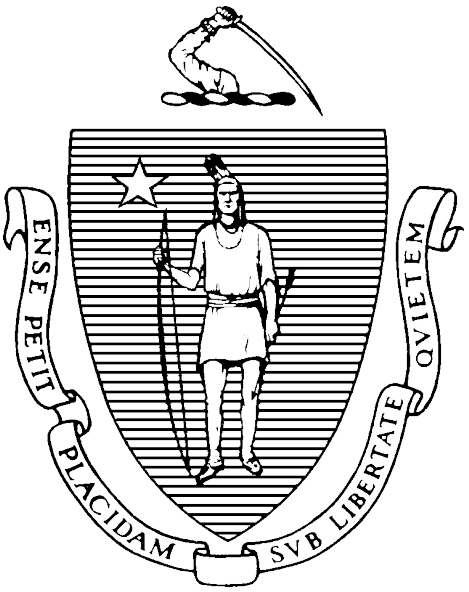
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THE COMMONWEALTH OF MASSACHUSETTS

Secretary of the Commonwealth - William Francis Galvin

The Massachusetts Register

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209	H 4477	Authorizing William "Rob" Cargill to Take the Civil Service Examination for the Position of Firefighter in the City of Haverhill Notwithstanding the Maximum Age Requirement.	9/10/2026
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218	H 5248	Authorizing the City of Beverly to Continue the Employment of John G. Lelacheur as Police Chief.	9/22/2026
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220	H 4862	Authorizing the Town of Monterey to Continue the Employment of Police Officer Jennifer O. Brown.	9/24/2026

STATE REGISTER OF HISTORIC PLACES

WEEKS OF: August 2 to September 19, 2026

For further information call the Massachusetts Historical Commission (617-727-8470)

ACTIONS TAKEN UNDER 950 CMR 71.00

Town/Property/Agency	Finding	Date
NONE		

ADDITIONAL LISTINGS UNDER 950 CMR 71.00

Town/Name/Address	Designation	Date	Number of Properties
Boston (Fenway)			
New England Conservatory of Music 290 Huntington Ave	LL	8/25/2026	1
Boston (Roxbury)			
Folsom, Alonzo W. and Henry A. Double House 3-4 Folsom Ave	LL	9/9/2026	1
Haverhill			
Peaslee, John Garrison House 790 East Broadway	PR	8/11/2026	1
Lynn			
The Osmund and Liberty Building Historic District 103 and 87-93 Liberty St	NRDIS	7/24/2026	2
Melrose			
Benjamin Lynde House Local Historic District 244 Main St	LHD	7/22/2026	1
Nantucket			
Auld Lang Syne Cottage – Hussey, Zaccheus House 6 Broadway	PR	9/17/2026	1
New Bedford			
New Bedford Whaling National Historical Park Roughly bounded by US Rte 6, Acushnet Ave, South Water St, Union St, Mass Rte 18/JFK Memorial Hwy, and MacArthur Dr	NRDIS	9/29/2025	70
Pittsfield			
White Terrace Apartments 592-596 North St, 2-8 White Ter	NRIND	8/24/2026	3
Wenham			
Old Farm 9 Maple St	PR	8/13/2026	3

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
COMMONWEALTH OF MASSACHUSETTS
ONE ASHBURTON PLACE, BOSTON, MA 02108
(617) 573-1600

Division of Health Care Finance and Policy

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

KIAME MAHANIAH, MD, MBA
SECRETARY

Administrative Bulletin 26-20

114.1 CMR 41.00: *Rates of Payment for Services Provided to Industrial Accident Patients by Hospitals*

Effective July 1, 2026

Publication of Payment on Account Factors for Hospital Services

The Executive Office of Health and Human Services (EOHHS), pursuant to 114.1 CMR 41.05(1) and (3) and in accordance with Section 123 of Chapter 224 of the Acts of 2012, is publishing the Payment on Account Factors (PAFs) for acute and non-acute hospital services provided to industrial accident patients, effective July 1, 2026. The current PAFs for acute and nonacute hospital services will continue through December 31, 2026, when EOHHS anticipates publishing updated PAFs for acute and nonacute hospital services effective January 1, 2027, based on updated hospital cost reporting required pursuant to 957 CMR 9.04: *Financial Data Reporting Requirements For Health Care Entities And Affiliated Entities*.

The application of the PAFs to all billed charges payable pursuant to 114.1 CMR 41.00 results in the payment of the average percentage of charges paid by the private sector to each hospital for its services. This payment calculation shall be deemed to meet the test of reasonable cost of medical services prescribed by M.G.L. c. 152, the Workers' Compensation Act. No lesser amount will be paid unless agreed to by the provider, insurer, and employer.

The PAFs for acute and non-acute hospital services provided on or after July 1, 2026, are listed in tables 1 and 2.

Table 1: PAFs for Acute Hospital Services

Acute Hospitals	**PAF**
Anna Jaques Hospital	45.32%
Athol Memorial Hospital	35.56%
Baystate Franklin Medical Center	43.23%
Baystate Medical Center	53.30%
Baystate Noble Hospital	43.87%
Baystate Wing Hospital	44.89%
Berkshire Medical Center	58.49%
Beth Israel Deaconess Hospital - Milton	46.87%
Beth Israel Deaconess Hospital - Needham	52.31%
Beth Israel Deaconess Hospital - Plymouth	48.87%
Beth Israel Deaconess Medical Center	54.97%
Boston Medical Center	40.13%
Brigham and Women's Faulkner Hospital	43.98%
Brigham and Women's Hospital	42.40%
Cambridge Health Alliance	46.29%
Cape Cod Hospital	64.98%
Cooley Dickinson Hospital	52.75%
Dana-Farber Cancer Institute	43.09%
Emerson Hospital	45.26%
Fairview Hospital	61.91%
Falmouth Hospital	60.06%
Harrington Memorial Hospital	30.96%
HealthAlliance Clinton	30.15%
Heywood Hospital	43.71%
Holyoke Medical Center	38.13%
Lahey Health - Winchester Hospital	50.63%
Lahey Hospital and Medical Center	55.86%
Lawrence General Hospital	50.73%
Lowell General Hospital	45.09%
Marlborough Hospital	34.66%
Martha's Vineyard Hospital	72.38%
Massachusetts General Hospital	43.35%
Melrose Wakefield Hospital	51.87%
Mercy Medical Center	48.74%
MetroWest Medical Center	21.06%
Milford Regional Medical Center	54.66%
Morton Hospital - A Steward Family Hospital Inc.	56.62%
Mount Auburn Hospital	58.19%
Nantucket Cottage Hospital	65.24%

Acute Hospitals	**PAF**
Nashoba Valley Medical Center - A Steward Family Hospital Inc.	47.61%
New England Baptist Hospital	71.20%
Newton-Wellesley Hospital	43.64%
North Adams Regional Hospital	52.70%
North Shore Medical Center	43.64%
Northeast Hospital	41.53%
Saint Vincent Hospital	23.59%
Signature Healthcare Brockton Hospital	35.98%
South Shore Hospital	61.44%
Southcoast Hospitals Group	43.06%
Steward Carney Hospital Inc.	72.83%
Steward Good Samaritan Medical Center	49.81%
Steward Holy Family Hospital Inc.	48.16%
Steward Norwood Hospital Inc.	36.47%
Steward Saint Anne's Hospital Inc.	47.47%
Steward St. Elizabeth's Medical Center	55.99%
Sturdy Memorial Hospital	67.13%
Tufts Medical Center	51.04%
UMass Memorial Medical Center	39.22%
Acute Hospital Median PAF for Out-of-State and New Hospitals	**47.54%**

Table 2: PAFs for Non-acute Hospital Services

Non-acute Hospitals	**PAF**
Curahealth Stoughton	52.43%
Encompass Braintree Rehabilitation Hospital	49.05%
Encompass New England Rehabilitation Hospital	58.68%
Encompass Rehabilitation Hospital of Western Massachusetts	55.73%
Fairlawn Rehabilitation Hospital, an affiliate of Encompass Health	65.71%
Spaulding Hospital - Cambridge	48.09%
Spaulding Rehabilitation Hospital - Boston	43.87%
Spaulding Rehabilitation Hospital - Cape Cod	41.36%
Whittier Rehabilitation Hospital - Bradford	46.71%
Whittier Rehabilitation Hospital - Westborough	58.47%
Nonacute Hospital Median PAF for Out-of-State and New Hospitals	**50.74%**

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

October 9, 2026

Gaming Commission, Massachusetts	205 CMR 255.00	10/20/26 @ 9:30 A.M. Written comments accepted until 10/19/26 by 5:00 P.M.
Health and Human Services, Executive Office of	101 CMR 206.00	11/13/26 @ 10:00 A.M. Written comments accepted until 11/13/26 by 5:00 P.M.
	101 CMR 316.00, 317.00 & 318.00	10/16/26 @ 10:00 A.M. Written comments accepted until 10/16/26 by 5:00 P.M.
	101 CMR 351.00	10/16/26 @ 1:00 P.M. Written comments accepted until 10/16/26 by 5:00 P.M.
Medical Assistance, Division of	130 CMR 408.000	10/16/26 @ 12:00 P.M. Written testimony will be accepted until 10/16/26 by 5:00 P.M.
	130 CMR 433.000	10/16/26 @ 11:00 A.M. Written testimony accepted until 10/16/26 by 5:00 P.M.
Public Health, Department of	105 CMR 700.000	10/19/26 @ 2:00 P.M. All comments must be received by 10/19/26 before 5:00 P.M.
Revenue, Department of	830 CMR 62.00 (62.3.1)	11/10/26 @ 11:00 A.M. Written comments accepted until 11/10/26 by 5:00 P.M.
	830 CMR 62.00 (62.6.3)	11/10/26 @ 2:00 P.M. Written testimony accepted until 11/10/26 by 5:00 P.M.

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 a regulation. The regulation was promulgated pursuant to G.L. c. 23N, § 4 as part of the Commission's regulatory process, and concerns the following regulation:

205 CMR 255.00: *Play Management*

The proposed amendments to 205 CMR 255 are intended to provide additional clarity. The section titles of 205 CMR 255 are being corrected to be consistent throughout the regulation. The notification requirement set forth by 205 CMR 255.03(2) is being amended to be a monthly or every 30 days. In 205 CMR 255.03(5), the term "business day" is being changed to "day" to better define an ambiguous term.

Scheduled hearing date and time:

Tuesday, October 20, 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 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: 273 048 821 498 340 PASSCODE: Wm98ok6T
DIAL IN BY PHONE: (213) 631-9908 PHONE CONFERENCE ID: 600 112 329#

A complete copy of the draft regulation 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 can email autumn.birarelli@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 October 19, 2026.**

Additionally, please find the Small Business Impact Statement 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 amendment to **205 CMR 255.00**: *Play Management.* The regulation amendment is authorized by M.G.L. c. 23N, § 4.

This regulation is being promulgated as part of the process of updating regulations governing sports wagering in the Commonwealth. It sets forth the requirements regarding sports wagering play management.

The proposed amendment to 205 CMR 255.00 applies to entities licensed by the Commission under G.L. c. 23N. Accordingly, this regulation is unlikely to have an impact on small businesses. 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:

   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 are design standards to encourage uniformity in compliance.

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:

   There are 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:

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

This amendment is unlikely to have any impact on the formation of new businesses in the Commonwealth.

Massachusetts Gaming Commission
By:

/s/Autumn Birarelli
Autumn Birarelli
Staff Attorney

Dated: September 10, 2026

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

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 **Friday, November 13, 2026, at 10:00 a.m.** on the emergency adoption of amendments to the following regulation.

101 CMR 206.00: Standard Payments to Nursing Facilities

The regulation will go into effect as an emergency on October 1, 2026. The proposed amendments implement fiscal year 2027 (FY27) budget requirements. The following adjustments are being made to the rates, consistent with the FY27 budget.

- Updating standard nursing, operating, capital, pediatric, and other facility-specific rates for rate year 2027. The amendments apply a 7.04% cost adjustment factor to both nursing and operating standard payments and updates the patient-driven payment model (PDPM) nursing standard payment amounts accordingly. The operating cost standard payment increases to $128.14 per day. The capital cost adjustment factor is also updated to 6.65%.
- Revising financial statement reporting requirements.
- Revising the substance use disorder (SUD) add-on and replacing the SUD induction-period add-on with a medication for opioid use disorder (MOUD) add-on, including new eligibility, staffing, and compliance requirements.
- Reducing the bariatric add-on from $300 to $200 per member per day and clarifying its applicability with other add-ons.
- Strengthening staffing incentives by establishing an 8% downward adjustment for facilities at or below 3.00 hours per patient day (HPPD), while exempting facilities maintaining at least 4.00 HPPD from the direct care cost quotient (DCC-Q) downward adjustment.
- Removing expired COVID-19 preparedness payments and the prior rate year's $25 million statewide supplemental payment.
- Making annual conforming and technical updates to dates, reporting periods, quality measures, PDPM references, and other payment provisions.

The estimated annual fiscal impact of these amendments is $29,670,000 for rate-related amendments.

Register to testify and get instructions on how to join the hearing online at mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings. You can join by phone at (646) 558-8656. The meeting ID is 935 397 8200#.

You can submit written testimony instead of, or in addition to, live testimony. Submit written testimony to ehs-regulations@mass.gov as an attached Word or PDF document or as text within the body of the email. Put 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. You can also mail written testimony to EOHHS, c/o D. Briggs, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171. Written testimony will be accepted until 5:00 p.m. November 13, 2026. EOHHS specifically invites comments as to how the amendments may affect beneficiary access to care.

You can review the emergency regulation at mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings or request a copy in writing from MassHealth Publications, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171.

Email the Disability Accommodations Ombudsman at ADAAccommodations@mass.gov to make special accommodation requests. You can also call (617) 847-3468 (TTY: [617] 847-3788). Please allow two weeks to schedule sign language interpreters.

EOHHS may adopt a revised version of the emergency regulation after considering 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 mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings.

September 23, 2026

Small Business Impact Statement

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

CMR No and Title: 101 CMR 206.00: *Standard Payments to Nursing Facilities*

Estimate of the Number of Small Businesses Impacted by the Regulation: The regulation applies to all licensed nursing facilities in Massachusetts. There are approximately 300 such entities subject to the proposed emergency amendments, and some of those are small businesses.

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? The regulation requires nursing facilities to submit cost and financial statements, but this is not a new requirement. It also requires nursing facilities seeking certain additional payment add-ons and adjustments to submit reports demonstrating their eligibility and/or compliance, but this is not a new requirement.
No	Will small businesses have to implement additional recordkeeping procedures? Certain additional payment add-ons and adjustments require nursing facilities to maintain up-to-date records on eligibility and/or compliance, but there are no new requirements as a result of this regulation.
No	Will small businesses have to provide additional administrative oversight? The regulation does not require additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? Compliance does not require hiring additional employees.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? Compliance does not require hiring other professionals.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? The regulation does not require purchases or capital investments.
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.) Performance standards are not more appropriate than design or operational standards.
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?

Write Yes or No	Explain Briefly
	The regulation requires MassHealth-enrolled nursing facilities to comply with audits and produce records requested by the Executive Office of Health and Human Services (EOHHS), but this is not a new requirement. The regulation does not distinguish between small businesses and other businesses.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? The regulation does not require small businesses to provide educational services to keep up to date with regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The regulation establishes new and updated payment methodologies for MassHealth-enrolled nursing facility providers and is unlikely to deter or encourage the formation of small businesses.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The regulation establishes new and updated payment methodologies for MassHealth-enrolled nursing facility providers and is unlikely to deter or encourage the formation of small businesses.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? The regulation does not distinguish between small businesses and other businesses.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? The regulation does not distinguish between small businesses and other businesses.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? The regulation does not distinguish between small businesses and other businesses.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? Distinguishing small businesses from other businesses would not be practicable for this regulation.
No	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? Payment methodologies for MassHealth-enrolled nursing facilities are required by statute to be established through regulation.

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 Friday, October 16, 2026, at 10 a.m., relative to the emergency adoption of amendments to the following regulations.

101 CMR 316.00: Rates for Surgery and Anesthesia Services
101 CMR 317.00: Rates for Medicine Services
101 CMR 318.00: Rates for Radiology Services

The proposed amendments to 101 CMR 316.00, 101 CMR 317.00, and 101 CMR 318.00 add certified professional midwives (CPMs) as an eligible provider type, consistent with Chapter 186 of the Acts of 2024. The proposed amendments also establish codes S8415 (home delivery supply kit) and S4005 (interim labor) to support eligible low-risk MassHealth members who elect planned home birth services. The proposed rate for code S8415 is $500 per pregnancy based on market research to cover essential home birth supplies for eligible low-risk pregnancies. The proposed rate for code S4005 is set at individual consideration (IC) based on the rate for the same code established in 101 CMR 355.00: *Rates for Freestanding Birth Centers*.

In order to promote access to CPM services for eligible MassHealth members and ensure consistency with recent updates to state law (i.e., Chapter 186 of the Acts of 2024), the proposed amendments described above were adopted on an emergency basis on September 25, 2026, with rates effective for dates of service on and after October 1, 2026.

EOHHS is proposing these changes, subject to federal approval, to ensure that payments are consistent with efficiency, economy, and quality of care and satisfy the requirements of M.G.L. 118E, sections 13C and 13D. It is estimated that annual aggregate MassHealth expenditures will increase by $47,000 as a result of the proposed amendments. There is no fiscal impact on cities and towns. The proposed amendments are not anticipated to impose new costs on small businesses, and any impact on small business providers will vary based on the volume of services provided.

Register to testify and get instructions to join the hearing at 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 can submit written testimony instead of, or in addition to, live testimony. Submit written 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, 1 Enterprise Drive, 5th Floor, Quincy, MA 02171. Written testimony will be accepted through 5 p.m. on October 16, 2026. EOHHS specifically invites comments as to how the amendments may affect beneficiary access to care for MassHealth-covered services.

You can review the emergency regulation at www.mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings or request a copy in writing from MassHealth Publications, 1 Enterprise Drive, 5th Floor, Quincy, MA 02171.

Email the Disability Accommodations Ombudsman at ADAAccommodations@mass.gov to make special accommodation requests. You can also call (617) 847-3468, TTY: (617) 847-3788. Please allow two weeks to schedule sign language interpreters.

EOHHS may adopt a revised version of the emergency regulation after considering 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 mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings.

Date of Newspaper Ad: September 25, 2026

Small Business Impact Statement

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

CMR No and Title: 101 CMR 316.00: *Rates for Surgery and Anesthesia Services*
Estimate of the Number of Small Businesses Impacted by the Regulation: There are currently approximately 20,000 providers of physician services, including medicine, surgery and anesthesia, and radiology services. This number includes physicians and midlevel provider types (e.g., certified nurse practitioner).

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? The proposed amendments will not require small businesses to create, file, or issue additional reports.
No	Will small businesses have to implement additional recordkeeping procedures? The proposed amendments will not require small businesses to implement additional recordkeeping procedures.
No	Will small businesses have to provide additional administrative oversight? The proposed amendments will not require small businesses to provide additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? The proposed amendments will not require small businesses 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.)? The proposed amendments will not require small businesses 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? The proposed amendments will not require small businesses 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.) Performance standards are not more appropriate than design or operational standards to accomplish the regulatory objective of establishing rates for EOHHS health care services as the proposed regulation is required by statute under M.G.L. Chapter 118E, Section 13D.
No	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with the proposed regulation.
No	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities?

Write Yes or No	Explain Briefly
	The regulation does not require cooperation with additional audits, inspections or other regulatory enforcement activities.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? The proposed amendments will not require small businesses to provide educational services to keep up to date with regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts. This regulation governs payments for surgery and anesthesia services provided to publicly aided individuals and is applied uniformly among providers.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts. This regulation governs payments for surgery and anesthesia 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? The regulation does not provide for less stringent compliance or reporting requirements for small businesses. These requirements are applied uniformly to all surgery and anesthesia service providers to maintain consistency in the care provided to publicly aided individuals.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? The regulation does not provide for less stringent schedules or deadlines for compliance or reporting requirements for small businesses. These requirements are applied uniformly to all surgery and anesthesia service providers to maintain consistency in the care provided to publicly aided individuals.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? This regulation does not consolidate or simplify compliance or reporting requirements for small businesses. These requirements are applied uniformly to all surgery and anesthesia service providers to maintain consistency in the care provided to publicly aided individuals.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? The regulation establishes uniform program requirements and conditions of payment for the provision of surgery and anesthesia 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? The regulation does not have an adverse impact on small businesses and governs payments for surgery and anesthesia services provided to publicly aided individuals. It is applied uniformly regardless of whether the provider is a small business.

Small Business Impact Statement

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

CMR No and Title: 101 CMR 317.00: *Rates for Medicine Services*

Estimate of the Number of Small Businesses Impacted by the Regulation: There are currently approximately 20,000 providers of physician services, including medicine, surgery and anesthesia, and radiology services. This number includes physicians and midlevel provider types (e.g., certified nurse practitioner).

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? The proposed amendments will not require small businesses to create, file, or issue additional reports.
No	Will small businesses have to implement additional recordkeeping procedures? The proposed amendments will not require small businesses to implement additional recordkeeping procedures.
No	Will small businesses have to provide additional administrative oversight? The proposed amendments will not require small businesses to provide additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? The proposed amendments will not require small businesses 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.)? The proposed amendments will not require small businesses 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? The proposed amendments will not require small businesses 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.) Performance standards are not more appropriate than design or operational standards to accomplish the regulatory objective of establishing rates for EOHHS health care services as the proposed regulation is required by statute under M.G.L. Chapter 118E, Section 13D.
No	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with the proposed regulation.
No	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities?

Write Yes or No	Explain Briefly
	The regulation does not require cooperation with additional audits, inspections or other regulatory enforcement activities.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? The proposed amendments will not require small businesses to provide educational services to keep up to date with regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts. This regulation governs payments for medicine services provided to publicly aided individuals and is applied uniformly among providers.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts. This regulation governs payments for medicine 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? The regulation does not provide for less stringent compliance or reporting requirements for small businesses. These requirements are applied uniformly to all medicine service providers to maintain consistency in the care provided to publicly aided individuals.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? The regulation does not provide for less stringent schedules or deadlines for compliance or reporting requirements for small businesses. These requirements are applied uniformly to all medicine service providers to maintain consistency in the care provided to publicly aided individuals.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? This regulation does not consolidate or simplify compliance or reporting requirements for small businesses. These requirements are applied uniformly to all medicine service providers to maintain consistency in the care provided to publicly aided individuals.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? The regulation establishes uniform program requirements and conditions of payment for the provision of medicine 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? The regulation does not have an adverse impact on small businesses and governs payments for medicine services provided to publicly aided individuals. It is applied uniformly regardless of whether the provider is a small business.

Small Business Impact Statement

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

CMR No and Title: 101 CMR 318.00: *Rates for Radiology Services*

Estimate of the Number of Small Businesses Impacted by the Regulation: There are currently approximately 20,000 providers of physician services, including medicine, surgery and anesthesia, and radiology services. This number includes physicians and midlevel provider types (e.g., certified nurse practitioner).

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? The proposed amendments will not require small businesses to create, file, or issue additional reports.
No	Will small businesses have to implement additional recordkeeping procedures? The proposed amendments will not require small businesses to implement additional recordkeeping procedures.
No	Will small businesses have to provide additional administrative oversight? The proposed amendments will not require small businesses to provide additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? The proposed amendments will not require small businesses 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.)? The proposed amendments will not require small businesses 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? The proposed amendments will not require small businesses 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.) Performance standards are not more appropriate than design or operational standards to accomplish the regulatory objective of establishing rates for EOHHS health care services as the proposed regulation is required by statute under M.G.L. Chapter 118E, Section 13D.
No	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with the proposed regulation.
No	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities?

Write Yes or No	Explain Briefly
	The regulation does not require cooperation with additional audits, inspections or other regulatory enforcement activities.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? The proposed amendments will not require small businesses to provide educational services to keep up to date with regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts. This regulation governs payments for radiology services provided to publicly aided individuals and is applied uniformly among providers.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses in Massachusetts. This regulation governs payments for radiology 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? The regulation does not provide for less stringent compliance or reporting requirements for small businesses. These requirements are applied uniformly to all radiology service providers to maintain consistency in the care provided to publicly aided individuals.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? The regulation does not provide for less stringent schedules or deadlines for compliance or reporting requirements for small businesses. These requirements are applied uniformly to all radiology service providers to maintain consistency in the care provided to publicly aided individuals.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? This regulation does not consolidate or simplify compliance or reporting requirements for small businesses. These requirements are applied uniformly to all radiology service providers to maintain consistency in the care provided to publicly aided individuals.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? The regulation establishes uniform program requirements and conditions of payment for the provision of radiology 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? The regulation does not have an adverse impact on small businesses and governs payments for radiology services provided to publicly aided individuals. It is applied uniformly regardless of whether the provider is a small business.

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 October 16, 2026, at 1:00 p.m. relative to the emergency adoption of amendments to the following regulation.

101 CMR 351.00: Rates for Certain Adult Foster Care Services

The proposed amendments establish a new billing modifier and reduce the reimbursement rate for the one-time adult foster care (AFC) intake and assessment services when the Public Assessor Option (PAO), rather than the AFC provider, completes the initial member assessment.

The rate for the modified Intake and Assessment Services is proposed at $100. The reduced intake and assessment rate will compensate AFC providers for the remaining pre-admission and admission activities they will continue to perform when the PAO conducts the initial member assessment.

The purpose of this amendment is to promote service quality by standardizing AFC intake and assessment practices to align with the entire Long-Term Services and Supports (LTSS) program network. The addition of a modifier for intake and assessment services ensures that providers are compensated for their preadmission and admission activities that they will continue to perform after the implementation of the PAO. The anticipated effective date of the proposed amendment is on or after October 5, 2026.

All other rates are proposed to remain at their current levels. The estimated aggregate annual fiscal impact associated with the proposed amendments is a decrease in spending on AFC services of $1.27M.

Register to testify and get instructions to join the hearing online at mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings. You can join by phone at (646) 558-8656. The meeting ID is 935 397 8200#.

You can submit written testimony instead of, or in addition to, live testimony. Submit written testimony to ehs-regulations@mass.gov as an attached Word or PDF document or as text within the body of the email. Put 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. You can also mail written testimony to EOHHS, c/o D. Briggs, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171. Written testimony will be accepted until 5:00 p.m. on October 16, 2026. EOHHS specifically invites comments as

to how the amendments may affect member access to care for MassHealth-covered services.

You can review the emergency regulation at mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings. You can also request a copy in writing from MassHealth Publications, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171.

Email the Disability Accommodations Ombudsman at ADAAccommodations@mass.gov to make special accommodation requests. You can also call (617) 847-3468, TTY: (617) 847-3788. Please allow two weeks to schedule sign language interpreters.

EOHHS may adopt a revised version of the emergency regulation after considering 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 mass.gov/info-details/executive-office-of-health-and-human-services-public-hearings.

Date of Newspaper Ad: September 25, 2026

Small Business Impact Statement

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

CMR No and Title: 101 CMR 351.00: *Rates for Certain Adult Foster Care Services*

Estimate of the Number of Small Businesses Impacted by the Regulation: 195 Adult Foster Care Providers and 112 Group Adult Foster Care Providers

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? The proposed amendments will not require small businesses to create, file, or issue additional reports.
No	Will small businesses have to implement additional recordkeeping procedures? The proposed amendments will not require small businesses to implement additional record keeping procedures.
No	Will small businesses have to provide additional administrative oversight? The proposed amendments will not require small businesses to provide additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? The proposed amendments will not require small businesses to hire additional employees to remain in compliance.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? The proposed amendments will not require small businesses to hire other professionals.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? The proposed amendments will not require small businesses to purchase a product or make any other capital investments.
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.) The regulation is required by statute under M.G.L. Chapter 118E, §§ 13C and 13D, and establishes the rates to be paid by governmental units to providers of non-institutional health care services, including certain adult foster care services.
No	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with this regulation.

Write Yes or No	Explain Briefly
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? 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? The proposed amendments do not require small businesses to provide educational services to keep up to date with the regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The proposed amendments are unlikely to deter or encourage the formation of small businesses in Massachusetts.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The proposed amendments are unlikely to deter or encourage the formation of small businesses in Massachusetts.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? The regulation does not distinguish between small businesses and other businesses.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? The regulation contains requirements to report cost data to EOHHS upon request to enable EOHHS to develop rates for certain adult foster care services and 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? The proposed amendments do not distinguish between small businesses and other businesses. This regulation requires providers to submit documentation requested by the Commonwealth for the purposes of utilization and provider review to ensure compliance with requirements, including the timelines for reporting, and the regulation is applied uniformly among all providers.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? This regulation and its proposed amendments establish uniform conditions of payment for the provision of certain adult foster care 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? The regulation does not have an adverse impact on small businesses and governs payments for certain adult foster care services provided to publicly aided individuals. It is applied uniformly regardless of whether the provider is a small business.

Commonwealth of Massachusetts
Office of Medicaid
NOTICE OF PUBLIC HEARING

Under the authority of M.G.L. c. 6A, section 16 and in accordance with M.G.L. c. 30A, the Division of Medical Assistance (the Division) will hold a remote public hearing on October 16, 2026, at 12:00 p.m. relative to the emergency adoption of amendments to the following regulation.

130CMR 408.000: Adult Foster Care Services

The Executive Office of Health and Human Services (EOHHS) is proposing an emergency amendment to regulation 130 CMR 408.000. Adult foster care (AFC) services provide MassHealth members with assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), as well as nursing oversight and care management of the personal care provided by the AFC caregiver, which are overseen by a provider agency. The proposed amendment establishes the Public Assessor Option (PAO), which will administer the initial member assessments for AFC services on behalf of EOHHS. The AFC provider agency will no longer be required to complete the initial clinical evaluation when the PAO administers the initial member assessment. The purpose of this amendment is to promote service quality by standardizing AFC intake and assessment practices to align with the Long-Term Services and Supports (LTSS) program network. The anticipated effective date of the proposed amendment is on or after October 5, 2026. There is no fiscal impact on cities and towns.

Register to testify and get instructions to join the hearing online at mass.gov/info-details/masshealth-public-hearings. You can join by phone at (646) 558-8656. The meeting ID is 935 397 8200#.

You can submit written testimony instead of, or in addition to, live testimony. Submit written testimony to masshealthpublicnotice@mass.gov as an attached Word or PDF document or as text within the body of the email. Put 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. You can also mail written testimony to EOHHS, c/o D. Briggs, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171. Written testimony will be accepted until 5:00 p.m. on October 16, 2026, the Division specifically invites comments as to how the amendments may affect member access to care for MassHealth-covered services.

You can review the emergency regulation at mass.gov/info-details/masshealth-public-hearings. You can also request a copy in writing from MassHealth Publications, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171.

Email the Disability Accommodations Ombudsman at ADAAccommodations@mass.gov to make special accommodation requests. You can also call (617) 847-3468, TTY: (617) 847-3788. Please allow two weeks to schedule sign language interpreters.

The Division may adopt a revised version of the emergency regulation after considering 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 mass.gov/info-details/masshealth-public-hearings.

Date of Newspaper Ad: September 25, 2026

Small Business Impact Statement

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

CMR No and Title: 130 CMR 408.000: Adult Foster Care

Estimate of the Number of Small Businesses Impacted by the Regulation: 195 Adult Foster Care Providers and 112 Group Adult Foster Care Providers

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? Small businesses will not have to create, file, or issue additional reports as a result of the proposed amendments to this regulation.
No	Will small businesses have to implement additional recordkeeping procedures? Small businesses will not have additional responsibilities to keep records as a result of the proposed amendments to this regulation.
No	Will small businesses have to provide additional administrative oversight? Small businesses are not required by this regulation to provide additional administrative oversight as a result of the proposed amendments to this regulation.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? This regulation does not require small businesses to hire additional employees to remain in compliance.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? Small businesses are not required by this regulation to hire other professionals.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? This regulation does not require small businesses to purchase any particular product or make any capital investments.
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.) There are no performance standards that accomplish the regulatory objective. The purpose of the regulation is to establish MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care/group adult foster care services.
No	Do any other regulations duplicate or conflict with the proposed regulation? No regulations duplicate or conflict with this regulation.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? This regulation does require small businesses to cooperate with audits, inspections, or other regulatory enforcement activities. This requirement is applied uniformly to all providers to enable EOHHS and MassHealth to ensure program integrity and efficient and appropriate provision of services.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? This regulation does not require small businesses to provide educational services to keep up to date with the regulatory requirements.

Write Yes or No	Explain Briefly
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The regulation is not likely to deter the formation of small businesses in Massachusetts as this regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care/group adult foster care services.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The regulation is not likely to encourage the formation of small businesses in Massachusetts, as this regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care/group adult foster care services.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? This regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care/group adult foster care services. Any compliance and reporting requirements are applied uniformly to all providers to enable EOHHS and MassHealth to ensure program integrity and efficient and appropriate provision of services.
No	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? This regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care service/group adult foster care services. Any schedules or deadlines for compliance or reporting requirements are applied uniformly to all providers to enable EOHHS and MassHealth to ensure program integrity and efficient and appropriate provision of services.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? This regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care service/group adult foster care services. Compliance and reporting requirements are applied uniformly to all providers to enable EOHHS and MassHealth to ensure program integrity and efficient and appropriate provision of services.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? There are no performance standards that accomplish the regulatory objective. This regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care/group adult foster care services.
NO	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? The regulation does not have an adverse impact on small businesses. The regulation establishes MassHealth provider eligibility, member eligibility, clinical authorization process and criteria for MassHealth payment, and conditions of payment for adult foster care/group adult foster care services. This regulation is applied uniformly to all providers to enable EOHHS and MassHealth to ensure program integrity and efficient and appropriate provision of services.

Division of Medical Assistance

Commonwealth of Massachusetts

Office of Medicaid

NOTICE OF PUBLIC HEARING

Under the authority of M.G.L. c. 6A, section 16 and in accordance with M.G.L. c. 30A, the Division of Medical Assistance (the Division) will hold a remote public hearing on Friday, October 16, 2026, at 11 a.m. relative to the emergency adoption of amendments to the following regulation.

130 CMR 433.000: *Physician Services*

The proposed amendments to regulation 130 CMR 433.000 establish certified professional midwife (CPM) as a new MassHealth provider type. The proposed amendments set forth the requirements for MassHealth covered CPM services, which include, among other things, requirements covering the following areas: (1) provider eligibility requirements to enroll as a MassHealth provider of such services; (2) member eligibility requirements for the receipt of such services; (3) administrative requirements related to the delivery of such services; and (4) other requirements related to the provision of MassHealth covered services, including recordkeeping.

In order to promote access to CPM services for eligible MassHealth members, ensure consistency with recent updates to state law (i.e., Chapter 186 of the Acts of 2024), and to ensure that eligible CPMs can enroll in MassHealth in October 2026, the proposed amendments described above were adopted on an emergency basis, effective September 25, 2026. The proposed amendments are not anticipated to result in an increase in annual aggregate MassHealth expenditures. There is no fiscal impact on cities and towns.

Register to testify and get instructions to join the hearing online at mass.gov/info-details/masshealth-public-hearings. You can join by phone at (646) 558-8656. The meeting ID is 935 397 8200#.

You can submit written testimony instead of, or in addition to, live testimony. Submit written testimony to masshealthpublicnotice@mass.gov as an attached Word or PDF document or as text within the body of the email. Put 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. You can also mail written testimony to EOHHS, c/o D. Briggs, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171. Written testimony will be accepted until 5 p.m. on Friday, October 16, 2026. The Division specifically invites comments as to how the amendments may affect member access to care for MassHealth-covered services.

You can review the emergency regulation at mass.gov/info-details/masshealth-public-hearings. You can also request a copy in writing from MassHealth Publications, 1 Enterprise Drive, 4th Floor, Quincy, MA 02171.

Email the Disability Accommodations Ombudsman at ADAAccommodations@mass.gov to make special accommodation requests. You can also call (617) 847-3468, TTY: (617) 847-3788. Please allow two weeks to schedule sign language interpreters.

The Division may adopt a revised version of the emergency regulation after considering 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 mass.gov/info-details/masshealth-public-hearings.

Date of Newspaper Ad: September 25, 2026

Small Business Impact Statement

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

CMR No and Title: 130 CMR 433.000: Physician Services

Estimate of the Number of Small Businesses Impacted by the Regulation: 40

Write Yes or No	Explain Briefly
No	Will small businesses have to create, file, or issue additional reports? The proposed amendments to the regulation do not require small businesses to create, file, or issue additional reports.
Yes	Will small businesses have to implement additional recordkeeping procedures? Providers who wish to participate in MassHealth as a certified professional midwife (CPM) will be required to comply with the recordkeeping requirements set forth in this regulation, as well as those that apply to all MassHealth providers.
No	Will small businesses have to provide additional administrative oversight? The regulation does not require small businesses to provide additional administrative oversight.
No	Will small businesses have to hire additional employees in order to comply with the proposed regulation? Compliance does not require hiring additional employees.
No	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? Compliance does not require hiring additional employees.
No	Does the regulation require small businesses to purchase a product or make any other capital investments in order to comply with the regulation? The regulation does not require purchases or capital investments.
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.) Performance standards are not more appropriate than design or operational standards.
No	Do any other regulations duplicate or conflict with the proposed regulation? No other regulations duplicate or conflict with the proposed regulations.
Yes	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? Providers who wish to participate in MassHealth as a certified professional midwife (CPM) will be required to cooperate with the audit, inspection, and other regulatory enforcement activities set forth in this regulation, as well as those that apply to all MassHealth providers.
No	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements?

Write Yes or No	Explain Briefly
	The regulation does not require small businesses to provide educational services to keep up to date with the regulatory requirements.
No	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses.
No	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? The regulation is unlikely to deter or encourage the formation of small businesses.
No	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? 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? The regulation does not distinguish between small and other businesses.
No	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? The regulation does not distinguish between small and other businesses.
No	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? Distinguishing small businesses from other businesses would not be practicable for this regulation.
No	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? The regulation is required by statutes, and its goals could not be achieved through alternative methods.

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619
617-624-6000 | mass.gov/dph

Maura T. Healey
Governor

Kiame Mahaniah, MD, MBA
Secretary

Kimberley Driscoll
Lieutenant Governor

Robert Goldstein, MD, PhD
Commissioner

NOTICE OF PUBLIC HEARING

Notice is hereby given pursuant to M.G.L. c. 30A, §2, that the **Drug Control Program** within the Department of Public Health will hold a public hearing regarding a proposed amendments to regulation: **105 CMR 700.000:** ***Implementation of M.G.L. c. 94C***

The proposed amendments update the regulations which implement M.G.L. c. 94 C, the Controlled Substances Act which sets forth consistent standards for the safety, security and storage of controlled substances; outlines the requirements for practitioners and facilities to receive a Massachusetts Controlled Substances Registration (MCSR); and manages the Prescription Monitoring Program (PMP). The proposed amendments implement new statutes, align the regulation with other regulations, and clarify existing provisions.

The public hearing will be held at **2 pm on Monday, October 19, 2026.** The hearing will be conducted on a **moderated conference call**. The information for the moderated conference call is:

Dial-in Telephone Number:	888-996-4914
Participant Passcode:	4948916

A copy of the proposed regulation 105 CMR 700.000: *Implementation of M.G.L. c. 94C* may be viewed on the Department's website at www.mass.gov/dph/proposed-regulations or requested from the Office of the General Counsel by calling 617-624-5220.

Speakers who testify at the public hearing are requested to provide a copy of their oral testimony. The Department encourages all interested parties to submit testimony electronically to the following address: Reg.Testimony@mass.gov, or by mail to William Anderson, Office of the General Counsel, Department of Public Health, 250 Washington Street, Boston, MA 02108. All submissions must include the sender's full name and address. When electronically submitting comments, type "DCP Regulations" in the subject line and attach a Word document with your comments or type your comments in the body of your email. All submissions must include the sender's full name and address.

The Department will post all testimony that complies with these instructions on its website. **All comments must be submitted by 5:00 p.m. on Monday, October 19, 2026**. All comments received by the Department may be released in response to a request for public records.

If you are deaf or hard of hearing, or are a person with a disability who requires accommodation, please contact Stacy Hart at least 5 days before the hearing at Tel No. 857-274-1120, email Stacy.Hart@mass.gov, or TTY # 617-624-6001.



