facility-wide Serious Incident shall include, but is not limited to:

a. an outbreak of a serious communicable disease that is listed in 105 CMR 300.100: *Diseases Reportable to Local Boards of Health*;

b. an employee of a Residence found to be infected with a disease in a communicable form that is listed in 105 CMR 300.100;

c. pest infestation;

d. food poisoning as defined in 105 CMR 300.020: *Definitions*;

e. fire, flooding, or other natural disaster;

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f. structural damage to the Residence; and
g. A situation that displaces Residents from their Units for eight hours or more.
i. A situation that displaces Residents from their Units for eight hours or more must be reported to the EOAI Assisted Living Residences Certification Unit immediately.

5. A Resident-specific Serious Incident shall include, but is not limited to:
a. accidental injury;
b. a significant injury, including trauma to a Resident's head;
c. a Resident fall that resulted in a fracture or suspected fracture or head trauma;
d. a preventable pressure injury;
e. Unanticipated Death;
f. suicide or suicide attempt;
g. a physical or sexual assault by or against a Resident;
h. a complaint of Resident abuse, neglect, or exploitation; a complaint of suspected Resident abuse, neglect, or exploitation; or referral of a complaint of Resident abuse, neglect, or exploitation to a local or state authority;
i. a Medication Error requiring medical attention;
j. any use of a Restraint;
elopement with an absence of greater than 30 minutes;
k. misuse of a Resident's funds by the Residence or its staff;
l. any incident or injury involving Basic Health Services; and
m. Medication Diversion.

6. Any report required under 651 CMR 12.04(12)(c) shall be filed with the Assisted Living Certification Unit within 24 hours after the occurrence of the incident or accident via EOAI's online filing system. In the event the online filing system is inaccessible, a Residence must submit a temporary report *via* email and formally submit the official report *via* the online filing system as soon as the service becomes accessible. The information submitted in the incident report must be accurate and include all details associated with the incident. This requirement is in addition to the requirements of M.G.L. c. 19A, § 15, and of any other applicable law.

7. A Residence must cooperate with EOAI and other relevant authorities at all times, including investigations involving the provision of Basic Health Services.

(13) Communicable Disease Control Plan. The Residence must implement a plan to prevent and limit the spread of communicable disease. The plan shall conform to the currently accepted standards for principles of universal precautions based on DPH guidelines and shall include but need not be limited to the following components:

(a) A system to effectively identify and manage communicable diseases;

(b) Organized arrangements to provide the necessary supplies, equipment and personal protective equipment (PPE), consistent with transmission-based precautions under DPH guidelines; and

(c) A process for maintaining records of illnesses and associated incidents involving Residents as well as staff pursuant to 651 CMR 12.06(9)(a).

(14) Reports to EOAI.

(a) Annual Reports.

1. A Sponsor shall file annually, within 90 days following the end of an Assisted Living Residence's fiscal year on a form prescribed by EOAI, a statement and professional opinion prepared by a certified public accountant or comparable reviewer indicating whether the Assisted Living Residence is in sound fiscal condition and is maintaining sufficient cash flow and reserves to meet the requirements of the Service Plans established for its Residents. Upon written request to EOAI, the Secretary may extend such 90-day period by an additional period, not to exceed 30 days

2. Each Residence shall file annually on a form prescribed by EOAI, a completed report of aggregate information regarding Residents which is based, where applicable, on the most recent Resident assessments and Service Plans. The reporting period shall be January 1st through December 31st, and the report shall be submitted to EOAI no later than March 1st of the next year. Failure to timely submit a completed annual report will result in a finding of noncompliance.

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(b) Additional Reporting Requirements.

1. The Sponsor must notify EOAI in a form and format prescribed by EOAI at least 30 days prior to any Alteration of the Residence, its Units, or its operating plan. Such notice shall identify the specific changes made to any document which would amend, supplement, update or otherwise alter the operating plan, original Application or renewal for Certification. The notice shall be filed with EOAI at least 30 days prior to the effective date of the Alteration.

2. In addition to the requirements of 651 CMR 12.04(12)(c), the Sponsor shall forward to EOAI a copy of any report or citation of a violation of applicable provisions of the State Sanitary Code, State Building Code, fire safety regulations or other regulations affecting the health, safety, or welfare of Residents within seven days of receipt of notice of such violation.

3. Within 5 business days after an Assisted Living Residence Executive Director or Resident Care Director leaves their position, the Residence shall forward the contact information for any interim or new Executive Director or Resident Care Director to EOAI, including telephone number(s) and email address.

4. EOAI may determine further reporting is necessary and issue written notice to all Residences specifying the additional information required, including the prescribed format and any applicable submission deadlines. Each Residence shall, within the time frame provided in such notice, furnish the requested additional information in accordance with the instructions established by EOAI.

5. All information required by 651 CMR 12.03(2) or otherwise required by the Secretary shall be kept current by each Applicant or Sponsor.

(15) Controlled Substances. Each Residence shall create policies and procedures intended to prevent the theft or diversion of Controlled Substances prescribed to Residents who participate in SAMM, LMA, or Basic Health Services. Such procedures shall include:

(a) a reporting process by which any such incidents of theft or diversion are reported, documented and investigated;

(b) safeguards for the storage and disposal of all controlled substances that have been prescribed for Residents participating in SAMM, LMA, and Basic Health Services; and

(c) prompt reporting of any theft or diversion of any Controlled Substance to all appropriate agencies, including local law enforcement.

(16) Distribution of Information on Palliative Care and End-of-life Options.

(a) A Residence shall distribute culturally and linguistically suitable information regarding the availability of palliative care and end-of-life options to all Residents who have provided information indicating that their attending health care practitioner has:

1. diagnosed the Resident with a terminal illness or condition which can reasonably be expected to cause the Resident's death within six months, whether or not treatment is provided; or

2. determined that the Resident may benefit from hospice or palliative care services.

(b) This obligation shall be fulfilled by providing the Resident with:

1. information made available to the Residence by EOAI regarding the availability of palliative care and end-of-life options; or

2. information produced by the Residence that satisfies the requirements established by M.G.L. c. 111, § 227.

(c) Each Residence shall provide information to all physicians and nurse practitioners providing care within or on behalf of the Residence regarding the requirement of M.G.L. c. 111, § 227(c) that they offer to provide end-of-life counseling to Residents meeting the criteria established by 651 CMR 12.04(16)(a).

(d) Each Residence shall make available to EOAI proof that it is in compliance with 651 CMR 12.04(16)(a) through (c) upon request, or at the time of compliance review.

(17) Exemptions.

(a) At their discretion, the Secretary may grant an exemption from the requirements set forth in 651 CMR 12.04(1)(b), (c), and/or (5)(a)8 if it is determined that:

1. Public necessity and convenience requires such an exemption;

2. The granting of such an exemption shall prevent undue economic hardship; and

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3. The Assisted Living Residence otherwise meets the purposes of assisted living to provide a home-like residential environment.

(b) The Applicant/Sponsor shall request such an exemption in writing and shall enclose supporting documentation. The Secretary may grant such an exemption at their discretion.

(c) Exemption requests must be filed prior to the commencement of construction or renovation of the Residence. Any exemption request filed after construction or renovation has commenced will be deemed presumptively untimely unless the Applicant or Sponsor can demonstrate that there were specific and exigent circumstances that prevented the filing of the exemption request prior to commencement of construction or renovation of the Residence.

12.05: Record Requirements

All records created or maintained by the Assisted Living Residence shall be legible, recorded in ink, and contemporaneously signed and dated to indicate the name and position of the individual who makes the record entry. Computerized records systems which meet the equivalent requirements in 651 CMR 12.05 for permanency and accessibility, and which provide an auditable record of entries may be used as an alternative or supplement. All records must be retained for at least six years unless otherwise specified.

(1) Resident Record. The Assisted Living Residence shall develop and maintain written Resident records which shall remain confidential but for the limited exception of EOAI's enforcement of 651 CMR 12.00 or to the extent the Resident record is subject to disclosure as required by law. The Resident record and related documents are considered permanent and shall be maintained for the duration of the Resident's stay in the Assisted Living Residence and for at least six years after the date of termination of the Agreement. By January 1, 2027, the Residence must maintain an electronic copy of the Resident's records, including the Resident's Service Plan, and ensure that the electronic record is accessible remotely during an emergency. The Resident record shall include, at a minimum, the following:

(a) Resident assessment, documented in accordance with the requirements set forth at 651 CMR 12.04(7)(a) through (c);

(b) Service Plans documented in accordance with the requirements of 651 CMR 12.04(9);

(c) Progress notes, which shall document significant occurrences, either observed by or reported to Residence staff, including significant or continued changes in the Resident's behavior or memory; incidents involving injury, trauma, illness, or abuse or neglect of the Resident, including but not limited to the recording of incidents in which a Resident has been the victim of an assault by another Resident or the perpetrator of an assault on another resident, regardless of whether such a report would be required by law; alleged or actual violations of the Resident's rights as defined in 651 CMR 12.08; and changes in the Resident's Service Plan;

(d) Documentation of Introductory Visits set forth at 651 CMR 12.07(8);

(e) Documentation of Self-administered Medication Management, including the medication assessment required by 651 CMR 12.04(7)(a)4.a. through b.;

(f) Documentation of all aspects of Limited Medication Administration, if applicable. This includes, but is not limited to, a proper written medication order from an authorized prescriber, documentation of the name, dose, route of administration, and time the medication is administered. The nurse who administers the medication shall sign or initial the documentation;

(g) The following documents are also part of the Resident record, and may be kept in a separate location(s):

1. Any applicable guardianship orders, authorized powers of attorney, Health Care Proxy documents, living wills, Medical Orders for Life-Sustaining Treatment (MOLST)/Portable Orders for Life-Sustaining Treatment (POLST) documents and other relevant documents affecting or directing Resident care (including Department of Public Health Comfort Care/"Do Not Resuscitate Order Verification Form", provided that their existence and location is conspicuously documented in the Resident's record and they are immediately available in case of an emergency;

2. The original Residency Agreement and any documents which extend or amend the Residency Agreement; and

12.05: continued

3. The Disclosure of Rights and Services required by 651 CMR 12.08(3) and, if applicable, any disclosures provided to Residents receiving Basic Health Services as required by 651 CMR 12.08(5).