Small Business Impact Statement

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

CMR No.: 105 CMR 700.000: *Implementation of M.G.L. c. 94C*

Estimate of the Number of Small Businesses Impacted by the Regulation: The proposed regulatory amendments are not expected to impact small businesses.

Select Yes or No and Briefly Explain		
Yes	No X	Will small businesses have to create, file, or issue additional reports? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Will small businesses have to implement additional recordkeeping procedures? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Will small businesses have to provide additional administrative oversight? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Will small businesses have to hire additional employees in order to comply with the proposed regulation? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Does compliance with the regulation require small businesses to hire other professionals (e.g. a lawyer, accountant, engineer, etc.)? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	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 regulatory amendments are not expected to impact small businesses.* .
Yes	No X	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. Statute requires promulgation of regulations in order to implement the new statutory provisions pertaining to Licensed Certified Professional Midwives and expanded flexibilities for the administration of treatments for gender affirming care and sexually transmitted infections and exemptions for drug testing services.* *The remaining amendments clarify requirements and enhance flexibilities in the regulation or are corrective in nature.*

Yes	No X	Do any other regulations duplicate or conflict with the proposed regulation? *There are no other regulations that duplicate or conflict with the proposed amendments to this regulation, although new, complementary regulations are being developed for the licensure investigation and discipline of Licensed Certified Profession Midwives, certification of Certified Medication Aides and the oversight of long-term care facilities.*
Yes	No X	Does the regulation require small businesses to cooperate with audits, inspections or other regulatory enforcement activities? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Does the regulation require small businesses to provide educational services to keep up to date with regulatory requirements? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Is the regulation likely to *deter* the formation of small businesses in Massachusetts? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Is the regulation likely to *encourage* the formation of small businesses in Massachusetts? *No, the proposed regulatory amendments are not expected to impact small businesses.*
Yes	No X	Does the regulation provide for less stringent compliance or reporting requirements for small businesses? *No, the relevant statutes require a single compliance standard for all regulated parties, and is not expected to impact small businesses.*
Yes	No X	Does the regulation establish less stringent schedules or deadlines for compliance or reporting requirements for small businesses? *No, the relevant statutes require a single compliance standard for all regulated parties, and is not expected to impact small businesses.*
Yes	No X	Did the agency consolidate or simplify compliance or reporting requirements for small businesses? *The proposed amendments are intended to clarify and streamline the regulation, making it easier for all regulated parties to comply. The proposed regulatory amendments implement statutory requirements and are not expected to impact small businesses*
Yes	No X	Can performance standards for small businesses replace design or operational standards without hindering delivery of the regulatory objective? *No. The proposed changes must be made through regulation to implement statutory requirements creating a new Massachusetts controlled substance registration for a new licensed profession and to provide for additional flexibilities for pharmacists to administer treatments relating to gender affirming care and sexually transmissible infections.*
Yes	No X	Are there alternative regulatory methods that would minimize the adverse impact on small businesses? *No, the proposed regulatory amendments are not expected to impact small businesses.*

GEOFFREY E. SNYDER
COMMISSIONER

REBECCA H. FORTER
DEPUTY COMMISSIONER

The Commonwealth of Massachusetts
Department of Revenue
Rulings and Regulations Bureau
P.O. Box 9566
Boston, MA 02114-9566

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC HEARING

The Department of Revenue ("DOR") is holding this public hearing remotely. Details and instructions for participating and testifying remotely (such as through a phone line or online connection) at the remote public hearing will be published online at https://www.mass.gov/service-details/public-hearings-dor and are included in this notice below. If you plan to testify at the remote hearing, DOR strongly encourages you to register in advance; see below for instructions. DOR encourages you to submit written testimony in addition to, or instead of, providing testimony at the hearing; see below for instructions. Additionally, requests for copies of the proposed regulation will not be accepted in person. Details for obtaining copies of the proposed regulation are set forth below.

Join Zoom Meeting:
https://us02web.zoom.us/j/89911072162?pwd=qhPDPphh02bHLVbxrawbPTXLr8ymfl.1

Meeting ID: 899 1107 2162
Passcode: 512311

One tap mobile
1-309-205-3325

Join instructions
https://us02web.zoom.us/meetings/89911072162/invitations?signature=gw8Q2XdLp3GpmxSg30yHvAfP_vHW0n2EmMQ2Z84akcY

Pursuant to the provisions of General Laws Chapter 14, Section 6(1), Chapter 30A, Section 2, and Chapter 62C, Section 3, the Commissioner will hold a public hearing on the following proposed regulation:

830 CMR 62.3.1: Rent Deduction

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

Scheduled Hearing Date:

Tuesday, November 10, 2026 at 11 a.m.

Subject Matter:

830 CMR 62.3.1 explains the rules for claiming the personal income tax deduction for rent paid under G.L. c. 62, § 3. The regulation is being amended to reflect a statutory change increasing the maximum rent deduction allowed from $3,000 to $4,000, effective for taxable years beginning on or after January 1, 2023. Additional clarifying changes have been made to the regulation, particularly with respect to the examples.

Information:

Individuals who notify DOR of their intent to testify at the hearing will be afforded an earlier opportunity to speak. Speakers are strongly encouraged to notify DOR of their intention to testify at the hearing by emailing their full name, mailing address and organization or affiliation, if any to RulesandRegs@dor.state.ma.us by November 9, 2026.

Individuals may also submit written testimony by emailing the Rulings and Regulations Bureau at RulesandRegs@dor.state.ma.us.

Please submit electronic testimony as an attached Word document or as text within the body of the email with the name of the regulation in the subject line. All submissions 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 the Rulings and Regulations Bureau, Post Office Box 9566, Boston, Massachusetts 02114-9566. Written testimony must be submitted by 5:00 p.m. on November 10, 2026.

Copies of the proposed regulation will be sent electronically via e-mail to practitioners who are on the Rulings and Regulations Bureau's e-mail list. In addition, the proposed regulation is posted on the Department of Revenue's Web site at: https://www.mass.gov/info-details/proposed-regulations-dor.

Geoffrey E. Snyder
Geoffrey E. Snyder
Commissioner of Revenue

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

Small Business Impact Statement pursuant to G.L. c. 30A, §§ 2 and 3

830 CMR 62.3.1 explains the rules for claiming the personal income tax deduction for rent paid under G.L. c. 62, § 3. The Department estimates there are no small businesses impacted by this proposed regulation. No projected reporting, record keeping, or other administrative costs directed at small businesses have been identified as required for compliance with the proposed regulation. Additionally, the proposed regulation does not contain design or performance standards directed at small businesses and does not duplicate or conflict with other regulations of DOR. DOR has not identified any regulations of other agencies that conflict with this proposed regulation. And finally, the proposed regulation is likely to neither deter nor encourage the formation of new businesses, small or otherwise, in the Commonwealth.

GEOFFREY E. SNYDER
COMMISSIONER

REBECCA H. FORTER
DEPUTY COMMISSIONER

The Commonwealth of Massachusetts
Department of Revenue
Rulings and Regulations Bureau
P.O. Box 9566
Boston, MA 02114-9566

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC HEARING

The Department of Revenue ("DOR") is holding this public hearing remotely. Details and instructions for participating and testifying remotely (such as through a phone line or online connection) at the remote public hearing will be published online at https://www.mass.gov/service-details/public-hearings-dor and are included in this notice below. If you plan to testify at the remote hearing, DOR strongly encourages you to register in advance; see below for instructions. DOR encourages you to submit written testimony in addition to, or instead of, providing testimony at the hearing; see below for instructions. Additionally, requests for copies of the proposed regulation will not be accepted in person. Details for obtaining copies of the proposed regulation are set forth below.

Join Zoom Meeting
https://us02web.zoom.us/j/83812084798?pwd=SSjslIeZRuT0BKQ2FUot2sYCsIhZQv.1

Meeting ID: 838 1208 4798
Passcode: 272500

One tap mobile
1-309-205-3325

Join instructions
https://us02web.zoom.us/meetings/83812084798/invitations?signature=9RSLlYToBG-kFCJxZWZYfdafck7xV8xAlv70_8abHkE

Pursuant to the provisions of General Laws Chapter 14, Section 6(1), Chapter 30A, Section 2, and Chapter 62C, Section 3, the Commissioner will hold a public hearing on the following proposed regulation:

830 CMR 62.6.3: Lead Paint Removal Credit

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

Scheduled Hearing Date:

Tuesday, November 10, 2026 at 2 p.m.

Subject Matter:

830 CMR 62.6.3 explains the rules for claiming the credit allowed for the costs incurred in the removal of lead from a residential dwelling unit under G.L. c. 62, § 6(e). The regulation is being amended to reflect a statutory change increasing the maximum credit amount from $1,500 to $3,000, and from $500 to $1,500 for bringing a residential premises under interim control pending full compliance, per dwelling unit. The increases are effective for taxable years beginning on or after January 1, 2023. Additional changes have been made to the regulation to provide clarification, particularly with respect to the definitions.

Information:

Individuals who notify DOR of their intent to testify at the hearing will be afforded an earlier opportunity to speak. Speakers are strongly encouraged to notify DOR of their intention to testify at the hearing by emailing their full name, mailing address and organization or affiliation, if any to RulesandRegs@dor.state.ma.us by November 9, 2026.

Individuals may also submit written testimony by emailing the Rulings and Regulations Bureau at RulesandRegs@dor.state.ma.us.

Please submit electronic testimony as an attached Word document or as text within the body of the email with the name of the regulation in the subject line. All submissions 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 the Rulings and Regulations Bureau, Post Office Box 9566, Boston, Massachusetts 02114-9566. Written testimony must be submitted by 5:00 p.m. on November 10, 2026.

Copies of the proposed regulation will be sent electronically via e-mail to practitioners who are on the Rulings and Regulations Bureau's e-mail list. In addition the proposed regulation is posted on the Department of Revenue's Web site at: https://www.mass.gov/info-details/proposed-regulations-dor.

Geoffrey E. Snyder
Geoffrey E. Snyder
Commissioner of Revenue

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF REVENUE

Small Business Impact Statement pursuant to G.L. c. 30A, §§ 2 and 3

830 CMR 62.6.3 explains the rules for claiming the credit allowed for the costs incurred in the removal of lead from a residential dwelling unit under G.L. c. 62, § 6(e). The Department estimates there are no small businesses that may be impacted by this proposed regulation. No projected reporting, record keeping, or other administrative costs directed at small businesses have been identified as required for compliance with the proposed regulation. Additionally, the proposed regulation does not contain design or performance standards directed at small businesses and does not duplicate or conflict with other regulations of DOR. DOR has not identified any regulations of other agencies that conflict with this proposed regulation. And finally, the proposed regulation is likely to neither deter nor encourage the formation of new businesses, small or otherwise, in the Commonwealth.

THE COMMONWEALTH OF MASSACHUSETTS

Secretary of the Commonwealth - William Francis Galvin

2026 CUMULATIVE TABLE TO THE MASSACHUSETTS REGISTER
1565 - 1584

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
	- *Emergency*	1584	10/1/26
307.00	Rates for Psychiatric Day Treatment Center Services	1569	3/13/26
316.00	Rates for Surgery and Anesthesia Services - *Emergency*	1584	9/25/26
317.00	Rates for Medicine Services - *Emergency Refile* (MA Reg. # 1561)	1567	11/7/25
		1573	5/8/26
	- *Emergency*	1584	9/25/26
318.00	Rates for Radiology Services - *Emergency*	1584	9/25/26
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
348.00	Rates for Day Habilitation Services	1583	9/25/26
349.00	Rates for Early Intervention Program Services		
	- *Future Effective Regulation*	1565	7/1/26
		1576	7/1/26
351.00	Rates for Certain Adult Foster Care Services - *Emergency*	1584	10/5/26
355.00	Rates for Freestanding Birth Center Services	1567	2/13/26
361.00	Rates for Continuous Skilled Nursing Agency and Independent Nursing Services	1584	10/9/26
410.00	Rates for Competitive Integrated Employment Services	1580	8/14/26
411.00	Rates for Certain Placement, Support, and Shared Living Services	1584	10/9/26
412.00	Rates for Family Transitional Support Services	1584	10/9/26
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

		Issue	Effective Date
423.00	Rates for Certain In-home Basic Living Supports	1577	7/3/26
424.00	Rates for Certain Developmental and Support Services	1580	8/14/26
425.00	Rates for Certain Young Parent Support Programs	1578	7/17/26
426.00	Rates for Certain Adult Community Mental Health Services	1583	9/25/26
446.00	COVID-19 and Public Health Emergency Payment Rates for Certain Community Health Care Providers	1582	9/11/26
	- *Correction* (MA Reg. # 1582)	1583	9/11/26
514.00	Hospital Assessment - *Emergency*	1578	7/7/26
	- *Compliance* (MA Reg. # 1578)	1582	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
103 CMR	**Department of Correction**		
483.00	Visiting Procedures	1581	8/28/26
105 CMR	**Department of Public Health**		
125.000	Licensing of Radiologic Technologists	1564	1/2/26
	- *Correction* (MA Reg. # 1564)	1567	1/2/26
270.000	Blood Screening of Newborns for Treatable Diseases and Disorders	1575	6/5/26
726.000	Temporary Placement of Kratom in Schedule I Pursuant to M.G.L. c. 94C, § 2A - *Emergency*	1581	8/28/26
775.000	Certified Medication Aides in Long-term Care Facilities	1567	2/13/26
110 CMR	**Department of Children and Families**		
2.00	Glossary	1571	4/10/26
7.000	Services - *Emergency*	1564	12/12/25
	- *Compliance* (MA Reg. # 1564)	1570	12/12/25
124 CMR	**Massachusetts Office for Victim Assistance**		
2.00	Compensation for Victims of Violent Crimes		
	- *Compliance* (MA Reg. # 1554)	1564	8/4/25
	- *Correction* (MA Reg. # 1564)	1565	8/4/25
130 CMR	**Division of Medical Assistance**		
401.000	Independent Clinical Laboratory Services	1584	10/9/26
405.000	Community Health Center Services	1577	7/3/26
406.000	Pharmacy Services	1577	7/3/26
408.000	Adult Foster Care Services - *Emergency*	1584	10/5/26
409.000	Durable Medical Equipment Services	1579	7/31/26
410.000	Outpatient Hospital Services	1577	7/3/26
414.000	Independent Nursing Services	1584	10/9/26

		Issue	Effective Date
419.000	Day Habilitation Center Services	1583	9/25/26
420.000	Dental Services	1580	8/1/26
422.000	Personal Car Attendant Services	1577	7/3/26
428.000	Prosthetics Services	1579	7/31/26
432.000	Therapist Services	1579	7/31/26
433.000	Physician Services - *Emergency*	1584	9/25/26
438.000	Continuous Skilled Nursing Agency Services	1584	10/9/26
442.000	Orthotics Services	1579	7/31/26
449.000	Correctional Facility Services - *Emergency Refile* (MA Reg. # 1561).	1567	11/7/25
	- *Emergency Refile* (MA Reg. # 1561)	1573	11/7/25
	- *Emergency*	1578	7/2/26
	- *Compliance* (MA Reg. # 1578)	1583	7/2/26
450.000	Administrative and Billing Regulations	1579	7/31/26
501.000	Health Care Reform: MassHealth: General Policies	1567	2/13/26
502.000	Health Care Reform: MassHealth: The Eligibility Process	1567	2/13/26
503.000	Health Care Reform: MassHealth: Universal Eligibility Requirements	1567	2/13/26
505.000	Health Care Reform: MassHealth: Coverage Types	1567	2/13/26
506.000	MassHealth: Financial Requirements	1566	1/30/26
	- *Correction* (MA Reg. # 1566)	1568	1/30/26
508.000	MassHealth: Managed Care Requirements	1578	7/17/26
515.000	MassHealth: General Policies	1567	2/13/26
516.000	MassHealth: The Eligibility Process	1567	2/13/26
	- *Correction* (MA Reg. # 1567)	1569	2/13/25
517.000	MassHealth: Universal Eligibility Requirements.	1567	2/13/26
519.000	MassHealth: Coverage Types	1567	2/13/26
522.000	MassHealth: Other Division Programs	1567	2/13/26
205 CMR	**Massachusetts Gaming Commission**		
3.00	Harness Horse Racing - *Emergency*	1571	3/27/26
	- *Emergency Refile* (MA Reg. # 1571)	1578	3/27/26
	- *Compliance* (MA Reg. # 1571)	1580	3/27/26
		1580	8/14/26
17.00	Review of a Proposed Transfer of Interests in a Racing Meeting License - *Emergency*	1580	7/22/26
101.00	M.G.L. c. 23K Adjudicatory Proceedings	1572	4/24/26
116.00	Persons Required to Be Licensed or Qualified	1569	3/13/26
133.00	Voluntary Self-exclusion	1574	5/22/26
134.00	Licensing and Registration of Employees, Vendors, Junket Enterprises and Representatives, and Labor Organizations	1572	4/24/26
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		Issue	*Effective Date*
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Docket # 630

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 206.00**

CHAPTER TITLE: **Standard Payments to Nursing Facilities**

AGENCY: **Executive Office of Health and Human Services**

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

Governs the payments for services rendered to publicly aided and industrial accident residents by nursing facilities, including residents in a residential care unit of a nursing facility.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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.*

EOHHS is required by state law to establish rates to be paid by state governmental units for health care services, including for nursing facility services. These rates are required by state law to appear in regulation. Nursing facility rates are required by state statute to be established as of October 1 of each year. This emergency regulation must be adopted by October 1, 2026.

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: 09-21-26

Regulatory Review approval: 09-21-26

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: _____

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

For the first and second year: **The estimated annual fiscal impact of these amendments is $29,670,000.**

For the first five years:

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: **N/A**

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 101 CMR 206.00.

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: **Sep 25 2026**

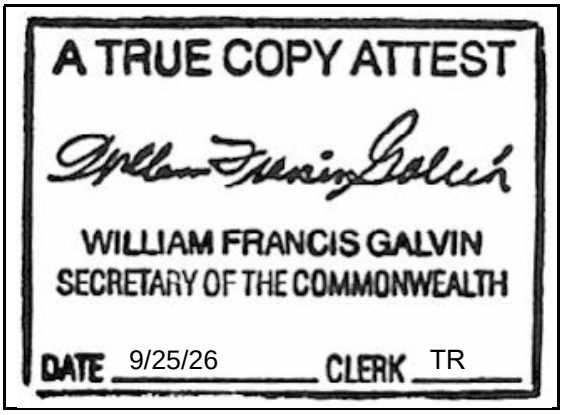
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/1/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an emergency regulation.	**There are no replacement pages.**



101 CMR 206.00: STANDARD PAYMENTS TO NURSING FACILITIES

Section

206.01: Scope and Purpose
206.02: General Definitions
206.03: General Payment Provisions
206.04: Nursing Standard Payments and Operating Cost Standard Payments
206.05: Capital Payments
206.06: Adjustments to Standard Nursing Facility Rates
206.07: Payments for Individuals in a Disaster Struck Nursing Facility
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206.11: Rates for Severe Mental and Neurological Disorder Services
206.12: Direct Care Cost Quotient
206.13: Average Staffing Hours Incentive
206.14: Special Requirements Related to St. 2022, c. 268
206.15: Add-on for Members with Complicated High-cost Care Needs
206.16: Severability

206.01: Scope and Purpose

101 CMR 206.00 governs the payments beginning October 1, 2026, for services rendered to publicly aided and industrial accident residents by nursing facilities including residents in a residential care unit of a nursing facility. 101 CMR 206.00 does not govern nursing facility payments pursuant to a contract with the Office of Medicaid.

206.02: General Definitions

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

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

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

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

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

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

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

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

206.02: continued

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

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

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

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

Executive Office of Health and Human Services (EOHHS). The executive department of the Commonwealth of Massachusetts established under M.G.L. c. 6A, § 2 that, through the Executive Office of Elder Affairs, the MassHealth program, and other agencies within EOHHS, as appropriate, operates and administers the programs of medical assistance and medical benefits under M.G.L. c. 118E and that serves as the single state agency under § 1902(a)(5) of the Social Security Act.

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

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

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

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

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

206.02: continued

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

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

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

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

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

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

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

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

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

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

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

206.02: continued

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

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

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

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

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

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

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

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

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

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

Reported Costs. All costs reported in the cost report.

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

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

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

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

206.02: continued

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

206.03: General Payment Provisions

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

(a) The nursing standard payments and the operating cost standard payments are established in 101 CMR 206.04. The base year for the nursing standard payments and the operating cost standard payments beginning October 1, 2026, is 2023. The nursing standard payments and operating cost standard payments are increased from the base year by a cost adjustment factor of 7.04%

(b) The capital payments are established in 101 CMR 206.05. The base year for the capital payments beginning October 1, 2025, is 2023. The capital payments are increased from the base year by a cost adjustment factor of 6.65%.

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

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

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

206.04: Nursing Standard Payments and Operating Cost Standard Payments

(1) Nursing Standard Payments.

(a) Nursing Standard Payment Calculation. Beginning October 1, 2026, nursing facilities will receive the following nursing standard payments:

PDPM Nursing HIPPS Code (Acuity Level)	PDPM Nursing Case Mix Index (2026)	Nursing Standard Payment
A (ES3)	3.84	$442.48
B (ES2)	2.90	$334.17
C (ES1)	2.77	$319.19
D (HDE2)	2.27	$261.57
E (HDE1)	1.88	$216.63
F (HBC2)	2.12	$244.29
G (HBC1)	1.76	$202.80
H (LDE2)	1.97	$227.00
I (LDE1)	1.64	$188.98
J (LBC2)	1.63	$187.82
K (LBC1)	1.35	$155.56
L (CDE2)	1.77	$203.96
M (CDE1)	1.53	$176.30
N (CBC2)	1.47	$169.39
O (CA2)	1.03	$118.69
P (CBC1)	1.27	$146.34
Q (CA1)	0.89	$102.55
R (BAB2)	0.98	$112.93

206.04: continued

PDPM Nursing HIPPS Code (Acuity Level)	PDPM Nursing Case Mix Index (2024)	Nursing Standard Payment
S (BAB1)	0.94	$108.32
T (PDE2)	1.48	$170.54
U (PDE1)	1.39	$160.17
V (PBC2)	1.15	$132.51
W (PA2)	0.67	$77.20
X (PBC1)	1.07	$123.30
Y (PA1)	0.62	$71.44

(b) Nursing Standard Payment Adjustment. Beginning October 1, 2026, eligible nursing facilities will receive adjustments to their standard nursing payments at 101 CMR 206.04(1)(a), which will be calculated and determined as follows.

1. Calculate each facility's average nursing standard payment rate in effect as of September 30, 2026, weighted by the facility's average PDPM nursing case mix during the period of January 1, 2025, through December 31, 2025. For each facility, add this value to the facility's average Nursing Standard Payment Adjustment in effect as of September 30, 2026, weighted by the facility's average PDPM nursing case mix during the period of January 1, 2025, through December 31, 2025.

2. Calculate each facility's average proposed nursing standard payment rate, beginning October 1, 2026, using the nursing rates as defined in 101 CMR 206.04(1)(a) and weighted by the facility's average PDPM nursing case mix during the period of January 1, 2025, through December 31, 2025.

3. To determine a facility's eligibility for the Nursing Standard Payment Adjustment, determine whether the facility is a pediatric facility. If the facility is a pediatric facility; then

a. Determine whether the value calculated in 101 CMR 206.04(1)(b)2. is less than the value calculated in 101 CMR 206.04(1)(b)1.

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

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

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

(2) Operating Cost Standard Payments. Beginning October 1, 2026, nursing facilities will receive operating cost standard payments of $128.14.

206.05: Capital Payments

(1) Nursing Facility Capital Payments. Beginning October 1, 2026, nursing facilities will receive capital payments calculated as follows, with exceptions as described in 101 CMR 206.05(2) through 101 CMR 206.05(5).

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

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

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

206.05: continued

(2) Nursing Facility Capital Payment Adjustments. Beginning October 1, 2026, nursing facilities will receive capital payment adjustments calculated as follows.

(a) If a nursing facility's capital payment as calculated in 101 CMR 206.05(1) is less than 90% of its capital payment as of September 30, 2026, the facility will receive the capital payment listed in 101 CMR 206.05(1), plus an upward adjustment equal to the difference between the capital payment as calculated in 101 CMR 206.05(1) and 90% of the facility's capital payment as of September 30, 2026, subject to the limitations described in 101 CMR 206.05(4).

(b) If a nursing facility's capital payment as calculated in 101 CMR 206.05(1) is greater than 150% of its capital payment as of September 30, 2026, the facility will receive the capital payment calculated in 101 CMR 206.05(1), less a downward adjustment equal to the difference between the capital payment as calculated in 101 CMR 206.05(1) and 150% of the facility's capital payment as of September 30, 2026.

(3) Revised Capital Payment.

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

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

1. new facilities that open pursuant to a determination of need and facilities with newly licensed beds that are added pursuant to a determination of need;
2. facilities with renovations made pursuant to a determination of need;
3. facilities that submitted detailed architectural or engineering plans for, or evidence of, applications made to local government agencies for planning, zoning, or building permits or other regulatory approvals, including approvals required by the Department of Public Health, required in connection with conversion of rooms with three or more residents to one- and two-bedded rooms or two-bedded rooms to one-bedded rooms.

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

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

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

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

206.05: continued

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

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

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

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

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

206.06: Adjustments to Standard Nursing Facility Rates

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

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

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

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

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

1. Medicaid Allowable Skilled Nursing Facility Costs. Total allowable skilled nursing facility costs, divided by total skilled nursing facility days, times skilled nursing facility Medicaid days.
2. Medicaid Allowable Nursing Facility Costs. Total allowable nursing facility costs, divided by total nursing facility days, times nursing facility Medicaid days.
3. Total Allowable Medicaid Costs. The sum of the amount determined in 101 CMR 206.06(1)(d)1. and 2.

206.06: continued

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

(2) Quality Adjustments. Beginning October 1, 2026, a nursing facility may be eligible for a quality adjustment in the form of an increase or decrease applied to the facility's nursing standard rate and operating standard rate at each PDPM nursing case mix category. The quality adjustment will be equal to the sum of the percent increase or decrease assessed for performance on each of the following three quality measures: Quality Achievement Based on CMS Score, Quality Achievement Based on DPH Score, and Quality Achievement Based on CMS Score on Number of Hospitalizations.

(a) Quality Achievement Based on CMS Score. The quality adjustment a nursing facility will incur under the measure "Quality Achievement Based on CMS Score" will be based on the facility's overall rating on the Centers for Medicare and Medicaid Services Nursing Home Compare 5-Star Quality Rating Tool as of April 2026, as described in the table below. Facilities that CMS has designated as not rated due to a history of serious quality issues (*i.e.*, Special Focus Facilities) will be considered to have a score of 1 for the purposes of this quality adjustment.

CMS Overall Score as of April 2026	Adjustment Percentage
0	-2.50%
1	-2.00%
2	-1.00%
3	0.00%
4	1.00%
5	2.00%

(b) Quality Achievement Based on DPH Score. The quality adjustment a nursing facility will incur under the measure "Quality Achievement Based on DPH Score" will be based on the facility's performance on the Department of Public Health's Nursing Facility Survey Performance Tool (DPH NFSPT) as of April 1, 2026, as follows:

DPH NFSPT Score as of April 1, 2026	Adjustment Percentage
108 or less	-3.00%
109 – 113	-2.00%
114 – 118	0.00%
119 – 123	1.00%
124+	2.00%

(c) Quality Score Based on CMS Number of Hospitalizations. The quality adjustment a nursing facility will incur under the measure "Quality Score Based on CMS Number of Hospitalizations" will be based on the facility's adjusted score on the Centers for Medicare and Medicaid Services Nursing Home Claims Quality Measure for number of hospitalizations per 1000 long-stay resident days as of June 1, 2026, as follows:

206.06: continued

CMS Adjusted Score	Adjustment Percentage
1.33 or less	2.00%
1.34 – 1.69	1.00%
1.7	0.00%
1.71 – 2.13	-1.00%
2.14+	-2.00%

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

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

1. maintain a fully kosher kitchen and food service operation that is, at least annually, rabbinically approved or certified; and in accordance with all applicable requirements of law related to kosher food and food products, including, but not limited to, M.G.L. c. 94, § 156;

2. provide to the Center a written certification from a certifying authority, including the complete name, address, and phone number of the certifying authority, that the applicant's nursing facility maintains a fully kosher kitchen and food service operation in accordance with Jewish religious standards. For purpose of 101 CMR 206.06(3)(a)2., the phrase "certifying authority" will mean a recognized kosher certifying organization or rabbi who has received Orthodox rabbinical ordination and is educated in matters of Orthodox Jewish law;

3. provide a written certification from the administrator of the nursing facility that the percentage of the nursing facility's residents requesting kosher foods or products prepared in accordance with Jewish religious dietary requirements is at least 50%; and

4. upon request, provide the Center with documentation of expenses related to the provision of kosher food services, including but not limited to, invoices and payroll records.

(b) Payment Amounts.

1. To determine the add-on amount, EOHHS will determine the statewide median dietary expense per day for all facilities. The add-on equals the difference between the eligible nursing facility's dietary expense per day and the statewide median dietary expense per day, not to exceed $5 per day. In calculating the per day amount, EOHHS will include allowable expenses for dietary and dietician salaries, payroll taxes and related benefits, food, dietary purchased service expense, dietician purchased service expense, and dietary supplies and expenses. The days used in the denominator of the calculation will be the higher of the nursing facility's actual days or 96% of available bed days.

2. EOHHS will compare the sum of the add-on amounts multiplied by each nursing facility's projected annual rate period Medicaid days to the state appropriation. In the event that the sum exceeds the state appropriation, each nursing facility's add-on will be proportionally adjusted.

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

(6) Nursing Cost. Eligible facilities will receive a $103.58 *per diem* add-on to reflect the difference between the standard payment amounts and actual base year nursing spending. To be eligible for such payment, the Department of Public Health must certify to EOHHS that over 75% of the nursing facility's residents have a primary diagnosis of multiple sclerosis.

206.06: continued

(7) Pediatric Nursing Facilities.

(a) Beginning October 1, 2026, EOHHS will determine payments to facilities licensed to provide pediatric nursing facility services using allowable reported operating costs, excluding administrative and general costs, from the nursing facility's 2019 Cost Report. EOHHS will include an administrative and general payment capped at the 85th percentile of the 2019 statewide administrative and general costs. EOHHS will apply an appropriate cost adjustment factor to operating, and administrative and general costs.

(b) The operating component of the rate is increased by a cost adjustment factor of 3.68% to the pediatric facility operating rates in effect as of September 30, 2026.

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

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

(d) Beginning October 1, 2026, EOHHS will determine capital payments to facilities licensed to provide pediatric nursing facility services by applying a cost adjustment factor of 3.14% to the pediatric facility capital rates in effect as of September 30, 2026.

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

(10) Residential Care Beds. Beginning October 1, 2026, the total payment for nursing and other operating costs for residential care beds in a dually licensed nursing facility is $140.41.

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

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

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

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

(14) High Medicaid Adjustment. Beginning October 1, 2026, a nursing facility may be eligible for a High Medicaid Adjustment to its payment rate, based on the proportion of the facility's total resident days which are Massachusetts Medicaid days, as reported on the facility's quarterly User Fee Assessment Forms covering the period April 1, 2025, through March 31, 2026. For the purpose of determining eligibility for the High Medicaid Adjustment, the proportion of the facility's total resident days which are Massachusetts Medicaid days will be rounded to the nearest hundredth of a percent.

(a) A facility for which its Massachusetts Medicaid days are at least 70.00% and less than 75.00% of its total resident days will receive a 3% upward adjustment applied to its nursing standard rate and operating standard rate at each PDPM nursing case mix category.

(b) A facility for which its Massachusetts Medicaid days are at least 75.00% and less than 90.00% of its total resident days will receive a 6% upward adjustment applied to its nursing standard rate and operating standard rate at each PDPM nursing case mix category.

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

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

206.06: continued

(15) Maximum Change Adjustment. Beginning October 1, 2026, a nursing facility will be subject to an adjustment to its total standard nursing facility *per diem* rate at each PDPM nursing case mix category established through 101 CMR 206.04, 101 CMR 206.05, 101 CMR 206.06(2) through (14), and 101 CMR 206.12(4), if a facility's proposed total average *per diem* rate, beginning October 1, 2026, calculated using the facility's average PDPM nursing case mix in the period January 1, 2025, through December 31, 2025, using the 2026 Centers for Medicare and Medicaid Services (CMS) PDPM case mix index, is greater than 112% or less than 90% of the facility's total average *per diem* standard nursing facility rate that was in effect on September 30, 2026, calculated using the facility's average PDPM nursing case mix in the period January 1, 2025, through December 31, 2025, using the 2024 CMS PDPM case mix index. The adjustment will be calculated as follows:

(a) determine the facility's proposed total average *per diem* rate, calculated using the facility's average PDPM nursing case mix in the period January 1, 2025, through December 31, 2025, using the 2026 CMS PDPM index and pursuant to 101 CMR 206.04, 101 CMR 206.05, 101 CMR 206.06(2) through (14), and 101 CMR 206.12(4);

(b) determine 112% of the facility's average *per diem* rate that was in effect on September 30, 2026, calculated using the facility's average PDPM nursing case mix in the period January 1, 2025, through December 31, 2025, using the 2024 CMS PDPM index;

(c) determine 90% of the facility's average *per diem* rate that was in effect on September 30, 2026, calculated using the facility's average PDPM nursing case mix in the period January 1, 2025, through December 31, 2025, using the 2024 CMS PDPM index;

(d) if the amount calculated in 101 CMR 206.06(15)(a) is greater than the amount calculated in 101 CMR 206.06(15)(b), then subtract the amount calculated in 101 CMR 206.06(15)(a) from the amount calculated in 101 CMR 206.06(15)(b). If the amount calculated in 101 CMR 206.06(15)(a) is less than the amount calculated in 101 CMR 206.06(15)(c), then subtract the amount calculated in 101 CMR 206.06(15)(a) from the amount calculated in 101 CMR 206.06(15)(c);

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

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

206.07: Payments for Individuals in a Disaster Struck Nursing Facility

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

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

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

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

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

206.07: continued

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

206.08: Reporting Requirements

(1) Required Cost Reports.

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

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

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

(d) Financial Statements. Each nursing facility must file or cause to be filed a complete copy of the financial statements for each entity for which it files (or causes to be filed) a cost report with the Center pursuant to 957 CMR 7.00: *Nursing Facility Cost Reporting* for the fiscal period that most closely corresponds to the applicable cost report's reporting period. If a nursing facility, realty company, management company, or the parent organization of any such entity obtains independent audited financial statements, a complete copy of each entity's audited financial statements must be filed with the Center. If a nursing facility, realty company, management company, or the parent organization of any such entity does not obtain audited financial statements, a complete copy of each entity's unaudited financial statements must be filed with the Center.

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

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

(g) Ownership Disclosure Form. Each provider must complete and file an Ownership Disclosure Form each calendar year with EOHHS in the manner and by the deadline specified by EOHHS *via* administrative bulletin.

(2) General Cost Reporting Requirements.

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

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

206.08: continued

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

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

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

(f) Other Cost Reporting Requirements.

1. Administrative Costs.
   a. The following expenses must be reported as administrative:
      i. all compensation, including payroll taxes and benefits, for the positions of administrator, assistant administrator, administrator-in-training, business manager, secretarial and clerical staff, bookkeeping staff, and all staff or consultants whose duties are primarily administrative rather than directly related to the provision of on-site care to residents or to the on-site physical upkeep of the nursing facility;
      ii. expenses related to tasks performed by persons at a management level above that of an on-site provider department head, that are associated with monitoring, supervising, and/or directing services provided to residents in a nursing facility as well as legal, accounting, financial, and managerial services or advice including computer services and payroll processing; and
      iii. expenses related to policy-making, planning, and decision-making activities necessary for the general and long-term management of the affairs of a nursing facility, including but not limited to the following: the financial management of the provider, including the cost of financial accounting and management advisory consultants, the establishment of personnel policies, the planning of resident admission policies, and the planning of the expansion and financing of the provider.
   b. Providers must report the cost of administrative personnel to the appropriate account. The cost of administrative personnel includes all expenses, fees, payroll taxes, fringe benefits, salaries, or other compensation.
   c. Providers may allocate administrative costs among two or more accounts. The provider must maintain specific and detailed time records to support the allocation.
2. Draw Accounts. Providers may not report or claim proprietorship or partnership drawings as salary expense.
3. Expenses that Generate Income. Providers must identify the expense accounts that generate income.
4. Fixed Costs.
   a. Additions. If the square footage of the building is enlarged, providers must report all additions and renovations as building additions.
   b. Allocation. Providers must allocate all fixed costs, except equipment, on the basis of square footage. A provider may elect to specifically identify equipment related to the nursing facility. The provider must document each piece of equipment in the fixed asset ledger. If a provider elects not to identify equipment, it must allocate equipment on the basis of square footage.
   c. Replacement of Beds. If a provider undertakes construction to replace beds, it must write off the fixed assets that are no longer used to provide care to publicly aided residents and may not identify associated expenses as related to the care of Massachusetts publicly aided residents.

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

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

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

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

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

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

(g) Special Cost Reporting Requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) The cost must be reasonable.

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

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

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

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

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

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

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

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

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

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

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

10. prescribed legend drugs for individual patients;

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

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

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

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

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

(4) Filing Deadlines.

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

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

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

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

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

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

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

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

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

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

(7) Penalties. If a provider does not file the required cost reports listed in 101 CMR 206.08(1)(a) through (g) by the due date, EOHHS may reduce the provider's rates for current services by 5% on the day following the date the submission is due and 5% for each month of noncompliance thereafter. The reduction may accrue cumulatively such that the rate reduction equals 5% for the first month late, 10% for the second month late, and so on. The rate will be restored effective on the first of the month following the date the cost report is filed.

206.09: Special Provisions

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

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

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

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

206.10: Other Payment Provisions

(1) Temporary Resident Add-on.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) the resident requires tracheostomy services;

(c) the resident's MDS assessment demonstrates that the resident meets the clinical criteria under Section O—Special Treatments, Procedures, and Programs, Item O0100E1 (Tracheostomy Care), with response A ("On Admission"), B ("While a Resident"), or C ("At Discharge") selected, as applicable to the MDS assessment type; and

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

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

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

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

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

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

(a) For dates of service beginning December 22, 2021, and notwithstanding any regulatory provision to the contrary, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for the administration of COVID-19 monoclonal antibody treatments and COVID-19 antiviral treatments to eligible MassHealth members and provided in a manner supported by medical evidence, provided in accordance with the emergency use authorization (EUA) issued by the federal Food and Drug Administration (FDA) or provided in accordance with full FDA approval, and provided in accordance with any guidance issued by DPH, the FDA, or CMS with respect to such treatments. Nursing facilities are required to ensure that any such monoclonal antibody treatments or antiviral treatments administered at the facility are administered by individuals whose education, credentials, and training qualify them to render such services.

(b) The costs of services described in 101 CMR 206.10(8)(a) are not included in the prospective payment system operating or nursing standard payment rates determined under 101 CMR 206.03 and 101 CMR 206.04. The costs of providing such services will be considered non-allowable costs under 101 CMR 206.08(3)(h)12.

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

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

(9) COVID-19 Vaccine Administration Claims.

(a) For dates of service beginning October 1, 2021, and notwithstanding any regulatory provision to the contrary, nursing facilities may submit separate claims to MassHealth on a fee-for-service basis for COVID-19 vaccine administration services, provided to eligible MassHealth members in accordance with an EUA issued by the FDA or full FDA approval, and in accordance with any guidance issued by the FDA or CMS with respect to such services. Nursing facilities are required to ensure that any such services administered by the facility are administered by individuals whose education, credentials, and training qualify them to render such services.

(b) The costs of services described in 101 CMR 206.10(9)(a) are not included in the prospective payment system operating or nursing standard payment rates determined under 101 CMR 206.03 and 101 CMR 206.04. The costs of providing such services will be considered non-allowable costs under 101 CMR 206.08(3)(h)12.

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

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

(13) Homelessness Rate Add-on.

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

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

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

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

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

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

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

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

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

(b) Non-applicability with Other Payments. A nursing facility may not receive this add-on for a member for whom the facility is receiving on the same dates of service a Medicaid transitional add-on under 101 CMR 206.10(7), a SUD add-on or a medications for opioid use disorder (MOUD) add-on under 101 CMR 206.10(14), a behavioral indicator add-on under 101 CMR 206.10(16), a bariatric add-on under 101 CMR 206.10(21), a *per diem* rate for severe mental or neurological disorders under 101 CMR 206.11, a temporary resident add-on under 101 CMR 206.10(1), or a complicated high-cost care need add-on under 101 CMR 206.15.