(h) In addition to the items required in 651 CMR 12.08(2)(a) through (g), for Residents receiving Basic Health Services from a Residence certified to provide Basic Health Services, the following shall apply:

1. the Resident record must also include, at a minimum, the following:

a. active valid Medical Orders signed and dated within the past 12 months authorizing the provision of Basic Health Services, and expired Medical Orders, if applicable;

b. written consent to receive Basic Health Services as referenced in 651 CMR 12.04(3)(a)2.a. from the Resident, Legal Representative, or if applicable, the Resident's Health Care Agent;

c. Resident assessments conducted in accordance with 651 CMR 12.04(9);

d. a record documenting each time Basic Health Services are provided to a Resident; and

e. the original Residency Agreement and any supplemental documents concerning the provision of Basic Health Services.

(2) Census Record. Each Residence shall maintain a current census document. Each census document shall be kept for a minimum of two years and be updated at least weekly, listing. The census document shall be available and accessible at all times. The census document must include the name of and level of assistance for each Resident, and clearly indicate:

(a) Residents residing in each occupied certified Unit;
(b) Residents residing in traditional Units;
(c) Residents residing in Special Care Units;
(d) Residents receiving Basic Health Services;
(e) Residents using Transfer Assistive Devices or Mobility Assistive Devices;
(f) Residents receiving oxygen;
(g) Residents receiving Self-administered Medication Management;
(h) Residents receiving Limited Medication Administration;
(i) Residents on leave of absence;
(j) Residents who will need special assistance during an emergency and what type of assistance is required; and
(k) Residents who are veterans.

(3) Personnel Record Requirements. The Assisted Living Residence shall develop and maintain written personnel records and maintain copies of its personnel policies and procedures. Each personnel record shall include at a minimum the following:

(a) Job description signed and dated by the employee;
(b) Educational preparation and work experience;
(c) A copy of any current licensure or certification, including a current certification for cardiopulmonary resuscitation (CPR) and automated external defibrillation (AED) training, if applicable;
(d) Documentation of completion of the 54-hour Personal Care Services Training set forth in 651 CMR 12.07(7), if applicable;
(e) Documentation of attendance at Personnel Orientation as set forth in 651 CMR 12.07;
(f) Documentation of the successful completion of all required trainings;
(g) Documentation of reports of criminal offender record information;
(h) Documentation of annual performance evaluation;
(i) Documentation of attendance at in-service training; and
(j) Copies of any disciplinary letters or reports.

(4) Basic Health Services Personnel Records. The Residence shall develop and maintain written personnel records that identify the staff who are authorized to provide Basic Health Services and maintain records of the qualifications and applicable licenses of such staff. The Residence must also document the required trainings attended by employees providing Basic Health Services and retain all performance evaluations.

12.05: continued

(5) Communication Logs. The Residence must maintain a staff communication log for each 24-hour period that communicates information necessary to maintain the continuity of care for all Residents. The communication log must be retained for the duration of each Certification period and until the Residence is recertified.

(6) Emergency Response System Logs. The Residence must record and maintain all instances of and response times to Resident emergency response system calls, including the date, time of call, time of response, name of Resident, and name(s) of responding staff. The emergency response system log must be retained for the duration of each Certification period and until the Residence is recertified.

(7) SCR Hourly Safety Check Logs. The Residence must record and maintain a log of hourly safety checks performed in the SCR Units during the twelve hours overnight, including the date and time, the name of the Resident checked, and the name of the staff performing the overnight check. The SCR hourly safety check log must be retained for the duration of each Certification period and until the Residence is recertified.

(8) Fall Logs. The Residence must record and maintain a detailed fall log that records all incidents of falls, including the date and time, the location, the circumstances, the injuries sustained, and the immediate staff response. This log must be reviewed regularly by Residence staff for quality assurance and improvement purposes and be made available to EOAI as requested. The fall log must be retained for the duration of each Certification period and until the Residence is recertified.

(9) Quality Assurance and Performance Improvement Meeting Minutes. The Residence shall create and retain minutes of all meetings of the quality assurance and performance improvement committee held pursuant to 651 CMR 12.04(11)(g) for EOAI review. The meeting minutes must be retained for the duration of each Certification period and until the Residence is recertified.

12.06: Staffing Requirements

No person working in an Assisted Living Residence shall have been convicted of a felony related to the theft or illegal sale of a Controlled Substance.

(1) Qualifications for the Executive Director. The Executive Director of an Assisted Living Residence shall be at least 21 years old and must have demonstrated experience in administration, supervision, and management skills. The Executive Director must also have a Bachelor's degree or equivalent experience in human services management, housing management or nursing home management. The Executive Director must be of good moral character, and must never have been convicted of a felony.

(2) Qualifications for the Resident Care Director. The Resident Care Director of an Assisted Living Residence must have a minimum of five years' experience working with older adults or persons with disabilities or have a nursing degree with a minimum of two years' experience working with older adults or persons with disabilities. The Resident Care Director shall be qualified by experience and training to develop, maintain and implement or arrange for the implementation of individualized Service Plans. The Resident Care Director must also have a Bachelor's degree or equivalent experience, and knowledge of aging and disability issues. The requirement mandating a minimum of five years' experience working with older adults or persons with disabilities or having a nursing degree with a minimum of two years' experience working with older adults or persons with disabilities shall be effective as of January 1, 2027. This requirement shall not apply to a Resident Care Director hired before January 1, 2027. The qualification requirements for a Resident Care Director hired before January 1, 2027 are that the Resident Care Director must have a minimum of two years' experience working with older adults or persons with disabilities. The Resident Care Director shall be qualified by experience and training to develop, maintain and implement or arrange for the implementation of individualized Service Plans. The Resident Care Director must also have a Bachelor's degree or equivalent experience, and knowledge of aging and disability issues.

12.06: continued

(3) General Staffing Requirements.

(a) All staff shall possess appropriate qualifications to perform the job functions assigned to them.

(b) The Residence must have a minimum of one staff member available at all times who is certified in cardiopulmonary resuscitation (CPR) and in the use of an automated external defibrillator (AED). This requirement shall apply starting on January 1, 2027.

1. All persons certified to provide automated external defibrillation and cardiopulmonary resuscitation shall:

a. Successfully complete a course in cardiopulmonary resuscitation and in the use of an automated external defibrillator that meets or exceeds the standards established by the American Heart Association or the American National Red Cross;

b. Have evidence that course completion is current and not expired;

c. Complete a recertification course prior to the expiration date on their certification.

(c) No person working in a Residence shall have been determined by an administrative board or court to have violated any local, state or federal statute, regulation, ordinance, or other law reasonably related to the safety and well-being of a Resident at an Assisted Living Residence or patient at a health care facility.

(d) The Residence shall designate at least one licensed nurse employed by or under written agreement with the Residence to:

1. Conduct introductory visits pursuant to 651 CMR 12.07(8);

2. Conduct initial clinical assessments prior to a Resident moving to the Residence pursuant to 651 CMR 12.04(7)(a);

3. Oversee Self-Administered Medication Management (SAMM);

4. Conduct 20 hours of the Personal Care Services Training Requirements that is specific to the provision of Personal Care Services pursuant to 651 CMR 12.07(7) for all applicable staff. This requirement must be fulfilled be a qualified Registered Nurse with a valid Massachusetts license;

5. Conduct biannual evaluation of the provision of Personal Care Services by Personal Care Staff pursuant to 651 CMR 12.07(9);

6. Oversee and provide Limited Medication Administration (LMA) to Residents; and

7. Develop and oversee Service Plans as required in 651 CMR 12.04(8)(a) and 651 CMR 12.04(9)(c).

The designated licensed nurse must provide on site services for a minimum number of hours each week, scaled to the Residence's size, Resident acuity and needs, and be available on call 24 hours a day to support staff and respond to changes in Resident condition.

(e) The Residence shall contract with or employ a responsible clinician who is a licensed provider in the Commonwealth (*e.g.* a registered nurse, nurse practitioner, or physician) who shall be the automated external defibrillator person in charge for the Residence. The responsible clinician shall oversee and coordinate the following:

1. Maintenance and testing of equipment in accordance with the manufacturer's guidelines;

2. Certification and training of Residence personnel;

3. Periodic performance review of the Residence's automated external defibrillation activity; and

4. Development of policies and procedures consistent with current medical practice regarding the use of automated external defibrillators.

(f) All employees of the Residence shall know the names and be able to readily obtain the contact information of the current Executive Director and Resident Care Director of the Residence at all times.

(4) Staffing Levels.

(a) Each Residence must develop and implement a process for determining its staffing levels. The plan must include an assessment, to be conducted at least quarterly but more frequently if the Residence so chooses, of the appropriateness of staffing levels.

12.06: continued

(b) The Residence shall have sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled Resident needs as required by the Residents' assessments and Service Plans on a 24-hour per day basis. The Residence's staffing shall be sufficient to respond promptly and effectively to individual Resident emergencies. The Residence's staff is required to be awake at all times while on duty. The Residence shall have a plan to secure staffing necessary to respond to emergency, life safety and disaster situations affecting Residents.

(c) If the Residence accepts Residents who require the use of a Lift Device, the Residence shall have sufficient staffing at all times to meet the needs of these Residents in accordance with the Residence's Lift Device policy. The Residence must follow the manufacturer's guidance in determining the number of staff required to safely use and operate Lift Devices.

(d) If a Residence uses a third-party vendor for staffing, the Residence shall have an employee of the Residence who is trained on the Residence's policies and procedures working on the premises at all times or the third-party vendor must have completed the Residence's general training and orientation.

(e) The Residence is responsible for ensuring all staff and third-party vendors are following the Residence's policies and procedures.

(f) If a public health emergency is declared, EOAI may issue directions and guidance related to staffing on how to address the public health emergency.

(5) Special Care Residence Staffing.

(a) A Special Care Residence shall have sufficient staff qualified by training and experience awake and on duty at all times to meet the 24-hour per day scheduled and reasonably foreseeable unscheduled needs of all Residents of a Special Care Residence based upon the Resident assessments and Service Plans. A Special Care Residence's staffing shall be sufficient to respond promptly and effectively to individual Resident emergencies.

(b) For the purposes of 651 CMR 12.06(5)(a), it shall never be considered sufficient to have fewer than two staff members in a Special Care Residence.

(c) Staffing Exemption:

1. At their sole discretion, the Secretary may grant an exemption from the requirement set forth in 651 CMR 12.06(5)(b) and allow one staff member and one Floater to be on duty during an overnight shift if it is determined that:
   a. the physical design of the Special Care Residence is conducive to the provision of sufficient care to all Residents;
   b. staff members possess the means to conduct immediate communication with each another;
   c. the waiver request is not based on a fluctuation in Residence occupancy; and
   d. the safety and welfare of Residents are not compromised.
2. The Applicant/Sponsor shall request such an exemption in writing and shall enclose supporting documentation. The Secretary may grant such an exemption at their sole discretion. The Secretary's granting of the staffing exemption in a Special Care Residence shall expire on the stated expiration date of the Certification. The Applicant/Sponsor must reapply for the staffing exemption at least 30 days before the stated expiration date of the Certification. The Secretary may, at any time, revoke such an exemption. The decision to revoke the exemption is final.

(6) Staffing for Basic Health Services.

(a) Basic Health Services must be provided by a Clinical Professional capable of providing such services within their scope of practice.

(b) The Residence shall designate a qualified member of staff to:

1. ensure compliance with the Basic Health Services operating plan and relevant policies, procedures, and other applicable regulations;
2. monitor the provision of Basic Health Services to Residents;
3. obtain and update Medical Orders as necessary;
4. ensure complete and accurate records are kept in accordance with the requirements of 651 CMR 12.00 and other applicable regulations;
5. assign duties and communicate with Personal Care Staff as needed;
6. review quality control and assurance practices concerning the provision of Basic Health Services at the Residence;

12.06: continued

7. track and evaluate the performance of those providing Basic Health Services; and
8. ensure Resident Service Plans are updated as soon as necessary.

(c) The Residence must ensure sufficient staffing levels to provide the Basic Health Services required by Residents in a safe and effective manner.

(d) The Residence shall have a licensed nurse working on the Residence's premises for at least 16 hours during the day (*e.g.*, 7:00 A.M. through 11:00 P.M.) each day.

(e) The Residence must provide staff access to a licensed practical nurse or registered nurse who has knowledge of the Residents' clinical needs for consultation at all times related to the administration of Basic Health Services and to ensure patient safety and clinical competence in the application of Basic Health Services. The consultative nurse shall not be required to be physically present on the premises but must have the ability to virtually assess the Resident. The Residence and nurse must have adequate technology, including video conferencing and monitoring capabilities (*e.g.*, visual assessment of vital signs such as oxygen saturation levels), so that the nurse can obtain the clinical information necessary to make informed decisions, provide timely interventions, and help reduce unnecessary emergency room visits.

(f) The Residence shall have a plan to secure staffing necessary to ensure the continuation of Basic Health Services as required by a Resident's Service Plan, and in response to emergency, safety, and disaster situations affecting Residents.

(g) All Clinical Professionals employed by Residences certified to provide Basic Health Services to Residents must be Basic Life Support (BLS) certified.

(7) Emergency Situations. The Residence shall have a plan to secure staffing necessary to respond to emergency, safety and disaster situations affecting Residents.

(8) Special Care Residence Manager. A Special Care Residence must designate an individual who will be responsible for all Special Care operations. The Manager of a Special Care Residence shall be at least 21 years old, must have a minimum of two years' experience working with older adults or individuals with disabilities, knowledge of aging and disability issues, demonstrated experience in administration, and demonstrated supervisory and management skills. The Special Care Residence Manager must also have a Bachelor's degree or equivalent experience in human services management, housing management or nursing home management. The Special Care Residence Manager must be of good moral character and must never have been convicted of a felony.

(9) Contagious Disease and Vaccination Requirements.

(a) No person shall be permitted to work in a Residence if infected with a contagious disease in a communicable form that could endanger the health of residents or other employees. The Residence shall maintain accurate records of illnesses and associated incidents involving staff as part of its Communicable Disease Control Plan pursuant to 651 CMR 12.04(13).

(b) Consistent with any guidelines, schedules, and reporting requirements established by the Secretary, each Residence shall ensure that all personnel comply with the vaccination requirements of 651 CMR 12.06.

(c) For the purposes of 651 CMR 12.06, "personnel" means an individual or individuals who either work at or come to the Residence and who are employed by or affiliated with the Residence, whether directly, by contract with another entity, or as an independent contractor, paid or unpaid including, but not limited to, employees, members of the medical staff, contract employees or staff, students, and volunteers, whether or not such individual(s) provide direct care.

(d) For the purposes of 651 CMR 12.06, "mitigation measures" mean measures that personnel who are exempt from vaccination in accordance with 651 CMR 12.06(9)(g) must take to prevent viral infection and transmission.

(e) Influenza Vaccine.

1. Subject to the provisions of 651 CMR 12.06(9)(g), each Residence shall ensure that all personnel are vaccinated annually with seasonal influenza vaccine, inactivated or live, or an attenuated influenza vaccine, including a seasonal influenza vaccine.
2. Each Residence shall provide all personnel with information about the risks and benefits of influenza vaccine.

12.06: continued

3. Each Residence shall notify all personnel of the influenza vaccination requirements of this section and provide guidance to personnel regarding how to receive influenza vaccination.

(f) Coronavirus Disease 2019 (COVID-19) Vaccine.

1. For the purposes of 651 CMR 12.06, "COVID-19 vaccination" means being up to date with COVID-19 vaccines as recommended by the Centers for Disease Control and Prevention (CDC).

2. Subject to the provisions of 651 CMR 12.06(9)(g), each Residence shall ensure all personnel have received the COVID-19 vaccination.

3. Each Residence shall provide all personnel with information about the risks and benefits of COVID-19 vaccination.

4. Each Residence shall notify all personnel of the COVID-19 vaccination requirements of 651 CMR 12.06(9) and provide guidance to personnel regarding how to receive COVID-19 vaccination.

(g) Exemptions.

1. A Residence shall not require personnel to receive a vaccine pursuant to 651 CMR 12.06(9)(e) or (f) if the individual declines the vaccine.

2. An individual who is exempt from vaccination shall sign a statement certifying that they are exempt from vaccination and they received information about the risks and benefits of influenza vaccination and COVID-19 vaccination.

3. For any individual subject to the exemption, the Residence shall require such individual to take mitigation measures, consistent with guidance from EOAI.

(h) Documentation. A Residence shall require, and maintain for all personnel, proof of current vaccination pursuant to 651 CMR 12.06(9)(e) and (f), or the personnel's exemption statement as required by 651 CMR 12.06(9)(g). Such information shall be made available by the Residence for review by EOAI during a Compliance Review pursuant to 651 CMR 12.09.

(i) Each Residence shall ensure all personnel are vaccinated against other novel pandemic or novel influenza virus(es) in accordance with guidelines issued by the Commissioner of the Department of Public Health.

(j) Nothing in 651 CMR 12.00 shall be read to prohibit facilities from establishing policies and procedures for influenza and COVID-19 vaccination of personnel that exceed the requirements set forth in 651 CMR 12.06(9).

12.07: Training Requirements

The purposes of the requirements of 651 CMR 12.07 are to ensure employees of Assisted Living Residences have a clear understanding of their jobs and the way in which their work intersects with and supports the work of other employees, of the policies and procedures of the Residence, of the rights of the Residents, and of the particular and distinctive service needs and health concerns of the Residents. All curricula for training should reflect current standards of practice and care, be designed to enhance the professionalism of the employees, and to enable employees to provide good service. Training requirements may be satisfied by such means as practical demonstration, lectures, lectures with accompanying role playing, video with facilitated discussion, and other generally accepted techniques. No more than two of the seven hours required for orientation may be conducted by un-facilitated media presentations by such means as video or audio. Instructors and facilitators shall be appropriately qualified by training or demonstrated experience. The Residence shall maintain documentation in the employee's personnel file regarding the completion of training or eligibility for any exemption.

(1) General Orientation. Prior to active employment, all staff and contracted providers who will have direct contact with Residents and all food service personnel must receive a seven-hour orientation which includes the following topics:

(a) Philosophy of independent living in an Assisted Living Residence;
(b) Resident Bill of Rights;
(c) Elder Abuse, Neglect and Financial Exploitation;
(d) Residence policies and procedures related to disaster and emergency preparedness;
(e) Communicable diseases, including but not limited to, AIDS/HIV and Hepatitis B;

12.07: continued

(f) Infection control in the Residence and the principles of universal precautions based on DPH guidelines;
(g) Communication Skills;
(h) Review of the aging process;
(i) Dementia/Cognitive Impairment including a basic overview of the disease process, communication skills and behavioral interventions;
(j) Resident health and related problems;
(k) General overview of the employee's specific job requirements;
(l) The Residence's policy on emergency response to acute health issues, and first aid;
(m) Sanitation and Food Safety;
(n) The policies concerning smoking on the Residence's premises;
(o) The proper use, administration, and maintenance of oxygen, including safety protocols; and
(p) the disaster and emergency preparedness plan required in 651 CMR 12.04(12)(a).

(2) Additional General Orientation Requirements.
(a) At least one hour of general orientation training shall be devoted to the topic of elder abuse, neglect, and financial exploitation.
(b) At least two hours of general orientation training shall be devoted to the topic of dementia and cognitive impairments. All curricula for training related to dementia shall reflect current standards of practice and care.
(c) In addition to the requirements relative to the general orientation set forth in 651 CMR 12.07(1)(a) through (p), all personnel providing Personal Care Services shall receive at least one additional hour of orientation devoted to the topic of Self-administered Medication Management provided by a nurse.
(d) Both the Executive Director and Resident Care Director shall receive an additional two-hour training devoted to dementia care topics.
(e) A Residence may include the use of techniques such as the shadowing of more experienced employees during the first five days of an employee's tenure.

(3) Orientation for Staff Working within Special Care Residences. In addition to completing requirements for general orientation as set forth under 651 CMR 12.07(1)(a) through (p), all new employees who work within a Special Care Residence and have direct contact with Residents must receive seven hours of additional training on topics related to the specialized care needs of the Resident population (*e.g.*, communication skills, creating a therapeutic environment, interpreting manifestations of distress, decisional capacity, sexuality, family issues, and caregiver support).