(c) Relevant Definitions.

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

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

(14) Substance Use Disorder (SUD) Add-on and Medications for Opioid Use Disorder (MOUD) Add-on.

(a) Eligibility Criteria.

1. For dates of service beginning October 1, 2026, a nursing facility that meets the criteria set forth in 101 CMR 206.10(14)(a)3. will be eligible for a member-specific SUD add-on of $45 per member per day for each member residing in the facility for whom MassHealth is the primary payer, who has a documented eligible diagnosis listed in 101 CMR 206.10(14)(b), whose BIMS score is between 8 and 15 based on their most recent MDS 3.0 assessment, and who receives at least one SUD service or treatment listed in 101 CMR 206.10(14)(c).

2. For dates of services beginning October 1, 2026, a nursing facility that meets the criteria set forth in 101 CMR 206.10(14)(a)3. and 4. will be eligible for a member-specific MOUD add-on of $100 per member per day for each member residing in the facility for whom MassHealth is the primary payer, who has a documented eligible diagnosis listed in 101 CMR 206.10(14)(b), and who receives at least one SUD service or treatment listed in 101 CMR 206.10(14)(c).

3. The facility will be eligible to receive the SUD and MOUD add-ons under 101 CMR 206.10(14)(a)1. and 2. only if

a. the facility submits to EOHHS an attestation in a form and manner specified by EOHHS by the deadline specified by EOHHS regarding the facility's policies and procedures to provide services to residents with SUD; and

b. The facility submits to EOHHS

i. an attestation in a form and manner specified by EOHHS by the deadline specified by EOHHS, certifying that the facility has executed an appropriate agreement to share data and collaborate with at least one Opioid Treatment Program (OTP) and including agreed-upon policies and procedures for collaboration with the OTP as specified by EOHHS in administrative bulletin or other written issuance; and

ii. a copy of the executed agreement.

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4. The facility will be eligible to receive the MOUD add-on under 101 CMR 206.10(14)(a)2. only if it meets an average of at least 3.01 HPPD for the quarter October 1, 2026 through December 31, 2026 and at least 3.28 HPPD for calendar quarters beginning January 1, 2027. HPPD calculations will be made in accordance with 101 CMR 206.13(3).

(b) ICD-10 Groups. For the purposes of the SUD add-on, eligible ICD-10 diagnosis groups include F10 (alcohol-related disorders) and F19 (other psychoactive substance use-related disorders). For the purposes of the MOUD add-on, the eligible ICD-10 diagnosis group is F11 (opioid-related disorders).

(c) Eligible Services or Treatment. For the purposes of the SUD add-on, eligible services or treatment include medications for the treatment of SUD and other SUD-related services or treatment as specified by EOHHS in subregulatory guidance. For purposes of the MOUD add-on, eligible services or treatment includes only MOUD as specified by EOHHS in subregulatory guidance.

(d) Denial of Payment and Overpayments. Facilities that fail to meet the requirements under 101 CMR 206.10(14)(a), (b), or (c) may be denied further SUD and MOUD add-on payments and will be subject to overpayment action under 130 CMR 450.237: *Overpayments: Determination*. Facilities that claim the MOUD add-on under 101 CMR 206.10(14)(a)2. and that are subsequently determined not to have met the applicable HPPD requirements under 101 CMR 206.10(14)(a)4. will be entitled only to the SUD add-on amount for the applicable dates of service. The difference between the MOUD add-on amount paid to the facility and the SUD add-on amount for those dates of service will constitute an overpayment subject to recovery under 130 CMR 450.237: *Overpayments: Determination*. Facilities that refuse to admit a resident with SUD solely because of their SUD diagnosis may be denied the SUD and MOUD add-ons for the rest of the rate year and may be subject to sanctions under 130 CMR 450.238: *Sanctions: General*.

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

(f) Non-applicability with Other Payments. A nursing facility may not receive the SUD add-on for a member for whom the facility is receiving, on the same dates of service, the MOUD add-on. In addition, a nursing facility receiving the SUD add-on or the MOUD add-on may not receive, on the same dates of service, a behavioral indicator add-on under 101 CMR 206.10(16), a homelessness add-on under 101 CMR 206.10(13), a *per diem* rate for severe mental or neurological disorders under 101 CMR 206.11, or a complicated high-cost care need add-on under 101 CMR 206.15.

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

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

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

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

2. MassHealth is the primary payer for the member's nursing facility services at the time of home dialysis services received in the nursing facility.

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

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

(16) Behavioral Indicator Add-on.

(a) Eligibility Criteria. For dates of service beginning October 1, 2022, a nursing facility will be eligible for a member-specific behavioral indicator add-on of $50 per member per day for each member residing in the facility for whom MassHealth is the primary payer and who was coded as 2 or 3 on one or more of the following Minimum Data Set 3.0 (MDS 3.0) indicators: Behavioral Health (E0200A, E0200B, or E0200C), Rejection of Care (E0800), or Wandering (E0900). For dates of service beginning October 1, 2025, a nursing facility will be eligible for a member-specific behavioral indicator add-on of $45 per member per day for each member residing in the facility for whom MassHealth is the primary payer and who was coded as 2 or 3 on one or more of the following Minimum Data Set 3.0 (MDS 3.0) indicators: Behavioral Health (E0200A, E0200B, or E0200C); Rejection of Care (E0800); or Wandering (E0900). The add-on is meant to offset additional costs associated with certain members with behavioral conditions (for example, members with severe dementia).

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

(c) Denial of Payment and Overpayments. Facilities that fail to meet the requirements under 101 CMR 206.10(16)(a) or (b) may be denied further behavioral indicator add-on payments and may be subject to overpayment action under 130 CMR 450.237: *Overpayments*: *Determination*. In addition, facilities that refuse to admit a resident with behavioral health needs solely because of their behavioral health needs may be denied the behavioral indicator add-on for the rest of the rate year and may be subject to sanctions under 130 CMR 450.238: *Sanctions: General*.

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

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

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

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

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

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

206.10: continued

(21) Bariatric Add-on.

(a) For dates of service beginning on October 1, 2026, nursing facilities may receive a member-based rate add-on of $200 per member per day for each member residing in a facility for whom MassHealth is the primary payer and all of the following conditions are met:

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

(b) Non-applicability with Other Payments. A nursing facility may not receive this payment for a member for whom the facility is receiving on the same dates of service a Medicaid Transitional add-on under 101 CMR 206.10(7), a homelessness rate add-on under 101 CMR 206.10(13), a severe mental and neurological disorder add-on under 101 CMR 206.11, or a complicated high-cost care need add-on under 101 CMR 206.15.

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

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

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

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

(23) Supplemental Payment for Qualified Nursing Facilities Located on Martha's Vineyard.

(a) Beginning October 1, 2025, a nursing facility located within eight miles of Martha's Vineyard Critical Access Hospital will qualify for a supplemental payment to support additional allowable costs. Each qualified nursing facility will receive a proportional payment of the total amount available of $3,800,000.

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

1. Calculate the total of all qualified nursing facilities' Massachusetts Medicaid days, as reported on quarterly User Fee Assessment Forms for the period April 1, 2024, through March 31, 2025.
2. Determine each qualified nursing facility's proportion of Massachusetts Medicaid days as a total of all qualified nursing facility Massachusetts Medicaid days.
3. Multiply the proportion of each facility's Medicaid User Fee days by the total amount available of $3,800,000.

206.11: Rates for Severe Mental and Neurological Disorder Services

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

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

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

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

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

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

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

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

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

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

206.11: continued

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

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

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

206.12: Direct Care Cost Quotient

(1) Beginning October 1, 2020, nursing facilities must have a Direct Care Cost Quotient (DCC-Q), as described in 101 CMR 206.12(2), of at least 75%. For the rate year beginning October 1, 2022, a nursing facility rate will be subject to a downward adjustment if the facility failed to be at or above the 75% DCC-Q threshold for the period of July 1, 2021, through June 30, 2022. For rate years beginning on or after October 1, 2023, a nursing facility rate will be subject to a downward adjustment if the facility fails to be at or above the 75% DCC-Q threshold in the previous full fiscal year. For rate years beginning on or after October 1, 2026, a nursing facility rate will be subject to a downward adjustment if the facility fails to be at or above the 75% DCC-Q threshold in the previous full calendar year.

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

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

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

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

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

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

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

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

206.12: continued

(5) Exemption Criteria for the DCC-Q Downward Adjustment

(a) For rate years beginning on or after October 1, 2026, nursing facilities that had less than 5,000 Massachusetts Medicaid days, as reported on their quarterly User Fee Assessment Forms for the period January 1, 2025, through December 31, 2025, will be exempt from the downward adjustment set forth in 101 CMR 206.12(4).

(b) For rate years beginning on or after October 1, 2026, a nursing facility will be exempt from the DCC-Q downward adjustment under 101 CMR 206.12(4) if the facility is at or above an average HPPD of 4.00 in each of the four calendar quarters of 2025, calculated as described in 101 CMR 206.13(3).

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

206.13: Average Staffing Hours Incentive

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

(2) (a) As of January 1, 2021, a nursing facility that fails to meet an average of at least uu3.58 HPPD in accordance with 101 CMR 206.13(1), is subject to a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter.

(b) As of October 1, 2025, for HPPD calculated based on staffing levels in calendar quarters starting in October 2025, a nursing facility that fails to meet an average of at least 3.58 HPPD in accordance with 101 CMR 206.13(1) is subject to a downward adjustment that will be equal to 0.5% for HPPD between 3.57 and 3.48; 1% for HPPD between 3.47 and 3.38; 1.5% for HPPD between 3.37 and 3.28; and 3% for HPPD at 3.27 or below. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235: *Overpayments*.

HPPD Average (for calendar quarters beginning October 1, 2025)	**Downward Adjustment Percentage**
3.58 or above	0%
3.57 – 3.48	0.5%
3.47 – 3.38	1%
3.37 – 3.28	1.5%
3.27 or below	3%

(c) As of October 1, 2026, a nursing facility that fails to meet an average of at least 3.58 HPPD in accordance with 101 CMR 206.13(1) is subject to a downward adjustment that will be equal to 0.5% for HPPD between 3.57 and 3.48; 1% for HPPD between 3.47 and 3.38; 1.5% for HPPD between 3.37 and 3.28; 3% for HPPD between 3.27 and 3.01; and 8% for HPPD at 3.00 or below. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235: *Overpayments.*

206.13: continued

HPPD Average (for calendar quarters beginning October 1, 2026)	Downward Adjustment Percentage
3.58 or above	0%
3.57–3.48	0.5%
3.47–3.38	1%
3.37–3.28	1.5%
3.27–3.01	3%
3.00 or below	8%

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

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

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

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

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

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

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

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

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

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

(2) Complicated and High-cost Care Add-on Calculation. The add-on rate must be a daily rate equal to the total reasonable and allowable costs associated with the high-cost member as determined by EOHHS, above the standard nursing, capital, and operating costs considered and included in calculating the nursing facility's standard *per diem* rates established under 101 CMR 206.00, up to a maximum add-on of $600 per day. EOHHS must have sole discretion over what may be considered a reasonable and allowable cost for the purposes of calculating this add-on.

206.15: continued

The add-on for each resident must be effective on the later of the date the nursing facility receives MassHealth approval for the add-on or the date of the member's admission to the nursing facility. A nursing facility may not receive this add-on for a member for whom the facility is receiving on the same dates of service a Medicaid transitional add-on under 101 CMR 206.10(7), a homelessness rate add-on under 101 CMR 206.10(13), a SUD add-on or MOUD add-on under 101 CMR 206.10(14), a behavioral indicator add-on under 101 CMR 206.10(16), a bariatric add-on under 101 CMR 206.10(21), or a *per diem* rate for severe mental or neurological disorders under 101 CMR 206.11.

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

206.16: Severability

The provisions of 101 CMR 206.00 are severable. If any provision of 101 CMR 206.00 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 206.00 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

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

NON-TEXT PAGE

Docket # 631

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 316.00**

CHAPTER TITLE: **Rates for Surgery and Anesthesia Services**

AGENCY: **Executive Office of Health and Human Services**

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

101 CMR 316.00 governs the payment rates used by all governmental units for surgery and anesthesia services provided to publicly aided patients.

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

AGENCY CONTACT: **Deborah M. Briggs** PHONE: **617-921-1744**

ADDRESS: **MassHealth Publications, 1 Enterprise Drive, 5th 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.*

101 CMR 316.00 must be adopted by October 1, 2026, to align with Chapter 186 of the Acts of 2024.

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.*

A&F Approval: September 17, 2026
145 Letters: September 18, 2026

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: _____

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

For the first and second year: **$47,000 annually**

For the first five years:

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: **n/a**

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:*

101 CMR 316.00 is being amended.

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: **Sep 25 2026**

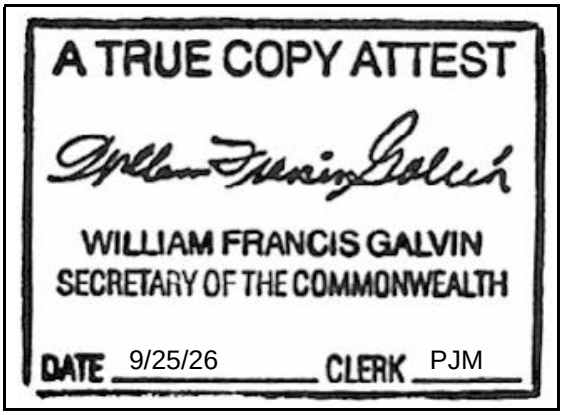
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/25/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no replacement pages.**



101 CMR 316.00: RATES FOR SURGERY AND ANESTHESIA SERVICES

Section

316.01: General Provisions
316.02: General Definitions
316.03: General Rate Provisions
316.04: Maximum Allowable Fees – Anesthesia Services
316.05: Maximum Allowable Fees – Surgical Services
316.06: Severability

316.01: General Provisions

(1) Scope and Purpose.

(a) 101 CMR 316.00 governs the payment rates used by all governmental units for surgery and anesthesia services provided to publicly aided patients. Rates for services provided to individuals covered by the Workers' Compensation Act, M.G.L. c. 152, are not set forth in 101 CMR 316.00, but are at 114.3 CMR 40.00: *Rates for Services under M.G.L. c. 152, Worker's Compensation Act*.

(b) The following laboratory services have a professional and technical component: 83020, 84165, 84166, 84181, 84182, 85390, 85576, 86255, 86256, 86320, 86325, 86327, 86334, 86335, 87164, 87207, 88371, 88372 and 89060. Payment rates for the professional component are contained herein. Payment rates for the technical component for these codes are contained in 101 CMR 320.00: *Rates for Clinical Laboratory Services*.

(2) Applicable Dates of Service. Rates contained in 101 CMR 316.00 apply for dates of service on or after January 1, 2025, except as otherwise noted.

(3) Coverage.

(a) Payment rates in 101 CMR 316.00 are used to pay for surgical and anesthesia services rendered to patients in a private medical office, freestanding ambulatory surgical center, licensed clinic, hospital or other inpatient or outpatient facility or department, or other appropriate setting by an individual eligible provider, when an eligible provider bills for the medical services rendered and no other payment method applies.

(b) The rates of payment under 101 CMR 316.00 are full compensation for patient care rendered to publicly aided patients as well as for any related administrative or supervisory duties in connection with patient care. The rates of payment also reimburse all overhead expenses associated with the service provided, without regard to where the care is rendered.

(4) Disclaimer of Authorization of Services. 101 CMR 316.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 101 CMR 316.00. Governmental units that purchase care are responsible for the definition, authorization, coverage policies, and approval of care and services provided to publicly aided patients.

(5) Coding Updates and Corrections. EOHHS may publish procedure code updates and corrections in the form of an administrative bulletin. Updates may reference coding systems including, but not limited to, the American Medical Association's *Current Procedural Terminology* (CPT).

(a) The publication of such updates and corrections will list

1. codes for which the code numbers change, with the corresponding cross references between the new codes and the codes being replaced. Rates for such updated codes are set at the rate of the code that is being replaced;
2. deleted codes for which there are no corresponding new codes; and
3. codes for entirely new services that require pricing. EOHHS will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

(b) For entirely new codes that require new pricing and have Medicare assigned relative value units (RVUs) (or, for applicable services, Medicare rates), EOHHS may list these codes and price them according to the rate methodology used in setting physician rates. When Medicare RVUs (or, for applicable services, Medicare rates) are not available, EOHHS may apply individual consideration in reimbursing for these new codes until appropriate rates can be developed.

The text of the regulations published in the electronic version of the Massachusetts Register is unofficial and for informational purposes only. The official version is the printed copy which is available from the State Bookstore at http://www.sec.state.ma.us/spr/sprcat/catidx.htm.

316.01: continued

(6) Administrative Bulletins. EOHHS may issue Administrative Bulletins to add, delete, or otherwise update codes or modifiers, and to clarify its policy on and understanding of substantive provisions of 101 CMR 316.00. EOHHS may also issue Administrative Bulletins to clarify to which duly licensed or certified health care professionals or students the rate methods in 101 CMR 316.00 apply.

316.02: General Definitions

Meaning of Terms. The five-digit procedure codes and two-digit modifiers included in 101 CMR 316.00, and their corresponding descriptions, utilize the Healthcare Common Procedure Code System (HCPCS) for Level I and Level II coding. Level I CPT-4 codes are obtained from the Physicians' 2023 *Current Procedural Terminology* (CPT), copyright 2022 by the American Medical Association (AMA), unless otherwise specified. Level II codes are obtained from the 2023 HCPCS, maintained jointly by the Centers for Medicare & Medicaid Services (CMS), the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. HCPCS is a listing of descriptive terms and identifying codes and modifiers for reporting medical services and procedures performed by physicians and other health care professionals, as well as associated nonphysician services. No fee schedules, basic unit value, relative value guides, conversion factors, or scales are included in any part of the Physicians' *Current Procedure Terminology*. For code descriptions, *see* the anesthesia and surgery service code spreadsheets on the EOHHS rates website at: www.mass.gov/regulations/101-CMR-31600-surgery-and-anesthesia-services.

In addition, terms used in 101 CMR 316.00 have the meanings set forth in 101 CMR 316.02.

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.

Eligible Provider. The rates established in 101 CMR 316.00 apply in accordance with 101 CMR 316.01 to the following types of providers who meet conditions of participation of the governmental unit purchasing such services, and to the extent specified by such governmental unit. Eligible providers must provide such services in accordance with generally accepted professional standards and in accordance with state licensing requirements and certification by national credentialing bodies as required by law.

(a) A licensed physician (other than an intern, resident, fellow, or house officer), licensed podiatrist, and licensed dentist.

(b) A provider of radiation oncology services. Radiation oncology services may be rendered by eligible providers such as, but not limited to, independent radiation oncology centers. These eligible providers must be physically and financially independent of a hospital or a physician's office.

(c) A clinic licensed by the Massachusetts Department of Public Health in accordance with 105 CMR 140.000: *Licensure of Clinics* to provide surgical diagnostic services.

(d) A freestanding birth center facility that is not operating under a hospital's license, and is licensed as a birth center by the Massachusetts Department of Public Health pursuant to 105 CMR 142.000: *Operation and Maintenance of Birth Centers*.

(e) An advanced practice registered nurse who is authorized by the Board of Registration in Nursing to practice as a certified nurse practitioner, certified nurse midwife, clinical nurse specialist, psychiatric clinical nurse specialist, or a certified registered nurse anesthetist (CRNA).

(f) A licensed physician assistant who is authorized by the Board of Registration for Physician Assistants to practice as a physician assistant.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

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316.02: continued

Facility Setting Fee. Payments for services provided by an individual eligible provider in a hospital (including, without limitation, a hospital inpatient department, outpatient department, emergency department, and hospital licensed health center), or skilled nursing facility or freestanding ambulatory surgical center (ASC), will be made according to a facility setting fee when an applicable facility setting fee has been established for that procedure.

Global Delivery. Includes direct provision and supervision of case management, maternal education (including, but not limited to, nutrition, pregnancy and childbirth, and reproductive health), and obstetrical risk assessment and monitoring, in addition to pelvic or Cesarean-section delivery, all routine prenatal visits, and one postpartum visit.

Governmental Unit. The Commonwealth, any department, agency, board, or commission of the Commonwealth and any political subdivision of the Commonwealth.

Individual Consideration (I.C.). Surgical procedures that are authorized but not listed in 101 CMR 316.00, surgical procedures performed in unusual circumstances, and services designated I.C. are individually considered items. The governmental unit or purchaser analyzes the eligible provider's report of services rendered and charges submitted under the appropriate unlisted services or procedures category. The governmental unit or purchaser determines appropriate payment for procedures designated I.C. in accordance with the following standards and criteria:

(a) the amount of time required to perform the service;
(b) the degree of skill required to perform the service;
(c) the severity or complexity of the patient's disease, disorder, or disability;
(d) any applicable relative-value studies;
(e) any complications or other circumstances that may be deemed relevant;
(f) the policies, procedures and practices of other third party insurers;
(g) the payment rate for prescribed drugs as set forth in 101 CMR 331.00: *Prescribed Drugs*; and
(h) a copy of the current invoice from the supplier.

Modifiers. Listed services may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate two-digit number or letters to the procedure code.

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.

Publicly Aided Individual (or Publicly Aided Patient). A person who receives health care and services for which a governmental unit is in whole or in part liable under a statutory program of public assistance.

Separate Procedure. Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a separate procedure in the procedure description. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.

Surgical Team Fee. Reimbursement for highly complex surgical procedures requiring the expertise of several physicians (usually of different specialties) and other highly skilled, specially-trained personnel. More than one surgeon may be performing parts of the procedure simultaneously. The unit fee is payable to the director of the surgical team and includes all assistant surgeon fees; there are no separate payments for assisting surgical services. The director of the surgical team is expected to distribute the unit fee to the members of the surgical team.

Unlisted Procedure or Service. A service or procedure that may be provided that is not listed in 101 CMR 316.05. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service.

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316.03: General Rate Provisions

(1) Rate Determination. Rates of payment for services for which 101 CMR 316.00 applies are the lowest of

(a) the eligible provider's usual fee to patients other than publicly aided patients;

(b) the eligible provider's actual charge submitted; or

(c) the allowable fees in accordance with 101 CMR 316.04 (for anesthesia services), or the schedule of allowable fees set forth in 101 CMR 316.05 (for surgical services), as applicable, and taking into account appropriate modifiers and any other applicable rate provision(s) in accordance with 101 CMR 316.03.

(2) Supplemental Payment.

(a) Eligibility. An eligible provider who is a physician, certified nurse practitioner, physician assistant, or CRNA is eligible for a supplemental payment for services to publicly aided individuals eligible under Titles XIX and XXI of the Social Security Act if the following conditions are met:

1. the eligible provider is employed by a nonprofit group practice that was established in accordance with St. 1997, c. 163 and is affiliated with a Commonwealth-owned medical school;

2. such nonprofit group practice must have been established on or before January 1, 2000, in order to support the purposes of a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school; and

3. the services are provided at a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school.

(b) Payment Method. This supplemental payment may not exceed the difference between

1. payments to the eligible provider made pursuant to the rates applicable under 101 CMR 316.03(1), 101 CMR 317.03(1): *Rate Determination* and 101 CMR 318.03(1): *Rate Determination*; and

2. the federal upper payment limit established by the Centers for Medicare & Medicaid Services.

(3) Rate Variations Based on Practice Site. Payments for certain services provided by individual eligible providers that can be routinely furnished in physicians' offices are reduced when such services are furnished in facility settings. 101 CMR 316.05 establishes facility setting fees applied to services rendered in a facility when a practice site differential is warranted.

(4) Allowable Fee for Certain Eligible Providers. Payment for services provided by eligible providers who are certified nurse practitioners, clinical nurse specialists, psychiatric clinical nurse specialists, and physician assistants as specified in 101 CMR 316.02, is 85% of the fees contained in 101 CMR 316.05.

(5) Global Surgical Package. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. Reimbursement for these procedures includes payment for services related to the surgery when furnished by the eligible provider who performs the surgery. The services included in the global surgical package may be furnished in any setting, *e.g.*, in hospitals, ASCs, physicians' offices. Included in the global fee is preoperative period of one day for major surgery and the postoperative period of 90 days for major surgery, as determined by the Centers for Medicare & Medicaid Services (CMS). The postoperative period for minor surgery is either zero or ten days depending on the procedure, as determined by CMS. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon.

(6) Obstetrical Services. Obstetrical fees contained in 101 CMR 316.05 are intended to include only the procedure or procedures performed and care to the publicly aided patient while hospitalized with the exception of global delivery (59400, 59510, 59610, 59618). Outpatient antepartum and postpartum obstetrical care may be billed under the appropriate medical procedure code in accordance with 101 CMR 317.00: *Rates for Medicine Services*. Medical problems complicating labor and delivery management or medical complications of pregnancy may require additional resources or services and should be identified by utilizing the appropriate procedure codes in 101 CMR 317.00: *Rates for Medicine Services* in addition to the procedure codes for maternity care listed in 101 CMR 316.05.

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316.05: continued

Code	NFAC	FAC	Global	PC	TC	Description (*see* surgery services code spreadsheet at www.mass.gov/regulations/101-CMR-31600-surgery-and-anesthesia)
88375	-	-	$35.13	-	-	
88377	-	-	$312.90	$46.26	$266.63	
88380	-	-	$95.21	$38.56	$56.65	
88381	-	-	$159.68	$17.19	$142.49	
88387	-	-	$25.49	$19.40	$6.09	
88388	-	-	$28.02	$17.11	$10.91	
88399	-	-	I.C.	-	-	
89049	$219.27	$44.64	-	-	-	
89060	-	-	-	$13.01	-	
89220	-	-	$14.40	-	-	
89230	-	-	$2.07	-	-	
89240	-	-	I.C.	-	-	
14301*	$826.94	$649.90	-	-	-	
14302*	-	-	$158.36	-	-	
20912*	-	-	$366.14	-	-	
21120*	$516.70	$391.08	-	-	-	
21123*	-	-	$645.50	-	-	
21137*	-	-	$566.99	-	-	
21139*	-	-	$821.82	-	-	
21208*	$1,288.87	$553.11	-	-	-	
21209*	$635.47	$473.96	-	-	-	
21210*	$1,385.87	$569.50				
21296*	-	-	$313.37	-	-	
30410*	-	-	$1,097.92	-	-	
30420*	-	-	$1,122.86	-	-	
30465*	-	-	$792.47	-	-	
31750*	-	-	$1,042.44	-	-	
64716*	-	-	$388.19	-	-	
64771*	-	-	$437.32	-	-	
G0105	$414.57	$204.78	-	-	-	
G0121	$414.80	$205.01	-	-	-	
S2260	-	-	I.C.	-	-	
S2265	-	-	I.C.	-	-	
S2266	-	-	I.C.	-	-	
S2267	-	-	I.C.	-	-	
S4005	-	-	I.C.	-	-	
S8415	-	-	$500	-	-	

* *See* 101 CMR 316.05(1)

(c) Surgical Services. Fee Schedule for Facial Feminization Surgery Services to Treat Gender Dysphoria.

1. NFAC – "Non-facility". These amounts apply when service is performed in a non-facility setting.
2. FAC – "Facility". These amounts, also known as the Facility Setting Fee, apply when service is performed in a facility setting.
3. Global Fee. These amounts apply when no site of service differential rate is specified.

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316.05: continued

Code	NFAC	FAC	Global	PC	TC	Description (*see* surgery services code spreadsheet at www.mass.gov/regulations/101-CMR-31600-surgery)
14301	$1,182.78	$929.56	-	-	-	
14302	-	-	$226.50	-	-	
20912	-	-	$523.69	-	-	
21120	$739.04	$559.37	-	-	-	
21123	-	-	$923.26	-	-	
21137	-	-	$810.98	-	-	
21139	-	-	$1,175.46	-	-	
21208	$1,843.49	$791.12	-	-	-	
21209	$908.92	$677.91	-	-	-	
21210	$1,982.23	$814.56	-	-	-	
21296	-	-	$448.21	-	-	
30410	-	-	$1,570.36	-	-	
30420	-	-	$1,606.04	-	-	
30465	-	-	$1,133.49	-	-	
31750	-	-	$1,491.02	-	-	
64716	-	-	$555.23	-	-	
64771	-	-	$625.51	-	-	

316.06: Severability

The provisions of 101 CMR 316.00 are hereby declared to be severable, and if any such provisions or the application of such provisions to any person or circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions to eligible providers or circumstances other than those held invalid.

REGULATORY AUTHORITY

101 CMR 316.00: M.G.L. c. 118E.

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Docket # 632

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 317.00**

CHAPTER TITLE: **Rates for Medicine Services**

AGENCY: **Executive Office of Health and Human Services**

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

101 CMR 317.00 governs the payment rates used by all governmental units for medical services provided to publicly aided patients.

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

AGENCY CONTACT: **Deborah M. Briggs** PHONE: **617-921-1744**

ADDRESS: **MassHealth Publications, 1 Enterprise Drive, 5th 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.*

101 CMR 317.00 must be adopted by October 1, 2026, to align with Chapter 186 of the Acts of 2024.

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.*

A&F Approval: September 17, 2026
145 Letters: September 18, 2026

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: _____

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

For the first and second year: **$47,000 annually**

For the first five years:

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:

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:*

101 CMR 317.00 is being amended.

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: **Sep 25 2026**

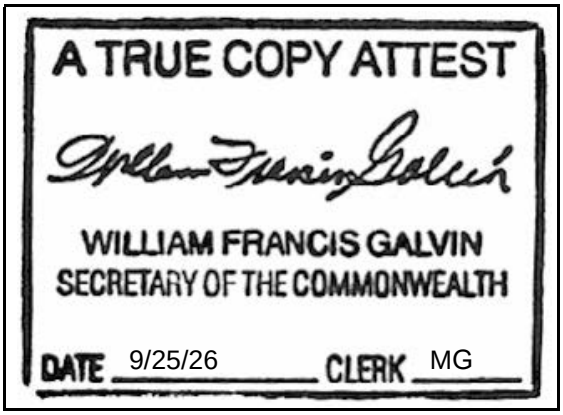
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/25/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no Replacement Pages.**



101 CMR 317.00: RATES FOR MEDICINE SERVICES

Section

317.01: General Provisions
317.02: General Definitions
317.03: General Rate Provisions
317.04: Maximum Allowable Fees – Medical Services
317.05: Severability

317.01: General Provisions

(1) Scope and Purpose. 101 CMR 317.00 governs the payment rates used by all governmental units for medical services provided to publicly aided patients. Rates for services provided to individuals covered by the Workers' Compensation Act, M.G.L. c. 152, are not set forth in 101 CMR 317.00, but are at 114.3 CMR 40.00: *Rates for Services under M.G.L. c. 152, Worker's Compensation Act*.

(2) Applicable Dates of Service. Rates contained in 101 CMR 317.00 apply for dates of service on or after October 1, 2026, except as otherwise noted.

(3) Coverage.

(a) Payment rates in 101 CMR 317.00 are used to pay for medical services rendered to patients in a private medical office, licensed clinic, hospital, or other inpatient or outpatient facility or department, independent diagnostic testing facility, patient's residence, or other appropriate setting by an individual eligible provider, when an eligible provider bills for the medical services rendered and no other payment method applies.

(b) The rates of payment under 101 CMR 317.00 are full compensation for patient care rendered to publicly aided patients as well as for any related administrative or supervisory duties in connection with patient care. The rates of payment also reimburse all overhead expenses associated with the service provided, without regard to where the care is rendered.

(4) Disclaimer of Authorization of Services. 101 CMR 317.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 101 CMR 317.00. Governmental units that purchase care are responsible for the definition, authorization, coverage policies, and approval of care and services provided to publicly aided patients.

(5) Coding Updates and Corrections. EOHHS may publish procedure code updates and corrections in the form of an administrative bulletin. Updates may reference coding systems including but not limited to the American Medical Association's *Current Procedural Terminology* (CPT).

(a) The publication of such updates and corrections will list

1. codes for which the code numbers change, with the corresponding cross references between the new codes and the codes being replaced. Rates for such updated codes are set at the rate of the code that is being replaced;
2. deleted codes for which there are no corresponding new codes; and
3. codes for entirely new services that require pricing. EOHHS will list these codes and apply Individual Consideration (IC) reimbursement for these codes until appropriate rates can be developed.

(b) For entirely new codes that require new pricing and have Medicare assigned relative value units (RVUs) (or, for applicable services, Medicare rates), EOHHS may list these codes and price them according to the rate methodology used in setting physician rates. When Medicare RVUs (or, for applicable services, Medicare rates) are not available, EOHHS may apply Individual Consideration in reimbursing for these new codes until appropriate rates can be developed.

(6) Administrative Bulletins. EOHHS may issue Administrative Bulletins to add, delete, or otherwise update codes or modifiers, and to clarify its policy on and understanding of substantive provisions of 101 CMR 317.00. EOHHS may also issue Administrative Bulletins to clarify to which duly licensed or certified health care professionals or students the rate methods in this regulation apply, including in the event that the Department of Public Health issues an Order pursuant to M.G.L. c. 94C, and 105 CMR 700.003(H).

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317.02: General Definitions

The five-digit procedure codes, and two-digit modifier codes included in 101 CMR 317.00, and their corresponding descriptions, utilize the Healthcare Common Procedure Code System (HCPCS) for Level I and Level II coding. Level I CPT-4 codes are obtained from the Physicians' 2023 *Current Procedural Terminology* (CPT), copyright 2022 by the American Medical Association (AMA), unless otherwise specified. Level II codes are obtained from the 2023 HCPCS, maintained jointly by the Centers for Medicare & Medicaid Services (CMS), the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. HCPCS is a listing of descriptive terms and identifying codes and modifiers for reporting medical services and procedures performed by physicians and other health care professionals, as well as associated nonphysician services. No fee schedules, basic unit value, relative value guides, conversion factors, or scales are included in any part of the Physicians' *Current Procedure Terminology*. For code descriptions, *see* the medicine services code spreadsheet at www.mass.gov/regulations/101-CMR-31700-medicine.

In addition, terms used in 101 CMR 317.00 have the meanings set forth in 101 CMR 317.02.

Child and Adolescent Needs and Strengths (CANS). A tool that provides a standardized way to organize information gathered during a psychiatric diagnostic assessment and is a treatment and service decision support tool for children and adolescents younger than 21 years old.

CMS. Centers for Medicare & Medicaid Services.

Correctional Facility. Any building, enclosure, space or structure used for the custody, control and rehabilitation of committed offenders and of such other persons as may be placed in custody therein in accordance with law.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT). A program of health screening and other medical services for publicly assisted individuals younger than 21 years old as required by federal law.

Eligible Provider. The rates established in 101 CMR 317.00 apply in accordance with 101 CMR 317.01 to the following types of providers who meet conditions of participation of the governmental unit purchasing such services, and to the extent specified by such governmental unit. Eligible providers must provide such services in accordance with generally accepted professional standards and in accordance with state licensing requirements and certification by national credentialing bodies as required by law.

(a) A licensed physician (other than an intern, resident, fellow, or house officer), licensed podiatrist, licensed dentist, licensed chiropractor, and licensed optometrist.

(b) A provider of diagnostic medical services. Such medical diagnostic services may be rendered by eligible providers such as, but not limited to, independent diagnostic testing facilities (IDTFs). These eligible providers must be physically and financially independent of a hospital or a physician's office.

(c) A provider of radiation oncology services. Radiation oncology services may be rendered by eligible providers such as, but not limited to, independent radiation oncology centers. These eligible providers must be physically and financially independent of a hospital or a physician's office.

(d) A clinic licensed by the Massachusetts Department of Public Health in accordance with 105 CMR 140.000*: Licensure of Clinics* to provide medical diagnostic services.

(e) A freestanding birth center facility that is not operating under a hospital's license, and is licensed as a birth center by the Massachusetts Department of Public Health pursuant to 105 CMR 140.000*: Licensure of Clinics*.

(f) An advanced practice registered nurse who is authorized by the Board of Registration in Nursing to practice as a certified nurse practitioner, certified nurse midwife, clinical nurse specialist, psychiatric clinical nurse specialist, or a certified registered nurse anesthetist (CRNA).

(g) A licensed physician assistant who is authorized by the Board of Registration for Physician Assistants to practice as a physician assistant.

(h) A registered nurse providing tobacco cessation services.

(i) A tobacco cessation counselor who has completed appropriate training in tobacco cessation counseling according to the qualification criteria established by the purchasing governmental unit.

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317.02: continued

(j) A pharmacist who is registered by the Board of Registration in Pharmacy.
(k) An acupuncturist who is licensed by the Board of Registration in Medicine to practice acupuncture.
(l) A correctional facility operating in the Commonwealth of Massachusetts.
(m) A licensed certified professional midwife who is authorized by the Board of Registration in Midwifery to practice as a certified professional midwife.

Eligible Provider for Administration of Vaccines. A licensed physician, certified nurse practitioner, certified nurse midwife, clinical nurse specialist, psychiatric clinical nurse specialist, physician assistant, registered pharmacist, correctional facility, certified professional midwife, or other health care professional certified in accordance with 105 CMR 700.000: *Implementation of M.G.L. c. 94C*, and any home health agency certified as a provider of home health services under the Medicare Health Insurance Program for the Aged (Title XVIII) is eligible to administer vaccines, if it otherwise meets such conditions of participation and coverage set forth by a purchasing governmental unit. Any other providers authorized by the Massachusetts Department of Public Health to possess and administer vaccines are also eligible if they otherwise meet such conditions of participation and coverage set forth by a purchasing governmental unit.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Facility Setting Fee. Payments for services provided by an individual eligible provider in a hospital (including, without limitation, a hospital inpatient department, outpatient department, emergency department, and hospital licensed health center), or skilled nursing facility or freestanding ambulatory surgical center (ASC), will be made according to a facility setting fee when an applicable facility setting fee has been established for that procedure.

Governmental Unit. The Commonwealth, any department, agency, board or commission of the Commonwealth and any political subdivision of the Commonwealth.

Individual Consideration. Medical services that are authorized but not listed in 101 CMR 317.00, medical services performed in unusual circumstances, and services designated "IC" are Individually Considered items. The governmental unit or purchaser analyzes the eligible provider's report of services rendered and charges submitted under the appropriate unlisted services or procedures category. The governmental unit or purchaser determines appropriate payment for procedures designated IC in accordance with the following standards and criteria:
(a) the amount of time required to perform the service;
(b) the degree of skill required to perform the service;
(c) the severity or complexity of the patient's disease, disorder, or disability;
(d) any applicable relative-value studies;
(e) any complications or other circumstances that may be deemed relevant;
(f) the policies, procedures, and practices of other third-party insurers;
(g) the payment rate for prescribed drugs as set forth in 101 CMR 331.00: *Prescribed Drugs*; and
(h) a copy of the current invoice from the supplier.

Modifiers. Listed services may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate two-digit number or letters.

Participating Correctional Facility (Facility). Any correctional facility that is a Department of Corrections state prison, county jail or house of correction, or a Department of Youth Services hardware secure or staff secure track 1 facility or unit that is not an institution of mental diseases as defined in 42 CFR 435.1010: *Definitions relating to institutional status*, and that is enrolled as a MassHealth provider.

Physical Medicine. The physical medicine procedure codes apply only when
(a) the physician prescribed the needed therapy; and
(b) the services are provided by the physician or a licensed physical or occupational therapist employed by the physician.

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.

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317.02: continued

Publicly Aided Individual (or Publicly Aided Patient). A person who receives health care and services for which a governmental unit is in whole or in part liable under a statutory program of public assistance.

Referral. The transfer of the total or specific care from one eligible provider to another.

Separate Procedure. Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a separate procedure in the procedure description. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.

Unlisted Procedure or Service. A service or procedure may be provided that is not listed in 101 CMR 317.04. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service.

317.03: General Rate Provisions

(1) Rate Determination. Rates of payment for services for which 101 CMR 317.00 applies are the lowest of

(a) the eligible provider's usual fee to patients other than publicly aided individuals;

(b) the eligible provider's actual charge submitted; or

(c) 1. the schedule of allowable fees set forth in 101 CMR 317.04(4), taking into account appropriate modifiers and any other applicable rate provision(s) in accordance with 101 CMR 317.03 or 317.04(1); or

2. for drugs, vaccines, and immune globulins administered in a physician's office, the fee specified in 101 CMR 317.04(1)(a), taking into account any other applicable rate provision(s) in accordance with 101 CMR 317.04(1).