(4) Training for Employees Supporting Basic Health Services.
(a) Prior to providing Basic Health Services to Residents, all Clinical Professionals employed by Residences certified to provide Basic Health Services to Residents must receive a minimum of two hours of training designed to ensure employee understanding and competency with the provision of Basic Health Services to Residents, including the Residence's Basic Health Services operating plan, policies and procedures concerning Basic Health Services, and the requirements of 651 CMR 12.00.
(b) On an ongoing basis, all Personal Care Staff employed by Residences certified to provide Basic Health Services must receive two hours of training every 12 months. The training must be designed to ensure that the Personal Care Staff understand the Basic Health Services provided, understand the Residence's policies and procedures concerning Basic Health Services, understand how to provide Resident care in coordination with Basic Health Services, and how to report changes in a Resident's condition to a licensed nurse or other Clinical Professional.
(c) All completed trainings must be documented and maintained in the employee's personnel file.

12.07: continued

(5) Ongoing In-Service Education and Training.

(a) A minimum of ten hours per year of ongoing education and training is required for all employees, with at least two hours on the specialized needs of Residents with Alzheimer's disease and related dementia. The curriculum used for the ongoing education and training shall cover the following topics: Alzheimer's disease and dementia; person-centered care; assessment and care planning; activities of daily living; and dementia-related behaviors and communication. The ongoing education and training must also include the policies concerning smoking on the Residence's premises, the proper use, maintenance and safety protocols concerning oxygen, and the disaster and emergency preparedness plan required pursuant to 651 CMR 12.04(12)(a).

(b) All Personal Care Staff and Clinical Professionals must receive training on:

1. The proper installation, use, and maintenance of Transfer Assistive Devices or Mobility Assistive Devices;

2. How to instruct Residents on the safe use of Transfer Assistive Devices or Mobility Assistive Devices;

3. The difference between Transfer Assistive Devices and prohibited Restraints;

4. Recognizing and reporting potential safety hazards related to Transfer Assistive Device or Mobility Assistive Device use; and

5. Monitoring Residents for changes in condition that may affect the safe use of the Transfer Assistive Device or Mobility Assistive Device.

(c) All Personal Care Staff and all Clinical Professionals must complete an initial training regarding the Lift Device program, if applicable. The Lift Device training shall also be completed by Personal Care Staff and Clinical Professionals annually, if applicable. The completion of the initial and annual Lift Device trainings shall be documented in the employee's personnel file. The Lift Device program is required to ensure Personal Care Staff and Clinical Professionals understand the proper use and operation of Lift Devices. The training shall include the correct use and understanding of safe Resident movement. The training must include a lift program guide, pertinent instruction materials from lift equipment manufacturers, and also include a practice evaluation.

(d) Employees working in a Special Care Residence must receive an additional four hours of training per year related to the Residents' specialized needs. Such training shall include the development of communications skills for Residents with dementia.

(e) In addition to the general ten-hour continuing education requirement for all employees, Executive Directors shall complete an additional five hours of training which shall be intended to complement the individual's background and experience. Credits for completing annual continuing education requirements for Executive Directors may be transferable to other Residences.

(f) No more than 50% of the ongoing training requirement may be conducted by unfacilitated media presentations by such means as video or audio.

(g) Upon submitting proof in a manner and form prescribed by EOAI, training received within the past 18 months at another Assisted Living Residence, a similar facility or agency may be used to satisfy the requirements of 651 CMR 12.07. Satisfaction of the requirements of the general orientation shall not be used to fulfill the requirements of 651 CMR 12.04(5).

(h) Specialized Training Requirements.

1. All Personal Care Staff shall be trained in the Residence's policy on emergency response to acute health issues and first aid, and must also complete at least one hour of ongoing education and training per year on the topic of Self-administered Medication Management; and

2. All employees and providers shall receive ongoing in-service education and training, provided by a professional with relevant experience, that is designed to ensure orientation training is reinforced, from among the following topics:

a. Behavioral interventions, including prevention of manifestations of distress such as aggressive behavior and de-escalation techniques (mandatory);

b. Defining, recognizing and reporting elder abuse (mandatory);

c. Communication and teamwork;

d. The aging process, including typical changes and those related to disease;

e. The causes and prevention of falls and related injuries, and the Residence's established policies and procedures for an Evidence Informed Falls Prevention Program;

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f. The effects of dehydration;
g. Alzheimer's disease and cognitive impairments;
h. Conflict resolution;
i. Resident rights;
j. Self-administered Medication Management;
k. Death and dying;
l. Maintaining skin integrity;
m. Nutrition;
n. Emergency procedures; and
o. Training which addresses topics required in the general orientation.

(6) Each residence shall conduct an annual training needs assessment to prepare the curriculum for its required training and establish a process by which it will evaluate the efficacy of its training program.

(7) Personal Care Services Provider Training Requirements. Assisted Living Residence Personal Care Staff and contracted providers of Personal Care Services must complete an additional 54 hours of training prior to providing Personal Care Services to a Resident, 20 hours of which must be specific to the provision of Personal Care Services. The 20 hours of Personal Care training must be conducted by a qualified Registered Nurse with a valid Massachusetts license.

(a) The 54 hours of training must include the following topics:
1. Bathing and personal care;
2. The effects of dehydration;
3. Maintaining skin integrity;
4. Self-administered Medication Management;
5. Elimination;
6. Nutrition;
7. Human Growth, Development and Aging;
8. Family Dynamics;
9. Grief, Loss, Death and Dying;
10. Mobility;
11. Fall prevention;
12. Mental health, depression and loneliness;
13. Maintenance of a Clean, Safe and Healthy Environment;
14. Home Safety; and
15. Assistance with Appliances.

(b) Documentation of completion of the 54-hour training for Assisted Living Residence Personal Care Staff and contract providers who provide Personal Care Services shall be transferable for each employee from one Residence to another.

(8) Introductory Visit and Review. Prior to or within 48 hours after the provision of Personal Care Services to a Resident, a licensed nurse shall review the Resident's Service Plan with all relevant Personal Care Staff. This review may be conducted in the Resident's Unit or at another appropriate location within the Residence, as determined by the nurse. The Personal Care Staff must demonstrate competence in the assigned personal care tasks (including Self-administered Medication Management) in the Resident's Service Plan. Such competence may be demonstrated either through a verbal review of these tasks or, if deemed necessary by the licensed nurse, by the demonstrated performance of the tasks by such workers. An Introductory Visit shall also be conducted and documented in the Resident's record whenever the Resident's personal care needs change significantly, as determined by the nurse. Such documentation shall be kept current.

(9) Supervision. A qualified nurse shall, at least once every six months, evaluate the Personal Care Services provided by Personal Care Staff of the Residence or by contracted providers. A written record of the staff or provider's performance of personal care skills shall be completed after each evaluation and shall be kept in the employee's personnel file. Personal Care Staff who provide Self-administered Medication Management shall also be evaluated on their awareness of and compliance with SAMM regulations and the applicable Residence policies and procedures.

12.07: continued

(10) Exemptions. The following individuals are exempt from Personal Care Services Provider Training Requirements as set forth in 651 CMR 12.07(7). However, these individuals must complete the general orientation and Ongoing In-service Education and Training as set forth in 651 CMR 12.07(1) through (3) and 651 CMR 12.07(5).

(a) Registered Nurse (RN) and a Licensed Practical Nurse (LPN) with a valid license in Massachusetts;

(b) Nurse's Aides with documentation of successful completion of nurse's aide training;

(c) Home Health Aides with documentation of having successfully completed the Certified Health Aide training program; and

(d) Personal Care Homemakers with documentation of having successfully completed a Personal Care Homemaker training program (54 Hours).

(11) Food Service Personnel. Before commencing employment in an Assisted Living Residence, the person(s) managing the dietary department (*e.g.* food services manager and chef) must complete a food service sanitation course which meets the applicable requirements of 105 CMR 590.003: *Food*.

12.08: Resident Rights and Required Disclosures

Prior to scheduling a formal meeting with a prospective Resident, the Residence shall inform him or her of the right to be accompanied by a Legal Representative, Resident Representative, or other advisor. During its first formal meeting with a prospective Resident, the Residence shall deliver to and verbally review with the prospective Resident a consumer guide developed by EOAI and the Disclosure of Rights and Services required by 651 CMR 12.08(3), which incorporates the provisions of 651 CMR 12.08(1). At the time of or prior to the execution of the Residency Agreement or the transfer of any money to a Sponsor by or on behalf of a prospective Resident, whichever first shall occur, the Sponsor shall deliver to and verbally review with the prospective Resident, the person with whom the contract is entered into, and, if applicable, the prospective Resident's Legal Representative a copy of the Residency Agreement, which shall state all applicable costs and terms of payment, services offered and not offered, shared risks, and all other important terms and conditions of the Agreement. All documents shall be written in plain language and published in typeface no smaller than 14-point type. EOAI may require that any applicable disclosure statement be in the form and format as required by EOAI.