(2) Supplemental Payment.

(a) Eligibility. An eligible provider who is a physician, certified nurse practitioner, physician assistant, or CRNA is eligible for a supplemental payment for services to publicly aided individuals eligible under Titles XIX and XXI of the Social Security Act if the following conditions are met:

1. the eligible provider is employed by a nonprofit group practice that was established in accordance with St. 1997, c. 163 and is affiliated with a Commonwealth-owned medical school;

2. such nonprofit group practice must have been established on or before January 1, 2000, in order to support the purposes of a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school; and

3. the services are provided at a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school.

(b) Payment Method. This supplemental payment may not exceed the difference between

1. payments to the eligible provider made pursuant to the rates applicable under 101 CMR 316.03(1): *Rate Determination*, 101 CMR 317.03(1), and 101 CMR 318.03(1): *Rate Determination*; and

2. the federal upper payment limit established by the Centers for Medicare & Medicaid Services.

(3) Rate Variations Based on Practice Site. Payments for certain services provided by individual eligible providers that can be routinely furnished in physicians' offices are reduced when such services are furnished in facility settings. 101 CMR 317.04 establishes facility setting fees applied to services rendered in a facility when a practice site differential is warranted.

(4) The sum of the professional and technical components of an individual procedure will not be greater than the allowable global fee set forth in 101 CMR 317.04(4).

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The official version is the printed copy which is available from the State Bookstore at http://www.sec.state.ma.us/spr/sprcat/catidx.htm.

317.03: continued

(5) Allowable Fee for Certain Eligible Providers. Payment for services provided by eligible providers who are certified nurse practitioners, psychiatric clinical nurse specialists, clinical nurse specialists, physician assistants, registered nurses, certified professional midwives, tobacco cessation counselors, pharmacies that utilize pharmacists, or other health care professionals certified in accordance with 105 CMR 700.000: *Implementation of M.G.L. c. 94C*, and home health agencies as specified in 101 CMR 317.02 is 85% of the fees contained in 101 CMR 317.04. 101 CMR 317.03(5) does not apply to the EPSDT add-on code S0302 described in 101 CMR 317.03(7) or for tobacco cessation services, for medical nutrition therapy (97802, 97803, 97804, G0270, G0271), for diabetes self-management training (G0108, G0109), for the administration of behavioral health or developmental screenings (96110, 96127, and related modifiers), or for the perinatal depression screening (S3005 and related modifiers) services listed in 101 CMR 317.04(4). The rates listed in 101 CMR 317.04(4) for tobacco cessation services performed by certain eligible providers already reflect the appropriate rate and no further rate adjustment applies (*see* codes 99407, 99407-SA, -TD, -TF, -HQ, -U1, -U2, and -U3).

(6) Behavioral Health and Developmental Screening Services. Payment for the administration and scoring of standardized behavioral health and developmental screening tools is available to certain eligible providers (physicians, certified nurse midwives, certified nurse practitioners, physician assistants, community health centers, hospital outpatient departments, or such eligible providers employed by a physician or community health center if authorized by the governmental unit) and is allowed for MassHealth purchase only when accompanied by a modifier. Appropriate codes and related modifiers for the standardized behavioral health screening tools are listed in a separate fee table in 101 CMR 317.04(4). For purposes of these modifiers, "Behavioral health need identified" or "Developmental services need identified" means the provider administering the screening tool, in her or his professional judgment, identifies a child with a potential behavioral health or developmental services need.

(7) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Add-on Code. To identify a completed well child office visit including all age-appropriate components of the EPSDT schedule, use code S0302 in addition to the appropriate preventive medicine service in 101 CMR 317.04(4). S0302 is always performed in addition to the primary procedure and must never be reported as a stand-alone code.

(8) Services and Payments Covered under Other Regulations. Rules and reimbursement rates for the Medicine service codes listed in the chart below are contained in other EOHHS regulations, except when an eligible provider that is a licensed physician is billing those codes in conjunction with a medical (nonroutine) diagnosis code.

Regulation Title	Regulation Number	Affected Services
Rates for Hearing Services	101 CMR 323.00	Audiologic Codes 92590 to 92595
Rates for Vision Care Services and Ophthalmic Materials	101 CMR 315.00	Ophthalmological Service Codes 92002, 92004, 92012, 92014, 92015; Spectacle Service Codes 92340-92342, 92370 and Screening Code 99173

(9) CPT Category III Codes. All medicine related CPT category III codes are included as a part of 101 CMR 317.00 and have an assigned fee of IC.

(10) PCC Plan Enhanced Fee. Primary Care Clinicians (PCCs) receive an enhanced rate for certain types of primary and preventive care visits provided to PCC Plan members enrolled with the PCC on the date of service. The enhanced fee specified in 101 CMR 353.03: *General Payment Provisions* is added to the rate for the procedure code billed. The MassHealth agency pays PCCs an enhanced fee for delivering primary care services in accordance with the terms of the PCC provider contract.

The text of the regulations published in the electronic version of the Massachusetts Register is unofficial and for informational purposes only. The official version is the printed copy which is available from the State Bookstore at http://www.sec.state.ma.us/spr/sprcat/catidx.htm.

317.03: continued

(11) Child and Adolescent Needs and Strengths (CANS): Psychiatric Diagnostic Interview Examination for Children and Adolescents Younger than 21 Years Old. Psychiatrists or psychiatric clinical nurse specialists who complete the CANS for a MassHealth child or adolescent younger than 21 years old during a Psychiatric Diagnostic Interview Examination should bill using procedure code 90791 accompanied by modifier HA.

317.04: Maximum Allowable Fees – Medical Services

(1) Drugs, Medications, Supplies, and Laboratory Specimen Collections.

(a) Payment rates for drugs, vaccines, and immune globulins administered in a physician's office are equal to the fee listed in the Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing File. For drugs, vaccines, and immune globulins administered in a physician's office that are not listed in the Quarterly ASP Medicare Part B Drug Pricing File, codes are listed in 101 CMR 317.04(4) with payment set by IC, which will apply until such time as the code is listed in the Quarterly ASP Medicare Part B Drug Pricing File.

(b) Supplies and materials used in preparation for or as part of a procedure (*e.g.*, bandages, laboratory kits, syringes, or disposable gloves) are not reimbursed separately, but are included in the office visit rate. In addition, no supplemental charge can be submitted nor payment allowed for routine specimen collection in a physician's office and preparation for clinical laboratory analysis (and activities related thereto), *e.g.*, venipuncture, urine, fecal and sputum samples, culturing, swabbing, and scraping for removal of tissues.

(c) Where applicable, payments for drugs, medicines, supplies, and related materials dispensed to patients are in accordance with rates that are the subject matter of other regulations that may be in effect and germane to the item in question (*e.g.*, laboratory, pharmacy, medical supplies, *etc.*). In other instances where the use of another regulation is not appropriate, certain supplies and materials (except eyeglasses) provided by the physician over and above those usually included with the office visit or other services rendered should be billed under code 99070.

(d) Payment for drugs and/or biologicals may be claimed in addition to an office visit. Drugs that are considered routine and integral to the delivery of a physician's professional services in the course of diagnosis or treatment are not reimbursable. Such drugs are commonly provided without charge or are included in the physician's fee for the service. Drugs and/or biologicals available free of charge from the Massachusetts Department of Public Health are not payable items. When an immunization or injection is the primary purpose of an office or other outpatient visit, the provider may bill only for the injectable material and its administration. Payment for both vaccine administration and an office visit is allowable only when the vaccine administration is a medically necessary, separately identifiable service.

(e) Allowable Fee for COVID-19 Treatment. The allowable fees for monoclonal antibodies and their administration for the treatment of COVID-19 are 100% of the corresponding Medicare Part B payment rates, without geographic adjustment. Payment for the administration of monoclonal antibodies provided by eligible providers who are certified nurse practitioners, psychiatric clinical nurse specialists, clinical nurse specialists, physician assistants, registered nurses, pharmacies that utilize pharmacists, or other health care professionals certified in accordance with 105 CMR 700.000: *Implementation of M.G.L. c. 94C*, and home health agencies as specified in 101 CMR 317.02 is 85% of the allowable fee.

(f) Allowable Fee for COVID-19 Vaccine and Vaccine Administration. The allowable fees for COVID-19 vaccines and their administration are 100% of the corresponding Medicare Part B payment rates, without geographic adjustment. Payment for administration of the COVID-19 vaccine provided by eligible providers who are certified nurse practitioners, psychiatric clinical nurse specialists, clinical nurse specialists, physician assistants, registered nurses, pharmacies that utilize pharmacists, or other health care professionals certified in accordance with 105 CMR 700.000: *Implementation of M.G.L. c. 94C*, and home health agencies as specified in 101 CMR 317.02 is 85% of the allowable fee.

(2) Unless otherwise specified, guidelines, notes, and definitions provided in the 2023 CPT Coding Handbook are applicable to the use of the procedure codes and modifiers listed below, as well as their corresponding descriptions. For code descriptions, *see* the medicine services code spreadsheet at www.mass.gov/regulations/101-CMR-31700-medicine.

The text of the regulations published in the electronic version of the Massachusetts Register is unofficial and for informational purposes only. The official version is the printed copy which is available from the State Bookstore at http://www.sec.state.ma.us/spr/sprcat/catidx.htm.

Docket # 633

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 318.00**

CHAPTER TITLE: **Rates for Radiology Services**

AGENCY: **Executive Office of Health and Human Services**

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

101 CMR 318.00 governs the payment rates used by all governmental units for radiology services provided to publicly aided patients.

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

AGENCY CONTACT: **Deborah M. Briggs** PHONE: **617-921-1744**

ADDRESS: **MassHealth Publications, 1 Enterprise Drive, 5th 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.*

101 CMR 318.00 must be adopted by October 1, 2026, to align with Chapter 186 of the Acts of 2024.

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.*

A&F Approval: September 17, 2026
145 Letters: September 18, 2026

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: _____

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

For the first and second year: **$47,000 annually**

For the first five years:

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:

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:*

101 CMR 318.00 is being amended.

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: **Sep 25 2026**

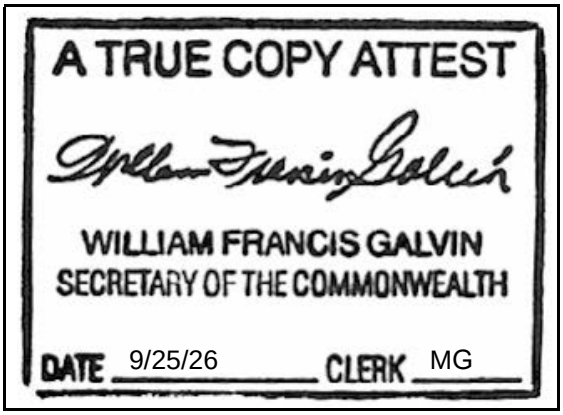
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/25/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no Replacement Pages.**



101 CMR 318.00: RATES FOR RADIOLOGY SERVICES

Section

318.01: General Provisions
318.02: General Definitions
318.03: General Rate Provisions
318.04: Maximum Allowable Fees – Radiology Services
318.05: Severability

318.01: General Provisions

(1) Scope and Purpose. 101 CMR 318.00 governs the payment rates used by all governmental units for radiology care and services provided to publicly aided patients. Rates for services provided to individuals covered by M.G.L. c. 152 (the Workers' Compensation Act) are not set forth in 101 CMR 318.00, but are at 114.3 CMR 40.00: *Rates for Services under M.G.L. c. 152, Worker's Compensation Act*.

(2) Applicable Dates of Service. Rates contained in 101 CMR 318.00 apply for dates of service on or after October 1, 2026, except as otherwise noted.

(3) Coverage.

(a) Payment rates in 101 CMR 318.00 are used to pay for radiology services rendered to patients in a private medical office, licensed clinic, hospital or other inpatient or outpatient facility or department, independent diagnostic testing facility, patient's residence, or other appropriate setting by an individual eligible provider, when an eligible provider bills for the medical services rendered and no other payment method applies.

(b) The rates of payment under 101 CMR 318.00 are full compensation for patient care rendered to publicly aided patients as well as for any related administrative or supervisory duties in connection with patient care. The rates of payment also reimburse all overhead expenses associated with the service provided, without regard to where the care is rendered.

(4) Disclaimer of Authorization of Services. 101 CMR 318.00 is not authorization for or approval of the procedures for which rates are determined pursuant to 101 CMR 318.00. Governmental units that purchase care are responsible for the definition, authorization, coverage policies, and approval of care and services provided to publicly aided patients.

(5) Coding Updates and Corrections. EOHHS may publish procedure code updates and corrections in the form of an administrative bulletin. Updates may reference coding systems including, but not limited to, the American Medical Association's *Current Procedural Terminology (CPT).*

(a) The publication of such updates and corrections will list

1. codes for which the code numbers change, with the corresponding cross-references between the new codes and the codes being replaced. Rates for such updated codes are set at the rate of the code that is being replaced;
2. deleted codes for which there are no corresponding new codes; and
3. codes for entirely new services that require pricing. EOHHS will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

(b) For entirely new codes that require new pricing and have Medicare assigned relative value units (RVUs) (or, for applicable services, Medicare rates), EOHHS may list these codes and price them according to the appropriate rate methodology used in setting physician rates. When Medicare RVUs (or, for applicable services, Medicare rates) are not available, EOHHS may apply individual consideration in reimbursing for these new codes until appropriate rates can be developed.

(6) Administrative Bulletins. EOHHS may issue administrative bulletins to add, delete, or otherwise update codes or modifiers, and to clarify its policy on and understanding of substantive provisions of 101 CMR 318.00. EOHHS may also issue administrative bulletins to clarify to which duly licensed or certified health care professionals or students the rate methods in this regulation apply.

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The official version is the printed copy which is available from the State Bookstore at http://www.sec.state.ma.us/spr/sprcat/catidx.htm.

318.02: General Definitions

Meaning of Terms. The five-digit procedure codes and two-digit modifiers included in 101 CMR 318.00, and their corresponding descriptions, utilize the Healthcare Common Procedure Code System (HCPCS) for Level I and Level II coding. Level I CPT-4 codes are obtained from the Physicians' 2023 *Current Procedural Terminology* (CPT), copyright 2022 by the American Medical Association (AMA), unless otherwise specified. Level II codes are obtained from the 2020 HCPCS, maintained jointly by the Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association, and the Health Insurance Association of America. HCPCS is a listing of descriptive terms and identifying codes and modifiers for reporting medical services and procedures performed by physicians and other health care professionals, as well as associated nonphysician services. No fee schedules, basic unit value, relative value guides, conversion factors, or scales are included in any part of the Physicians' *Current Procedure Terminology*. For code descriptions, *see* the radiology services code spreadsheet at www.mass.gov/regulations/101-CMR-31800-radiology.

In addition, terms used in 101 CMR 318.00 have the meanings set forth in 101 CMR 318.02.

Eligible Provider. The established rates apply in accordance with 101 CMR 318.01 to the following types of providers who meet conditions of participation of the governmental unit purchasing such services, and to the extent specified by such governmental unit. Eligible providers must provide such services in accordance with accepted professional standards and in accordance with state licensing requirements and certification by national credentialing bodies as required by law.

(a) A licensed physician (other than an intern, resident, fellow, or house officer), licensed podiatrist, licensed dentist, licensed chiropractor, and licensed optometrist.

(b) A provider of therapeutic and diagnostic radiology services. Such radiology services may be rendered by eligible providers such as, but not limited to, independent diagnostic testing facilities (IDTFs). These eligible providers must be independent of a hospital or a physician's office.

(c) A provider of radiation oncology services. Radiation oncology services may be rendered by eligible providers such as, but not limited to, independent radiation oncology centers. These eligible providers must be independent of a hospital or a physician's office.

(d) A clinic licensed by the Massachusetts Department of Public Health in accordance with 105 CMR 140.000*: Licensure of Clinics* to provide radiology services.

(e) A freestanding birth center facility that is not operating under a hospital's license, and is licensed as a birth center by the Massachusetts Department of Public Health pursuant to 105 CMR 140.000*: Licensure of Clinics*.

(f) An advanced practice registered nurse who is authorized by the Board of Registration in Nursing to practice as a certified nurse practitioner, certified nurse midwife, clinical nurse specialist, psychiatric clinical nurse specialist, or a certified registered nurse anesthetist (CRNA).

(g) A licensed physician assistant who is authorized by the Board of Registration for Physician Assistants to practice as a physician assistant.

(h) A licensed certified professional midwife who is authorized by the Board of Registration in Midwifery to practice as a certified professional midwife.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Governmental Unit. The Commonwealth, any department, agency, board, or commission of the Commonwealth and any political subdivision of the Commonwealth.

Individual Consideration (I.C.). Radiology services that are authorized but not listed in 101 CMR 318.00, radiology services performed in unusual circumstances, and services designated "I.C." are individually considered items. The governmental unit or purchaser analyzes the eligible provider's report of services rendered and charges submitted under the appropriate unlisted services or procedures category. The governmental unit or purchaser determines appropriate payment for procedures designated I.C. in accordance with the following standards and criteria:

(a) the amount of time required to perform the service;
(b) the degree of skill required to perform the service;
(c) the severity or complexity of the patient's disease, disorder, or disability;
(d) any applicable relative value studies;
(e) any complications or other circumstances that may be deemed relevant;

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318.02: continued

(f) the policies, procedures, and practices of other third-party insurers;
(g) the payment rate for prescribed drugs as set forth in 101 CMR 331.00: *Prescribed Drugs*; and
(h) a copy of the current invoice from the supplier.

Modifiers. Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate two-digit number.

Publicly Aided Individual (or Publicly Aided Patient). A person who receives health care and services for which a governmental unit is in whole or in part liable under a statutory program of public assistance.

Radiology Services. Radiology services including diagnostic ultrasound, radiation oncology, and nuclear medicine provided for the assessment and/or treatment of a medical condition, injury, or illness.

Separate Procedure. Some of the listed procedures are commonly carried out as an integral part of a total service, and as such do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a separate procedure in the procedure description. Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.

Supervision and Interpretation Only. When a procedure is performed by two eligible physicians, the radiologic portion of the procedure is designated as "radiological supervision and interpretation". When an eligible physician performs both the procedure and the imaging supervision and interpretation, a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used. The radiological supervision and interpretation codes are not applicable to the Radiology Oncology subsection.

Unlisted Procedure or Service. A service or procedure that may be provided that is covered, but not listed in 101 CMR 318.04. When reporting such a service, the appropriate "Unlisted Procedure" code may be used to indicate the service.

318.03: General Rate Provisions

(1) Rate Determination. Rates of payment for services for which 101 CMR 318.00 applies are the lowest of
(a) the eligible provider's usual fee to patients other than publicly aided individuals;
(b) the eligible provider's actual charge submitted; or
(c) the schedule of allowable fees set forth in 101 CMR 318.04(3), taking into account appropriate modifiers and any other applicable rate provision(s) in accordance with 101 CMR 318.03.

(2) Supplemental Payment.
(a) Eligibility. An eligible provider who is a physician, certified nurse practitioner, physician assistant, or CRNA is eligible for a supplemental payment for services to publicly aided individuals eligible under Titles XIX and XXI of the Social Security Act if the following conditions are met:
1. the eligible provider is employed by a nonprofit group practice that was established in accordance with St.1997, c.163 and is affiliated with a Commonwealth-owned medical school;
2. such nonprofit group practice must have been established on or before January 1, 2000, in order to support the purposes of a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school; and
3. the services are provided at a teaching hospital affiliated with and appurtenant to a Commonwealth-owned medical school.

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318.03: continued

(b) Payment Method. This supplemental payment may not exceed the difference between
1. payments to the eligible provider made pursuant to the rates applicable under 101 CMR 316.03(1): *Rate Determination*, 101 CMR 317.03(1): *Rate Determination* and 318.03(1); and
2. the federal upper payment established by the Centers for Medicare & Medicaid Services.

(3) The sum of the professional and technical components of an individual procedure will not be greater than the allowable global fee set forth in 101 CMR 318.04(3).

(4) Allowable Fee for Certain Eligible Providers. Payment for services provided by eligible providers who are certified nurse practitioners, certified professional midwives, psychiatric clinical nurse specialists, clinical nurse specialists, and physician assistants as specified in 101 CMR 318.02, is 85% of the fees contained in 101 CMR 318.04.

(5) CPT Category III Codes. All radiology-related CPT category III codes are included as a part of 101 CMR 318.00 and have an assigned fee of I.C.

318.04: Maximum Allowable Fees – Radiology Services

(1) Unless otherwise specified, guidelines, notes, and definitions provided in the 2023 CPT Coding Handbook are applicable to the use of the procedure codes and modifiers listed below, as well as their corresponding descriptions. For code descriptions, *see* the radiology services code spreadsheet at www.mass.gov/regulations/101-CMR-31800-radiology.

(2) Modifiers.
(a) 26: Professional Component. The component of a service or procedure representing the physician's or other qualified health care professional's work interpreting or performing the service or procedure. (When the physician or other qualified health care professional component is reported separately, the addition of modifier 26 to the procedure code will allow payment of the professional component allowable fee (PC Fee) contained in 101 CMR 318.04(3), adjusted by 101 CMR 318.03 as applicable.)
(b) 51: Multiple Procedures. Most radiology services do not require modifier 51. Modifier 51 applies only to nuclear medicine procedure codes 78306, 78320, 78802, 78803, 78806 and 78807 and should be used only when a whole body bone, tumor, or infection study is performed on the same day prior to a SPECT bone, tumor, or infection study, respectively. Under these circumstances, the modifier must be used to report multiple procedures performed at the same session. The service code for the major procedure or service must be reported without a modifier. The secondary, additional, or lesser procedure(s) must be identified by adding modifier 51 to the end of the service code for the secondary procedure(s). (The addition of modifier 51 to the second and subsequent procedure codes allows payment of 50% of the allowable fee contained in 101 CMR 318.04(3), adjusted by 101 CMR 318.03 as applicable, to the eligible provider. Note: This modifier should not be used with designated "add-on" codes or with codes in which the narrative begins with "each additional".)
(c) 52: Reduced Services. Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's or other qualified health care professional's election. Under these circumstances, the service provided can be identified by its usual procedure number and addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
(d) 59: Distinct Procedural Service. To identify a procedure distinct or independent from other services performed on the same day, add modifier 59 to the end of the appropriate service code. Modifier 59 is used to identify services/procedures that are not normally reported together, but are appropriate under certain circumstances, for example, different site or organ system. However, when another already established modifier is appropriate, it should be used rather than modifier 59.

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Docket # 634

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 351.00**

CHAPTER TITLE: **Rates for Certain Adult Foster Care Services**

AGENCY: **Executive Office of Health and Human Services**

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

Governs the payment rates for adult foster care (AFC) services, including group adult foster care (GAFC), provided to publicly aided individuals purchased by governmental units.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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.*

This emergency amendment is in response to the Governor's budget constraints in SFY2027 and needs to be in effect as soon as possible to realize the full savings. Also, the implementation of the Public Assessor Option will promote service quality by standardizing AFC and GAFC intake and assessment practices to align with the LTSS program network.

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: 9/18/26

Regulatory Review approval: 9/18/26

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: _____

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

For the first and second year: **Estimated aggregate annual fiscal impact is a decrease in spending on AFC services of $1.27M.**

For the first five years:

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:

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 101 CMR 351.00.

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: **Sep 25 2026**

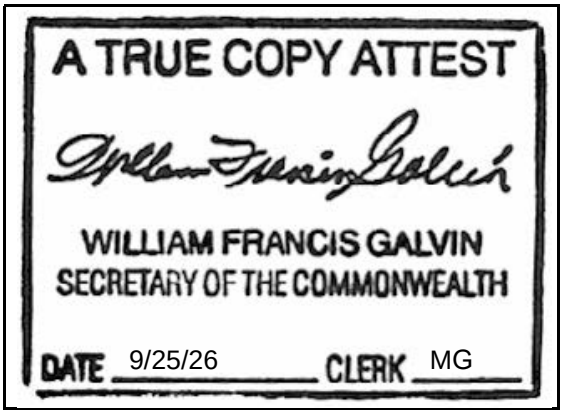
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/5/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no Replacement Pages.**



101 CMR 351.00: RATES FOR CERTAIN ADULT FOSTER CARE SERVICES

Section

351.01: General Provisions
351.02: Definitions
351.03: Rate Provisions
351.04: Filing and Reporting Requirements
351.05: Severability

351.01: General Provisions

(1) Scope and Purpose. 101 CMR 351.00 governs the MassHealth payment rates for adult foster care services and group adult foster care services described in 130 CMR 408.000: *Adult Foster Care* that are provided by participating providers to eligible publicly aided individuals.

(2) Applicable Dates of Service. The rates in 101 CMR 351.00 apply for dates of service provided on or after October 5, 2026.

(3) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify provisions of 101 CMR 351.00.

(4) Coding Updates and Corrections. EOHHS may publish service code updates and corrections in the form of an administrative bulletin if the coding system adds, deletes, or changes relevant codes.

(5) Disclaimer of Authorization of Services. 101 CMR 351.00 is neither authorization for nor approval of the services for which rates are determined pursuant to 101 CMR 351.00. Governmental units that purchase services described in 101 CMR 351.00 are responsible for the definition, authorization, and approval of services provided to publicly aided individuals.

351.02: Definitions

As used in 101 CMR 351.00, unless the context requires otherwise, terms have the meanings in 101 CMR 351.02.

Activities of Daily Living (ADLs). Fundamental personal care tasks as defined in 130 CMR 408.402: Activities of Daily Living (ADLs) performed as part of an individual's routine of self-care. ADLs include, but are not limited to, eating, toileting, dressing, bathing, transferring, and ambulation.

Adult Foster Care (AFC). Services as defined in 130 CMR 408.402: Adult Foster Care.

Adult Foster Care (AFC) Caregiver. A person selected, supervised, and paid by the provider for the provision of direct care in accordance with 130 CMR 408.415(A): *Direct Care*.

AFC Level I. A level of payment for adult foster care services provided to a member who meets the clinical criteria of 130 CMR 408.419(D)(1): *AFC Level I Service Payment*.

AFC Level II. A level of payment for adult foster care services provided to a member who meets the clinical criteria of 130 CMR 408.419(D)(2): *AFC Level II Service Payment*.

Alternative Caregiver Days. A short-term placement during which a member receives adult foster care from an alternative care provider when the AFC caregiver is temporarily unavailable or unable to provide care.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Governmental Unit. The Commonwealth, any board, commission, department, division, or agency of the Commonwealth, and any political subdivision of the Commonwealth.

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351.02: continued

Group Adult Foster Care (GAFC). Services as defined in 130 CMR 408.402: Adult Foster Care.

Intake and Assessment Services. Services as defined in 130 CMR 408.402: AFC Intake and Assessment Services and outlined in 130 CMR 408.431(A): *Preadmission Procedures and Activities* provided to a MassHealth member referred to a provider for AFC services.

MassHealth. A program of medical care and assistance that includes, but is not limited to, payment for certain health care services to eligible residents of the Commonwealth established under M.G.L. c. 118E and administered by the Executive Office of Health and Human Services through its Office of Medicaid.

Medical Leave of Absence (MLOA). A short-term absence during which a member does not receive AFC from the AFC caregiver because the member is temporarily admitted to a hospital or nursing facility.Member. A MassHealth eligible member who has received clinical authorization by either MassHealth or its designated screening agent for payment of adult foster care.

Member. A MassHealth eligible member who has received clinical authorization by either MassHealth or its designated screening agent for payment of adult foster care.

Nonmedical Leave of Absence (NMLOA). A short-term absence during which a member does not receive AFC from the AFC caregiver because the member is away from the AFC-qualified setting for nonmedical reasons.

Provider. An organization that meets the requirements of 130 CMR 408.000: *Adult Foster Care* and that contracts with MassHealth to provide adult foster care or group adult foster care to eligible MassHealth members.

Public Assessor Option (PAO). An entity contracted by and acting on behalf of EOHHS to administer initial clinical assessments of members seeking in scope Long-Term Services and Supports (LTSS) services.

Publicly Aided Individual. A person who receives health care and other services for which a governmental unit is in whole or in part liable under a statutory program of public assistance.

Service Code. The standardized code from the Healthcare Common Procedure Coding System (HCPCS).

351.03: Rate Provisions

(1) Reimbursement as Full Payment. The payment rates in 101 CMR 351.00 are full compensation for all adult foster care services or group adult foster care services rendered to members, including any related administrative or supervisory duties in connection with the provision of AFC services or GAFC services outlined in 130 CMR 408.000: *Adult Foster Care*.

(2) Payment Rates. The rates for AFC services, including GAFC services, are set forth in 101 CMR 351.03(2).

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351.03: continued

Table 1: Rates and Modifiers for AFC and GAFC Services

Service Code-Modifier	Rate	Unit	Service Description
S5140	$54.37	*Per Diem*	AFC Level I
S5140-TG	$91.31	*Per Diem*	AFC Level II
S5140-TF	$54.37	*Per Diem*	AFC Level I Alternative Caregiver Day
S5140-U5	$91.31	*Per Diem*	AFC Level II Alternative Caregiver Day
S5140-U6	$54.37	*Per Diem*	AFC Level I MLOA Day
S5140-TG-U6	$91.31	*Per Diem*	AFC Level II MLOA Day
S5140-U7	$54.37	*Per Diem*	AFC Level I NMLOA Day
S5140-TG-U7	$91.31	*Per Diem*	AFC Level II NMLOA Day
T1028	$266.62	Per Admission	AFC Intake and Assessment Services
T1028-U1	$100.00	Per Admission	AFC Intake and Assessment Services with PAO
H0043	$50.00	*Per Diem*	GAFC

351.04: Filing and Reporting Requirements

(1) Required Reports. Reporting requirements are governed by 957 CMR 6.00*: Cost Reporting Requirements*.

(2) Penalty for Noncompliance. A purchasing governmental unit may impose a penalty in the amount of up to 15% of its payments to any provider that fails to submit required information. The purchasing governmental unit will notify the provider in advance of its intention to impose a penalty under 101 CMR 351.04(2).

351.05: Severability

The provisions of 101 CMR 351.00 are severable. If any provision of 101 CMR 351.00 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 351.00 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

101 CMR 351.00: M.G.L. c. 118E.

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NON-TEXT PAGE

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Docket # 1192

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 408.000**

CHAPTER TITLE: **Adult Foster Care Services**

AGENCY: **Division of Medical Assistance**

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

Governs MassHealth providers of AFC and GAFC services and provides program requirements and conditions of payment for the provision of AFC/GAFC services to MassHealth members.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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.*

This emergency amendment is in response to the Governor's budget constraints in SFY2027 and needs to be in effect as soon as possible to realize the full savings. Also, the implementation of the Public Assessor Option will promote service quality by standardizing AFC and GAFC intake and assessment practices to align with the LTSS program network.

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: 9/18/26

Regulatory Review approval: 9/18/26

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: _____

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: _____

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 408.000.

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: **Sep 25 2026**

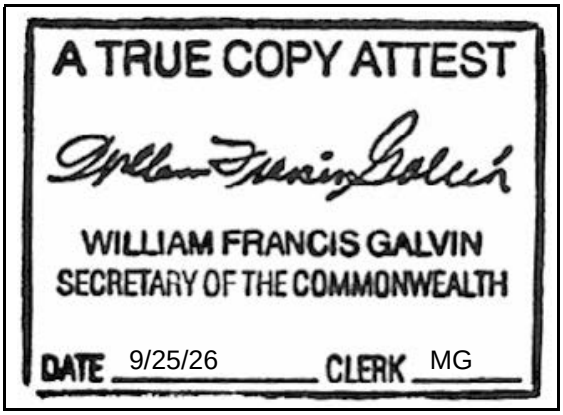
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/5/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no Replacement Pages.**



408.402: continued

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). A facility, or distinct part of a facility, that provides intermediate care facility services as defined under 42 CFR § 440.150, and that meets federal conditions of participation, and is licensed by the state primarily for the diagnosis, treatment, or rehabilitation for individuals with intellectual disabilities; and provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health or rehabilitative services to help individuals function at their greatest ability.

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

Medical Leave of Absence (MLOA). A short-term absence from an AFC-qualified setting, during which a member does not receive AFC services because the member is temporarily admitted to a hospital, nursing facility, or other medical setting.

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

Multidisciplinary Professional Team (MDT). A team employed or contracted by the provider, including, but not limited to, a program director, a registered nurse, or a licensed practical nurse; and a care manager; and which may also include an AFC community support specialist, who works in conjunction with the AFC caregiver.

Nonmedical Leave of Absence (NMLOA). A short-term absence from an AFC-qualified setting, during which a member does not receive AFC services for nonmedical reasons.

Nursing Facility. An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured people, people with disabilities, or sick persons, or on a regular basis, health-related care and services to individuals who, because of their mental or physical condition require care and services that meet the requirements of Sections 1919(a), through (d) of the Social Security Act, and is licensed under and certified by the Massachusetts Department of Public Health.

Plan of Care. A person-centered, written plan based on clinical and psychosocial evaluations, describing activities to meet a member's medical, physical, emotional, and social needs and goals for AFC.

Primary Care Provider (PCP). A physician or a physician assistant or nurse practitioner who operates under the supervision of a physician.

Primary Care Provider (PCP) Summary Form. The form that a PCP uses to order AFC.

Provider. An organization that meets the requirements of 130 CMR 408.404 and contracts with MassHealth as the provider for AFC.

Public Assessor Option (PAO). An entity contracted by and acting on behalf of EOHHS to administer initial clinical assessments of members seeking in scope Long-Term Services and Supports (LTSS) services.

Qualified Setting. A location for the provision of AFC that meets all of the standards described in 130 CMR 408.435.

Resident Care Facility. A facility or distinct units licensed as a level IV by the DPH under 105 CMR 150.000: *Licensing of Long-term Care Facilities* that are not certified to participate in Medicare or Medicaid and that provides a protective living environment and minimum basic care.

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408.402: continued

Significant Change. A major change in the member's status that
(1) is permanent;
(2) impacts more than one area of the member's health status; and
(3) requires a multidisciplinary review or revision of the care plan. A significant change is presumed when a member authorized to receive AFC services does not receive AFC services for 90 days or more, or when the provider is seeking a change in service amount or payment level.

Qualified Setting. A location for the provision of AFC that meets all of the standards described in 130 CMR 408.435.

Resident Care Facility. A facility or distinct units licensed as a level IV by the DPH under 105 CMR 150.000: *Licensing of Long-term Care Facilities* that are not certified to participate in Medicare or Medicaid and that provides a protective living environment and minimum basic care.

Significant Change. A major change in the member's status that
(1) is permanent;
(2) impacts more than one area of the member's health status; and
(3) requires a multidisciplinary review or revision of the care plan. A significant change is presumed when a member authorized to receive AFC services does not receive AFC services for 90 days or more, or when the provider is seeking a change in service amount or payment level.

408.403: Eligible Members

(A) MassHealth Members. MassHealth-eligible members 16 years of age or older, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* that specifies, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

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

408.404: Provider Eligibility

(A) An organization seeking to participate in MassHealth as an AFC provider must
(1) enter into a contract with the MassHealth agency;
(2) maintain a business office in Massachusetts and be duly authorized to conduct a business in Massachusetts that delivers health and human services to elders or people with disabilities. Such business offices must:
(a) be available to members during regular, posted business hours;
(b) be physically accessible to members with disabilities;
(c) have clear access and space for storing of business records;
(d) have a sign visible from outside the facility identifying the business name and hours that the business office is open;
(e) have a publicly listed business name, address, and local toll-free telephone number that is answered by customer service staff during business hours and that has Telecommunication Device for the Deaf/Teletype (TTY/TDD) transmission and reception capability; provided, that during business hours, this number cannot be a pager, answering service, voice message system, or cell phone; and
(f) maintain a 24-hour voice message system;
(3) accept MassHealth payments as payment in full for all AFC;
(4) establish, maintain, and comply with written policies and procedures to comply with 130 CMR 408.000;

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408.404: continued

(5) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 408.000;
(6) agree to comply with all the provisions of 130 CMR 408.000, 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations.
(7) participate in any AFC provider orientation required by EOHHS;
(8) meet all provider participation requirements described in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*;
(9) agree to pay AFC caregivers on a timely basis for services provided at applicable compensation levels.
(10) be accredited by the National Committee for Quality Assurance (NCQA), the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other nationally recognized accreditation organizations determined acceptable by the MassHealth agency. AFC providers must provide evidence of accreditation in accordancewith 130 CMR 408.404(A)(10) in the form and format as required by the MassHealth agency;
(11) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the AFC provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 408.000 in the form and format as required by the MassHealth agency; and
(12) provide evidence in the form and format required by the MassHealth agency that the organization is actively billing for and serving at least eight individuals at the time of accreditation and re-accreditation.

(B) The MassHealth agency requires documentation from applicants seeking to become AFC providers. All required application documentation must be submitted and approved in order to participate as an AFC provider in MassHealth. All required MassHealth application documentation will be specified by the MassHealth agency.

408.415: Scope of Adult Foster Care Services

(A) Direct Care. The AFC provider must ensure the delivery of direct care to members in a qualified setting, as described in 130 CMR 408.435, by a qualified AFC caregiver, as described in 130 CMR 408.434, who lives in the residence and paid by the AFC provider. AFC must be ordered by a PCP and delivered by a qualified AFC caregiver under the oversight of the registered nurse and the MDT in accordance with each member's written plan of care. Direct care includes 24-hour supervision, and daily assistance with ADLs and IADLs as defined in 130 CMR 408.402.

(B) Nursing Oversight. The AFC provider must provide nursing oversight by a registered nurse or licensed practical nurse under the supervision of a registered nurse who meets the qualifications as described in130 CMR 408.433(C)(2)(a) and 130 CMR 408.433(E)(1), who is not related to the member, and who is licensed in Massachusetts. Nursing oversight services must be individualized to meet the needs of each member in accordance with the member's AFC plan of care and must include all of the following activities:
(1) completing or coordinating all applicable clinical assessments and clinical evaluations, provided that only a registered nurse can complete such assessments and evaluations, except when the clinical assessment is completed by the PAO;
(2) developing the member's interim and final AFC plan of care, with input from the member or responsible party, all members of the MDT, and other individuals designated by the member;
(3) completing a semi-annual health status report for each member;
(4) ensuring implementation of the AFC plan of care;
(5) coordinating the delivery of AFC with any other health services or supportive services the member is receiving from MassHealth or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS) services, Department of Mental Health (DMH) services, and MassAbility services;
(6) conducting on-site visits with each member at the qualified setting:

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408.415: continued

(a) for members authorized for AFC level I service payment, the nurse must conduct on-site visits every other month, or more often as the member's condition warrant where such visits alternate with the required visits by the care manager to ensure the member receives one visit by the nurse or care manager every month, as determined by the MDT in accordance with 130 CMR 408.433(B), a community support specialist may conduct up to three non-consecutive on-site visits per 12-month period in place of the nurse; and

(b) for AFC level II service payment, the nurse must conduct on-site visits every month, or more often as the member's condition warrants, to ensure the member receives one visit by the nurse and one visit by the care manager every month, if determined appropriate by the MDT in accordance with 130 CMR 408.433(B), a community support specialist may conduct up to six non-consecutive on-site visits per 12-month period in place of the nurse;

(7) completing a nursing progress note for each on-site visit or encounter and upon significant change;

(8) monitoring each member's health status and documenting those findings in the member's medical record for each on-site visit or encounter, or more often as the member's condition warrants;

(9) educating the member about hygiene and health concerns;

(10) reporting changes in the member's condition to the member's PCP;

(11) coordinating and implementing the PCP form and approval for AFC with the member, AFC caregiver, and AFC provider personnel;

(12) developing, in conjunction with the MDT the AFC caregiver, and the member or responsible party, an emergency backup and personal care contingency plan for each member receiving AFC that includes an alternative plan for the member if the AFC caregiver is temporarily unable to provide care; and

(13) overseeing, monitoring, supporting, training, and evaluating AFC caregivers.