(1) Resident Rights. Every Resident of an Assisted Living Residence shall have the right to:

(a) Live in a decent, safe, and habitable residential living environment;

(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy;

(c) Privacy within the Resident's Unit subject to rules of the Assisted Living Residence reasonably designed to promote the health, safety and welfare of Residents;

(d) Retain and use their own personal property, space permitting, in the Resident's living area so as to maintain individuality and personal dignity;

(e) Private communications, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of her or his choice;

(f) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community;

(g) Directly engage or contract with licensed or certified health care providers to obtain necessary health care services in the Resident's Unit or in such other space in the Assisted Living Residence as may be available to Residents to the same extent available to persons residing in their own homes, and with other necessary care and service providers, including, but not limited to, the pharmacy of the Resident's choice subject to reasonable requirements of the Residence. The Resident may select a medication packaging system within reasonable limits set by the Assisted Living Residence. Any Assisted Living Residence policy statement that sets limits on medication packaging systems must first be approved by EOAI;

(h) Manage their own financial affairs, unless the Resident has a Legal Guardian or other court-appointed representative with the authority to manage the Resident's financial affairs;

(i) Exercise civil and religious liberties;

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(j) Present grievances and recommended changes in policies, procedures, and services to the Sponsor, Executive Director or staff of the Assisted Living Residence, government officials, or any other person without restraint, interference, coercion, discrimination, or reprisal. This right includes access to representatives of the Statewide Long-Term Care Ombudsman program established under M.G.L. c. 6A, § 16CC, the Elder Protective Services program established under M.G.L. c. 19A, §§ 14 through 26, and the Disabled Persons Protection Commission (DPPC) established under M.G.L. c. 19C;

(k) Upon request, obtain from the Assisted Living Residence, the name and contact information of the Executive Director, Resident Care Director, and any other persons responsible for their care or the coordination of their care;

(l) Confidentiality of all records and communications to the extent provided by law;

(m) Have all reasonable requests responded to promptly and adequately within the capacity of the Assisted Living Residence;

(n) Upon request, obtain an explanation of the relationship, if any, of the Residence to any health care facility or educational institution to the extent the relationship relates to their care or treatment;

(o) Obtain from a person designated by the Residence a copy of any rules or regulations of the Residence which apply to their conduct as a Resident;

(p) Privacy during medical treatment or other rendering of services within the capacity of the Assisted Living Residence;

(q) Informed consent to the extent provided by law;

(r) Not be evicted from the Assisted Living Residence except in accordance with the provisions of landlord/tenant law as established by M.G.L. c. 186 or M.G.L. c. 239 including, but not limited to, an eviction notice and utilization of such court proceedings as are required by law;

(s) Be free from Restraints;

(t) Receive an itemized bill for fees, charges, expenses and other assessments for the provision of Resident services, Personal Care Services, and optional services;

(u) Have a written notice of the Residents' Rights published in typeface no smaller than 14-point type posted in a prominent place or places in the Assisted Living Residence where it can be easily seen by all Residents. This notice shall include the address, and telephone number of the Long-Term Care Ombudsman Program, and the telephone number of the Elder Abuse Hotline;

(v) Be informed in writing by the Sponsor of the Assisted Living Residence of the community resources available to assist the Resident in the event of an eviction procedure against him or her. Such information shall include the name, address and telephone number of the Long-Term Care Ombudsman Program.

(w) To organize and participate in self-governed, confidential Resident groups in the Residence;

(x) To participate in self-governed, confidential family groups; and

(y) Have family member(s) or other Resident Representatives meet in the Residence with the families or Resident Representative(s) of other Residents in the Residence.

(z) Be able to review a copy of the Residence's disaster and emergency preparedness plan at any time.

(2) Residency Agreement.

(a) The Residency Agreement shall include, at a minimum, the following:

1. Charges, expenses and other assessments for the provision of Resident services, Personal Care Services, Lodging and meals, and optional services;

2. All fees associated with the provision of Basic Health Services, if applicable;

3. The agreement of the Resident to make payment of the charges specified;

4. The policy and procedures regarding a Resident's financial liability or other expectation for payment of services during Resident absences from the Residence;

5. Arrangements for payment;

6. A Resident grievance procedure which meets the requirements of 651 CMR 12.08(1)(j);

7. The Sponsor's covenant to comply with applicable federal and state laws and regulations concerning consumer protection and protection from abuse, neglect and financial exploitation of the elderly and disabled;

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8. The conditions under which the Residency Agreement may be terminated by either party, including criteria the Residence may use to determine whether the conditions have been met, and the length of the required notice period for termination of the Residency Agreement;
9. Reasonable rules for the conduct and behavior of staff, management and the Resident;
10. The Resident's rights required by 651 CMR 12.08(1);
11. A clear explanation of the services included in any fees, a description and itemization of all other bundled services as well as an explanation of other services available at an additional charge;
12. An explanation of any limitations on the services the Residence will provide, specifically including any limitations on services to address specific Activities of Daily Living and behavioral management. Such explanation shall also include a description of the role of the nurse(s) employed by the Residence, and the nursing and personal care worker staffing levels;
13. An explanation of the eligibility requirements for any available subsidy programs, including a statement of any costs associated with services beyond the scope of the subsidy program for which the Resident or their Legal Representative would be responsible;
14. The refund policies for all Administrative Fees, deposits, and other charges; and
15. A copy of the Residence's medication management policy: its Self-administered Medication Management (SAMM) policy, including its policy on assistance with as-necessary or PRN medication when part of the SAMM plan; and, if applicable, Limited Medication Administration.

(b) If the Disclosure of Rights and Services required by 651 CMR 12.08(3) fully states all of the items required by 651 CMR 12.08(2)(a)6., 9., 10., 12., 13. and 15., the Residency Agreement may incorporate those requirements by reference.

(c) The Residency Agreement may include the agreement of the Sponsor to provide or arrange for the provision of additional services, including, but not limited to, the following:
1. Barber and beauty services, sundries for personal consumption, and other amenities; and
2. Local transportation for medical and recreational purposes.

(d) The Residency Agreement shall be for a term not to exceed one year and may be renewable upon the agreement of both parties.

(e) The Residency Agreement shall be for a single or double living Unit in the Residence with lockable entry doors on each Unit which meet the bathroom, Bathing Facility and kitchenette requirements of 651 CMR 12.04(1).

(f) A Residency Agreement for a Residence receiving funding through MassDevelopment pursuant to M.G.L. c. 23A, which otherwise meets the requirements of 651 CMR 12.08(2), may be executed for an initial period not to exceed 13 months.

(g) A Resident may voluntarily agree to vacate their Unit in accordance with their Residency Agreement. A Resident may not be evicted from the Resident's Unit following termination of the Residency Agreement except in accordance with the provisions of landlord/tenant law as set forth in M.G.L. c. 186 and M.G.L. c. 239.

(3) Disclosure of Rights and Services. The disclosure statement shall include, at a minimum, the following:

(a) The number and type of Units the Residence is certified to operate;

(b) The number of staff currently employed by the Residence, by shift, an explanation of how the Residence determines staffing, and the availability of overnight staff, and shall provide this information separately for any Special Care Residence within the Residence;

(c) A copy of the list of Residents' Rights set forth in 651 CMR 12.08(1);

(d) An explanation of the eligibility requirements for any subsidy programs including a statement of any additional costs associated with services beyond the scope of the subsidy program for which the Resident or their Legal Representative would be responsible. This explanation should also state the number of available Units, and whether those Units are shared;

(e) A copy of the Residence's medication management policy, its Self-administered Medication Management policy for dealing with medication that is prescribed to be taken "as necessary", and an explanation of its Limited Medication Administration policy;

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(f) An explanation of any limitations on the services the Residence will provide, including, but not limited to, any limitations on specific services to address Activities of Daily Living and any limitations on behavioral management;
(g) An explanation of the role of the nurse(s) employed by the Residence;
(h) An explanation of entry criteria and the process used for Resident assessment;
(i) A statement on the number of staff who are qualified to administer cardiopulmonary resuscitation (CPR) and use an Automated External Defibrillator (AED), and the Residence's policy on the circumstances in which CPR will be administered and when an AED will be used;
(j) An explanation of the conditions under which the Residency Agreement may be terminated by either party, including the criteria the Residence may use to determine whether conditions have been met, and the length of the required notice period for termination of the Residency Agreement;
(k) An explanation of the physical design features of the Residence including that of any Special Care Residence;
(l) An illustrative sample of the Residence's Service Plan, an explanation of its use, the frequency of review and revisions, and the signatures required;
(m) An explanation of the different or special types of diets available;
(n) A list of enrichment activities, including the minimum number of hours provided each day;
(o) An explanation of the security policy of the Residence, including the procedure for admitting guests;
(p) A copy of the instructions to Residents in the Residence's disaster and emergency preparedness plan;
(q) A statement of the Residence's policy and procedures, if any, on the circumstances under which it will, with the member's permission, include family members in meetings and planning;
(r) Each Residence that provides special care shall provide a written statement describing its special care philosophy and mission, and explaining how it implements this philosophy and achieves the stated mission.
(s) If a Residence allows non-Residents to use any of its facilities, such as a swimming pool, gymnasium or other meeting or function room, it shall disclose the fact of such usage to its Residents. Said disclosure shall:
1. inform the Residents of the existence of non-regulated programming on-site;
2. disclose the amount of interaction or shared use of the facilities; and
3. describe any resultant impact on Residence staffing.
(t) The policy for a Resident's financial liability or other expectation for payment of services during Resident absences from the Residence;
(u) A statement regarding the procedures that will take place during an emergency and an evacuation;
(v) The policies and procedures concerning smoking on the Residence's premises; and
(w) The policies and procedures regarding the proper use, administration, and maintenance of oxygen, including safety protocols.

(4) Additional Disclosures. EOAI may develop specific documents that must be included with the Residency Agreement and disclosed to both current and prospective Residents. EOAI may require Residences to submit such documents to EOAI regularly or upon any change. EOAI may make these documents public. EOAI may require that the Residence post these documents on the Residence's website in the form and format as prescribed by EOAI. Each Resident or Legal Representative executing the Residency Agreement must also sign any required documents in the presence of a witness.

(5) Disclosures regarding Basic Health Services. A Residence providing Basic Health Services must create a written disclosure containing information pertaining to all Basic Health Services offered to current and prospective Residents.
(a) Such written disclosure must include, but is not necessarily limited to, the following:
1. the Residence's philosophy and mission regarding how Basic Health Services are provided;

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2. the processes employed to ensure continuity of services for when a Resident leaves the Residence such as during a leave of absence (for medical or personal reasons), or the termination of the residency;
3. the processes used for assessment, service planning, and implementation of Basic Health Services for Residents;
4. the roles of family and others who provide support to the Resident receiving Basic Health Services;
5. program costs, including options should a Resident no longer be able to afford Basic Health Services;
6. a statement informing the Resident of any limitations regarding the provision of Basic Health Services; and
7. any additional information EOAI may require.

(b) The disclosure must be provided to EOAI and distributed to all Residents, Legal Representatives, or Resident Representatives, if applicable, the Long-Term Care Ombudsman, and the Residents' Health Care Agents, if applicable.

(c) Any changes to the Residence's disclosure statement must be provided in advance to EOAI, and subsequently provided to all Residents, Legal Representatives, or Resident Representatives, if applicable, the Long-Term Care Ombudsman, and the Residents' Health Care Agents, if applicable.

12.09: Compliance Reviews and Findings of Noncompliance of Assisted Living Residences

(1) Purpose. EOAI or its authorized designee shall conduct a compliance review of an Assisted Living Residence prior to the issuance of any initial or renewal Certification to determine compliance with M.G.L. c. 19D and 651 CMR 12.00. An authorized designee shall not be a Sponsor of an Assisted Living Residence.