(C) Care Management. Care management must be provided by a qualified AFC care manager, as described in 130 CMR 408.433(C)(3)(a), who is not related to the member, and who is responsible for coordinating care and monitoring the needs of the member in conjunction with the registered nurse. Care management performed by the AFC care manager must include the following activities:

(1) conducting initial and ongoing psychosocial evaluation of a member's appropriateness for AFC;

(2) evaluating, supporting, and training AFC caregivers;

(3) assisting with the development of the member's interim and final AFC plan of care with input from the member or responsible party, all members of the MDT, and other individuals designated by the member.

(4) ensuring implementation of the AFC plan of care;

(5) conducting on-site visits with each member at the qualified setting:

(a) for AFC level I service payment, the care manager must conduct on-site visits every other month, or more often as the member's condition warrants, where such visits alternate with the required visits by the nurse to ensure the member receives one visit by the nurse or care manager every month, provided that, as determined by the MDT in accordance with 130 CMR 408.433(B), a community support specialist may conduct up to three non-consecutive on-site visits per 12-month period in place of the AFC care manager;

(b) for AFC level II service payment, the care manager must conduct on-site visits every month, or more often as the member's condition warrants, to ensure the member receives one visit by the nurse and one visit by the care manager every month. If determined appropriate by the MDT in accordance with 130 CMR 408.433(B), an AFC community support specialist may conduct up to six non-consecutive on-site visits per 12-month period in place of the care manager;

(6) assisting with coordination of AFC with any other health services or supportive services the member is receiving from MassHealth, a managed care organization, an accountable care organization or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS) services, Department of Mental Health (DMH) services, and MassAbility services;

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408.415: continued

(7) completing a care manager progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
(8) reporting changes in the member's condition to the member's AFC nurse;
(9) assisting with making referrals to appropriate service providers if the member requires services other than those provided by the AFC provider;
(10) conducting regular, periodic evaluations, at least annually, to ensure that each qualified setting where AFC is provided meets the requirements of 130 CMR 408.435;
(11) providing timely assistance and responding to urgent or emergency needs of the member; and
(12) developing, in conjunction with the MDT, the AFC caregiver, and the member or responsible party, an emergency backup and personal care contingency plan for each member, receiving AFC that includes an alternative plan for the member if the AFC caregiver is temporarily unable to provide care.

(D) AFC Community Support Specialist On-site Visits. An AFC community support specialist who is qualified as described in 130 CMR 408.433(D)(1), who is not related to the member, and who has the responsibilities described in 130 CMR 408.433(D)(2) may conduct on-site visits of the member at the qualified setting in place of the nurse or care manager if determined appropriate by the MDT in accordance with 130 CMR 408.433(B).

408.416: Clinical Eligibility Criteria for AFC

A member must meet the following clinical eligibility criteria for receipt of AFC.

(A) AFC must be ordered by the member's PCP.

(B) The member has a medical or mental condition that requires daily hands-on (physical) assistance or cueing and supervision throughout the entire activity in order for the member to successfully complete at least one of the following activities:
(1) Bathing – a full-body bath or shower or a sponge (partial) bath that may include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri-area that may include personal hygiene such as: combing or brushing of hair, oral care (including denture care and brushing of teeth), shaving, and, when applicable, applying make-up;
(2) Dressing – upper and lower body, including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps, or zippers;
(3) Toileting – member is incontinent (bladder or bowel) or requires assistance or routine catheter or colostomy care;
(4) Transferring – member must be assisted or lifted to another position;
(5) Mobility (ambulation) – member must be physically steadied, assisted, or guided during ambulation indoors and outdoors, or is unable to self-propel a wheelchair appropriately without the assistance of another person; and
(6) Eating – if the member requires constant supervision and cueing during the entire meal, or physical assistance with consuming a portion or all of the meal.

408.417: Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, members seeking AFC must undergo a clinical assessment to assess the member's clinical status and need for AFC. Completed clinical assessment documentation must be submitted to MassHealth, or its designee, in the form and format requested by the MassHealth agency. A new clinical assessment is required annually and upon significant change.

(B) Prior Authorization.
(1) As a prerequisite for payment of AFC, the AFC provider must obtain prior authorization from the MassHealth agency or its designee before the first date of service delivery and annually thereafter, and upon significant change.
(2) Prior authorization determines the medical necessity for AFC as described under 130 CMR 408.416 and in accordance with 130 CMR 450.204: *Medical Necessity*.
(3) Prior authorization may specify the service level for payment for the service.

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408.417: continued

(4) Prior authorization does not establish or waive any other prerequisites for payment such as the member's financial eligibility described in 130 CMR 503.007: *Potential Sources of Health Care* and 130 CMR 517.008: *Potential Sources of Health Care*.

(5) When submitting a request for prior authorization for payment of AFC to the MassHealth agency, or its designee, the AFC provider must submit requests in the form and format as required by the MassHealth agency. The AFC provider must include all required information including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of prior authorization.

(6) 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.

(C) Notice of Determination of Prior Authorization.

(1) Notice of Approval. If the MassHealth agency or its designee approves a request for prior authorization, it will send written notice to the member and the AFC provider.

(2) Notice of Denial or Service Modification. If the MassHealth agency or its designee denies, or approves with a service modification, request for prior authorization of AFC, the MassHealth agency or its designee will notify both the member and the AFC provider. The notice will state the reason for the denial or service modification and contain information about the member's right to appeal and the appeal procedure.

(3) 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*.

(D) Review Requirement. The MassHealth agency, or its designee, may at any time review prior authorization of MassHealth members including, but not limited to, instances in which there has been a significant change in the member's status as defined in 130 CMR 408.402.

408.418: Quality Management

AFC providers must participate in any quality management and program integrity processes established by the MassHealth agency, including making any necessary data available and access to visit the provider's place of business upon request by the MassHealth agency or its designee.

408.419: Conditions for Payment

(A) The MassHealth agency pays an AFC provider for AFC in accordance with the applicable payment methodology and rate schedule established by the EOHHS. Rates of payment for AFC do not cover or include any amount for room and board.

(B) Payment for AFC is subject to the conditions, exclusions, and limitations set forth in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays an AFC provider for AFC only if

(1) the person receiving AFC is eligible under 130 CMR 408.403;

(2) the member meets the clinical eligibility criteria for AFC in accordance with 130 CMR 408.416;

(3) the AFC provider has obtained prior authorization for AFC in accordance with 130 CMR 408.417.

(4) the member resides in an AFC-qualified setting in accordance with 130 CMR 408.435;

(5) the AFC provider bills at the payment level authorized by the MassHealth agency or its designee; and

(6) the AFC provider is not billing for days that are non-covered days under 130 CMR 408.437.

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408.430: continued

(e) medication management;
(f) universal precautions;
(g) infection control and communicable disease;
(h) recognizing and reporting abuse (physical, sexual, emotional, psychological) neglect, self-neglect, and financial exploitation;
(i) discharge criteria; and
(j) member and caregiver counseling.

(B) Clinical Assessment and Clinical Evaluations. If required by MassHealth, the AFC provider's MDT must perform a clinical assessment by completing a clinical assessment screening tool designated by the MassHealth agency as well as all any other applicable clinical evaluations for each member except when completed by the PAO,

(1) before admission to AFC;
(2) upon significant change; and
(3) annually on the anniversary date of the member's admission to AFC.

(C) AFC Plan of Care. The plan of care must be based upon clinical evaluations and contain the following elements: prioritized goals and objectives that consider and document the needs, goals and preferences of the member; the resources to be utilized; and a plan for continuity of care. The goals and actions of the plan of care must be measurable and reflect the member's desired outcomes for AFC and address medical, social, and other services needed and chosen by the member. The plan of care must reflect the member's needs, current care and treatment, problem identification with appropriate follow-up, and implementation with interventions and evaluation. The plan of care must be in language that is understandable to the member, and to the individuals important in supporting the member.

(1) Within five working days of a member's admission to AFC, the AFC provider's MDT, the member, and others as designated by the member must design an interim AFC plan of care. The interim plan must be signed by the registered nurse and include, at a minimum, an outline of a temporary schedule of care provided that will be used until the final AFC plan of care is completed.

(2) Within 30 calendar days of a member's admission to AFC, the AFC provider's MDT, the member or responsible party, the AFC caregiver, and others designated by the member must develop the final AFC plan of care. The final plan of care must be signed by the member, the registered nurse, and the care manager, and must include:

(a) a treatment plan describing how, and by whom, the member's service needs will be met 24 hours per day, seven days per week, that is based on the member's PCP's summary, physical examination, and all applicable clinical evaluations;
(b) an evaluation, completed by the MDT, of the member's ability to manage safely in the qualified setting for a maximum of three hours a day without the presence of a qualified caregiver;
(c) a current and updated list and contact information for
1. an alternative caregiver, if identified; and
2. the primary contact person who is able to address the member's needs and is available if an unforeseen event occurs that prevents the member's AFC caregiver from providing services; and
(d) documentation of any other health services or supportive services the member is receiving from the MassHealth agency or other agencies or organizations (for example, adult day health, visiting nurse services, therapy services, services provided by DDS, DMH, and MassAbility, or counseling services).

(3) The plan of care must be based upon
(a) the member's strengths, preferences, and member identified goals and desired outcomes for AFC;
(b) clinical evaluation;
(c) the AFC caregiver's care log;
(d) the nursing progress notes;
(e) the care manager's progress notes;
(f) the AFC community support specialist's progress notes;
(g) the PCP Summary Form and approval to participate in AFC;

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(h) documentation of the member's PCP annual visit and the member's physical examination; and

(i) the member's discharge and transition plan.

(4) For members who meet the requirements for receiving AFC level I service payment, the AFC provider must annually review the plan of care and send a copy of the member's health-status report to the member's PCP.

(5) For members who meet the requirements for level II service payment, the AFC provider must semi-annually review the plan of care and send a copy of the member's health status report to the member's PCP.

(6) Review of the plan of care under 130 CMR 408.430(C)(4) or (5) will be conducted by the MDT with participation from the member or responsible party, the AFC caregiver, and others as designated by the member. If a plan of care is modified, the AFC provider must send a copy of the plan of care to the member's PCP.

(7) The member, health care proxy, or surrogate identified by a member with decisional capacity must be afforded the opportunity to attend all plan-of-care meetings.

(8) The AFC provider must establish emergency policies and procedures in writing and include them with the member's plan of care including, at a minimum, an emergency file (such as an emergency fact sheet) on the member that must contain

(a) the name and telephone number of the member's PCP;

(b) the member's diagnosis;

(c) any special treatments or medications the member may need;

(d) insurance information;

(e) emergency contact information for notification of the family or legal guardian;

(f) procedures to be followed in the event a member is missing or lost; and

(g) procedures for handling medical emergencies.

(D) Recordkeeping. The AFC provider must maintain records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records including, but not limited to, the following, must be accessible and made available on-site for inspection by the MassHealth agency:

(1) administrative records, including

(a) payroll and staff records, including evidence of completed staff orientation and training;

(b) financial records;

(c) member utilization;

(d) staffing levels;

(e) complaints and grievances;

(f) documentation related to the qualified setting;

(g) documentation related to the AFC caregiver and alternative caregivers;

(h) contracts for subcontracted services;

(i) documentation of the preadmission procedure described in 130 CMR 408.431(A);

(j) contracts for independent contractor services, including a description of how the AFC provider will supervise the independent contractors and their services; and

(k) maintain job descriptions that include titles, reporting authority, qualifications, and responsibilities;

(2) member records, which must contain at a minimum all of the following:

(a) initial preadmission and admission information, including

1. the member information sheet;
2. the prior authorization by the MassHealth agency or its designee; and
3. clinical evaluations;

(b) medical information, including

1. a copy of the most recent physical examination (within the past 12 months);
2. the PCP's authorization and summary;
3. the member's semi-annual health-status reports and documentation that the health-status reports were sent to the PCP;
4. the member's medical history;
5. the member's tuberculosis screening documentation;
6. the member's a list of any known allergies;
7. information about the member's dietary requirements;

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8. a list of the member's current medications;
9. if designated by the member, advance directives and the name of the health-care proxy; and
10. the ADL needs as outlined in 408.416(B);

(c) progress notes, including
1. nursing notes;
2. care manager notes;
3. AFC community support specialist notes; and
4. caregiver service documentation (log of care received);

(d) correspondence from family, therapists, PCP, other service providers, or others, including a managed care organization or an accountable care organization, about the care of the member in the AFC program;

(e) the AFC plan of care, including any documentation forming the basis of the plan of care;

(f) the discharge plan;

(g) legal documentation, for example, signed authorizations for release of information;

(h) critical incident reports in a form and format designated by the MassHealth agency;

(i) the member's post-discharge status;

(j) documentation of the AFC caregiver's daily schedule; and

(k) documentation of the care required to be provided by the MDT; and

(3) records of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(E) Reporting.

(1) Incident Reporting. The AFC provider must immediately notify the MassHealth agency of any of the following incidents and follow up in writing within three business days:

(a) the death of a member;

(b) a fire or other natural or unnatural disaster in either the qualified setting or the AFC administrative office;

(c) a life-threatening accident or incident;

(d) a serious communicable disease contracted by AFC staff, an AFC caregiver or a member;

(e) any allegation of abuse or neglect of or by the member; and

(f) a member missing from a qualified setting.

(2) Program Reporting. The AFC provider must submit all of the following information in the format and time frames as requested by the MassHealth agency:

(a) clinical and statistical information;

(b) cost and expense information;

(c) member satisfaction survey results, including the survey developed by the provider, and a description of how the findings will be addressed.

(d) change in AFC provider contact information; and

(e) any additional information requested by the MassHealth agency or its designee related to the provider's provision of AFC services.

(f) data necessary to measure the quality of the services delivered by the provider as required by MassHealth.

(F) Quality Improvement Plan. Each AFC provider must conduct a biennial survey of members, caregivers, and staff and develop a quality improvement plan that addresses issues and concerns raised by the survey. The provider must maintain the survey and quality improvement plan.

(G) AFC Caregiver Compensation. Each AFC provider must agree to pay AFC caregivers on a timely basis for services provided at applicable compensation levels for which a minimum amount may be established by the MassHealth agency by bulletin or other written issuance. Any such bulletin or written issuance will be concurrent with the rates established pursuant to M.G.L. c. 118E, § 13D, and 101 CMR 351.00: *Rates for Certain Adult Foster Care Services*.

408.431: Preadmission and Admission Procedures

(A) Preadmission Procedures and Activities.

(1) Preadmission Procedures. Before admitting a member in AFC, the AFC provider must perform all of the activities in 130 CMR 408.431(A)(2). Intake and assessment services are provided to members seeking admission to AFC but who may have not yet received prior authorization by the MassHealth agency or its designee, for AFC. The AFC provider must conduct a preadmission meeting with the member, and if applicable or requested, the member's family, other informal caregivers, and any other health or social service provider

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involved in the member's care. The nurse must determine that the AFC provider is able to meet all of the ADL and IADL needs of the member prior to admitting the member to AFC, as well as use the meeting to obtain information about the member's overall health characteristics, psychosocial condition, nutritional habits, financial and health insurance information, housing situation, formal and informal supports in place, and ethnic and cultural background. The AFC provider must also use this meeting to inform the member and the member's family about the scope of AFC to be provided and any other relevant information;

(2) Preadmission Activities. Prior to admitting the member, the AFC provider must perform the following intake and assessment services under the direction of the MassHealth agency:

(a) conduct clinical evaluations of the need for AFC, except when completed by the PAO;

(b) review and approve AFC caregiver applicants;

(c) instruct members on the rules, policies, and procedures of the AFC program;

(d) identify appropriate potential AFC caregivers and qualified settings, including conducting on-site interviews in the qualified setting;

(e) schedule meetings with the member or responsible party and potential AFC caregiver;

(f) match the member with the most appropriate potential AFC caregiver;

(g) provide information on the member's rights and responsibilities when receiving AFC services;

(h) provide instruction and initial training of AFC caregivers; and

(i) schedule the member's move-in date with the AFC caregiver in circumstances in which the member is moving into the AFC caregiver's home.

(B) Admission Activities. Upon the AFC provider's receipt of the MassHealth agency's initial prior authorization authorizing the member to receive services and, by the end of the fifth day of service, the AFC provider must perform the following activities:

(1) Complete and submit a written notification to the member and, if applicable, the member's legal guardian. The notice must at a minimum specify the following:

(a) that the member has been admitted to AFC;

(b) the member's interim AFC plan of care, as outlined in 130 CMR 408.430(C)(1);

(c) the respective responsibilities of the member and the member's family, the AFC provider, and the AFC caregiver;

(d) emergency procedures; and

(e) reasons for discharge from the AFC provider.

(2) Create a member record. By the first day of AFC, the AFC provider must obtain all the necessary documentation from the member's PCP and other service providers on or before the first date of service. The documentation must include

(a) the PCP Summary Form and order for AFC that documents that the member has been examined in the past 12 months and that the MassHealth member's condition requires support with activities of daily living that is provided by the AFC provider;

(b) the member's medical history;

(c) results of a PCP visit within the past three months; however if the PCP has completed a physical examination in the past 12 months and there has been no change in the members medical status, and the PCP has deemed a second physical is not medically necessary, the PCP may document and sign such a statement on the PCP Summary Form;

(d) results of a physical examination given within the past 12 months. If the individual has been hospitalized in the preceding three months, a complete discharge summary may be used to fulfill the physical examination requirement;

(e) a list of current medications, treatments, and other services provided;

(f) a statement of special dietary requirements;

(g) a statement indicating any contraindications or limitations to the individual's participation;

(h) recommendations for other services, if applicable; and

(i) a list of known allergies, if any.

(3) Conduct on-site visits according to the member's AFC service payment level.

(a) For members receiving AFC level I service payment, the initial visit must be conducted on the first day of AFC and may be conducted by the registered nurse, licensed practical nurse, or care manager

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(b) For members receiving AFC level II service payment, the initial visit must be conducted on the first day of AFC and must be conducted by the AFC provider's registered nurse or licensed practical nurse. For the first month of service, weekly visits must be made by the registered nurse or licensed practical nurse.

(4) Provide the member by day 30 a written copy of the member's completed AFC plan of care.

408.432: Discharge Procedures

(A) A member must be discharged by the AFC provider upon the member's request, or if the member ceases to benefit from AFC, including the following circumstances:

(1) the member no longer meets the clinical eligibility criteria for AFC;

(2) the member demonstrates behavioral or other problems that may endanger the member, the AFC caregiver, or AFC provider staff;

(3) the member's clinical needs are beyond the scope of AFC;

(4) the member's needs cannot be met by the AFC provider;

(5) the member does not reside in an AFC-qualified setting;

(6) the member selects another service that is duplicative of AFC; or

(7) the member transitions to another AFC provider.

(B) For all discharges, the AFC provider must

(1) develop a discharge and transition plan that must

(a) include the date and reason for discharge;

(b) identify any referrals by the AFC provider to other appropriate service providers for any health or social services required by the member;

(c) ensure continuity of care by the member, including during transitions of care as specified in the AFC plan of care;

(d) be dated and signed by the AFC registered nurse, the AFC care manager, and the member; and

(e) require at least one follow-up telephone call within 30 business days after discharge to determine the member's post-discharge status and condition;

(2) provide assistance to the member in identifying and locating another provider;

(3) arrange for the member to be discharged and transitioned to the provider identified in 130 CMR 408.432(B)(2);

(4) coordinate the discharge and transition with the member, member's family or legal guardian, and staff of the program or agency to which the member is to be transferred; and

(5) maintain current level of services until the member is admitted with a new provider.

408.433: Adult Foster Care Staff Qualifications and Responsibilities

All staff directly employed by the AFC provider, as well as any contract staff, *per diem* staff, backup staff, or anyone providing AFC on behalf of the AFC provider to members must meet the following requirements.

(A) General Staff Requirements.

(1) Prior to hiring or contracting with any staff the AFC provider must:

(a) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications;

(b) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual for employment;

(c) conduct a Sex Offender Registry Information (SORI) check;

(d) conduct Office of Inspector General (OIG) check;

(e) conduct licenses and certification checks and validate that the candidate has obtained all necessary licenses and certifications and that all licenses and certifications are current;

(f) ensure that each AFC staff person is not related to or legally responsible for the member receiving AFC; and

(g) ensure that each AFC registered nurse, licensed practical nurse, care manager, and AFC community support specialist has received a tuberculosis screening within the previous 12 months;

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(2) On an ongoing basis, the AFC provider must

(a) ensure that all registered nurses, licensed practical nurses, care managers, and AFC community support specialists receive tuberculosis screenings in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health;

(b) ensure that all staff are appropriately trained and managed, which must include, but not be limited to, training in recognition and reporting of abuse of elders and persons with disabilities and provider services;

(c) have available at all times a sufficient number of educated, experienced, trained, and competent personnel to provide AFC to elders or adults with disabilities;

(d) evaluate staff annually using standardized evaluation measures;

(e) maintain a record of each performance evaluation in a separate personnel file for each staff member; and

(f) include in each staff member's personnel file any staff incident or accident reports.

(B) Multidisciplinary Professional Team. Each AFC provider must have an MDT, which works in conjunction with the AFC caregiver, to meet the nursing, oversight, and care-management needs of members. The MDT must include a program director, a registered nurse or a licensed practical nurse, and an AFC care manager, and may include an AFC community support specialist. The registered nurse or the AFC care manager may assume the role of program director. For each employee and independent contractor, the AFC provider must maintain a job description that includes the title, reporting authority, qualifications, and responsibilities. The MDT must meet to discuss AFC services provided to a member upon significant change of the member or more often as the member's condition warrants, but not less frequently than every six months. The MDT may determine when AFC community support specialist visits are appropriate in place of a registered nurse, licensed practical nurse, or AFC care manager visit based on member needs and as specified in 130 CMR 408.415(B)(6), 408.415(C)(5), and 408.415(D).

(C) The Multidisciplinary Professional Team Staff Qualifications and Responsibilities

(1) Program Director. The AFC provider must employ a program director who is a health-care professional.

(a) Qualifications. The program director must have a bachelor's degree and a minimum of five years of recent professional health-care experience working with elders or adults. A master's degree in a relevant health-care discipline may be substituted for two of the required five years of work experience. At least one of those years must have been spent in an administrative role.

(b) Responsibilities. The responsibilities of the program director include

1. development and implementation of the AFC provider's policies and procedures in 130 CMR 408.430(A);

2. direction and supervision of all aspects of the AFC program;

3. oversight of the hiring, training, supervision, firing, and evaluation, of all AFC employees and independent contractors;

4. payment of a stipend to all AFC caregivers for their services, and in accordance with any minimum amount established by the MassHealth agency pursuant to 130 CMR 408.404(A)(9);

5. the fiscal administration of the AFC program, including billing, budget preparation, and required program statistical and financial reports; and

6. ensuring that the AFC provider meets all of the requirements in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations.*

(2) Registered Nurse. The AFC provider must employ or independently contract with a registered nurse. The registered nurse may function as the program director.

(a) Qualifications. The registered nurse must be fully licensed by the Massachusetts Board of Registration in Nursing. The registered nurse must have at least two years of recent experience in the direct care of elders or adults with disabilities.

(b) Responsibilities. The responsibilities of the registered nurse include

1. completing and coordinating all applicable clinical assessments and clinical evaluations, except when completed by the PAO;

2. developing and reviewing on an ongoing basis each member's AFC plan of care;

3. provide oversight to AFC caregivers in conjunction with the care manager;

4. reviewing the PCP Summary Form;

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5. monitoring the health status of all members to ensure that all needed AFC is properly delivered;
6. reporting changes in the health status of any member to the member's PCP;
7. reviewing AFC caregiver logs at a minimum of every 30 days;
8. conducting on-site visits with each member at the qualified setting in accordance with 130 CMR 408.415(B)(6);
9. completing a nursing progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
10. submitting semiannual health-status reports to the member's PCP;
11. planning for and implementing discharges and transition from the AFC program;
12. conducting an orientation for each AFC caregiver before the AFC caregiver begins personal care; and
13. providing ongoing training to AFC caregivers on health and aging.

(3) Care Manager. The AFC provider must employ or independently contract with a care manager. The AFC care manager may function as the program director.

(a) Qualifications. The care manager must have

1. a bachelor's degree, a social worker license from the Massachusetts Board of Registration in Social Work, and at least two years of recent experience working with elders or adults with disabilities; or
2. a bachelor's degree and two years of clinical experience in the care of elders or people with disabilities.

(b) Responsibilities. The responsibilities of the care manager include

1. conducting ongoing evaluations of the AFC qualified setting;
2. obtaining a social history and conducting a psychosocial evaluation;
3. provide oversight to AFC caregivers in conjunction with the registered nurse;
4. participating in the development, implementation, and ongoing review of the AFC plan of care;
5. conducting on-site visits with each member at the qualified setting in accordance with 130 CMR 408.415(C)(5);
6. completing a care-management progress note corresponding with each on-site visit or encounter and upon significant change;
7. reviewing AFC caregiver logs at a minimum of every 30 days;
8. assisting with obtaining information and accessing other health-care and community services;
9. reviewing and documenting the fire and safety procedures for the qualified setting;
10. participating in discharge and transition planning and implementation; and
11. reviewing, as needed and at least annually the suitability of the qualified setting.

(4) Staff Qualification Substitution. For any staff member on the MDT that does not meet the qualifications as stated in 130 CMR 408.433, the AFC provider must receive a written approval from the MassHealth agency for substitution of the qualification prior to hiring.

(D) AFC Community Support Specialist. The AFC provider may employ or independently contract with community support specialists.

(1) Qualifications. A community support specialist must have at least one year of experience working with elders or adults with disabilities.

(2) Responsibilities. The responsibilities of a community support specialist include

(a) conducting on-site visits with the member at the qualified setting in accordance with 130 CMR 408.415(B)(6), 408.415(C)(5) and 408.415(D);

(b) participating in the development, implementation, and ongoing review of the AFC plan of care;

(c) completing a community support specialist progress note corresponding with each on-site visit and encounter with members; and

(d) providing to the member and caregiver culturally appropriate health education, information, support, and counseling.

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(E) Licensed Practical Nurse. The AFC provider may employ or independently contract with a licensed practical nurse.

(1) Qualifications. The licensed practical nurse must be licensed by the Massachusetts Board of Registration in Nursing and in good standing with the Board.

(2) Responsibilities. Under the direction and supervision of the AFC provider RN, licensed practical nurses may:

(a) complete and coordinate all applicable clinical assessments and clinical evaluations;

(b) develop and review on an ongoing basis each member's AFC plan of care;

(c) provide oversight to AFC caregivers in conjunction with the care manager;

(d) review the PCP Summary Form;

(e) monitor the health status of all members to ensure that all needed AFC is properly delivered;

(f) report changes in the health status of any member to the member's PCP;

(g) review AFC caregiver logs at a minimum of every 30 days;

(h) conduct on-site visits with each member at the qualified setting in accordance with 130 CMR 408.415(B)(6);

(i) complete a progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;

(j) submit semiannual health-status reports to the member's PCP;

(k) plan for and implementing discharges and transition from the AFC program;

(l) conduct an orientation for each AFC caregiver before the AFC caregiver begins personal care; and

(m) provide ongoing training to AFC caregivers on health and aging.

(F) AFC Staff Training Requirements.

(1) The AFC provider must provide initial and periodic training to all staff members who are responsible for the care of a member. Records of completed training must be kept on file and updated regularly by the AFC provider.

(2) The AFC provider must hold an orientation for new staff within one month of hire. This orientation must include the following topics:

(a) delivery of AFC by the AFC provider;

(b) AFC provider written policies and procedures;

(c) the requirements of 130 CMR 408.000;

(d) AFC provider staff roles and responsibilities;

(e) caring for people with disabilities, elders, individuals with Alzheimer's disease and related disorders, behavioral health issues and cognitive impairments, including behavioral interventions, behavior acceptance, and accommodations;

(f) observation, reporting, and documentation of the member's status and the care provided, including AFC caregiver log entries;

(g) basic first aid, cardiopulmonary resuscitation (CPR) and emergency procedures including the Heimlich maneuver;

(h) universal precautions and infection control practices;

(i) information about local health, fire, safety, and building codes;

(j) privacy and confidentiality;

(k) multidisciplinary team approach;

(l) medication management;

(m) communication and interpersonal skills;

(n) advance directives;

(o) prevention of and reporting of, abuse, neglect, mistreatment/and misappropriation/financial exploitation;

(p) completing and filing critical incident reports;

(q) techniques of providing safe personal care assistance: good body mechanics;

(r) human rights, nondiscrimination and cultural sensitivity;

(s) recognizing the physical, emotional and developmental needs of the individuals in their care and working in a manner that respects them, their privacy and their property;

(t) recognizing, responding to and reporting change in condition, emergencies and knowledge of emergency procedures, including the AFC provider's fire, safety, and disaster plans; and

(u) relevant provisions of the Health Insurance Portability and Accountability Act of 1996.

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(G) AFC Backup Staff Coverage. The AFC provider must ensure the availability of professional and direct care backup staff if coverage is required due to illness, vacation, or other reasons. All staff providing backup coverage must possess an equal or greater level of licensure and certification required for each position, and must meet all other requirements of regular staff members.

408.434: Adult Foster Care Caregiver Qualifications and Responsibilities

(A) General Requirements. The AFC provider must

(1) uniformly administer an evaluation of all prospective AFC caregivers to ensure that the individuals meet all of the necessary qualifications defined in 130 CMR 408.434(B);

(2) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual from performing as an AFC caregiver;

(3) conduct a Sex Offender Registry Information (SORI) check;

(4) conduct Office of Inspector General (OIG) check;

(5) ensure that each AFC caregiver has received a tuberculosis screening within the prior 12 months, and thereafter every two years in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health;

(6) ensure that the AFC caregiver is not serving more than a total of three persons, no more than two of whom are authorized for AFC level II service payment, in the qualified setting regardless of service provided or payer source;

(7) ensure that all AFC caregivers are appropriately trained and managed; and

(8) ensure that the AFC caregiver is in the qualified setting to provide the appropriate amount of necessary care to meet the member's needs.

(B) Qualifications. Each AFC caregiver must

(1) be a responsible person who is at least 18 years old, with the ability to make mature and accurate judgments and with no mental, physical, or other impairments that would interfere with the adequate performance of the duties and responsibilities of an AFC caregiver;

(2) not suffer from alcohol or substance use disorder;

(3) be able to live with the member and devote appropriate time necessary to provide needed personal care to the member to ensure the member's safety and well-being at all times;

(4) not be a family member, as defined in 130 CMR 408.402;

(5) not serve in another role within a member's MDT (*e.g.*, cannot be a member's AFC care manager and also the member's AFC caregiver); and

(6) meet all other requirements established by the AFC provider for an AFC caregiver.

(C) Responsibilities. The AFC caregiver must

(1) supervise and assist with ADLs and IADLs of a member that is necessary for the member's health and well-being;

(2) monitor and report any nonurgent or nonemergency changes in the member's medical condition to the member's AFC provider. In cases of emergency, the AFC caregiver must report directly to the most appropriate provider and follow up with the AFC provider;

(3) maintain the qualified setting consistent with the requirements of 130 CMR 408.435;

(4) complete a caregiver log;

(5) send the completed caregiver log at the end of each month to the program's registered nurse where it is maintained as part of the member's file;

(6) provide ongoing supervision to the member of health-related activities, such as:

(a) issuing reminders to the member about prescribed medications;

(b) timely refilling of the member's prescriptions;

(c) assisting with or arranging for member transportation to medical and other appointments;

(d) assisting the member to comply with health-care instructions from health-care providers; and

(e) promptly arranging for medical care that the member needs;

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(7) notify the AFC provider of the need for alternative care of the member; and
(8) immediately notify the AFC provider when any of the following events occur:
(a) death of a member;
(b) a medical emergency or any significant change in a member's health or level of functioning;
(c) a fire, accident, injury, or contraction of a serious communicable disease by the member or AFC caregiver;
(d) any planned or unexpected departure from the residence by a member or AFC caregiver; and
(e) all other member or caregiver incidents or accidents.

(D) AFC Caregiver Training Requirements.
(1) AFC providers must provide AFC caregivers a minimum of eight hours of in-service training per year on topics that complement or reinforce the topics listed in 130 CMR 408.434(D)(2) with at least one hour of training on recognizing, responding to, communicating, and reporting changes in condition, critical incidences, emergencies, and knowledge of emergency procedures, including the AFC provider's fire, safety, and disaster plans. Records of completed training must be kept on file and updated regularly by AFC providers.
(2) The initial orientation training sessions must include the following topics:
(a) techniques of providing safe delivery of ADLs and IADLs and good body mechanics;
(b) delivery of AFC by the AFC provider;
(c) written policies and procedures of the AFC provider;
(d) the requirements of 130 CMR 408.000;
(e) the roles and responsibilities of AFC provider staff and AFC caregivers;
(f) caring for people with disabilities, elders, individuals with Alzheimer's disease and related disorders, behavioral health issues and cognitive impairments, including behavioral interventions, behavior acceptance, and accommodations;
(g) observation, reporting and documentation of the member's status and the care provided including AFC caregiver log entries;
(h) basic first aid, cardiopulmonary resuscitation (CPR), and emergency procedures, including the Heimlich maneuver;
(i) universal precautions and infection control and practices;
(j) information about local health, fire, safety, and building codes;
(k) privacy and confidentiality;
(l) communication and interpersonal skills;
(m) advance directives;
(n) prevention of, and reporting of, abuse, neglect, mistreatment and misappropriation/ financial exploitation;
(o) completing and filing critical incident reports;
(p) human rights, nondiscrimination and cultural sensitivity;
(q) recognizing the physical, emotional, and developmental needs of the individuals in their care and working in a manner that respects them, their privacy and their property;
(r) recognizing, responding to, communicating, and reporting change in condition, critical incidences, emergencies, and knowledge of emergency procedures, including the AFC provider's fire, safety, and disaster plans; and
(s) relevant provisions of the Health Insurance Portability and Accountability Act of 1996.

408.435: Adult Foster Care Qualified Setting Requirements

Any residence where AFC is provided must be qualified by the AFC provider and meet the setting requirements of 130 CMR 408.435.

(A) The qualified setting must be
(1) a private residence located in Massachusetts, occupied by the AFC caregiver, and not subject to state licensure or certification as a hospital, nursing facility, resident care facility, group home, ICF/IID Disability, or ALR;

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Multidisciplinary Professional Team (MDT). A team employed or contracted by the provider, including but not limited to, a program director, a registered nurse or a licensed practical nurse, and a care manager.

Nursing Facility. An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, rehabilitation services for the rehabilitation of injured people, people with disabilities, or sick persons, or on a regular basis, health-related care and services to individuals who, because of their mental or physical condition require care and services that meet the requirements of Sections 1919(a), through (d) of the Social Security Act, and is licensed under and certified by the Massachusetts Department of Public Health.

Plan of Care. A person-centered, written plan based on clinical and psychosocial evaluations, describing activities to meet a member's medical, physical, emotional, and social needs and goals for GAFC.

Primary Care Provider (PCP). A physician or a physician assistant or nurse practitioner who operates under the supervision of a physician.

Primary Care Provider (PCP) Summary Form. The form that a PCP uses to order GAFC.

Provider. An organization that meets the requirements of 130 CMR 408.504 and contracts with MassHealth as the provider for GAFC.

Public Assessor Option (PAO). An entity contracted by and acting on behalf of EOHHS to administer initial member assessments for in scope Long-Term Services and Supports (LTSS) services

Significant Change. A major change in the member's status that
(1) is permanent;
(2) impacts more than one area of the member's health status; and
(3) requires a multidisciplinary review or revision of the care plan. A significant change is presumed when a member authorized to receive services does not receive services for 90 days or more, or when the provider is seeking a change in service amount or payment level.

408.503: GAFC Eligible Members

(A) MassHealth Members. MassHealth eligible members 22 years of age or older may receive GAFC, subject to the restrictions and limitations described in 130 CMR 450.105: *Coverage Types* that specifies, for each MassHealth coverage type, which services are covered and which members are eligible to receive those services.

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

408.504: GAFC Provider Eligibility

(A) An organization seeking to participate in MassHealth as a GAFC provider must:
(1) enter into a contract with the MassHealth agency;
(2) maintain a business office in Massachusetts and be duly authorized to conduct a business in Massachusetts that delivers health and human services to elders or people with disabilities. Such business offices must:
(a) be available to members during regular, posted business hours;
(b) be physically accessible to members with disabilities;
(c) have clear access and space for storing of business records;
(d) have a sign visible from outside the facility identifying the business name and hours that the business office is open;
(e) have a publicly listed business name, address and local toll-free telephone number that is answered by a customer service staff during business hours and that has Telecommunication Device for the Deaf/Teletype (TTY/TDD) transmission and reception capability; provided, that during business hours, this number cannot be a pager, answering service, voice message system, or cell phone; and
(f) maintain a 24-hour voice message system;

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(3) accept MassHealth payments as payment in full for all GAFC services;
(4) establish, maintain, and comply with written policies and procedures to comply with 130 CMR 408.000;
(5) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 408.000;
(6) agree to comply with all the provisions of 130 CMR 408.000, 130 CMR 450.000: *Administrative and Billing Regulations,* and all other applicable MassHealth rules and regulations.
(7) participate in any GAFC provider orientation required by EOHHS;
(8) meet all provider participation requirements described in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*; and
(9) be certified as an assisted living residence pursuant to 651 CMR 12.00: *Certification Procedures and Standards for Assisted Living Residences* and provide GAFC only to members who reside at such residence or be accredited by the National Committee for Quality Assurance (NCQA), the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or other nationally recognized accreditation organizations determined acceptable by the MassHealth agency. GAFC providers must provide evidence of such certification or accreditation in accordance with 130 CMR 408.504(A)(9) in the form and format as required by the MassHealth agency;
(10) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the GAFC provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 408.504(A)(10) in the form and format as required by the MassHealth agency; and
(11) provide evidence in the form and format required by the MassHealth agency that the organization is actively billing for and serving at least eight individuals at the time of accreditation and re-accreditation.

(B) The MassHealth agency requires documentation from applicants seeking to become GAFC providers. All required application documentation must be submitted and approved in order to participate as a GAFC provider in MassHealth. All required MassHealth application documentation will be specified by the MassHealth agency.

408.505: Scope of Group Adult Foster Care Services

(A) Direct Care. Direct care includes daily assistance with ADLs and IADLs as defined in 130 CMR 408.502. The GAFC provider must ensure the delivery of direct care to members by a qualified GAFC direct care aide, as described in 130 CMR 408.524(C), who is supervised by the GAFC provider. GAFC must be ordered by a PCP and delivered by a qualified GAFC direct care aide under the supervision of the registered nurse and the MDT in accordance with each member's written plan of care. Direct care includes daily assistance with ADLs and IADLs as defined in 130 CMR 408.502.

(B) Nursing Oversight. The GAFC provider must provide nursing oversight by a registered nurse or licensed practical nurse under the supervision of a registered nurse who meets the qualifications as described in 130 CMR 408.524(B)(2)(a) and 130 CMR 408.524(D)(1), who is not related to the member, and who is licensed in Massachusetts. Nursing oversight services must be individualized to meet the needs of each member in accordance with the member's GAFC plan of care and must include all of the following activities:
(1) completing or coordinating all applicable clinical assessments and clinical evaluations, provided that a licensed practical nurse may complete clinical assessments and evaluations only under the supervision of a registered nurse, except when the clinical assessment is completed by the PAO;
(2) developing the member's interim and final GAFC plan of care with input from the member or responsible party, all members of the MDT, and other individuals designated by the member;
(3) completing a semi-annual health status report for each member;
(4) ensuring implementation of the GAFC plan of care;

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(5) coordinating the delivery of GAFC with any other health services or supportive services the member is receiving from MassHealth or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS), Department of Mental Health (DMH) services, Executive Office of Elder Affairs, and MassAbility services;

(6) conducting on-site visits with each member at the member's home every other month or more often as the member's condition warrants, where such visits alternate with the required visits by the care manager to ensure the member receives one visit by the nurse or care manager every month;

(7) completing a nursing progress note for each on-site visit or encounter and upon significant change;

(8) monitoring each member's health status and documenting those findings in the member's medical record for each on-site visit or encounter, or more often as the member's condition warrants;

(9) educating the member about hygiene and health concerns;

(10) reporting changes in the member's condition to the member's PCP;

(11) coordinating and implementing the PCP form and approval for GAFC with the member and GAFC provider personnel;

(12) developing, in conjunction with the MDT, the GAFC direct care aide, and the member or responsible party, an emergency backup and personal care contingency plan for each member receiving GAFC that includes an alternative plan for the member if the GAFC provider is temporarily unable to provide care; and

(13) overseeing, monitoring, supporting, training, and evaluating GAFC direct care aides.