(2) Frequency. EOAI or its authorized designee shall conduct compliance reviews of Assisted Living Residences prior to initial certification, no less than once every two years at Residences' biennial certification in accordance with 651 CMR 12.09(3)(a) and no less than once every year for Residences certified to provide Basic Health Services in accordance with 651 CMR 12.09(3)(b). In addition, EOAI may conduct a compliance review any time it has cause to believe that an Assisted Living Residence is in violation of an applicable section of M.G.L. c. 19D or any applicable EOAI regulation, in accordance with 651 CMR 12.09(3)(c).

(3) Compliance Reviews and Findings of Noncompliance.

(a) Initial and Biennial Certification Compliance Review. A compliance review conducted as part of an initial or biennial certification shall include, at a minimum, the following:

1. A review of the operating plan and an inspection of every part of the common areas of the Assisted Living Residence. The inspector may, in their discretion, interview the Applicant or Sponsor, Executive Director, staff and Residents of the Assisted Living Residence. An inspector shall have the authority to confidentially and privately interview the Applicant or Sponsor, Executive Director, staff, and Residents. Interviews with Residents shall be conducted privately and shall be confidential;
2. An inspection of the living quarters of any Resident, but only with the Resident's prior consent;
3. An examination of any and all documents within a Resident's record, including Service Plans and written progress reports, incident reports (or similar documents), Residency Agreement, and any other financial or contractual agreements specific to the Resident. The Resident may give consent in writing, on a form developed by EOAI, orally, or by a sign of affirmation if the Resident is not able to give consent by other means. Consent may include consent to photocopy such materials. If consent is obtained by a means other than writing, confirmation of the consent shall be written in the review record;
4. A review of staff and contracted provider records, including personnel files;

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5. Reviews of Residences certified to provide Basic Health Services shall also include an inspection of records associated with the provision of Basic Health Services, a review of Residence employee qualifications, the Residence's operating plan as it pertains to the provision of Basic Health Services, and the documentation created and maintained by the Residence for Residents who received Basic Health Services during the previous 12-month period;

6. A review of all other books, records, and other documents maintained in relation to the operations of the Residence; and

7. A review of the quality improvement and assurance plans, including Resident satisfaction surveys.

(b) Annual Compliance Review for Basic Health Services. A compliance review of a Residence certified to provide Basic Health Services will be conducted annually on the years that the compliance review for biennial recertification in accordance with 651 CMR 12.09(3)(a) is not conducted. Such compliance review for Basic Health Services will include review of the compliance for the provision of Basic Health Services and related requirements pursuant to 651 CMR 12.09(3)(a)5., and may include a review of a portion or subset of additional items described at 651 CMR 12.09(3)(a), or such other items determined to be relevant to such annual compliance review for Basic Health Services in EOAI's sole authority.

(c) Interim Compliance Review. EOAI may conduct compliance reviews other than those described at 651 CMR 12.09(3)(a) and 12.09(3)(b) at the discretion of EOAI at such other times EOAI has cause to believe that a Residence is in violation of an applicable section of M.G.L. c. 19D or 651 CMR 12.00. The interim compliance review may include a review of a portion or subset of the items described at 651 CMR 12.09(3)(a), or such other items determined to be relevant to such interim compliance review in EOAI's sole authority.

(d) Findings of Noncompliance. EOAI may make findings of noncompliance with M.G.L. c. 19D or 651 CMR 12.00 as a result of conducting a compliance review or when EOAI has cause to determine a Residence fails to meet the requirements of M.G.L. c. 19D or 651 CMR 12.00.

(e) Refusal to grant EOAI timely access to Residents, staff, all books, records, and other documents maintained regarding the operations of the Residence shall constitute valid basis to modify, suspend, revoke or deny an application for an initial or renewal Certification, or issue a fine of not more than $500 for each day of such failure or refusal to comply. EOAI shall be authorized to photocopy such materials or request the Residence send copies of identified materials to EOAI *via* facsimile or other electronic means.

(4) Compliance Review Reports, Findings of Noncompliance, Actions by EOAI, and Responses. Whenever a compliance review is conducted, or where EOAI otherwise makes determinations of findings of noncompliance with the requirements of 651 CMR 12.00, EOAI or its designee shall prepare written findings summarizing all pertinent information obtained during such compliance review or such other determination of findings and shall not disclose confidential or privileged information obtained in connection with the review or determination of findings.

(a) Notice of Compliance. If EOAI finds that the Applicant or Sponsor is in compliance with M.G.L. c. 19D or 651 CMR 12.00, EOAI shall mail a copy of its findings to the Applicant or Sponsor within ten days after the compliance review is completed.

(b) Notice of Noncompliance. If EOAI finds that the Applicant or Sponsor is not in compliance with M.G.L. c. 19D or 651 CMR 12.00, EOAI shall forward a notice of noncompliance to the Applicant or Sponsor. The notice shall describe the noncompliance with particularity, indicate the specific portion of the law(s) or regulation(s) which have been violated, and shall include the corrective action to be taken by the Applicant or Sponsor within a time period deemed reasonable by the Secretary. The notice of noncompliance also shall include a description of the action that may be taken by the Secretary if the corrective action is not completed. The notice shall be delivered by hand or by certified mail, return receipt requested, or by first-class mail postage prepaid, and by email, within ten days after completion of the review of the Assisted Living Residence.

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(c) Corrective Action. Whenever EOAI finds, upon inspection or through information in its possession, that a Residence is not in compliance with any law(s), regulation(s), governing such program, EOAI may, in its discretion, require the Residence to implement any corrective action it deems necessary, including:

1. Ceasing the enrollment of new Residents;
2. Reducing the number of Residents served;
3. Changing the staffing patterns or staffing levels, or staffing qualifications; or
4. Requiring additional training of the Executive Director or staff.
5. Factors which may be considered by EOAI in determining the nature of the corrective action to be imposed include, but are not limited to:
   a. Any instances of noncompliance at the Residence;
   b. The risk that the instances of noncompliance present to the health, safety, and welfare of residents;
   c. The nature, scope, severity, degree, number, and frequency of the instances of noncompliance;
   d. The Applicant or Sponsor's failure to correct the noncompliance;
   e. Any ongoing pattern of noncompliance;
   f. Any previous enforcement action(s); and
   g. The results of any past corrective action plans or orders.

(d) Modification, Suspension, Revocation or Refusal to Issue or Renew Certification. EOAI may modify, suspend, revoke, deny or refuse to issue or renew a Certification, which may solely be applicable to the Certification to provide Basic Health Services as determined by EOAI, in any case in which it finds any of the following:

1. There has been a failure or refusal to comply with any applicable law, regulation, corrective order, notice of sanction, or suspension agreement;
2. The Applicant or Sponsor submitted any misleading or false statement or report required under 651 CMR 12.00;
3. The Applicant or Sponsor refused to submit any report or make available any records required under 651 CMR 12.00;
4. The Applicant or Sponsor refused to admit, at a reasonable time, any employee of EOAI authorized by the Secretary to investigate or inspect, in accordance with 651 CMR 12.00; or
5. The Applicant or Sponsor failed to obtain Certification prior to opening a program or residence or prior to changing the location of a program or residence except as allowed in 651 CMR 12.00.

(e) Fine.

1. In General. If EOAI determines that there has been a failure or refusal to comply with the requirements of 651 CMR 12.00 or any applicable statute or other legal requirement, EOAI may issue a fine of not more than $500 for each day of each such failure or refusal to comply.
2. Basic Health Services. In accordance with M.G.L. c. 19D, §§ 10(h) and 10(i)
   a. If EOAI determines that a Residence provided or offered to provide Basic Health Services without Certification to provide Basic Health Services, EOAI may issue a fine of not more than $1,000.00 per day for each day of such provision or offering, or both.
   b. If EOAI determines an incident involving Basic Health Services results in injury to a resident, EOAI may impose a fine or otherwise take an enforcement action.

(f) Effect. An Applicant or Sponsor shall not qualify for a Certification from EOAI for five years after a final agency decision to revoke or refuse to issue or renew a Certification held by the Applicant or Sponsor. Thereafter, an Applicant or Sponsor shall be eligible only if he or she can demonstrate a significant change in circumstances. EOAI may, at its sole discretion, consider an application for Certification prior to the expiration of the five-year period, if it determines that a significant change in circumstances has occurred. Such exercise of its discretion shall not be appealable.

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(g) Emergency Action.

1. EOAI may, in its discretion, modify, suspend, revoke, or refuse to renew a Residence's Certification without prior notice if EOAI finds at the time of the review, or at any other time, that the Applicant or Sponsor is not in compliance with M.G.L. c. 19D or 651 CMR 12.00 and that such noncompliance presents an immediate threat to the health, safety, or welfare of Residents. The Applicant or Sponsor shall be notified of any such modification, suspension, or revocation of a Certification by written notice, hand delivered, or mailed to the applicant or sponsor via first class mail, certified or registered, return receipt requested.

2. Before imposing a modification, suspension, revocation, or refusing to renew a Residence's Certification, EOAI may require immediate corrective action by the Residence. In such cases, EOAI will identify the nature of the correction and the time frame in which to make those corrections. The corrective action will be directly based upon the nature of the findings, and the timeframe within which the action must be taken will be reasonable.

3. The modification, suspension, or revocation of the Certification or refusal to renew the Certification shall remain in effect pending resolution through the Administrative Review and hearing process, if applicable.

(h) Response to Notice. The Applicant or Sponsor shall respond in writing to EOAI within ten days after receiving the notice of noncompliance, and indicate its agreement or disagreement with the EOAI findings. Failure of the Applicant or Sponsor to respond within the ten-day period to the Notice of Noncompliance will be deemed to be agreement with the findings.

1. If the Applicant or Sponsor agrees with the findings, a signed, written plan of correction for each cited finding must be submitted to EOAI within a timeframe acceptable to EOAI. Each plan of correction shall include the following details:

a. Corrective Actions. A specific description of the measures that have been or will be taken to address the findings.

b. Preventative Measures. A description of the actions that will be implemented to prevent the recurrence of the findings or similar issues.

c. Responsibility. The designation of the individual(s) responsible for monitoring the implementation of the corrective actions to ensure that the findings do not recur; and.

d. Timeline. The date by which the corrections will be achieved.