(C) Care Management. Care management must be provided by a qualified GAFC care manager, as described in 130 CMR 408.524(B)(3)(a), who is not related to the member, and who is responsible for coordinating care and monitoring the needs of the member in conjunction with the registered nurse. Care management performed by the GAFC care manager must include the following activities:

(1) conducting initial and ongoing psychosocial evaluation of a member's appropriateness for GAFC;

(2) evaluating, supporting, and training GAFC direct care aides;

(3) assisting with the development of the member's interim and final GAFC plan of care with input from the member or responsible party, all members of the MDT, and other individuals designated by the member;

(4) ensuring implementation of the GAFC plan of care;

(5) conducting on-site visits with each member at the member's home every other month, or more often as the member's condition warrants, where such visits alternate with the required visits by the nurse or care manager to ensure the member receives one visit by the care manager or nurse every month;

(6) assisting with coordination of GAFC with any other health services or supportive services the member is receiving from MassHealth, a managed care organization, an accountable care organization or other agencies or organizations including, but not limited to, visiting nurse services, therapy services, Department of Developmental Services (DDS), Department of Mental Health (DMH) services, and MassAbility services;

(7) completing a care manager progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;

(8) reporting changes in the member's condition to the member's GAFC nurse;

(9) assisting with making referrals to appropriate service providers if the member requires services other than those provided by the GAFC provider;

(10) providing timely assistance and responding to urgent or emergency needs of the member; and

(11) developing, in conjunction with the MDT, the GAFC direct care aide, and the member or responsible party, an emergency backup and personal care contingency plan for each member receiving GAFC that includes an alternative plan for the member if the GAFC provider is temporarily unable to provide care.

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408.506: GAFC Clinical Eligibility Criteria

A member must meet the following clinical eligibility criteria for receipt of GAFC:

(A) GAFC has been ordered by the member's PCP; and

(B) The member has a medical or mental condition that requires daily assistance with at least one of the ADLs described at 130 CMR 408.506(C). Such assistance must be either:
(1) hands-on (physical) assistance, or
(2) cueing and supervision throughout the entire ADL.

(C) The following activities constitute ADLs applicable to GAFC eligibility:
(1) bathing: a full-body bath or shower or a sponge (partial) bath which must include washing and drying of face, chest, axillae (underarms), arms, hands, abdomen, back and peri-area that may include personal hygiene such as combing or brushing of hair, oral care (including denture care and brushing of teeth), shaving, and, when applicable, applying make-up;
(2) dressing: upper and lower body, including street clothes and undergarments, but not solely help with shoes, socks, buttons, snaps, or zippers;
(3) toileting: member is incontinent (bladder or bowel) or requires assistance or routine catheter or colostomy care;
(4) transferring: member must be assisted or lifted to another position;
(5) mobility (ambulation): member must be physically steadied, assisted, or guided during ambulation indoors and outdoors, or is unable to self-propel a wheelchair appropriately without the assistance of another person; and
(6) eating: if the member requires constant supervision and cueing during the entire meal, or physical assistance with consuming a portion or all of the meal.

408.507: GAFC Clinical Assessment and Prior Authorization

(A) Clinical Assessment. As part of the prior authorization process, members seeking GAFC must undergo a clinical assessment to assess the member's clinical status and need for GAFC. Completed clinical assessment documentation must be submitted to the MassHealth agency, or its designee, in the form and format requested by the MassHealth agency. A new clinical assessment is required annually and upon significant change. The MassHealth agency reserves the right to conduct the clinical assessment.

(B) Prior Authorization.
(1) As a prerequisite for payment of GAFC, the GAFC provider must obtain prior authorization from the MassHealth agency or its designee before the first date of service delivery and annually thereafter, and upon significant change.
(2) Prior authorization determines the medical necessity for GAFC as described under 130 CMR 408.507 and in accordance with 130 CMR 450.204: *Medical Necessity*.
(3) Prior authorization may specify the service amount for payment for the service.
(4) Prior authorization does not establish or waive any other prerequisites for payment such as the member's financial eligibility described in 130 CMR 503.007: *Potential Sources of Health Care* and 130 CMR 517.008: *Potential Sources of Health Care*.
(5) When submitting a request for prior authorization for payment of GAFC to the MassHealth agency, or its designee, the GAFC provider must submit requests in the form and format required by the MassHealth agency. The GAFC provider must include all required information including, but not limited to, documentation of the completed clinical assessment conducted by the MassHealth agency or its designee; other nursing, medical or psychosocial evaluations or assessments; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of prior authorization.
(6) 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.

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(C) Notice of Determination of Prior Authorization.

(1) Notice of Approval. If the MassHealth agency or its designee approves a request for prior authorization, it will send written notice to the member and the GAFC provider.

(2) Notice of Denial or Service Modification. If the MassHealth agency or its designee denies, or approves with a service modification, a request for prior authorization of GAFC, the MassHealth agency or its designee will notify both the member and the GAFC provider. The notice will state the reason for the denial or service modification and contain information about the member's right to appeal and the appeal procedure.

(3) 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*.

(D) Review Requirement. The MassHealth agency, or its designee, may at any time, review prior authorization of MassHealth members including, but not limited to, instances in which there has been a significant change in the member's status as defined in 130 CMR 408.502.

408.508: GAFC Quality Management

Providers must participate in any quality management and program integrity processes established by the MassHealth agency, including making any necessary data available and access to visit the provider's place of business upon request by the MassHealth agency or its designee.

408.509: GAFC Conditions for Payment

(A) The MassHealth agency pays a GAFC provider for GAFC in accordance with the applicable payment methodology and rate schedule established by the EOHHS. Rates of payment for GAFC do not cover or include any amount for room and board.

(B) Payment for GAFC is subject to the conditions, exclusions, and limitations set forth in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) The MassHealth agency pays a GAFC provider for GAFC only if

(1) the member receiving GAFC is eligible under 130 CMR 408.503;

(2) the member meets the clinical eligibility criteria for GAFC in accordance with 130 CMR 408.506;

(3) the GAFC provider has obtained prior authorization for GAFC in accordance with 130 CMR 408.507;

(4) the GAFC provider bills for GAFC provided by direct care aides with the use of electronic visit verification (EVV) in the form and format as required by EOHHS; and

(5) the GAFC provider is not billing for days that are non-covered days under 130 CMR 408.526.

(D) If a member changes from one GAFC provider to another GAFC provider, a new assessment is required and the new GAFC provider must obtain prior authorization. The previous GAFC provider must continue to provide GAFC to the member while the new GAFC provider is obtaining prior authorization and until the member is admitted and receiving services from the new GAFC provider. The previous GAFC provider must discharge the member from its GAFC program before the new GAFC provider may bill the MassHealth agency for GAFC. The MassHealth agency will pay only one GAFC provider per day for the provision of GAFC to a member.

(E) The GAFC provider must review each member in its care to ensure that clinical eligibility criteria for GAFC continue to be met. A GAFC provider must not bill and the MassHealth agency will not pay for any member who does not meet the clinical criteria for GAFC.

(F) MassHealth payment to GAFC providers begins on the later of:

(1) the effective date of the prior authorization from the MassHealth agency; or

(2) the first date on which GAFC is provided to the member.

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(G) MassHealth payment to a GAFC provider ends on the date on which a member no longer meets the clinical criteria for GAFC described in 130 CMR 408.456, is no longer receiving GAFC, or no longer has a prior authorization in effect, whichever comes first.

(H) The MassHealth agency pays a GAFC provider for days that an eligible member receives GAFC services. A GAFC provider may not bill for non-service days and the MassHealth agency does not pay for any period during which an eligible member does not receive GAFC.

408.521: GAFC Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, the GAFC provider must meet all of the following requirements.

(A) Policies and Procedures Manual. Each GAFC provider must develop, maintain, annually review, and update a comprehensive policies and procedures manual governing the delivery of GAFC services. Each manual at a minimum must contain a mission statement; the goals and objectives of the program; an organizational chart describing the lines of authority and communication needed to manage the GAFC program, including the lines of authority fordelegation of responsibility down to the member care level; job descriptions that include titles, reporting authority, qualifications and responsibilities; and a description of the governing body. Additionally, each policy and procedure manual must contain the following:

(1) administrative policies and procedures including, but not limited to:
   (a) human resource and personnel;
   (b) staff and staffing requirements;
   (c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
   (d) staff education and training;
   (e) GAFC provider staff evaluation and monitoring;
   (f) emergencies, including fire, safety and disasters, including notifying the fire department and police in emergencies, relocating members during an emergency, and coordinating alternative GAFC providers when a member is relocated;
   (g) MassHealth basics and member rights;
   (h) human rights and nondiscrimination;
   (i) incident and accident reporting;
   (j) staff and member grievances;
   (k) cultural competency;
   (l) quality assurance and improvement;
   (m) direct care aide training;
   (n) emergency services and plans;
   (o) first aid and cardiopulmonary resuscitation requirements;
   (p) Health Insurance Portability and Accountability Act (HIPAA);
   (q) coordination of GAFC with other services the member is receiving; and
   (r) procedures to be followed if a member is missing or lost; and

(2) clinical policies and procedures including, but not limited to:
   (a) clinical evaluations;
   (b) privacy and confidentiality;
   (c) 24-hour emergency coverage, including medical and other emergencies;
   (d) documentation of visits and progress notes;
   (e) medication management;
   (f) universal precautions;
   (g) infection control and communicable disease;
   (h) recognizing and reporting abuse (physical, sexual, emotional, psychological) neglect, self-neglect and financial exploitation;
   (i) discharge criteria; and
   (j) member counseling.

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(B) Clinical Assessment and Clinical Evaluations. If required by MassHealth, the GAFC provider's MDT must perform a clinical assessment by completing a clinical assessment screening tool designated by the MassHealth agency as well as all other applicable clinical evaluations for each member, except when completed by the PAO,

(1) before admission to GAFC;
(2) upon significant change; and
(3) annually on the anniversary date of the member's admission to GAFC.

(C) GAFC Plan of Care. The plan of care must be based upon clinical evaluations and contain the following elements: prioritized goals and objectives that consider and document the needs, goals and preferences of the member; the resources to be utilized; and a plan for continuity of care. The goals and actions of the plan of care must be measurable and reflect the member's desired outcomes for GAFC and address medical, social, and other services needed and chosen by the member. The plan of care must reflect the member's needs, current care and treatment, problem identification with appropriate follow-up, and implementation with interventions and evaluation. The plan of care must be in language that is understandable to the member, and to the individuals important in supporting the member.

(1) Within five working days of a member's admission to GAFC, the GAFC provider's MDT, the member, and others as designated by the member must design an interim GAFC plan of care. The interim plan must be signed by the registered nurse and include, at a minimum, an outline of a temporary schedule of care provided that will be used until the final GAFC plan of care is completed.

(2) Within 30 calendar days of a member's admission to GAFC, the GAFC provider's MDT, the member or responsible party, and others designated by the member must develop the final GAFC plan of care. The final plan of care must be signed by the member, the registered nurse, and the care manager. The final signed plan of care must be sent to the PCP. The final plan of care must include:

(a) a treatment plan describing how, and by whom, the member's service needs will be met seven days a week that is based on the member's PCP's summary, physical examination, and all applicable clinical evaluations; and

(b) documentation of any other health services or supportive services the member is receiving from MassHealth or other agencies or organizations (for example, adult day health, visiting nurse services, therapy services, services provided by DDS, DMH, and MassAbility, or counseling services, including behavioral health).

(3) The plan of care must be based upon:

(a) the member's strengths, preferences, and member identified goals and desired outcomes for GAFC;
(b) clinical evaluation;
(c) the GAFC direct care aide's care log;
(d) the nursing progress notes;
(e) the care manager's progress notes;
(f) the PCP Summary Form and approval to participate in GAFC;
(g) documentation of the member's PCP annual visit and the member's physical examination; and
(h) the member's discharge and transition plan.

(4) For members who meet the requirements for GAFC service payment, the GAFC provider must annually review the plan of care and send a copy of the member's health status report to the member's PCP.

(5) Review of the plan of care will be conducted by the MDT with participation from the member or responsible party and others as designated by the member at a minimum of every six months, or more often as warranted by changes in the member's condition or other significant changes. If a plan of care is modified, the GAFC provider must send a copy of the plan of care to the member's PCP.

(6) The member, health care proxy, or surrogate identified by a member with decisional capacity must be afforded the opportunity to attend all plan of care meetings.

(7) The GAFC provider must establish emergency policy and procedures in writing and include them with the member's plan of care including, at a minimum, an emergency file (such as an emergency fact sheet) on the member that must contain:

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(a) the name and telephone number of the member's PCP;
(b) the member's diagnosis;
(c) any special treatments or medications the member may need;
(d) insurance information;
(e) emergency contact information for notification of the family or legal guardian;
(f) procedures to be followed in the event a member is missing or lost; and
(g) procedures for handling medical emergencies.

(D) Recordkeeping. The GAFC provider must maintain records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records including, but not limited to, the following, must be accessible and made available on-site for inspection by the MassHealth agency:

(1) administrative records, including:
(a) payroll and staff records, including evidence of completed staff orientation and training, members served per day, and timesheets;
(b) financial records;
(c) member utilization;
(d) staffing levels;
(e) complaints and grievances;
(f) documents related to the member's home;
(g) contracts for subcontracted services;
(h) contracts for independent contractor services, including a description of how the GAFC provider will supervise the independent contractors and their services;
(i) documentation of the preadmission procedure described in 130 CMR 408.522(A); and
(j) maintain job descriptions that include titles, reporting authority, qualifications and responsibilities.

(2) member records, which must contain at a minimum all of the following:
(a) initial admission information, including
1. the member information sheet;
2. the prior authorization by the MassHealth agency or its designee; and
3. clinical evaluations;
(b) medical information, including:
1. a copy of the most recent physical examination (within the past 12 months);
2. the PCP's authorization and summary;
3. the member's semi-annual health-status reports and documentation that the health status reports were sent to the PCP;
4. the member's medical history;
5. the member's tuberculosis screening documentation;
6. list of the member's known allergies;
7. information about the member's dietary requirements;
8. a list of the member's current medications;
9. if designated by the member, advance directives and the name of the health-care proxy; and
10. the ADL needs as outlined in 130 CMR 408.506(B);
(c) progress notes, including;
1. nursing notes;
2. care manager notes; and
3. service documentation (log of care received);
(d) correspondence from family, therapists, PCP, other service providers, or others, including a managed care organization or an accountable care organization, about the care of the member in the GAFC program;
(e) the GAFC plan of care, including any documentation forming the basis of the plan of care, and documentation that the signed final plan of care was sent to the PCP;
(f) the discharge plan;
(g) legal documentation, for example, signed authorizations for release of information;
(h) critical incident reports in a form and format designated by the MassHealth agency;
(i) the member's post-discharge status;
(j) documentation of the direct care aide's daily schedule; and

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(k) documentation of the care required to be provided by the MDT;

(3) records of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(E) Reporting.

(1) Incident Reporting. The GAFC provider must immediately notify the MassHealth agency of any of the following incidents and follow up in writing within three business days:

(a) the death of a member;

(b) a fire or other natural or unnatural disaster in either the qualified setting or the GAFC administrative office;

(c) a life-threatening accident or incident;

(d) a serious communicable disease contracted by GAFC staff or a member;

(e) any allegation of abuse or neglect of or by the member; and

(f) a member missing from a qualified setting.

(2) Program Reporting. The GAFC provider must submit all of the following information in the format and time frames as requested by the MassHealth agency:

(a) clinical and statistical information;

(b) cost and expense information;

(c) member satisfaction survey results, including the survey developed by the provider, and a description of how the findings will be addressed;

(d) change in GAFC provider contact information;

(e) any additional information requested by the MassHealth agency or its designee related to the provider's provision of GAFC services; and

(f) data necessary to measure the quality of the services delivered by the provider as required by the MassHealth agency.

(F) Quality Improvement Plan. Each GAFC provider must conduct a biennial survey of members and staff and develop a quality improvement plan that addresses issues and concerns raised by the survey. The provider must maintain the survey and quality improvement plan.

(G) Electronic Visit Verification (EVV). Each GAFC provider must use EVV in the form and format as required by EOHHS.

408.522: GAFC Preadmission and Admission Procedures

Before admitting a member in GAFC, the GAFC provider must perform all of the activities in 130 CMR 408.522(A)(2). Intake and assessment services are provided to members seeking admission to GAFC, but who may have not yet received prior authorization by the MassHealth agency or its designee for GAFC.

(A) Preadmission Procedures and Activities

(1) Preadmission Procedures. Before admitting a member in GAFC the GAFC provider must conduct a preadmission meeting with the member, and if applicable or requested, the member's family, other informal caregivers, and any other health or social service provider involved in the member's care. The nurse must determine that the GAFC provider is able to meet the ADL and IADL needs of the member prior to admitting the member to GAFC, as well as use the meeting to obtain information about the member's overall health characteristics, psychosocial condition, nutrition habits, financial and health insurance information, housing situation, formal and informal supports in place, and ethnic and cultural background. The GAFC provider must also use this meeting to inform the member and the member's family about the scope of GAFC to be provided and any other relevant information;

(2) Preadmission Activities. Prior to admitting the member, the GAFC provider or the Public Assessor Option (PAO) must perform the following intake and assessment services:

(a) conduct clinical evaluations of the need for GAFC;

(b) instruct members on the rules, policies, and procedures of the GAFC program; and

(c) provide information on the member's rights and responsibilities when receiving GAFC services.

(B) Admission Activities. Upon the GAFC provider's receipt of the MassHealth agency's initial prior authorization authorizing the member to receive services, and by the end of the fifth day after admission, the GAFC provider must perform all four of the following activities:

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408.522: continued

(1) Complete and submit a written notification to the member and, if applicable, the member's legal guardian. The notice must, at a minimum, specify the following:
(a) that the member has been admitted to GAFC;
(b) the member's interim GAFC plan of care as outlined in 130 CMR 408.521(C)(1);
(c) the respective responsibilities of the member and the GAFC provider;
(d) emergency procedures; and
(e) reasons for discharge from the GAFC provider.

(2) Create a member record. By the first day of GAFC services, the GAFC provider must obtain all the necessary documentation from the member's PCP and other service providers on or before the first date of service. The documentation must include:
(a) the PCP Summary Form and order for GAFC that documents that the member has been examined in the past 12 months and that the MassHealth member's condition requires support with activities of daily living that is provided by the GAFC provider. If the member has a behavior health need, the provider must obtain supporting documentation from the PCP if applicable that may include a psychiatric diagnosis and treatment plan from the member's behavioral health provider;
(b) the member's medical history;
(c) results of a PCP visit within the past three months; however if the PCP has completed a physical examination in the past 12 months and there has been no change in the members medical status, and the PCP has deemed a second physical is not medically necessary, the PCP may document and sign such a statement on the PCP Summary Form;
(d) results of a physical examination given within the past 12 months. If the individual has been hospitalized in the preceding three months, a complete discharge summary may be used to fulfill the physical examination requirement;
(e) a list of current medications, treatments, and other services provided;
(f) a statement indicating any contraindications or limitations to the individual's participation;
(g) recommendations for other services, if applicable; and
(h) a list of known allergies, if any.

(3) Conduct an on-site visit on the day of admission by the GAFC nurse.

(4) Conduct on-site visits at least weekly for the first four weeks, including the first visit on the day of admission. Such on-site visits must be conducted by the nurse and care manager on alternating weeks.

(5) Provide the member by day 30, a written copy of the member's completed GAFC plan of care.

408.523: GAFC Discharge Procedures

(A) A member must be discharged by the GAFC provider upon the member's request, or if the member ceases to benefit from GAFC, including the following circumstances:
(1) the member no longer meets the clinical eligibility criteria for GAFC;
(2) the member demonstrates behavioral or other problems that may endanger the member or GAFC provider staff;
(3) the member's clinical needs are beyond the scope of GAFC;
(4) the member's needs cannot be met by the GAFC provider;
(5) the member selects another service which is duplicative of GAFC; or
(6) the member transitions to another GAFC provider.

(B) For all discharges, the GAFC provider must:
(1) develop a discharge and transition plan, which must:
(a) include the date and reason for discharge;
(b) identify any referrals by the GAFC provider to other appropriate service providers for any health or social services required by the member;
(c) ensure continuity of care by the member, including during transitions of care, as specified in the GAFC plan of care;
(d) be dated and signed by the GAFC registered nurse, the GAFC care manager, and the member; and

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408.523: continued

(e) require at least one follow-up telephone call within 30 business days after discharge to determine the member's post-discharge status and condition.

(2) provide assistance to the member in identifying and locating another provider;

(3) arrange for the member to be discharged and transitioned to the provider identified in 130 CMR 408.523(B)(2);

(4) coordinate the discharge and transition with the member, member's family or legal guardian, and staff of the program or agency to which the member is to be transferred; and

(5) maintain current services until the member is admitted with a new provider.

408.524: GAFC Staff Qualifications and Responsibilities

All staff directly employed by the GAFC provider, as well as any contract staff, *per diem* staff, backup staff, or anyone providing GAFC on behalf of the GAFC provider to members must meet the following requirements.

(A) General Staff Requirements.

(1) Prior to hiring or contracting with any staff the GAFC provider must:

(a) check the candidate's references and job history and ensure that the candidate meets all of the required experience, education, and qualifications before hiring;

(b) conduct a Criminal Offender Records Information (CORI) check and determine whether any offender records may disqualify the individual for employment;

(c) conduct a Sex Offender Registry Information (SORI) check;

(d) conduct Office of Inspector General (OIG) check;

(e) conduct licenses and certification checks and validate that the candidate has obtained all necessary licenses and certifications and that all licenses and certifications are current;

(f) ensure that each GAFC staff person is not related to or legally responsible for the member receiving GAFC; and

(g) ensure that each GAFC direct care aide, registered nurse, licensed practical nurse, and care manager has received a tuberculosis screening within the previous 12 months.

(2) On an ongoing basis, the GAFC provider must:

(a) ensure that all GAFC direct care aides, registered nurses, licensed practical nurses, and care managers receive tuberculosis screenings in accordance with current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Massachusetts Department of Public Health;

(b) ensure that all staff are appropriately trained and managed, which must include, but not be limited to, training in recognition and reporting of abuse of elders and persons with disabilities and provider services;

(c) evaluate staff annually using standardized evaluation measures;

(d) maintain a record of each performance evaluation in a separate personnel file for each staff member; and

(e) include in each staff member's personnel file any staff incident or accident reports.

(B) The Multidisciplinary Professional Team Staff Qualifications and Responsibilities.

(1) Program Director. The GAFC provider must employ a program director who is a healthcare professional.

(a) Qualifications. The program director must have a bachelor’s degree and a minimum of five years of recent professional health care experience working with elders or adults. A master’s degree in a relevant health care discipline may be substituted for two of the required five years of work experience. At least one of those years must have been spent in an administrative role

(b) Responsibilities. The responsibilities of the program director include:

1. development and implementation of the GAFC provider's policies and procedures in 130 CMR 408.521(A);

2. direction and supervision of all aspects of the GAFC program;

3. oversight of the hiring, training, supervision, firing, and evaluation of all GAFC employees and contractors;

4. the fiscal administration of the GAFC program, including billing, budget preparation, and required program statistical and financial reports;

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5. ensuring the MDT reviews GAFC direct care aide logs every six months;
6. ensuring that either the nurse or the case manager reviews the GAFC direct care aide logs every month; and
7. ensuring that the GAFC provider meets all of the requirements in 130 CMR 408.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(2) Registered Nurse. The GAFC provider must employ or independently contract with a registered nurse. The registered nurse may function as the program director, provided that a nurse functioning as the program director is employed by the GAFC provider and is not an independent contractor.

(a) Qualifications. The registered nurse must be fully licensed by the Massachusetts Board of Registration in Nursing. The registered nurse must have at least two years of recent experience in the direct care of elders or adults with disabilities.

(b) Responsibilities. The responsibilities of the registered nurse include:

1. completing and coordinating all applicable clinical assessments and clinical evaluations, except when completed by the PAO;
2. developing and reviewing on an ongoing basis each member's GAFC plan of care;
3. selecting, training, evaluating, and supervising GAFC direct care aides in conjunction with the care manager;
4. reviewing the PCP Summary Form;
5. monitoring the health status and treatment plans of all members to ensure that all needed GAFC is properly delivered;
6. reporting changes in the health status of any member to the member's PCP;
7. reviewing GAFC direct care aide logs at a minimum of every 30 days;
8. conducting on-site visits with each member at the qualified setting in accordance with 130 CMR 408.505(B)(6);
9. completing a nursing progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;
10. submitting semiannual health-status reports to the member's PCP;
11. planning for and implementing discharges and transition from the GAFC program;
12. conducting an orientation for each GAFC direct care aide before the GAFC direct care aide begins personal care; and
13. providing ongoing training to GAFC direct care aides on health and aging.

(3) GAFC Care Manager. The GAFC provider must employ or independently contract with a care manager. The GAFC care manager may function as the program director, provided that a care manager functioning as the program director is employed by the GAFC provider and is not an independent contractor.

(a) Qualifications. The care manager must have

1. a bachelor's degree, a social worker license from the Massachusetts Board of Registration in Social Work, and at least two years of recent experience working with elders or adults with disabilities; or
2. a bachelor's degree and two years of clinical experience in the care of elders or people with disabilities.

(b) Responsibilities. The responsibilities of the care manager include:

1. obtaining a social history and conducting a psychosocial evaluation;
2. participating in the development, implementation, and ongoing review of the GAFC plan of care;
3. conducting on-site visits with each member at the member's home in accordance with 130 CMR 408.505(C)(5);
4. completing a care-management progress note corresponding with each on-site visit or encounter and upon significant change;
5. reviewing GAFC direct care aide logs at a minimum of every 30 days
6. assisting with obtaining information and accessing other healthcare and community services;
7. reviewing and documenting the fire and safety procedures for the qualified setting;
8. participating in discharge and transition planning and implementation; and
9. conducting an initial review of the suitability of the member's home, and conducting a review at least annually, or more often as needed, the suitability of the member's home.

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408.524: continued

4. Staff Qualification Substitution. For any staff member on the MDT who does not meet the qualifications as stated in 130 CMR 408.524, the GAFC provider must receive a written approval from the MassHealth agency for substitution of the qualification prior to hiring.

(C) Direct Care Aide. The GAFC provider must employ or contract with direct care aides.

(1) Qualifications. The direct care aide must:

(a) not be a family member as defined in 130 CMR 408.502;

(b) have one or more years of experience working with elders and people with disabilities providing assistance with ADLs and IADLs; and

(c) hold a valid certification as a home health aide; or

(d) have been determined competent either through a competency evaluation program or by the GAFC provider's registered nurse in all of the following areas:

1. techniques for providing safe personal care assistance;
2. basic understanding of body functioning and changes in body function;
3. assisting participants at various levels of functioning;
4. caring for participants admitted at the Program and participants with Alzheimer's disease and related disorders, behavioral health issues, and cognitive impairments;
5. observation, reporting, and documentation of the members status and the care provided;
6. recognizing the physical, emotional, and developmental needs of the individuals in their care and working in a manner that respects them, their privacy, and their property;
7. preventing and reporting abuse, neglect, mistreatment and misappropriation;
8. communication and interpersonal skills;
9. safety and emergency procedures, including the Heimlich Maneuver;
10. maintenance of a clean, safe, and healthy environment; and
11. recognizing, responding to, and reporting emergencies and knowledge of emergency procedures.

(2) Responsibilities. The responsibilities of the GAFC direct care aide include:

(a) provision of hands-on or cueing and supervision with ADLs and IADLs, of a member in accordance with the individual's GAFC plan of care and that is necessary for the member's health and well-being including, but not limited to, identifying when a crisis intervention is necessary;

(b) monitoring and reporting any nonurgent or nonemergency changes in the member's medical condition to the nurse or care manager. In cases of emergency, report directly to the most appropriate provider and follow-up with a member of the MDT;

(c) providing ongoing supervision of health-related activities, such as:

1. Issuing reminders to the member about prescribed medications; and
2. Timely refilling of the member's prescriptions.

(d) completing a direct care aide log for each visit;

(e) sending the completed direct care aide log at the end of each month to the nurse where it is maintained as part of the member's file;

(f) notifying the GAFC provider of the need for alternative care of the member;

(g) immediately notifying the GAFC provider when any of the following events occur:

1. death of a member;
2. a medical emergency or any significant change in a member's health or level of functioning;
3. a fire, accident, injury, or contraction of a serious communicable disease by the member or GAFC direct care aide;
4. any planned or unexpected departure from the member's home by the member; and
5. all other member or caregiver incidents or accidents.

(h) use electronic visit verification (EVV) in the form and format as required by the MassHealth agency.

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408.524: continued

(D) Licensed Practical Nurse. The GAFC provider may employ or independently contract with a licensed practical nurse.

(1) Qualifications. The licensed practical nurse must be licensed by the Massachusetts Board of Registration in Nursing and in good standing with the Board.

(2) Responsibilities. Under the direction and supervision of the GAFC provider RN, licensed practical nurses may:

(a) complete and coordinate all applicable clinical assessments and clinical evaluations, except when completed by the PAO;

(b) develop and review on an ongoing basis each member's GAFC plan of care;

(c) review the PCP Summary Form;

(d) monitor the health status of all members to ensure that all needed GAFC is properly delivered;

(e) report changes in the health status of any member to the member's PCP;

(f) review GAFC direct care aide logs at a minimum of every 30 days;

(g) conduct on-site visits with each member at the qualified setting in accordance with 130 CMR 408.505(B)(6);

(h) complete a progress note corresponding with each on-site visit or encounter, or more often as the member's condition warrants;

(i) submit semiannual health-status reports to the member's PCP;

(j) plan for and implementing discharges and transition from the AFC program;

(k) conduct an orientation for each GAFC Direct Care Aide before the GAFC Direct Care Aide begins personal care; and

(l) provide ongoing training to GAFC Direct Care Aides on health and aging.

(E) GAFC Staff Training Requirements.

(1) GAFC providers must provide initial and periodic training to all staff members who are responsible for the care of a member. Records of completed training must be kept on file and updated regularly by the GAFC provider.

(2) The GAFC provider must hold an orientation for new staff within one month of hire. This orientation must include the following topics:

(a) techniques of providing safe delivery of ADLs, IADLs, and good body mechanics;

(b) delivery of GAFC by the GAFC provider;

(c) written policies and procedures of the GAFC provider;

(d) the requirements of 130 CMR 408.000;

(e) GAFC provider staff roles and responsibilities;

(f) caring for people with disabilities, elders, individuals with Alzheimer's disease and related disorders, behavioral health issues and cognitive impairments including behavioral interventions, behavior acceptance, and accommodations;

(g) observation, reporting and documentation of the member's status and the care provided, including GAFC direct care aide log entries;

(h) basic first aid, cardiopulmonary resuscitation (CPR), and emergency procedures, including the Heimlich Maneuver;

(i) universal precautions and infection control practices;

(j) information about local health, fire, safety, and building codes;

(k) privacy and confidentiality;

(l) multidisciplinary team approach;

(m) medication management;

(n) communication and interpersonal skills;

(o) advance directives;

(p) prevention of, and reporting of, abuse, neglect, mistreatment and misappropriation/financial exploitation;

(q) completing and filing critical incident reports;

(r) human rights, nondiscrimination and cultural sensitivity;

(s) recognizing the physical, emotional and developmental needs of the individuals in their care and working in a manner that respects them, their privacy and their property;

(t) recognizing, responding to, and reporting change in condition, emergencies and knowledge of emergency procedures, including the GAFC provider's fire, safety, and disaster plans; and

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(u) relevant provisions of the Health Insurance Portability and Accountability Act of 1996.

(F) GAFC Backup Staff Coverage. The GAFC provider must ensure the availability of professional and direct care backup staff if coverage is required due to illness, vacation, or other reasons. All staff providing backup coverage must possess an equal or greater level of licensure and certification required for each position, and must meet all requirements of staff members.

408.525: GAFC Emergency Services and Plans

The GAFC provider must establish written plans for medical and other emergencies. Emergency plans must include, at a minimum, the following:

(A) a written disaster plan for notifying the MassHealth agency of relocation of the member and ensuring the continuity of GAFC service delivery in the event of a fire, flood, or other natural or unnatural disaster, an easily accessible emergency plan for each member listing the member's name, telephone number of the member's physician, special medical needs, including treatments and medications, and emergency phone numbers as specified in 130 CMR 408.521(C)(6) for notification of the family or legal guardian, if identified, and a primary contact person who is able to address the member's needs and available if an unforeseen event occurs that prevents the member's GAFC provider from providing services;

(B) a written plan for emergency staff coverage;

(C) a written plan for emergency care and service in the event a member is displaced for any reason; and

(D) a written Continuity of Operations Plan that follows the guidelines from the Department of Public Health.

408.526: GAFC Non-covered Days

The MassHealth agency does not pay a GAFC provider when:

(A) the member is receiving any other personal care services including, but not limited to, personal care services under 130 CMR 422.000: *Personal Care Attendant Services*;

(B) the member receives home health aide services provided by a home health agency under 130 CMR 403.000: *Home Health Agency*;

(C) the member is a resident or inpatient of a hospital, nursing facility, ICF/IID, or other provider-operated residential facility subject to state licensure such as group homes licensed by the Department of Developmental Services (DDS) or the Department of Mental Health (DMH), or other facility that provides the member's medically necessary personal care; or

(D) the GAFC provider has not received prior authorization from the MassHealth agency.

408.527: Withdrawal by a GAFC Provider from MassHealth

A GAFC provider that intends to withdraw from MassHealth must satisfy all of the following obligations:

(A) MassHealth Notification.

(1) A GAFC provider electing to withdraw from participation in MassHealth must send written notice to the MassHealth agency or its designee, of the provider's intention to withdraw from the GAFC program. The GAFC provider must send the withdrawal notice by certified or registered mail (return receipt requested) to the MassHealth agency or its designee, no fewer than 90 days before the effective date of withdrawal.

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(2) In the instance of alleged emergency withdrawal, the GAFC provider must contact the MassHealth agency, or its designee, within one business day of the emergency withdrawal and follow-up, in writing, within three business days informing the MassHealth agency, or its designee, of the reasoning for such emergency withdrawal, and must provide proof in documentation or other form as the MassHealth agency may require. The GAFC provider must also notify all members and the MassHealth agency about the status of all members and any plans for relocation under 130 CMR 408.523.

(3) The GAFC provider must forward a list of all members currently receiving GAFC. The GAFC provider must notify the MassHealth agency in writing as members are placed in other programs or begin to receive alternative services, including the name of the new program or service and the members' start date in the new program or service.

(B) Notification to Member and Authorized Representatives.

(1) The GAFC provider must notify all members, authorized representatives of members and other funding sources in writing of the intended closing date no fewer than 90 days from the intended closing date, and specify the assistance to be provided to each member in identifying alternative services.

(2) On the same date on which the GAFC provider sends a withdrawal notice to the MassHealth agency, the provider must give notice, in hand, to all members to whom it is providing GAFC services and the member's authorized representatives, including those members who have been transferred to hospitals, or who are on medical or nonmedical leave of absence. The notice must advise that any member who is eligible for MassHealth on the effective date of the withdrawal must relocate to another GAFC provider participating in MassHealth to ensure continuation of MassHealth payment of services and must be determined eligible to continue to receive the services. A copy of this notice must be forwarded to the MassHealth agency. The notice must also state that the GAFC provider will work promptly and diligently to arrange for the relocation of members to MassHealth-participating GAFC providers or, if appropriate, to alternative community-service providers.

(C) Admission and Relocation Requirements.

(1) A GAFC provider must not admit any new MassHealth members after the date on which the withdrawal notice was sent to MassHealth. Members of the GAFC program, for whom prior authorization was sought prior to the withdrawal notice being sent, who are then authorized for GAFC after the notice of withdrawal are not considered newly admitted members.

(2) A GAFC provider that withdraws from participation in MassHealth must assist members to whom it has been providing GAFC services to identify and locate another GAFC provider, and must continue to provide its current level of GAFC services until all members receiving services from the GAFC provider have been admitted with a new GAFC provider or another qualified MassHealth provider.

(3) A GAFC provider seeking to withdraw from the MassHealth program will work promptly and diligently to arrange for the relocation of members to MassHealth participating GAFC or other qualified MassHealth providers. For relocation requirements, *see* 130 CMR 408.523.

REGULATORY AUTHORITY

130 CMR 408.000: M.G.L. c. 118E, §§ 7 and 12.

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Docket # 1194

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 433.000**

CHAPTER TITLE: **Physician Services**

AGENCY: **Division of Medical Assistance**

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

130 CMR 433.000 governs medical and surgery services rendered to publicly aided individuals under MassHealth by eligible providers.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah M. Briggs** PHONE: **617-921-1744**

ADDRESS: **MassHealth Publications, 1 Enterprise Drive, 5th 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.*

To comply with Chapter 186 of the Acts of 2024, the Executive Office of Health and Human Services (EOHHS) is proposing the amendments as an emergency adoption, effective September 25, 2026.

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.*

A&F Approval: September 17, 2026
145 Letters: September 18, 2026

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: _____

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

For the first and second year: **$47,000 annually**

For the first five years:

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:

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:*

130 CMR 433.000 is being amended.

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: **Sep 25 2026**

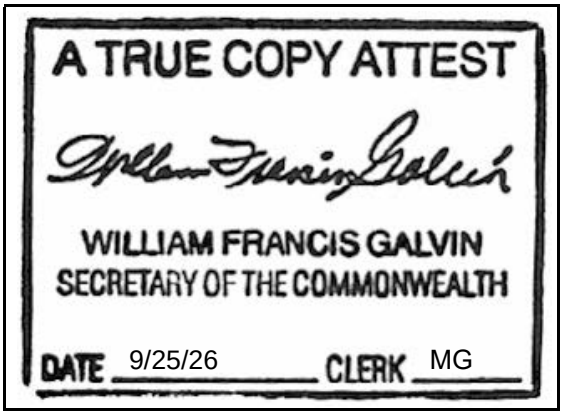
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/25/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no Replacement Pages.**



130 CMR 433.000: PHYSICIAN SERVICES

Section

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433.403: Provider Eligibility
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433.405: Maximum Allowable Fees
433.406: Individual Consideration
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433.413: Office Visits: Payment Limitations
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433.401: Definitions

The following terms used in 130 CMR 433.000 have the meanings given in 130 CMR 433.401 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 433.000 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 433.000 and in 130 CMR 450.000: *Administrative and Billing Regulations*.

Acupuncture. The insertion of metal needles through the skin at certain points on the body, with or without the use of herbs, with or without the application of an electric current, and with or without the application of heat to the needles, skin, or both.

Child and Adolescent Needs and Strengths (CANS). A tool that provides a standardized way to organize information gathered during behavioral-health clinical assessments. A Massachusetts version of the tool has been developed and is intended to be used as a treatment decision support tool for behavioral-health providers serving MassHealth members younger than 21 years old.

Consultant. A licensed physician whose practice is limited to a specialty and whose written advice or opinion is requested by another physician or agency in the evaluation or treatment of a member's illness or disability.

Consultation. A visit made at the request of another physician.

Controlled Substance. A drug listed in Schedule II, III, IV, V, or VI of the Massachusetts Controlled Substances Act (M.G.L. c. 94C).

Cosmetic Surgery. A surgical procedure that is performed for the exclusive purpose of altering appearance and is unrelated to disease or physical defect, or traumatic injury.

Couple Therapy. Therapeutic services provided to a couple for whom the disruption of their marriage, family, or relationship is the primary reason for seeking treatment.

Diagnostic Radiology Service. A radiology service intended to identify an injury or illness.

Domiciliary. For use in the member's place of residence, including a long-term-care facility.

Drug. A substance containing one or more active ingredients in a specified dosage form and strength. Each dosage form and strength is a separate drug.

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 individual, 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 furnished by a provider that is qualified to furnish such services, and are needed to evaluate or stabilize an emergency medical condition.

Family Planning. Any medically approved means, including diagnosis, treatment, and related counseling, that helps individuals of childbearing age, including sexually active minors, to determine the number and spacing of their children.

Family Therapy. A session for simultaneous treatment of two or more members of a family.

Group Therapy. Application of psychotherapeutic or counseling techniques to a group of persons, most of whom are not related by blood, marriage, or legal guardianship.