2. Following the receipt of a complete corrective action plan, EOAI will review the submission and notify the Applicant or Sponsor of its acceptability.

3. If the Applicant or Sponsor disagrees with any of the EOAI findings or actions, an Administrative Review may be initiated pursuant to 651 CMR 12.10.

(i) Consultation. The Applicant or Sponsor may request a consultation with EOAI about findings of noncompliance and any action taken or to be taken by EOAI. Such request will be granted at the discretion of EOAI. A consultation may take the form of an exit conference at the conclusion of a compliance review or other format as determined by EOAI in its sole authority.

12.10: Administrative Review: Procedure

If an Applicant or Sponsor disagrees with the EOAI finding(s) or action(s), it may request an Administrative Review by submitting its request, *via* certified mail, return receipt requested, together with a detailed written rebuttal of the findings within ten days of receipt of the notice of noncompliance.

12.10: continued

(1) EOAI Review.

(a) Informal Review. An Applicant or Sponsor who disagrees with an EOAI Compliance Review finding, other finding of noncompliance, or action taken or to be taken by EOAI in accordance 651 CMR 12.09 may request an Informal Review by the Director of the Assisted Living Certification Unit. The request for Informal Review must be submitted within ten days of the issuance of the findings. The Informal Review shall be scheduled within ten days of the receipt of the request for review, and shall consist of an informal presentation of the position of the Applicant or Sponsor, and review of any applicable written documents. If the matter is settled, the agreement shall be reduced to writing. If it is not, EOAI will issue a written decision within ten days.

(b) Informal Hearing. An Applicant or Sponsor who disagrees with the decision of the Informal Review may request an Informal Hearing before the Secretary or a designee. Such request shall be delivered by hand or by certified mail, return receipt requested, and must be submitted within ten days of the issuance of the Informal Review decision. EOAI shall schedule an Informal Hearing within 15 days after receipt of the request for Informal Hearing. The Informal Hearing shall consist of an informal presentation of the position of the parties and any applicable written documents. If the matter is settled at the Informal Hearing, EOAI and the Applicant or Sponsor shall reduce the settlement to writing. If the matter is not settled at the Informal Hearing, the Secretary or a designee shall review all material presented and within 30 days after the Informal Hearing, forward a decision to the Applicant or Sponsor.

(2) Formal Hearing.

(a) Initiation of Appeal. When EOAI has denied, revoked, suspended, or modified Certification, or issued fines in accordance with 651 CMR 12.09, the Applicant or Sponsor may appeal the final decision issued after the Informal Hearing by filing a notice of claim for adjudicatory proceeding with the Division of Administrative Law Appeals pursuant to 801 CMR 1.01: *Formal Rules*, and by filing a copy of the notice with the General Counsel of EOAI. The appeal shall be filed no later than 21 days after the decision on the Informal Hearing is issued.

(b) Scope of Review. If the hearing officer designated by the Division of Administrative Law Appeals finds by substantial evidence any single ground for denial, revocation, modification, suspension or refusal to renew an Application or Certification which ground constitutes a failure or refusal to comply with the requirements of M.G.L. c. 19D or 651 CMR 12.00, the hearing officer shall uphold the decision to deny, revoke, modify, suspend or refuse to renew such Application or Certification.

(c) Decision and Action by the Secretary of EOAI. The decision of the hearing officer shall be a tentative decision under 801 CMR 1.01(11)(c): *Tentative Decisions*. Within 30 days of receipt of the decision, the Secretary shall render a final decision to approve, modify, or disapprove the hearing officer's decision. The Appellant may submit a written statement to the Secretary concerning the tentative decision within seven days after receiving it, but shall not be entitled to a further hearing before the Secretary. The decision of the Secretary shall be the final administrative decision, and shall bind the parties unless the Appellant commences an action to obtain judicial review within 30 days after the date of the final decision.

(3) Enforcement. Nothing in 651 CMR 12.10 shall limit EOAI's ability to exercise its responsibility and authority to enforce the disputed regulation, finding, or action during the Administrative Review process. All completed reports, responses, and notices of final action shall be made available to the public at the department during business hours together with the responses of the Applicants or the Sponsors and said reports, responses, and notices of final action will be posted on EOAI's website. Nothing in 651 CMR 12.10 shall limit EOAI's responsibility to periodically review the Residence to determine whether it has achieved compliance with the statutory and regulatory requirements, and, if so, to issue the Certification subject to reasonable conditions.

(4) Notification. Whenever EOAI initiates an action to deny, suspend, modify, refuse to renew or revoke a Certification pursuant to 651 CMR 12.09(4), EOAI shall transmit a notice to each Resident, or Legal Representative and appropriate governmental agencies which:

12.10: continued

(a) Describes the action to be taken;
(b) Suggests the general timetable for the enforcement process and its possible effect on Residents; and
(c) Confirms that a second notice will be transmitted if the relocation of the Residents is imminent.

Whenever it appears likely that a Certification denial or revocation action commenced pursuant to 651 CMR 12.09(4) will result in the need for relocation of Residents, EOAI shall transmit a second notice to each Resident, or Legal Representative and appropriate governmental agencies informing each party of:

1. The status of the enforcement action;
2. Residents' rights under the Residency Agreement; and
3. The availability of information to Residents from EOAI and other sources regarding available legal assistance and assistance in relocation.

12.11: Right of Entry by EOAI and Contracting Agencies

Any duly designated officer or employee of EOAI shall have the right to enter and inspect, at any time without prior notice, the common areas and office areas of any Assisted Living Residence for which an Application has been received or for which Certification has been issued. Any Application shall constitute permission for such entry and inspection. Inspections of any Unit shall be with the oral or written consent of the Resident.

12.12: Penalties for Uncertified Operation

(1) Any person operating an Assisted Living Residence without Certification under M.G.L. c. 19D shall be subject to liability for a civil penalty of not more than $500.00 for each day of such violation assessable by the Superior Court.

(2) Any such violation shall constitute grounds for refusing to grant or renew, modifying or revoking the Certification of the Assisted Living Residence or of any part thereof.

(3) Notwithstanding the existence or use of any other remedy, EOAI may, in the manner provided by law, maintain an action in the name of the Commonwealth for an injunction or other process against any person to restrain or prevent the operation of an Assisted Living Residence without Certification under M.G.L. c. 19D.

(4) No person or entity shall knowingly refer an individual for residency to an uncertified Residence. Such violation shall be punishable by a civil penalty of not more than $500.00 for each such violation assessable by the Superior Court. Such violation shall constitute a violation of M.G.L. c. 93A.

12.13: Retaliation

(1) No Residence shall discharge, discipline, discriminate against or otherwise retaliate against an employee or Resident who, in good faith, files a complaint with or provides information to EOAI relative to what the employee or Resident reasonably believes is a violation of law, rule or regulation or poses a risk to public health or safety or Resident or staff well-being.

(2) A Residence in violation of this section shall be liable to the person retaliated against by a civil action for up to treble damages, costs and attorney's fees in the event such violation shall be determined to be egregious or willful.

12.14: Advisory Council

Notwithstanding any general or special law to the contrary, an advisory council shall be established within EOAI. The advisory council shall advise the Secretary of EOAI relating to the regulations authorized under M.G.L. c. 19D. The advisory council shall be comprised of nine members, the Secretary of Aging & Independence or a designee who shall serve as chairperson, the Secretary of Housing and Livable Communities or a designee; the Secretary of Health and Human Services or a designee, and six members to be appointed by the Governor upon nomination by the Secretary of Aging & Independence. Of such six nominees, the Secretary shall nominate three persons who represent Resident consumer interests and two persons who represent Sponsors and Executive Directors of Assisted Living Residences. The advisory council shall by majority vote establish its own rules and procedures. Members of the council shall be appointed for terms of one year each. The council shall meet not less than on a quarterly basis, and it shall prepare a report of its activities, not less than annually. The annual report shall be made available to the public and the General Court.

12.15: Inapplicability of Certain Laws and Regulations to Assisted Living Residences

In accordance with M.G.L. c. 19D, § 18(a), premises or portions of premises Certified as Assisted Living Residence shall not be subject to the following laws:

(a) the determination of need process applicable to health care facilities in the Commonwealth as set forth in M.G.L. c. 111, §§ 25B through 25H;

(b) the licensing requirements for hospitals or institutions for unwed mothers or clinics set forth in M.G.L. c. 111, § 51;

(c) the patients and Residents rights requirements set forth in M.G.L. c. 111, § 70E;

(d) the HTLV-III testing, confidentiality and informed consent requirements applicable to a health care facility under M.G.L. c. 111, § 70F; however, physicians for health care providers to Assisted Living Residences are subject to these requirements;

(e) the licensing requirements for convalescent and licensed nursing homes, licensed rest homes, charitable homes for the aged, intermediate care facilities for persons with an intellectual disability and infirmaries maintained in towns (long term care facilities) set forth in M.G.L. c. 111, § 71;

(f) the requirements for deposit of inpatient or Resident funds for a long term care facility as set forth in M.G.L. c. 111, § 71A;

(g) the requirements for classification of long term care facilities set forth in M.G.L. c. 111, § 72;

(h) the requirements for lighting and ventilation for convalescent or nursing homes set forth in M.G.L. c. 111, § 72C;

(i) the requirements for telephone access for long term care facilities set forth in M.G.L. c. 111, § 72D;

(j) the requirements for notices of violations, plans of correction, penalties and enforcement for long term care facilities set forth in M.G.L. c. 111, § 72E;

(k) the patient abuse reporting requirements applicable to long term care facilities under M.G.L. c. 111, §§ 72H through 72L;

(l) the receivership requirements for long term care facilities set forth in M.G.L. c. 111, §§ 72M through 72U;

(m) the requirements for storage space for long term care facility residents set forth in M.G.L. c. 111, § 72V;

(n) the requirements for long term care facility nurses aide training set forth in M.G.L. c. 111, § 72W;

(o) the requirements for no smoking areas in nursing homes as set forth in M.G.L. c. 111, § 72X;

(p) the requirements for nursing pool regulations for long term care facilities set forth in M.G.L. c. 111, § 72Y;

(q) the penalties regarding unlicensed operation of a long term care facility under M.G.L. c. 111, § 73;

(r) the exemption from Department of Public Health licensing or inspection rules regarding long term care facilities operated by the First Church of Christ, Scientist in Boston set forth in M.G.L. c. 111, § 73A;

12.15: continued

(s) the requirements for long term care facilities operated for duly ordained priests, or for members of the religious orders of the Roman Catholic Church in their own locations, buildings, Assisted Living Residence or headquarters to provide care for such priests or members of said religious orders set forth in M.G.L. c. 111, § 73B;

(t) the requirement for a special permit under local zoning by-laws for the use of structures as shared housing for older adults upon the issuance of a special permit as set forth in M.G.L. c. 40A, § 9.