High-risk Newborn Care. Care of a full-term newborn with a critical medical condition or of a premature newborn requiring intensive care.

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Home or Nursing Facility Visit. A visit by a physician to a member at a residence, nursing facility, extended care facility, or convalescent or rest home.

Hospital-licensed Health Center (HLHC). A facility that

(1) operates under a hospital's license but is not physically attached to the hospital;
(2) is subject to the fiscal, administrative, and clinical management of the hospital;
(3) provides services to patients solely on an outpatient basis;
(4) demonstrates CMS provider-based status in accordance with 42 CFR 413.65;
(5) meets all regulatory requirements for participation in MassHealth as a hospital-licensed health center; and
(6) is enrolled with the MassHealth agency as a hospital-licensed health center.

Hospital Visit. A bedside visit by a physician to a hospitalized member, except for routine preoperative and postoperative care.

Hysterectomy. A medical procedure or operation for the purpose of removing the uterus.

Independent Diagnostic Testing Facility (IDTF). A Medicare-certified diagnostic imaging center, freestanding MRI center, portable X-ray, sleep center, or mammography van in a fixed location or mobile entity independent of a hospital or physician's office, that performs diagnostic tests and meets the requirements of 130 CMR 431.000: *Independent Diagnostic Testing Services*.

Individual Psychotherapy. Private therapeutic services provided to a member to lessen or resolve emotional problems, conflicts, and disturbances.

Institutionalized Individual. An individual who is

(1) involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or other facility for the care and treatment of mental illness; or
(2) confined under a voluntary commitment in a psychiatric hospital or other facility for the care and treatment of mental illness.

Intensive Care Services. The services of a physician other than the attending physician, provided for a continuous period of hours (rather than days), required for the treatment of an unusual aspect or complication of an illness, injury, or pregnancy.

Interchangeable Drug Product. A product containing a drug in the same amounts of the same active ingredients in the same dosage form as another product with the same generic or chemical name that has been determined to be therapeutically equivalent (that is, "A-rated") by the Food and Drug Administration for Drug Evaluation and Research (FDA CDER), or by the Massachusetts Drug Formulary Commission.

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

MassHealth Drug List. A list of commonly prescribed drugs and therapeutic class tables published by the MassHealth agency. The MassHealth Drug List specifies the drugs that are payable under MassHealth. The list also specifies which drugs require prior authorization. Except for drugs and drug therapies described in 130 CMR 433.443(B), any drug that does not appear on the MassHealth Drug List requires prior authorization, as otherwise set forth in 130 CMR 433.000.

Mentally Incompetent Individual. An individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

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Midlevel Practitioner. A certified nurse practitioner, certified nurse midwife, certified professional midwife, certified registered nurse anesthetist, clinical nurse specialist, psychiatric clinical nurse specialist, and physician assistant. In general, subject to compliance with state and federal law, the requirements and limitations in 130 CMR 433.000 that apply to a physician, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage, also apply to midlevel practitioners.

Multiple-source Drug. A drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different names.

Non-drug Product List. A section of the MassHealth Drug List comprised of those products not classified as drugs (*i.e.*, blood testing supplies) that are payable by the MassHealth agency through the Pharmacy Program. Payment for these items is in accordance with rates published in 114.3 CMR 22.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment* and 101 CMR 317.00: *Medicine*. The MassHealth Non-drug Product List also specifies which of the included products require prior authorization.

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. The MassHealth agency requires a prescription for both prescription drugs and over-the-counter drugs (*see* 130 CMR 433.441(A)).

Not Otherwise Classified. A term used for service codes that should be used when no other service code is appropriate for the service provided.

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 and 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.

Oxygen. Gaseous or liquid medical-grade oxygen that conforms to United States Pharmacopoeia Standards.

Pharmacy Online Processing System (POPS). The online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and member eligibility verification.

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.

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.

Reconstructive Surgery. A surgical procedure performed to correct, repair, or ameliorate the physical effects of disease or physical defect (for example, correction of cleft palate), or traumatic injury.

Referral. The transfer of the total or specific care of a member from one physician to another. For the purposes of 130 CMR 433.000, a referral is not a consultation.

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Respiratory Therapy Equipment. A product that

(1) is fabricated primarily and customarily for use in the domiciliary treatment of pulmonary insufficiencies for its therapeutic and remedial effect;

(2) is of proven quality and dependability; and

(3) conforms to all applicable federal and state product standards.

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 disorders 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.

Sterilization. Any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

Therapeutic Radiology Service. A radiology service used to treat an injury or illness.

Therapy Visit. A personal contact provided as an office visit or outpatient visit for the purpose of providing a covered physical or occupational therapy service by a physician or licensed physical or occupational therapist employed by the physician. Additionally, speech therapy services provided by a physician as an office or outpatient visit is considered a therapy visit.

Unit-dose Distribution System. A means of packaging or distributing drugs, or both, devised by the manufacturer, packager, wholesaler, or retail pharmacist. A unit-dose contains an exact dosage of medication and may also indicate the total daily dosage or the times when the medication should be taken.

433.402: Eligible Members

(A)(1) MassHealth Members. The MassHealth agency pays for physician 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 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) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

433.403: Provider Eligibility

(A) Participating Providers.

(1) 130 CMR 433.000 applies to medical, radiology, laboratory, anesthesia, and surgery services provided to members by physicians participating in MassHealth as of the date of service.

(2) To be eligible for payment, a physician must be physically present and actively involved in the treatment of the member. Time periods specified in the service descriptions refer to the amount of time the physician personally spends with the member, except in the instances noted where the service can be performed under the direct supervision of the physician. For surgery, the physician must be scrubbed and must be present in the operating room during the major portion of an operation.

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(3) Provider participation requirements for certified nurse practitioners, certified nurse midwives, certified professional midwives, certified registered nurse anesthetists, clinical nurse specialists, psychiatric clinical nurse specialists, and physician assistants are also addressed in 130 CMR 433.000.

(B) In-state. An in-state physician is a physician who is licensed by the Massachusetts Board of Registration in Medicine.

(C) Out-of-state. An out-of-state physician must be licensed to practice in his or her state. The MassHealth agency pays an out-of-state physician for providing covered services to a MassHealth member only under the following circumstances.

(1) The physician practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and provides services to a member who resides in a Massachusetts community near the border of that physician's state.

(2) The physician provides services to a member who is authorized to reside out-of-state by the Massachusetts Department of Children and Families.

(3) The physician practices outside a 50-mile radius of the Massachusetts border and provides emergency services to a member.

(4) The physician practices outside a 50-mile radius of the Massachusetts border and obtains prior authorization from the MassHealth agency before providing a nonemergency service. Prior authorization will be granted only for services that are not available from comparable resources in Massachusetts, that are generally accepted medical practice, and that can be expected to benefit the member significantly. To request prior authorization, the out-of-state physician or the referring physician must send the MassHealth agency a written request detailing the proposed treatment and naming the treatment facility (*see* the instructions for requesting prior authorization in Subchapter 5 of the *Physician Manual*). The MassHealth agency will notify the member, the physician, and the proposed treatment facility of its decision. If the request is approved, the MassHealth agency will assist in any arrangements needed for transportation.

433.404: Nonpayable Circumstances

(A) The MassHealth agency does not pay a physician for services provided under any of the following circumstances.

(1) The services were provided by a physician who individually or through a group practice has contractual arrangements with an acute, chronic, or rehabilitation hospital, medical school, or other medical institution that involve a salary, compensation in kind, teaching, research, or payment from any other source, if such payment would result in dual compensation for professional, supervisory, or administrative services related to member care.

(2) The services were provided by a physician who is an attending, visiting, or supervising physician in an acute, chronic, or rehabilitation hospital but who is not legally responsible for the management of the member's case with respect to medical, surgery, anesthesia, laboratory, or radiology services.

(3) The services were provided by a physician who is a salaried intern, resident, fellow, or house officer. 130 CMR 433.404 does not apply to a salaried physician when the physician supplements his or her income by providing services during off-duty hours on premises other than those of the institution that pays the physician a salary, or through which the physician rotates as part of his or her training.

(4) The services were provided in a state institution by a state-employed physician or physician consultant.

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

(B) The MassHealth agency does not pay a physician for performing, administering, or dispensing any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment.

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(C) The MassHealth agency does not pay a physician for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay a physician for the diagnosis of male or female infertility.

(D) The MassHealth agency does not pay a physician for otherwise payable service codes when those codes are used to bill for circumstances that are not payable pursuant to 130 CMR 433.404.

433.405: Maximum Allowable Fees

The MassHealth agency pays for physician services with rates set by the Executive Office of Health and Human Services (EOHHS), subject to the conditions, exclusions, and limitations set forth in 130 CMR 433.000. EOHHS fees for physician services are contained in the following chapters of the Code of Massachusetts Regulations:

(A) 101 CMR 315.00: *Vision Care Services and Ophthalmic Services*

(B) 101 CMR 316.00: *Surgery and Anesthesia Services*

(C) 101 CMR 317.00: *Medicine*

(D) 101 CMR 318.00: *Radiology*

(E) 101 CMR 320.00: *Clinical Laboratory Services*

433.406: Individual Consideration

(A) The MassHealth agency has designated certain services in Subchapter 6 of the *Physician Manual* as requiring individual consideration. This means that the MassHealth agency will establish the appropriate rate for these services based on the standards and criteria set forth in 130 CMR 433.406(B). Providers claiming payment for any service requiring individual consideration must submit with such claim a report that includes a detailed description of the service, and is accompanied by supporting documentation that may include, 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 services requiring individual consideration unless it is satisfied that the report and documentation submitted by the provider are adequate to support the claim. *See* 130 CMR 433.410 for report requirements.

(B) The MassHealth agency determines the appropriate payment for a service requiring individual consideration 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;
(5) any complications or other circumstances that the MassHealth agency deems relevant;
(6) the policies, procedures, and practices of other third-party insurers;
(7) the payment rate for drugs as set forth in the MassHealth pharmacy regulations at 130 CMR 406.000: *Pharmacy*; and
(8) for drugs or supplies, a copy of the invoice from the supplier showing the actual acquisition cost.

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433.407: Service Limitations: Professional and Technical Components of Services and Procedures

Additional limitations are set forth in 130 CMR 433.413 and 433.437.

(A) Definitions.

(1) Professional Component – the component of a service or procedure representing the physician's work interpreting or performing the service or procedure.

(2) Technical Component – the component of a service or procedure representing the cost of rent, equipment, utilities, supplies, administrative and technical salaries and benefits, and other overhead expenses of the service or procedure, excluding the physician's professional component.

(B) Payment. A physician may bill for the professional component of a service or procedure or, subject to the conditions of payment set forth in 130 CMR 433.407(C), both the professional and technical components of the service or procedure. The MassHealth agency does not pay a physician for providing the technical component only of a service or procedure.

(C) Conditions of Payment for the Provision of Both the Professional and Technical Components of a Service or Procedure. Only the physician providing the professional component of the service or procedure may bill for both the professional and technical components. This constitutes a limited exception to 130 CMR 450.301: *Claims*. A physician may bill for providing both the professional and technical components of a service or procedure in the physician's office when the physician owns or leases the equipment used to perform the service or procedure, provides the technical component (either directly or by employing a technician), and provides the professional component.

433.408: Prior Authorization, Orders, Referrals, and Prescriptions

(A) Introduction.

(1) Subchapter 6 of the *Physician Manual* lists codes that require prior authorization as a prerequisite for payment. The MassHealth agency does not pay for services if billed under any of these codes, unless the provider has obtained prior authorization from the MassHealth agency before providing the service.

(2) A 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.

(B) Requesting Prior Authorization. All prior authorization requests must be submitted in accordance with the instructions in Subchapter 5 of the *Physician Manual*.

(C) Physician Services Requiring Prior Authorization. Services requiring prior authorization include, but are not limited to, the following:

(1) certain surgery services, including reconstructive surgery and gender affirming surgery;

(2) nonemergency services provided to a member by an out-of-state physician who practices outside a 50-mile radius of the Massachusetts border;

(3) certain vision care services; and

(4) certain behavioral health services.

(D) Mental Health and Substance Abuse Services Requiring Prior Authorization. Members enrolled with the MassHealth behavioral health contractor require service authorization before certain mental health and substance abuse services are provided. For more information, see 130 CMR 450.124: *Behavioral Health Services*.

(E) Therapy Services Requiring Prior Authorization. Prior authorization is required for the following therapy services provided by any MassHealth provider to eligible MassHealth members.

(1) more than 20 occupational-therapy visits or 20 physical-therapy visits, including group-therapy visits, for a member within a 12-month period; and

(2) more than 35 speech/language therapy visits, including group-therapy visits, for a member within a 12-month period.

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(F) Other Services Requiring Prior Authorization, Orders, Referrals, or Prescriptions. Many other services require prior authorization, or must first be ordered, referred, prescribed, or otherwise have their need substantiated by a physician or other practitioner before the MassHealth agency will cover the service. When such a service is medically necessary for an eligible MassHealth member, a treating physician or other practitioner shall provide such orders, referrals, prescriptions, medical necessity documentation, certifications, plans of care, examinations, or take such other actions that the MassHealth agency requires as a condition of payment for the service. Coverage requirements for particular MassHealth services are contained in the applicable MassHealth program regulations and guidance and are found in the MassHealth Provider Library.

These services include, but are not limited to, the following:

(1) transportation;
(2) drugs;
(3) home health services;
(4) nursing facility services;
(5) durable medical equipment; and
(6) therapy services.

433.409: Recordkeeping (Medical Records) Requirements

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the member's medical record. Payment for maintaining the member's medical record is included in the fee for the service.

(B) In order for a medical record to document completely a service or services to a member, that record must set forth the nature, extent, quality, and necessity of care provided to the member. When the information contained in a member's medical record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will disallow payment for the claimed service.

(C) The MassHealth agency may at its discretion request, and upon such request the physician must provide, any and all medical records of members corresponding to or documenting the services claimed, in accordance with M.G.L. c. 118E, § 38, and 130 CMR 450.205: *Recordkeeping and Disclosure*. The MassHealth agency may produce, or at its option may require the physician to produce, photocopies of medical records instead of actual records when compliance with 130 CMR 433.409(C) would otherwise result in removal of medical records from the physician's office or other place of practice.

(D) (1) Medical records corresponding to office, home, nursing facility, hospital outpatient department, and emergency department services provided to members must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following:

(a) the member's name and date of birth;
(b) the date of each service;
(c) the name and title of the person performing the service, if the service is performed by someone other than the physician claiming payment for the service;
(d) the member's medical history;
(e) the diagnosis or chief complaint;
(f) clear indication of all findings, whether positive or negative, on examination;
(g) any medications administered or prescribed, including strength, dosage, and regimen;
(h) a description of any treatment given;
(i) recommendations for additional treatments or consultations, when applicable;
(j) any medical goods or supplies dispensed or prescribed;
(k) any tests administered and their results; and

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(l) for members younger than 21 years old who are being treated by a physician or psychiatric clinical nurse specialist, a CANS completed during the initial behavioral-health assessment and updated at least once every 90 days thereafter.

(2) When additional information is necessary to document the reason for the visit, the basis for diagnosis, or the justification for future diagnostic procedures, treatments, or recommendations for return visits or materials, such information must also be contained in the medical record. Basic data collected during previous visits (for example, identifying data, chief complaint, or history) need not be repeated in the member's medical record for subsequent visits. However, data that fully document the nature, extent, quality, and necessity of care provided to a member must be included for each date of service or service code claimed for payment, along with any data that update the member's medical course.

(E) For inpatient visit services provided in acute, chronic, or rehabilitation hospitals, there must be an entry in the hospital medical record corresponding to and substantiating each hospital visit claimed for payment. An inpatient medical record will be deemed to document services provided to members and billed to the MassHealth agency if it conforms to and satisfies the medical record requirements set forth in 105 CMR 130.000: *Licensure of Hospitals*. The physician claiming payment for any hospital inpatient visit service is responsible for the adequacy of the medical record documenting such service. The physician claiming payment for an initial hospital visit must sign the entry in the hospital medical record that documents the findings of the comprehensive history and physical examination.

(F) Additional medical record requirements for radiology, psychiatry, and other services can be found in the applicable sections of 130 CMR 433.000.

(G) Compliance with the medical record requirements set forth in, referred to in, or deemed applicable to 130 CMR 433.000 will be determined by a peer-review group designated by the MassHealth agency as set forth in 130 CMR 450.206: *Determination of Compliance with Medical Standards*. The MassHealth agency will refuse to pay or, if payment has been made, will consider such payment to be an overpayment as defined in 130 CMR 450.235: *Overpayments* subject to recovery, for any claim that does not comply with the medical record requirements established or referred to in 130 CMR 433.000. Such medical record requirements constitute the standard against which the adequacy of records will be measured for physician services, as set forth in 130 CMR 450.205(B).

433.410: Report Requirements

(A) General Report. A general written report or a discharge summary must accompany the physician's claim for payment for any service that is listed in Subchapter 6 of the *Physician Manual* as requiring a report or individual consideration (I.C.), or if the code is for an unlisted service. This report must be sufficiently detailed to enable the MassHealth agency to assess the extent and nature of the service.

(B) Operative Report. For surgery procedures designated in Subchapter 6 of the *Physician Manual* as requiring individual consideration, the provider must attach operative notes to the claim. An operative report must state the operation performed, the name of the member, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and surgical assistants, and the technical procedures performed.

433.411: Child and Adolescent Needs and Strengths (CANS) Data Reporting

For each Child and Adolescent Needs and Strengths (CANS) conducted as described in 130 CMR 433.429, the physician or psychiatric clinical nurse specialist must report data collected during the assessment to the MassHealth agency, in the manner and format specified by the MassHealth agency.

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

The MassHealth agency pays for all medically necessary physician 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 433.000, and with prior authorization.

433.413: Office Visits: Payment Limitations

(A) Time Limit. Payment for office visits is limited to one visit per day per member per physician.

(B) Office Visit and Treatment/Procedure. The physician may bill for either an office visit or a treatment/procedure, but may not bill for both an office visit and a treatment/procedure for the same member on the same date when the office visit and the treatment/procedure are performed in the same location. This limit does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the treatment/procedure. This limitation does not apply to tobacco cessation counseling services provided by a physician or a qualified staff member under the supervision of a physician on the same day as a visit. This limitation does not apply to a treatment/procedure that is performed as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit (*see* 130 CMR 450.140: *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services: Introduction*); in such a case, the physician may bill for both an EPSDT visit and a treatment/procedure. Examples of treatment/procedures are suturing, suture removal, aspiration of a joint, and cast application or removal. X-rays, laboratory tests, and certain diagnostic tests may be billed for in addition to an office visit.

(C) Immunization or Injection.

(1) The physician may bill for either an office visit or vaccine administration, but may not bill for both an office visit and vaccine administration for the same member on the same date when the office visit and the vaccine administration are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same physician on the same day as the vaccine was administered.

(2) The MassHealth agency pays for the cost of the injectable material unless the Massachusetts Department of Public Health distributes the injectable material free of charge.

(D) Family Planning Office Visits. The MassHealth agency pays for office visits provided for the purposes of family planning. The MassHealth agency pays for any family planning supplies and medications dispensed by the physician at the physician's acquisition cost. To receive payment for the supplies and medications, the provider must attach to the claim a copy of the actual invoice from the supplier.

433.414: Outpatient Hospital Services: Payment

(A) Time Limit. Payment for outpatient hospital visits is limited to one outpatient hospital visit per day per member per physician.

(B) Visit and Treatment/Procedure.

(1) The physician may bill for either a hospital outpatient visit, or for a treatment/procedure during a hospital outpatient visit, but may not bill for both a visit and a treatment/procedure for the same member on the same date at the same hospital. This limitation does not apply to a significant, separately identifiable outpatient hospital visit provided by the same physician on the same day as the procedure or other service.

(2) The MassHealth agency pays either a physician or an outpatient hospital, but not both, for physician services provided in an outpatient hospital setting. The MassHealth agency does not separately pay a hospital for other professional services provided in an outpatient hospital setting.

(3) An outpatient hospital setting includes a hospital's outpatient department, emergency department, HLHC, and any other satellite of the hospital. A hospital outpatient visit includes a visit to any outpatient hospital setting.

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433.415: Inpatient Hospital Services: Service Limitations and Screening Requirements

(A) Hospital inpatient visit fees apply to visits by physicians to members hospitalized in acute, chronic, or rehabilitation hospitals. Payment is limited to one visit per day per member for the length of the member's hospitalization.

(B) The MassHealth agency does not routinely pay for visits to members who have undergone or who are expected to undergo surgery, since the allowable surgical fees include payment for the provision of routine inpatient preoperative and postoperative care. In unusual circumstances, however, the MassHealth agency does pay for such visits.

(C) The MassHealth agency pays only the attending physician for inpatient hospital visits, with the following exceptions.

(1) The MassHealth agency pays for a consultation by a physician other than the attending physician. (*See* 130 CMR 433.418 for regulations about consultations.)

(2) If it is necessary for a physician other than the attending physician to treat a hospitalized member, the other physician's services are payable. An explanation of the necessity of such visits must be attached to the claim. The MassHealth agency will review the claim and determine appropriate payment to the other physician.

(D) The MassHealth agency pays either a physician or an inpatient hospital, but not both, for physician services provided in an inpatient hospital setting. The MassHealth agency does not separately pay a hospital for other professional services provided in an inpatient hospital setting.

433.416: Nursing Facility Visits: Service Limitations

(A) Requirement for Approval of Admission. The MassHealth agency seeks to ensure that a MassHealth member receives nursing facility services only when available alternatives do not meet the member's need, and that every member receiving nursing facility services is placed appropriately according to the medical eligibility criteria, in accordance with 130 CMR 456.409 through 456.411.

(B) Service Limitations. Payment for a visit by a physician to members in nursing facilities or rest homes is limited to one visit per member per month, except in an emergency. Any medically necessary care required for the follow-up of a condition during the month must be billed as subsequent nursing facility care.

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a member's home is limited to one visit per member per day.

433.418: Consultations: Service Limitations

The MassHealth agency pays for only one initial consultation per member per case episode. Additional consultation visits per episode are payable as follow-up consultations.

433.419: Certified Nurse Midwife Services

(A) General. 130 CMR 433.419 applies specifically to certified nurse midwives (also known as nurse midwives). In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified nurse midwives, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays a certified nurse midwife or group practice for certified nurse midwife services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

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(2) the certified nurse midwife or group practice is not an employee of the hospital or other facility in which the certified nurse midwife services were performed, or is not otherwise paid by the hospital or facility for the service;
(3) the certified nurse midwife participates in MassHealth pursuant to the requirements of 130 CMR 433.419(C); and
(4) for an out-of-state certified nurse midwife the requirements of 130 CMR 433.403(C) are met.

(C) Certified Nurse Midwife Provider Eligibility. Any certified nurse midwife applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she
(1) is licensed to practice as a certified nurse midwife by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse midwife services are provided; and
(2) is a member of a group practice or is in a solo private practice;

(D) Consultation between a Certified Nurse Midwife and Physician. The MassHealth agency does not pay for a consultation between a certified nurse midwife and a physician as a separate service.

433.420: Obstetric Services: Introduction

The MassHealth agency offers two methods of payment for obstetric services: the fee-for-service method and the global-fee method. Fee for service requires submission of claims for services as they are performed and is available to a provider for all covered obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met.

433.421: Obstetric Services: Global-fee Method of Payment

(A) Definitions.
(1) Coverage Provider. a physician, certified nurse midwife, physician assistant, or certified nurse practitioner that is either a member of the same group practice as the Primary Provider, or who is in a separate practice from the Primary Provider and has a back-up coverage arrangement with the Primary Provider.
(2) Global Fee. a single inclusive fee for all prenatal and postpartum visits, and the delivery. The global fee is available only when the conditions in 130 CMR 433.421 are met.
(3) Non-coverage Provider. any provider that has no employment, contractual, or practice-coverage relationship with the Primary Provider, or his or her practice.
(4) Primary Provider. a physician or certified nurse midwife who has assumed responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and a minimum of one postpartum visit for a member.

(B) Conditions for Global Fee.
(1) Primary Provider Responsibilities. In order to qualify for payment of the global fee, the primary provider must perform, or coordinate a coverage provider's performance of, a minimum of six prenatal visits, the delivery, and a minimum of one postpartum visit for the member, and must also satisfy all other requirements in 130 CMR 433.421. The primary provider is the only clinician that may claim payment of the global fee. As an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A), the primary provider is not required to perform all components of the obstetric global service directly. All global-fee claims must use the delivery date as the date of service.
(2) Standards of Practice. All of the components of the obstetric global service must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.
(3) Coordinated Medical Management. The primary provider or coverage provider must coordinate the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:
(a) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;

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(b) coordination of medical management with necessary referral to other medical specialties and dental services; and

(c) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.

(4) Health-care Counseling. In conjunction with providing prenatal care, the primary provider or coverage provider must provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:

(a) EPSDT screening for teenage pregnant individuals;

(b) smoking and substance abuse;

(c) hygiene and nutrition during pregnancy;

(d) care of breasts and plans for infant feeding;

(e) obstetrical anesthesia and analgesia;

(f) the physiology of labor and the delivery process, including detection of signs of early labor;

(g) plans for transportation to the hospital;

(h) plans for assistance in the home during the postpartum period;

(i) plans for pediatric care for the infant; and

(j) family planning.

(5) Obstetrical-risk Assessment and Monitoring. The primary provider or coverage provider must manage the member's obstetrical risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services are paid separately from the global fee and should be billed for by the servicing provider on a fee for service basis. Such services may include, but are not limited to, the following:

(a) counseling specific to high risk patients (for example, antepartum genetic counseling);

(b) evaluation and testing (for example, amniocentesis); and

(c) specialized care (for example, treatment of premature labor).

(C) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same member, the following conditions apply.

(1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and a minimum of one postpartum visit) are provided directly by the primary provider, or a coverage provider. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).)

(2) If the primary provider bills for the global fee, no coverage provider may claim payment from the MassHealth agency. Payment of the global fee constitutes payment in full both to the primary provider and to all coverage providers who provided components of the obstetric global service.

(3) If the primary provider bills for the global fee, any non-coverage provider who performed prenatal visits or postpartum visits for the member may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no non-coverage provider may claim payment for the delivery.

(4) If the primary provider bills on a fee-for-service basis and does not bill a global fee, any other coverage or non-coverage provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services they provided to the same member.

(D) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a global fee. This includes services performed by the primary provider and any coverage providers. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each member's record in a way that allows for easy review of her obstetrical history.

433.422: Certified Professional Midwife Services

(A) General. 130 CMR 433.422 applies specifically to certified professional midwives. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified professional midwives, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

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(B) Conditions of Payment. The MassHealth agency pays a certified professional midwife or group practice for certified professional midwife services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 274 CMR or of the state licensing agency of another state in which the services are provided);

(2) the certified professional midwife or group practice is not an employee of the hospital or other facility in which the certified professional midwife services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) the certified professional midwife participates in MassHealth pursuant to the requirements of 130 CMR 433.422(C); and

(4) for an out of state certified professional midwife the requirements of 130 CMR 433.403(C) are met.

(C) Certified Professional Midwife Provider Eligibility. Any certified professional midwife applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that the applicant

(1) is licensed to practice as a certified professional midwife by the Department of Public Health or by the licensing agency of another state in which the certified professional midwife services are provided; and

(2) is a member of a group practice or is in a solo private practice.

(D) Consultation between a Certified Professional Midwife and Physician. The MassHealth agency does not pay for a consultation between a certified professional midwife and a physician as a separate service.

433.424: Obstetric Services: Fee-for-service Method of Payment

The fee-for-service method of payment is always available to a provider for obstetric services covered by the MassHealth agency as an alternative to the global fee referenced in 130 CMR 433.421. If the global-fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the MassHealth agency only on a fee-for-service basis, as specified in 130 CMR 433.424(A) through (D).

(A) When there is no primary provider for the obstetric services performed for the member, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the member may claim payment only on a fee-for-service basis.

(C) When a certified nurse midwife or a certified professional midwife is the primary provider and a physician performs a cesarean section, the certified nurse midwife or the certified professional midwife may claim payment for the prenatal visits only on a fee-for-service basis. The operating physician may claim payment for the cesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services

The MassHealth agency pays for ophthalmic materials in accordance with the vision care regulations at 130 CMR 402.000: *Vision Care Services*. The MassHealth agency pays for eye examinations subject to the following limitations.

(A) Comprehensive Eye Examinations.

(1) The MassHealth agency does not pay for a comprehensive eye examination if the service has been provided

(a) within the preceding 12 months, for a member younger than 21 years old; or

(b) within the preceding 24 months, for a member 21 years of age or older.

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(2) The restrictions at 130 CMR 433.425(A)(1) do not apply if one of the following complaints or conditions is documented in the member's medical record:

(a) blurred vision;
(b) evidence of headaches;
(c) systemic diseases, such as diabetes, hyperthyroidism, or HIV;
(d) cataracts;
(e) pain;
(f) redness; or
(g) infection.

(B) Consultation Service. The MassHealth agency pays for a consultation service only if it is provided independently of a comprehensive eye examination.

(C) Screening Services. The MassHealth agency does not pay for a screening service if two screening services have been furnished to the member within the preceding 12 months.

(D) Comprehensive Eye Examinations and Screening Services. A comprehensive eye examination includes a screening service. If the provider performs both a screening service and a comprehensive eye examination for the same member, the MassHealth agency pays for only the comprehensive eye exam.

(E) Tonometry. The MassHealth agency does not pay for a tonometry as a separate service when it is performed as part of a comprehensive eye examination, consultation, or screening service. When a tonometry is performed as a separate service to monitor a member who has glaucoma, the provider must use the appropriate service code.

433.426: Audiology Services: Service Limitations

The MassHealth agency pays for audiology services only when they are provided either by a physician, or by an audiologist licensed or certified in accordance with 130 CMR 426.404: *Provider Eligibility* who is employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only.

433.427: Allergy Testing: Service Limitations

(A) The MassHealth agency pays for allergy testing only when performed by or under the direction of a physician, certified nurse practitioner or clinical nurse specialist, or by a physician assistant under a physician's supervision. All fees include payment for physician observation and interpretation of the tests in relation to the member's history and physical examination. An initial consultation and allergy testing for a member may be billed by the same provider on the same date of service.

(B) The MassHealth agency does not pay for more than three blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation per member per year.

(C) Immunotherapy and desensitization (extracts) are covered services. The provider must indicate the amount and anticipated duration of the supply for immunotherapy and desensitization (extracts) on the claim form.

(D) The MassHealth agency pays for follow-up office visits for injections and reevaluation as office visits.

(E) The MassHealth agency pays for sensitivity tests only once per member per year, regardless of the type of tests performed or the number of visits required.

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433.428: Psychiatric Services: Introduction

(A) Covered Services. The MassHealth agency pays a physician or a psychiatric clinical nurse specialist (PCNS) for the psychiatry services described in 130 CMR 433.428 and 130 CMR 433.429.

(B) Non-covered Services.

(1) Nonphysician and Non-PCNS Services. Except as permitted in Section 603 of Subchapter 6 of the *Physician Manual*, the MassHealth agency does not pay a physician or PCNS for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician or PCNS.

(2) Research and Experimental Treatment. The MassHealth agency does not pay for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a member's clinical need.

(3) Nonmedical Services. The MassHealth agency does not pay a physician or PCNS for nonmedical services including, but not limited to, the following:

(a) vocational rehabilitation services;

(b) educational services;

(c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is payable);

(d) street-worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);

(e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and

(f) biofeedback.

(4) Nonmedical Programs. The MassHealth agency does not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other non-covered services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The MassHealth agency does not pay for psychological testing provided by a physician or a PCNS.

(C) Services Provided by a Psychiatric Clinical Nurse Specialist (PCNS).

(1) General. 130 CMR 433.428 and 130 CMR 433.429 apply specifically to physicians and psychiatric clinical nurse specialists. In general however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician, also apply to a psychiatric clinical nurse specialist (PCNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior authorization and other conditions of coverage.

(2) Conditions of Payment. The MassHealth agency pays a PCNS or group practice for PCNS services when

(a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(b) the PCNS or group practice is not an employee of the hospital or other facility in which the PCNS services were performed, or is not otherwise paid by the hospital or facility for the service;

(c) the PCNS participates in MassHealth pursuant to the requirements of 130 CMR 433.428(C)(3); and

(d) for an out-of-state PCNS, the requirements of 130 CMR 433.403(C) are met.

(3) PCNS Provider Eligibility. Any PCNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

(a) is licensed to practice as a PCNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the PCNS services are provided; and

(b) is a member of a group practice or is in a solo private practice.

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(4) Consultation Between a PCNS and a Physician. The MassHealth agency does not pay for a consultation between a PCNS and a physician as a separate service.

(D) Recordkeeping (Medical Records) Requirements. In addition to the provisions in 130 CMR 433.409, the following specific information must be included in the medical record for each member receiving psychiatric services:

(1) the condition or reason for which psychiatric services are provided;
(2) the member's diagnosis;
(3) the member's medical history;
(4) the member's social and occupational history;
(5) the treatment plan;
(6) the physician's or PCNS's short- and long-range goals for the member;
(7) the member's response to treatment; and
(8) if applicable, a copy of the signed consent for electroconvulsive therapy.

433.429: Psychiatric Services: Scope of Services

130 CMR 433.429 describes the services that a physician or a psychiatric clinical nurse specialist (PCNS) may provide, including the limitations imposed on those services by the MassHealth agency. For all psychotherapeutic services, the majority of time must be spent as personal interaction with the member; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The MasssHealth agency pays a physician or PCNS for individual psychotherapy provided to a member only when the physician or PCNS treats the member. This service includes diagnostics.

(B) Family and Couple Therapy. The MassHealth agency pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one fee per session, regardless of the number of family members present or the presence of a co-therapist.

(C) Group Psychotherapy.

(1) Payment is limited to one fee per group member with a maximum of 12 members per group regardless of the number of staff members present.
(2) The MassHealth agency does not pay for group therapy when it is performed as an integral part of a psychiatric day treatment program.

(D) Multiple-family Group Psychotherapy.

(1) Payment is limited to one fee per group member with a maximum of ten members per group regardless of the number of staff members present.
(2) The MassHealth agency does not pay for multiple-family group psychotherapy when it is performed as an integral part of a psychiatric day treatment program.

(E) Diagnostic Services. The MassHealth agency pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(F) Reevaluation. The MassHealth agency pays for the reevaluation of a member who has been out of treatment for at least six months. A provider may bill for a maximum of two one hour units per member per calendar year for the purpose of designing a treatment plan.

(G) Long-term Therapy. The MassHealth Agency defines long-term therapy as a combination of diagnostics and individual, couple, family, and group therapy planned to extend more than 12 sessions.

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(H) Short-term Therapy. The MassHealth agency defines short-term therapy as a combination of diagnostics and individual, couple, family, and group therapy planned to terminate within 12 sessions.

(I) Medication Review. The MassHealth agency pays for a member visit specifically for the prescription, review, and monitoring of psychotropic medication by a psychiatrist, or PCNS, or administration of prescribed intramuscular medication by a physician or a PCNS. If this service is not combined with psychotherapy, it must be billed as a minimal office visit. The MassHealth agency does not pay separately for medication review if it is performed on the same day as another service, except for psychotherapy for crisis.

(J) Case Consultation.

(1) The MassHealth agency pays only for a case consultation that involves a personal meeting with a professional of another entity.

(2) The MassHealth agency pays for case consultation only when telephone contact, written communication, and other nonreimbursable forms of communication clearly will not suffice. Such circumstances must be documented in the member's record. Such circumstances are limited to situations in which both the physician or PCNS and the other party are actively involved in treatment or management programs with the member (or family members) and where a lack of face to face communication would impede a coordinated treatment program.

(3) The MassHealth agency does not pay for court testimony.

(K) Family Consultation. The MassHealth agency pays for consultation with the natural or foster parent or legal guardian of a member younger than 21 years old who lives with the child and is responsible for the child's care, and who is not an eligible member, when such consultation is integral to the treatment of the member.

(L) Psychotherapy for Crisis Services. The MassHealth agency pays for psychotherapy for crisis as defined as an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma.

(1) This service is limited to face-to-face contacts with the member; psychotherapy for crisis service *via* telephone contact is not a reimbursable service.

(2) The need for psychotherapy for crisis services must be fully documented in the member's record for each date of psychotherapy for crisis services.

(3) This service is limited to one initial unit of service and up to three add-on units of service per date of service.

(M) Electroconvulsive Therapy. The MassHealth agency pays for electroconvulsive therapy only when it is provided in a hospital setting by a physician or PCNS and only when the physician or PCNS as well as the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(N) After-hours Telephone Service. The physician or PCNS must provide telephone coverage during the hours when the physician or PCNS is unavailable, for members who are in a crisis state.

(O) Acute Hospital Inpatient Visit. A visit to a hospitalized member in an acute hospital is payable only as a hospital visit (*see* 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided. Payment will be made for only one visit per member per day.

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(P) Frequency of Treatment. The MassHealth agency pays a physician or a PCNS for only one session of a single type of service provided to an individual member on a single date of service. Return visits on the same date of service are not reimbursable except for the provision of psychotherapy for crisis services, as described in 130 CMR 433.429(L). The MassHealth agency pays a physician or a PCNS for more than one mode of therapy provided to a member during one week only if clinically justified; that is, when any single approach has been shown to be necessary but insufficient. The need for additional modes of treatment must be documented in the member's record.

(Q) Child and Adolescent Needs and Strengths (CANS). Any physician or PCNS who provides individual, group, or family therapy to members younger than 21 years old must be certified every two years according to the process established by the Executive Office of Health and Human Services (EOHHS) to administer the CANS, must use the CANS during initial behavioral-health assessments before the initiation of therapy, and must update the CANS at least every 90 days thereafter during the treatment review process.

433.430: Dialysis: Service Limitations

(A) Medicare Coverage. Medicare is the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Members being treated for chronic renal disease must be referred to a MassHealth Enrollment Center or their Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. The MassHealth agency pays for hemodialysis only to hospitalized members who are

(1) being dialyzed for acute renal failure;

(2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or

(3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are payable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician, subject to all general conditions of payment including the requirement to obtain prior authorization as described in 130 CMR 433.408.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are covered by MassHealth in accordance with 130 CMR 430.000: *Rehabilitation Center Services* and 432.000: *Therapist Services*.

(C)(1) 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. The MassHealth agency does not pay for performance of a maintenance program, except as provided in 130 CMR 433.431(C)(2).

(2) In certain instances, the specialized knowledge and judgment of a licensed physician or 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 physician or a licensed therapist, all information that supports the medical necessity for performance of such services by a licensed physician or licensed therapist, rather than a nonphysician or non-therapist, must be documented in the medical record.

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433.432: Other Medical Procedures

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed for in addition to an office visit.

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure.

(C) Pulmonary Procedures. Fees for pulmonary procedures include payment for laboratory procedures, interpretations, and physician's services. These services may be billed for in addition to an office visit.

(D) Dermatological Special Procedures. These services may be billed for in addition to an office visit.

(E) Unlisted Procedures. Providers may bill for unlisted procedures only if there is no "Not otherwise classified" code.

433.433: Certified Nurse Practitioner Services

(A) General. 130 CMR 433.433 applies specifically to certified nurse practitioners (also known as nurse practitioners). In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to certified nurse practitioners, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(B) Conditions of Payment. The MassHealth agency pays either an independent certified nurse practitioner or group practice (in accordance with 130 CMR 433.433(C)), or the physician employer of a nonindependent certified nurse practitioner (in accordance with 130 CMR 433.433(E)), for certified nurse practitioner services when:

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(2) the certified nurse practitioner or group practice is not an employee of the hospital or other facility in which the certified nurse practitioner services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) (a) in the case of payment claimed by an independent certified nurse practitioner, or a group practice, the certified nurse practitioner participates in MassHealth pursuant to the requirements of 130 CMR 433.433(C); or

(b) in the case of payment claimed by a physician employer of a nonindependent certified nurse practitioner, the conditions of 130 CMR 433.433(E) are met; and

(4) for an out-of-state certified nurse practitioner the requirements of 130 CMR 433.403(C) are met.

(C) Independent Certified Nurse Practitioner Provider Eligibility: Submission Requirements. Only a certified nurse practitioner who meets the following requirements may enroll in MassHealth as an independent certified nurse practitioner:

(1) is licensed to practice as a certified nurse practitioner by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse practitioner services are provided; and

(2) is a member of a group practice or is in a solo private practice.