12.16: Emergency Waivers

The Secretary, or a designee, at their discretion and in consultation with the Commissioner of DPH, may temporarily waive, suspend, or modify one or more of the requirements of 651 CMR 12.00 as necessary to respond to an emergency situation, provided that any such waiver, suspension, or modification:

(1) is documented in writing;

(2) identifies the conditions that have made such a waiver necessary;

(3) identifies the specific requirement of 651 CMR 12.00 to be addressed and the action to be taken;

(4) is narrowly tailored to achieve its stated objective;

(5) is implemented to ensure the health, safety, and welfare of the citizens of the Commonwealth;

(6) is not in violation of any applicable federal or state law; and,

(7) ceases upon the termination of the emergency situation.

12.17: Use or Disclosure of Personal Data between and among EOHHS and EOHHS Agencies

EOAI may disclose information regarding a Residence or Resident to EOHHS or an EOHHS Agency when such disclosure is directly connected to the administration of an agency program or administrative oversight and the disclosure is not inconsistent with federal or state law.

REGULATORY AUTHORITY

651 CMR 12.00: M.G.L. c. 19A, § 6; M.G.L. c. 19D.

Docket # 585

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **801 CMR 4.00**

CHAPTER TITLE: **Rates**

AGENCY: **Executive Office for Administration and Finance**

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

801 CMR 4.02(262) sets forth the fees charged by the Board of Registration of Allied Mental Health and Human Services Professions. Chapter 177 of the Acts of 2022, an act addressing barriers to care for mental health, authorizes the Board to issue a new license category of "Licensed Supervised Mental Health Counselor" (LSMHC), as defined in 262 CMR 2.00. The Board is authorized to receive fees for the new licensee in M.G.L. c. 112, § 168. The amendment to 801 CMR 4.02(262) sets the application, original license and renewal fees for the LSMHC license.

REGULATORY AUTHORITY: **M.G.L. c. 112, §§ 163 through 172; c. 13, §§ 88 through 90**

AGENCY CONTACT: **Sheila York** PHONE: **781-636-7138**

ADDRESS: **250 Washington Street, 2nd Floor, Boston MA 02108**

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *if this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

Executive Office of Housing and Livable Communities (formerly DHCD) on 7/25/25
Massachusetts Municipal Association on 7/25/25
Notice to the Legislature on 12/2/25.

PUBLIC REVIEW - *M.G.L. c. 30A sections 2 and/or 3 requires notice of the hearing or comment period, including a small business impact statement, be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: **9/19/25**

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: **Minimal for both stakeholders and the Department.**

For the first five years: **Minimal for both stakeholders and the Department.**

No fiscal effect: **Minimal for both stakeholders and the Department.**

SMALL BUSINESS IMPACT - *M.G.L. c. 30A section 5 requires each agency to file an amended small business impact statement with the Secretary of the Commonwealth prior to the adoption of a proposed regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

Date amended small business impact statement was filed: **7/10/26**

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

Fees, Allied Mental Health Practitioners, Behavioral Analysis, Educational Psychology, Marriage and Family Therapy, Mental Health Counseling, and Rehabilitation Counseling

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) or repeal, replace or amend. List by CMR number:*

Amend 801 CMR 4.00

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: SIGNATURE ON FILE DATE: **Jul 16 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1579** DATE: **7/31/26**

EFFECTIVE DATE: **7/31/26**

CODE OF MASSACHUSETTS REGULATIONS

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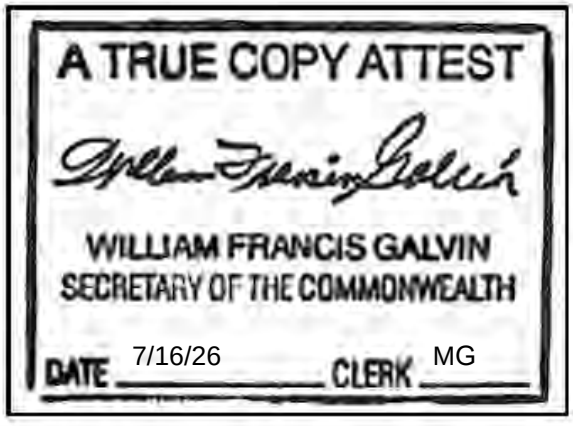

4.02: continued

262 Board of Registration of Allied Mental Health Professionals (continued)

(13)	Applied Behavior Analyst – Application	$117	per application
(14)	Applied Behavior Analyst – Original	155	per license
(15)	Applied Behavior Analyst – Renewal	155	biennial
(16)	Assistant Applied Behavior Analyst – Application	117	per application
(17)	Assistant Applied Behavior Analyst – Original	155	per license
(18)	Assistant Applied Behavior Analyst – Renewal	155	biennial
(19)	Supervised Mental Health Counselor license – Application	117	per application
(20)	Supervised Mental Health Counselor license – Original	155	per license
(21)	Supervised Mental Health Counselor license – Renewal	155	biennial

263 Board of Registration of Physicians Assistants

(1)	Physician Assistant License – Application and Temporary	$ 75	per application
(2)	Physician Assistant License – Original	150	per license
(3)	Physician Assistant License – Renewal	150	biennial

264 Board of Registration of Real Estate Appraisers

(1)	Trainee – Application	$113	per application
(2)	Trainee – Original	113	per license
(3)	Trainee – Renewal	113	per 2 years
(4)	Certified General – Application	338	per application
(5)	Certified General – Original	270	*per license
(6)	Certified General	270	*per 2 years
(7)	Certified Residential – Application	338	per application
(8)	Certified Residential – Original	270	*per license
(9)	Certified Residential – Renewal	270	*per 2 years
(10)	State Licensed – Application	338	per application
(11)	State Licensed – Original	270	*per license
(12)	State Licensed – Renewal	270	*per 2 years
(13)	Temporary License (all categories except Trainee)	150	per license
(14)	Continuing Education Course Approval – Original	113	per provider
(15)	Continuing Education Course Approval – Renewal	113	per 2 years
(16)	Primary Education Course Approval	225	per provider
(17)	Primary Education Course Approval – Renewal	225	per 2 years
(18)	Appraisal Management Company	500	per application
(19)	Appraisal Management Company – Original Registration	250	#per registration
(20)	Appraisal Management Company – Renewal	500	#per year
(21)	Change in Controlling Person or Employee in Charge	100	per change

* In addition to the above fees, the Commonwealth is required to collect a fee on behalf of the federal government. As of 2021, the fee is $120.00 for an initial license and $40.00 per year per Certificate Holder or Licensee. The federal government is authorized to change the amount of these fees.

* In addition to the above fees charged to appraisal management companies, the Commonwealth is required to collect on behalf of the federal government a fee of $25.00 per year per member of the appraiser panel of the appraisal management company who performed a qualifying transaction. The federal government is authorized to change the amount of this fee.

265 Board of Registration of Hearing Instrument Specialists

(1)	Hearing Instrument Specialist – Application	$130	per application
(2)	Hearing Instrument Specialist – Original	130	per license
(3)	Hearing Instrument Specialist – Renewal	130	biennial
(4)	Hearing Instrument Specialist – Apprentice Registration	250	per registration

4.02: continued

266 Board of Registration of Home Inspectors

(1)	Home Inspector – Application/Original License	$ 338 per application
(2)	Home Inspector – Reciprocity Application/Original License	338 per application
(3)	Home Inspector – Renewal	225 per renewal/biennial
(4)	Associate Home Inspector – Application/Original License	225 per application
(5)	Temporary Home Inspector – Application/Original License	225 per application

267 Board of Registration of Dieticians and Nutritionists

(1)	Dietician/Nutritionist - Application/Original License	$ 196 per application
(2)	Dietician/Nutritionist - Reciprocity Application/ Original License	196 per application
(3)	Dietician/Nutritionist - Renewal	130 per renewal/biennial

268 Board of Registration of Perfusionists

(1)	Perfusionist - Application/Original License	$ 225 per application
(2)	Perfusionist - Reciprocity Application/Original License	225 per application
(3)	Perfusionist - Renewal	150 per renewal/biennial
(4)	Perfusionist - Provisional Application/Original License	225 per application

269 Board of Registration of Massage Therapy

(1)	Massage Therapist (all type classes) – Application/Original License	$ 225 per application
(2)	Massage Therapist (all type classes) - Reciprocity Application/ Original License	225 per application
(3)	Massage Therapist (all type classes) – License Renewal	150 per renewal/annual
(4)	Massage Therapist Instructor – Application/Original License	225 per application
(5)	Massage Therapist Instructor – License Renewal	150 per renewal/annual
(6)	Solo Therapist Establishment (all type classes) – Application/Original	50 per application
(7)	Solo Therapist Establishment (all type classes) – License Renewal	50 per renewal/annual
(8)	Multiple Therapists Establishment (all type classes) – Application/Original License	150 per application
(9)	Multiple Therapists Establishment (all type classes) – License Renewal	150 per renewal/annual

270 Board of Registration of Genetic Counselors

(1)	Application for Provisional License/Provisional License	$ 300 per application
(2)	Renewal of Provisional License (one two-year renewal)	300 per one renewal
(3)	Application for Full License/Full License	300 per application
(4)	Renewal of Full License (biennial)	300 per renewal/biennial

271 Board of Examiners of Sheet Metal Workers

(1)	Master Sheet Metal Worker (all type classes)	$ 175 per application/ original license
(2)	Master Sheet Metal Worker (all type classes) - Renewal	100 biennial
(3)	Journeyperson Sheet Metal Worker (all type classes)	155 per application/ original license
(4)	Journeyperson Sheet Metal Worker (all type classes) - Renewal	80 biennial
(5)	Apprentice Sheet Metal Worker (all type classes)	65 per application/ original license
(6)	Apprentice Sheet Metal Worker (all type classes) - Renewal	40 biennial