(3) Any certified nurse practitioner applying to participate as an independent provider in MassHealth must submit documentation satisfactory to the MassHealth agency that he or she meets these requirements.

(D) Consultation between Certified Nurse Practitioner and Physician. The MassHealth agency does not pay for a consultation between a certified nurse practitioner and a physician as a separate service.

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(E) Submitting Claims for Nonindependent Certified Nurse Practitioners. Any certified nurse practitioner who does not meet the requirements of 130 CMR 433.433(C) is a nonindependent certified nurse practitioner and is not eligible to submit claims to MassHealth. As an exception to 130 CMR 450.301: *Claims*, an individual physician (who is neither practicing as a professional corporation nor a member of a group practice) who employs a nonindependent certified nurse practitioner may submit claims for services provided by a nonindependent certified nurse practitioner employee, but only if:

(1) the nonindependent certified nurse practitioner is licensed to practice as a certified nurse practitioner by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the certified nurse practitioner services are performed;

(2) such services are provided in accordance with 130 CMR 433.433(B); and

(3) payment is claimed by the physician employer in accordance with 130 CMR 450.301(B). (Refer to Subchapter 6 of the *Physician Manual* for appropriate modifiers.)

433.434: Physician Assistant Services

(A) General. 130 CMR 433.434 applies specifically to physician assistants. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians also apply to physician assistants, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage. Services provided by a physician assistant must be limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants*).

(B) Conditions of Payment. In accordance with 263 CMR: *Board of Registration of Physician Assistants*, the MassHealth agency does not pay physician assistants directly. The MassHealth agency pays a group practice employer of a physician assistant for physician assistant services. Physician assistant services are payable when:

(1) the services are limited to the scope of practice authorized by state law or regulation (including but not limited to 263 CMR: *Board of Registration of Physician Assistants* or of the state licensing agency of another state in which the services are provided);

(2) the physician assistant or group practice is not an employee of the hospital or other facility in which the physician assistant services were performed, or is not otherwise paid by the hospital or facility for the service;

(3) the services are provided pursuant to a formal supervisory arrangement with a physician, as further described in 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants* and 130 CMR 433.434(D);

(4) the physician assistant participates in MassHealth pursuant to the requirements of 130 CMR 433.434(C); and

(5) for an out-of-state physician assistant the requirements of 130 CMR 433.403(C) are met.

(C) Physician Assistant Provider Eligibility. Any physician assistant applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

(1) is licensed to practice as a physician assistant by the Massachusetts Board of Registration of Physician Assistants or by the licensing agency of another state in which the physician assistant services are provided; and

(2) is a member of a group practice comprising at least one physician.

(D) Supervisory Arrangement Requirements.

(1) The services of a physician assistant must be performed under the supervision of a physician in accordance with 263 CMR 5.00: *Scope and Practice and Employment of Physician Assistants*.

(2) Physician supervision of or consultation with a physician assistant is not payable as a separate service.

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433.435: Tobacco Cessation Services

(A) Introduction. MassHealth members are eligible to receive tobacco cessation counseling services described in 130 CMR 433.435(B) and pharmacotherapy treatment, including nicotine replacement therapy (NRT), in accordance with 130 CMR 406.000: *Pharmacy Services*.

(B) Tobacco Cessation Counseling Services.

(1) MassHealth covers a total of 16 group and individual counseling sessions per member per 12-month cycle, without prior authorization. These sessions may be any combination of group and individual counseling. All individual counseling sessions must be at least 30 minutes, except for intake sessions, which must be at least 45 minutes. Intake sessions are limited to two per member per 12-month cycle, without prior authorization.

(a) Individual counseling consists of face-to-face tobacco cessation counseling services provided to an individual member by a MassHealth-qualified provider of tobacco cessation services as set forth in 130 CMR 433.435(B) and (C).

(b) Group tobacco treatment counseling consists of a scheduled professional counseling session with a minimum of three and a maximum of 12 members and has a duration of at least 60 to 90 minutes.

(c) Individual and group counseling also includes collaboration with and facilitating referrals to other healthcare providers to coordinate the appropriate use of medications, especially in the presence of medical or psychiatric comorbidities.

(2) The individual and group tobacco cessation counseling services must include the following:

(a) education on proven methods for stopping the use of tobacco, including:

1. a review of the health consequences of tobacco use and the benefits of quitting;
2. a description of how tobacco dependence develops and an explanation of the biological, psychological, and social causes of tobacco dependence; and
3. a review of evidence-based treatment strategies and the advantages and disadvantages of each strategy;

(b) collaborative development of a treatment plan that uses evidence-based strategies to assist the member to attempt to quit, to continue to abstain from tobacco, and to prevent relapse, including:

1. identification of personal risk factors for relapse and incorporation into the treatment plan;
2. strategies and coping skills to reduce relapse risk;
3. a plan for continued aftercare following initial treatment; and

(c) information and advice on the benefits of nicotine replacement therapy or other proven pharmaceutical or behavioral adjuncts to quitting smoking, including:

1. the correct use, efficacy, adverse events, contraindications, known side effects, and exclusions for all tobacco dependence medications; and
2. the possible adverse reactions and complications related to the use of pharmacotherapy for tobacco dependence.

(C) Provider Qualifications for Tobacco Cessation Counseling Services.

(1) Qualified Providers.

(a) Physicians, registered nurses, certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists, and physician assistants may provide tobacco cessation counseling services without additional experience or training in tobacco cessation counseling services.

(b) All other providers of tobacco cessation counseling services must complete a course of training in tobacco cessation counseling by a degree-granting institution of higher education with a minimum of eight hours of instruction.

(2) Supervision of Tobacco Cessation Counseling Services. A physician must supervise all registered nurses and other individuals who qualify under 130 CMR 433.435(C)(1)(b) who are providers of tobacco cessation counseling services for whom the physician will submit claims.

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(D) Tobacco Cessation Services: Claims Submission.

(1) Physicians, independent certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, and clinical nurse specialists, or group practice employers of such clinicians may submit claims for tobacco cessation services when those clinicians provide tobacco cessation services directly to MassHealth members. A group practice employer of a physician assistant may submit claims for tobacco cessation services provided by the physician assistant. *See* Subchapter 6 of the *Physician Manual* for service code descriptions.

(2) As an exception to 130 CMR 450.301(A), a physician that is an employer of a nonindependent certified nurse practitioner, registered nurse, or individual who qualifies under 130 CMR 433.435(C)(1)(b), may submit claims for tobacco cessation services provided by that employee, but only if such services are provided in accordance with 130 CMR 433.435(B) and (C) and payment is claimed in accordance with 130 CMR 450.301(B).

433.436: Radiology Services: Introduction

The MassHealth agency pays for radiology services only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Services Provided by an Independent Diagnostic Testing Facility (IDTF). The MassHealth agency pays an IDTF as defined in 130 CMR 433.401 for applicable diagnostic tests in accordance with the independent diagnostic testing facility regulations at 130 CMR 431.000: *Independent Diagnostic Testing Services*.

(B) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (*see* 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X-rays must be labeled adequately with the following:

(1) the member's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays for those services in accordance with the EOHHS fee schedule. The MassHealth agency does not pay for the interpretation of an X-ray that was previously read and taken in the same hospital. However, the MassHealth agency does pay a physician for interpreting an X-ray that was previously read and taken in a different hospital.

(B) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the MassHealth agency pays for those services in accordance with the EOHHS fee schedule.

(C) Surgical Introductions and Interpretations. The MassHealth agency pays a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

(1) Only one surgical introduction per operative session is payable in accordance with the EOHHS fee schedule.

(2) In a single operative session:

(a) no more than three additional surgical introductions using the same puncture site are payable, each in accordance with the EOHHS fee schedule; and

(b) no more than three additional selective vascular studies using the same puncture site are payable, each at the maximum allowable fee.

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(3) Interpretations are payable in accordance with the EOHHS fee schedule, up to a maximum of three.

(D) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a member by one or more physicians are payable only if sufficient documentation for each is shown in the member's medical record.

(E) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component is divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a member are payable under MassHealth.

(A) Provider Eligibility. The MassHealth agency pays for laboratory tests only when they are performed on a member by a physician, certified nurse practitioner, certified nurse midwife, certified professional midwife, certified registered nurse anesthetist, psychiatric clinical nurse specialist, clinical nurse specialist, or physician assistant, or by an independent clinical laboratory certified by Medicare.

(B) Payment. The MassHealth agency pays a physician, certified nurse practitioner, certified nurse midwife, certified professional midwife, certified registered nurse anesthetist, psychiatric clinical nurse specialist, clinical nurse specialist, or group practice employer of such practitioners or of a physician assistant only for laboratory tests performed in the practitioner's office. If an independent clinical laboratory performs laboratory tests for a member, the MassHealth agency pays only the laboratory for those services.

(C) Information with Specimen. A physician who sends a specimen to an independent clinical laboratory participating in MassHealth must also send the following.

(1) a signed request for the laboratory services to be performed;
(2) the member’s MassHealth identification number; and
(3) the physician’s name, address and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The MassHealth agency does not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue).

(B) Professional Component of Laboratory Services. The MassHealth agency does not pay a physician for the professional component of a clinical laboratory service. The MassHealth agency pays a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The MassHealth agency does not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. Payment for laboratory services includes payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

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(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event may a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

(E) Forensic Services. The MassHealth agency does not pay for tests performed for forensic purposes or any purpose other than those described in 130 CMR 433.438 including, but not limited to:

(1) tests performed to establish paternity;

(2) tests performed pursuant to, or in compliance with, a court order (for example, monitoring for drugs of abuse); and

(3) postmortem examinations.

433.440: Acupuncture

(A) Introduction. MassHealth members are eligible to receive acupuncture for the treatment of pain as described in 130 CMR 433.440(C), for use as an anesthetic as described in 130 CMR 433.454(C), and for use for detoxification as described in 130 CMR 418.406(C)(3): *Substance Abuse Treatment: Acupuncture Detoxification*.

(B) General. 130 CMR 433.440 applies specifically to physicians and midlevel practitioners who are licensed practitioners of acupuncture.

(C) Acupuncture for the Treatment of Pain. MassHealth provides a total of 20 sessions of acupuncture for the treatment of pain per member per year without prior authorization. If the member's condition, treatment, or diagnosis changes, the member may receive more sessions of medically-necessary acupuncture treatment with prior authorization.

(D) Provider Qualifications for Acupuncture. MassHealth pays for acupuncture services only when the provider rendering the service is:

(1) a physician; or

(2) a midlevel practitioner who is licensed in acupuncture by the Massachusetts Board of Registration in Medicine under 243 CMR 5.00: *The Practice of Acupuncture*.

(E) Conditions of Payment. The MassHealth agency pays providers qualified to render acupuncture services in accordance with 130 CMR 433.440(D) for acupuncture services only when

(1) the services are limited to the scope of practice authorized by state law or regulation (such as 243 CMR 5.00: *The Practice of Acupuncture*); and

(2) the provider has a current license or certificate of registration from the Massachusetts Board of Registration in Medicine.

(F) Acupuncture Claims Submissions.

(1) Providers eligible to render acupuncture services in accordance with 130 CMR 433.440(D) may submit claims for acupuncture services when they provide those services directly to MassHealth members. *See* Subchapter 6 of the *Physician Manual* for service code descriptions and billing requirements.

(2) For MassHealth members receiving services under any of the acupuncture codes on the same date of service as an office visit, the provider may bill for either an office visit or the acupuncture code, but may not bill for both an office visit and the acupuncture code for the same member on the same date when the office visit and the acupuncture services are performed in the same location. This limitation does not apply to a significant, separately identifiable office visit provided by the same provider on the same day of the acupuncture service.

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433.441: Pharmacy Services: Drugs Dispensed in Pharmacies

Coverage of drugs and medical supplies dispensed to MassHealth members by MassHealth pharmacy providers, and related prescription requirements for prescribing prescribers, are governed by 130 CMR 406.000: *Pharmacy Services*.

433.447: Drugs Administered in the Office (Provider-administered Drugs)

(A) Drugs and biologicals dispensed in the office are payable, subject to the exclusions and service limitations at 130 CMR 433.404, 433.406, and 130 CMR 406.413(B): *Drug Exclusions* and (C): *Service Limitations*.

(B) The MassHealth agency does not pay a provider separately for drugs that are considered routine and integral to the delivery of a provider's professional services in the course of diagnosis or treatment. Such drugs are commonly provided without charge or are included in the provider's fee for the service.

(C) The MassHealth agency does not pay separately for any oral drugs dispensed in the office for which the provider has not requested and received prior authorization from the MassHealth agency, with the exception of oral vaccines and oral radiopharmaceuticals, which do not require prior authorization.

(D) Claims for drugs and biologicals that are listed in Subchapter 6 of the *Physician Manual* must include the name of the drug or biological, strength, dosage, and number of HCPCS units dispensed, NDC code, NDC units and NDC unit of measurement. In addition, for drugs and/or biologicals that are listed as requiring individual consideration in Subchapter 6 of the *Physician Manual*, a copy of the invoice showing the actual acquisition cost must be attached to the claim. Claims without this information are denied.

(E) The MassHealth agency pays only for prescription drugs that are approved by the U.S. Food and Drug Administration and manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to 42 U.S.C. 1396r-8. Payment is calculated in accordance with 101 CMR 331.00: *Prescribed Drugs*.

(F) The MassHealth agency does not pay for a biological if the Massachusetts Department of Public Health distributes the biological free of charge.

(G) Payment for drugs may be claimed in addition to an office visit.

433.449: Fluoride Varnish Services

(A) Eligible Members. Members must be younger than 21 years old to be eligible for the application of fluoride varnish.

(B) Qualified Personnel. Physicians, certified nurse practitioners, clinical nurse specialists, registered nurses, licensed practical nurses, physician assistants, and medical assistants may apply fluoride varnish subject to the limitations of state law. To qualify to apply fluoride varnish, the individual must complete a MassHealth-approved training on the application of fluoride varnish, maintain proof of completion of the training, and provide such proof to the MassHealth agency upon request.

(C) Fluoride Varnish Services: Claim Submission.

(1) A provider may bill for an office visit, in addition to the fluoride varnish application, only if fluoride varnish was not the sole service, treatment, or procedure provided during the visit.

(2) Physicians, independent certified nurse practitioners, and clinical nurse specialists or group practice employers of such clinicians, may submit claims for fluoride varnish services when those clinicians provide fluoride varnish services directly to MassHealth members. A group practice employer of a physician assistant may submit claims for fluoride varnish services provided by the physician assistant. *See* Subchapter 6 of the *Physician Manual* for service code descriptions.

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(3) As an exception to 130 CMR 450.301(A), a physician that is an employer of a non-independent certified nurse practitioner, registered nurse, licensed practical nurse, or medical assistant, may submit claims for fluoride varnish services provided by that employee, but only if such services are provided in accordance with 130 CMR 433.449(A) and (B), and payment is claimed in accordance with 130 CMR 450.301(B).

433.451: Surgery Services: Introduction

(A) Provider Eligibility. The MassHealth agency pays a physician for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (*See* 130 CMR 433.421(B)(2) for the single exception to this requirement.)

(B) Nonpayable Services. The MassHealth agency does not pay for

(1) any experimental, unproven, cosmetic, or otherwise medically unnecessary procedure or treatment;

(2) the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, MassHealth does pay for the diagnosis of male or female infertility;

(3) reconstructive surgery, unless the MassHealth agency determines, pursuant to a request for prior authorization, the service is medically necessary to correct, repair, or ameliorate the physical effects of disease or physical defect, or traumatic injury;

(4) services billed under codes listed in Subchapter 6 of the *Physician Manual* as not payable;

(5) services otherwise identified in the MassHealth regulations at 130 CMR 433.000 or 450.000 as not payable; and

(6) services billed with otherwise covered service codes when such codes are used to bill for nonpayable circumstances as described in 130 CMR 433.404.

(C) Definitions. The following terms have the meanings given for purposes of 130 CMR 433.451 and 433.452, unless otherwise indicated.

(1) Complications following Surgery – all additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications that do not require additional trips to the operating room.

(2) Evaluation and Management (E/M) Services – visits and consultations furnished by physicians in various settings and of various complexities as defined in the Evaluation and Management section of the American Medical Association's *Current Procedural Terminology (CPT)* code book.

(3) Intraoperative Services – intraoperative services that are normally a usual and necessary part of a surgical procedure.

(4) Major Surgery – a surgery for which the Centers for Medicare & Medicaid Services (CMS) determines the preoperative period is one day and the postoperative period is 90 days.

(5) Minor Surgery – a surgery for which CMS determines the preoperative period is zero days and the postoperative period is zero or ten days.

(6) Postoperative Period –

(a) The postoperative period for major surgery is 90 days.

(b) The postoperative period for minor surgery and endoscopies is zero or ten days.

(7) Postoperative Visits – follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery.

(8) Postsurgical Pain Management – postsurgical pain management by the surgeon, including supplies.

(9) Preoperative Period –

(a) The preoperative period for major surgery is one day.

(b) The preoperative period for minor surgery is zero days.

(10) Preoperative Visits – preoperative visits after the decision is made to operate, beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.

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433.452: Surgery Services: Payment

Surgical services and other invasive procedures are listed in the surgery and medicine section of the American Medical Association's *Current Procedural Terminology (CPT)* code book. The MassHealth agency pays for all medicine and surgery CPT codes in effect at the time of service, except for those codes listed in Section 602 of Subchapter 6 of the *Physician Manual*, subject to all conditions and limitations described in MassHealth regulations at 130 CMR 433.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(A) Visit and Treatment/Procedure on Same Day in Same Location. The MassHealth agency pays a provider for either a visit or a treatment/procedure, whichever fee is greater. The MassHealth agency does not pay for both a preoperative evaluation and management visit, and a treatment/procedure provided to a member on the same day when they are performed in the same location. For minor surgeries and endoscopies, the MassHealth agency does not pay separately for an evaluation and management service on the same day as the surgery or endoscopy. The limitations in 130 CMR 433.452(A) do not appy to a significant, separately identifiable evaluation and management service provided by the same provider on the same day of the procedure or other services. For payment information about obstetrical care, refer to 130 CMR 433.421.

(B) Payment for Global Surgical Package. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The services are included in the global surgical package regardless of setting including, but not limited to, hospitals, ambulatory surgical centers, and office settings.

(1) The following services are included in the payment for a global surgery when furnished by the provider who performs the surgery:

(a) preoperative visits;

(b) intraoperative visits;

(c) complications following surgery;

(d) postoperative visits;

(e) postsurgical pain management;

(f) miscellaneous services related to surgery including, but not limited to, dressing changes; local incisional care; removal of operative pack, cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric tubes, and rectal tubes; and changes and removal of tracheostomy tubes; and

(g) visits related to the surgery to a patient in an intensive care or critical care unit, if made by the surgeon. Intensive or critical care visits unrelated to surgery are not included in the global surgical package.

(2) The following services are not included in the payment for a global surgery and are separately payable by MassHealth. *See* 130 CMR 433.600 for a listing of modifiers, where applicable.

(a) the initial consultation or evaluation of the problem by the surgeon to determine the need for surgery;

(b) services of other physicians except where the surgeon and the other physician or physicians agree on the transfer of care during the global period. Such transfer agreement must be in writing and a copy of the written transfer agreement must be kept in the member's medical record;

(c) visits unrelated to the diagnosis for which the surgical procedure is performed;

(d) treatment for the underlying condition or an added course of treatment that is not part of the normal recovery from the surgery;

(e) diagnostic tests and procedures, including diagnostic radiological procedures;

(f) clearly distinct surgical procedures during the postoperative period that are not reoperations or treatment for complications resulting from the surgery. A new postoperative period begins with the subsequent surgical procedure. This exception includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure;

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(g) treatment for postoperative complications that require a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical that there would be insufficient time for transportation to an OR);
(h) a second, more extensive procedure required because the initial, less extensive procedure did not produce the desired outcome;
(i) immunotherapy management for organ transplants; and
(j) critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance by the physician.

(C) Payment for Multiple Surgeries. Multiple surgeries are separate procedures performed by a provider on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from intraoperative services and surgeries that are incidental to or components of a primary surgery (that is, bundled services). Bundled services are not paid separately. When two or more related procedures are performed on a patient during a single session or visit, the MassHealth agency pays the provider for the comprehensive code and denies or adjusts the component, incidental, or mutually exclusive procedure performed during the same session. The bundling guidelines that MassHealth applies are based upon generally accepted industry guidelines including, but not limited, to the National Correct Coding Initiative administered through the Centers for Medicare & Medicaid Services (CMS) and the *American Medical Association's Current Procedural Terminology* (CPT) code book. To receive payment for multiple surgeries, the provider must bill with the multiple surgery modifier. Additionally, the provider must use NCCI-related modifiers to receive payment, when appropriate, for two medically necessary, separately identifiable procedures performed on a member on the same date of service (*see* Subchapter 6 of the *Physician Manual* for a listing of allowed modifiers).

(D) Payment for Multiple Endoscopy Procedures. When multiple procedures are performed through the same endoscope, payment is made for the highest valued endoscopy procedure plus the difference between the next highest endoscopy procedure and the base endoscopy procedure. The base endoscopy procedure is included in the code for each of the multiple procedures. When two related endoscopies and an unrelated endoscopy are performed, the endoscopic payment rule stated above applies to the related endoscopies. Unrelated endoscopic procedures are treated as separate surgeries and paid as multiple surgeries pursuant to 130 CMR 433.452(C).

(E) Payment for Add-on Surgical Procedures. The Centers for Medicare & Medicaid Services (CMS) has identified certain procedures as add-on procedures that are always billed with another procedure. Add-on codes are identified in the CPT code book. By definition, these services do not stand alone and must be provided in conjunction with a primary surgical procedure or qualifying service. Both the service code for the primary procedure and add-on code are paid separately. The global surgery package provisions at 130 CMR 455.451 and 455.452 apply to the service code for the primary procedure.

(F) Payment for Bilateral Procedures. Bilateral surgeries are defined as procedures performed on both sides of the body during the same operative session or on the same day. To receive payment, the surgeon must use the bilateral surgery modifier with the appropriate service code. The provider must not use the bilateral surgery modifier with service codes containing the terms “bilateral” or “unilateral or bilateral” in their definitions, since the terminology of the code identifies the service as one whose payment accounts for any additional work required for bilateral surgery.

(G) Surgical Assistants. Some surgical procedures require a primary surgeon and an assistant surgeon. To receive payment, the assistant surgeon must use the appropriate modifier. Surgical codes that accept the surgical assistant modifiers are indicated in The Centers for Medicare & Medicaid Services *Correct Coding Initiative Guide*. In addition, the MassHealth agency does not pay for a surgical assistant if

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(1) any component of the surgery is billed using a team surgery modifier pursuant to 130 CMR 433.452(H) or a two-surgeon modifier pursuant to 130 CMR 433.452(I);
(2) the surgery services were provided in a teaching hospital that has an approved training program related to the medical specialty required for the surgical procedure and a qualified resident available to perform the services. If no qualified resident is available to perform the services, the MassHealth agency pays for a surgical assistant if the member's medical record documents that a qualified resident was unavailable at the time of the surgery; or
(3) the surgical procedure does not require the services of more than one surgeon.

(H) Team Surgery. Under some circumstances, the MassHealth agency pays for highly complex surgical procedures requiring the concomitant services of more than two surgeons as "team surgery". The MassHealth agency pays a single consolidated payment for team surgery to the director of the surgical team. To receive payment, the director of the team must use the team surgery modifier. Payment includes all surgical assistant fees. The director of the surgical team is expected to distribute the MassHealth payment to the other physician members of the surgical team.

(I) Two Surgeons (Co-surgery). The MassHealth agency pays for co-surgery when two surgeons work together as primary surgeons performing distinct parts of a reportable procedure. To receive payment, each surgeon must use the two surgeons modifier. Payment includes all surgical assistant fees.

433.454: Anesthesia Services

(A) Payment.
(1) Payment Determination. The MassHealth agency pays an anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) for anesthesia services as described in 101 CMR 316.00: *Surgery and Anesthesia*, and 130 CMR 433.454. Payment for anesthesia services is determined using a system of base anesthesia units and time anesthesia units.
(2) Base Anesthesia Units. Providers must report the administration of anesthesia on the claim by using the applicable five-digit anesthesia procedure code (00100-01999), and any applicable modifier. The anesthesia procedure code determines the number of base anesthesia units that correspond to the procedure. If a base anesthesia unit is not established for a service, the MassHealth agency pays using time anesthesia units only. When anesthesia is administered for multiple surgery procedures, only the base anesthesia units corresponding to the procedure with the largest number of units is used to determine payment. The number of base anesthesia units does not vary based on the type of anesthesia that is administered.
(3) Time Anesthesia Units.
(a) Payable Anesthesia Time. Payable anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for the induction of anesthesia in the operating room or equivalent area. Payable anesthesia time ends when the patient may be safely placed under postoperative supervision.
(b) Reporting Time Anesthesia Units. A provider must report only payable time anesthesia units in the number of units field on the claim. The provider must not include base anesthesia units or units that exceed the criteria set forth in 130 CMR 433.454(A)(3)(a) in the number of units field. Time anesthesia units are measured in minutes. One unit equals one minute.
(4) Personally Performed Anesthesia Services. Anesthesia procedures that are personally performed alone by either an anesthesiologist, or a CRNA not employed by the facility in which the anesthesia services are provided, are payable by MassHealth. For a CRNA, personally performed anesthesia services are those that a CRNA performs alone without medical direction of an anesthesiologist. Payment for personally performed anesthesia services may be claimed by appending the appropriate anesthesia modifier to the anesthesia procedure code. If a CRNA is employed by the facility in which the personally performed anesthesia services are provided, there is no separate payment for the CRNA's services. Refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.

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(5) Medical Direction and Medical Supervision. The MassHealth agency pays for medical direction as described in 101 CMR 316.00: *Surgery and Anesthesia* and 130 CMR 433.454(C). Refer to Subchapter 6 of the *Physician Manual* for appropriate modifiers. The MassHealth agency does not pay for medical supervision as further described in 130 CMR 433.454(D).

(B) Services Provided by a Certified Registered Nurse-anesthetist (CRNA).

(1) General. 130 CMR 433.454 applies specifically to physicians and CRNAs. In general however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to physicians, also apply to CRNAs, such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

(2) Conditions of Payment. The MassHealth agency pays a CRNA or group practice for CRNA services when

(a) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(b) the CRNA or group practice is not an employee of the hospital or other facility in which the CRNA services were performed, or is not otherwise paid by the hospital or facility for the service;

(c) the CRNA participates in MassHealth pursuant to the requirements of 130 CMR 433.454(B)(3);

(d) the services of the CRNA are provided under the supervision of a physician such that the operating physician or an anesthesiologist is immediately available if needed; and

(e) for an out of state CRNA the requirements of 130 CMR 433.403(C) are met.

(3) CRNA Provider Eligibility. A CRNA may enroll in MassHealth as a provider. Any CRNA applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency, that he or she

(a) is licensed to practice as a CRNA by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CRNA services are provided; and

(b) is a member of a group practice or is in a solo private practice.

(C) Medical Direction of Anesthesia Services. The MassHealth agency pays an anesthesiologist for medical direction of a CRNA as follows. The term medical direction is used in 130 CMR 433.454(C) for payment purposes only.

(1) Medical direction of anesthesia services occurs when an anesthesiologist is involved in no more than four concurrent anesthesia procedures and provides all of the following seven services to a patient:

(a) perform a pre-anesthetic examination and evaluation;

(b) prescribe the anesthesia plan;

(c) personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;

(d) ensure that any procedures in the certified registered nurse anesthesia plan that he or she does not perform, are performed by a qualified anesthetist;

(e) monitor the course of anesthesia administration at frequent intervals;

(f) remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) provide the indicated post-anesthesia care.

(2) If one or more of the above services in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by the anesthesiologist, the service is not considered medical direction.

(3) Ordinarily, the anesthesiologist should not furnish additional services to other patients while concurrently directing the administration of anesthesia. The anesthesiologist can, however, provide any of the following services to other patients while medically directing the administration of anesthesia without affecting the anesthesiologist's ability to provide medical direction.

(a) addressing an emergency of short duration in the immediate area;

(b) administering an epidural or caudal anesthetic to ease labor pain;

(c) periodic rather than continuous monitoring of an obstetrical patient;

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(d) receiving patients entering the operating suite for the next surgery;
(e) checking on or discharging patients from the post anesthesia care unit; and
(f) coordinating scheduling matters.

(4) Payment for medical direction of a CRNA may be claimed by appending the appropriate anesthesia modifier to the anesthesia procedure code.

(a) If an anesthesiologist provides medical direction of a CRNA who participates in MassHealth in accordance with 130 CMR 433.454(B)(3), and is not employed by the facility in which the anesthesia services are performed, the anesthesiologist receives 50% of the fee and the CNRA receives 50% of the fee.

(b) If an anesthesiologist provides medical direction of a CRNA employed by a facility in which the anesthesia service is performed, the anesthesiologist receives 50% of the fee, but no separate payment is made for the CRNA's services.

(c) Anesthesiologists and CRNAs should refer to subchapter 6 of the *Physician Manual* for appropriate modifiers.

(D) Medical Supervision of Anesthesia Services. The MassHealth agency does not pay a physician for medical supervision of a CRNA. The term medical supervision is used in this section for payment purposes only.

(1) Medical supervision of anesthesia services occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures and when the anesthesiologist provides some, but not all of the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g).

(2) Medical supervision also occurs when the seven required services under medical direction in 130 CMR 433.454(C)(1)(a) through (1)(g) are not performed by an anesthesiologist. This might occur in cases when the anesthesiologist:

(a) left the immediate area of the operating suite for more than a short duration;
(b) devotes extensive time to an emergency case; or
(c) was otherwise not available to respond to the immediate needs of the surgical patients.

(E) Acupuncture as an Anesthetic. The MassHealth agency pays for acupuncture as a substitute for conventional surgical anesthesia (*see* 130 CMR 433.440).

433.455: Abortion Services

(A) Payable Services.

(1) The MassHealth agency pays for an abortion service if both of the following conditions are met:

(a) the abortion is a medically necessary abortion, or the abortion is performed upon a victim of rape or incest when such rape or incest has been reported to a law enforcement agency or public health service within 60 days of the incident; and
(b) the abortion is performed in accordance with law.

(2) For the purposes of 130 CMR 433.455, a medically necessary abortion is one which, according to the medical judgment of a licensed physician, or, consistent with M.G.L. c. 112, § 12M and the time limitations established therein a physician assistant, certified nurse practitioner, certified professional midwife, or certified nurse midwife, is necessary in light of all factors affecting the pregnant individual's health.

(3) Unless otherwise indicated, all abortions referred to in 130 CMR 433.455 are payable abortions as defined in 130 CMR 433.455(A)(1) and (2).

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of abortion services. The MassHealth agency, any provider, any agent or employee of a provider must not mislead any member into believing that a decision to have or not to have an abortion will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for abortion services as well as for all other medical services covered by MassHealth.

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(C) Certification for Payable Abortion Form. All providers (*i.e.*, physicians, physician assistants, nurse practitioners, or nurse midwives) must complete a Certification for Payable Abortion (CPA 2) form and retain the form in the member's record. (Instructions for obtaining the CPA-2 form are in Appendix A of all provider manuals.) To identify those abortions that meet federal reimbursement standards, the MassHealth agency must secure on the CPA 2 form the certifications described in 130 CMR 433.455(C)(1), (2), and (3), when applicable. For all medically necessary abortions not included in 130 CMR 433.455(C)(1), (2), or (3), the certification described in 130 CMR 433.455(C)(4) is required on the CPA 2 form. The provider must indicate on the CPA-2 form which of the following circumstances is applicable, and must complete that portion of the form with the appropriate signatures.

(1) Life of the Pregnant Individual Would Be Endangered. The attending provider must certify that, in their professional judgment, the life of the pregnant individual would be endangered if the pregnancy were carried to term.

(2) Severe and Long-lasting Damage to Pregnant Individual's Physical Health. The attending provider and another provider must each certify that, in their professional judgment, severe and long-lasting damage to the pregnant individual's physical health would result if the pregnancy were carried to term. At least one of the providers must also certify that they are not an "interested provider", defined herein as one whose income is directly or indirectly affected by the fee paid for the performance of the abortion; or who is the spouse of, or another relative who lives with, a provider whose income is directly or indirectly affected by the fee paid for the performance of the abortion.

(3) Victim of Rape or Incest. The provider is responsible for submitting with the claim form signed documentation from a law enforcement agency or public health service certifying that the person upon whom the procedure was performed was a victim of rape or incest that was reported to the agency or service within 60 days of the incident. (A public health service is defined as either an agency of the federal, state, or local government that provides health or medical services, or a rural health clinic, provided that the agency's principal function is not the performance of abortions.) The documentation must include the date of the incident, the date the report was made, the name and address of the victim and of the person who made the report (if different from the victim), and a statement that the report included the signature of the person who made the report.

(4) Other Medically Necessary Abortions. The attending provider must certify that, in their medical judgment, for reasons other than those described in 130 CMR 433.455(C)(1), (2), and (3), the abortion performed was necessary in light of all factors affecting the pregnant individual's health.

433.456: Sterilization Services: Introduction

(A) Covered Services. The MassHealth agency pays for a sterilization service provided to an eligible member only if all of the following conditions are met.

(1) The member has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 433.457, and such consent is documented in the manner described in 130 CMR 433.458.

(2) The member is at least 18 years old at the time consent is obtained.

(3) The member is not a mentally incompetent individual or an institutionalized individual.

(B) Assurance of Member Rights. A provider must not use any form of coercion in the provision of sterilization services. The MassHealth agency, any provider, any agent or employee of a provider must not mislead any member into believing that a decision to have or not have a sterilization will adversely affect the member's entitlement to benefits or services for which the member would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of member records for sterilization services as well as for all other medical services covered by MassHealth.

(C) Retroactive Eligibility. The MassHealth agency does not pay for a sterilization performed during the period of a member's retroactive eligibility unless all conditions for payment listed in 130 CMR 433.456(A) are met.

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(D) Locations in Which Sterilizations May Be Performed.

(1) Male sterilization must be performed by a licensed physician in a physician's office, hospital, or sterilization clinic.

(2) Female sterilization must be performed by a licensed physician in a hospital, freestanding ambulatory surgery center, or sterilization clinic.

(3) A hospital, freestanding ambulatory surgery center, or sterilization clinic in which a sterilization is performed must be licensed in compliance 105 CMR 130.000: *Hospital Licensure* or 105 CMR 140.000: *Licensure of Clinics*, as applicable.

433.457: Sterilization Services: Informed Consent

A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained in accordance with the requirements specified in 130 CMR 433.457(A) and (B), and such consent is documented as specified in 130 CMR 433.458.

(A) Informed Consent Requirements.

(1) The person who obtains consent (a physician, nurse, or counselor, for example) must orally provide all of the following information and advice to the member requesting sterilization:

(a) advice that the member is free to withhold or withdraw consent for the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss of any federal- or state-funded program benefits to which the member otherwise might be entitled;

(b) a description of available alternative methods of family planning and birth control;

(c) advice that the sterilization procedure is considered irreversible;

(d) a thorough explanation of the specific sterilization procedure to be performed;

(e) a full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used;

(f) a full description of the benefits or advantages that may be expected as a result of the sterilization; and

(g) advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in 130 CMR 433.457(B)(1).

(2) The person who obtains consent must also:

(a) offer to answer any questions the member may have about the sterilization procedure;

(b) give the member a copy of the consent form;

(c) make suitable arrangements to ensure that the information and advice required by 130 CMR 433.457(A)(1) are effectively communicated to any member who is blind, deaf, or otherwise handicapped;

(d) provide an interpreter if the member does not understand the language used on the consent form or the language used by the person obtaining consent; and

(e) allow the member to have a witness of the member's choice present when consent is obtained.

(B) When Informed Consent Must Be Obtained.

(1) A member's consent for sterilization will be considered informed and voluntary only if such consent is obtained at least 30 days, but not more than 180 days, before the date of the sterilization procedure, except in the case of premature delivery or emergency abdominal surgery. A member may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since the member gave informed consent for the sterilization in the manner specified in 130 CMR 433.457. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

(2) A member's consent for sterilization will not be considered informed or voluntary if such consent is obtained or given while the member requesting sterilization is

(a) in labor or childbirth;

(b) seeking to obtain or obtaining an abortion; or

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(c) under the influence of alcohol or other substances that affect the individual's state of awareness.

(3) Shortly before the performance of the sterilization procedure, the physician performing the procedure must orally inform the member of all of the information and advice specified in 130 CMR 433.457(A)(1).

433.458: Sterilization Services: Consent Form Requirements

Informed consent for sterilization must be documented by the completion of the MassHealth agency's Consent for Sterilization form in accordance with the following requirements.

(A) Required Consent Form.

(1) One of the following Consent for Sterilization forms must be used:

(a) CS-18 – for members 18 through 20 years old; or

(b) CS-21 – for members 21 years of age or older.

(2) Under no circumstances will the MassHealth agency accept any other consent for sterilization form.

(B) Required Signatures. The member, the interpreter (if one was required), and the person who obtained the consent for sterilization must all sign and date the Consent for Sterilization form (CS-18 or CS-21) at the time of consent. After performing the sterilization procedure, the physician must sign and date the form.

(C) Required Distribution of the Consent Form. The Consent for Sterilization form (CS-18 or CS-21) must be completed and distributed as follows:

(1) the original must be given to the member at the time of consent; and

(2) a copy must be included in the member's permanent medical record at the site where the sterilization is performed.

(D) Provider Billing and Required Submissions.

(1) All providers must bill with the appropriate sterilization diagnosis and service codes, and must attach a copy of the completed Consent for Sterilization form (CS-18 or CS-21) to each claim made to the MassHealth agency for sterilization services. This provision applies to any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing. When more than one provider is billing the MassHealth agency (for example, the physician and the hospital), each provider must submit a copy of the completed sterilization consent form with the claim.

(2) A provider does not need to submit a Consent for Sterilization form (CS-18 or CS-21) with a claim for a medical procedure, treatment, or operation that is not for the purpose of rendering an individual permanently incapable of reproducing. If the appropriate service code used to bill for such a medical procedure, treatment, or operation is also used to bill for a sterilization, the claim will be denied unless at least one of the following justifications is present and documented on an attachment signed by the physician and attached to the claim.

(a) The medical procedure, treatment, or operation was a unilateral procedure and did not result in sterilization.

(b) The medical procedure, treatment, or operation was unilateral or bilateral, but the patient was previously sterile as indicated in the operative notes.

(c) The medical procedure, treatment, or operation was medically necessary for treatment of an existing illness or injury and was not performed for the purpose of sterilization; or

(d) The medical procedure, treatment, or operation was medically necessary for treatment of a life-threatening emergency situation and was not performed for the purpose of sterilization, and it was not possible to inform the member in advance that it would or could result in sterilization. Include the nature and date of the life-threatening emergency.

(3) In the circumstances set forth in 130 CMR 433.458(D)(2)(a) and (c), the medical records must also document that the member consented to the medical procedure, treatment, or operation after being informed that it would or could result in sterilization.

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(4) When more than one provider is billing the MassHealth agency under the circumstances specified in 130 CMR 433.458(D)(2) (for example, the physician and the hospital), each provider must submit a copy of the signed attachment along with the claim.

433.459: Hysterectomy Services

(A) Nonpayable Services. The MassHealth agency does not pay for a hysterectomy provided to a member under the following conditions.

(1) The hysterectomy was performed solely for the purpose of sterilizing the member.

(2) If there was more than one purpose for the procedure, the hysterectomy would not have been performed but for the purpose of sterilizing the member.

(B) Hysterectomy Information Form. The MassHealth agency pays for a hysterectomy only when the appropriate section of the Hysterectomy Information (HI-1) form is completed, signed, and dated as specified below.

(1) Prior Acknowledgment. Except under the circumstances specified below, the member and her representative, if any, must be informed orally and in writing before the hysterectomy operation that the hysterectomy will make her permanently incapable of reproducing. (Delivery in hand of the Hysterectomy Information (HI-1) form will fulfill the written requirement, but not the oral requirement.) Section (B) of the Hysterectomy Information (HI-1) form must be signed and dated by the member or her representative before the operation is performed, as acknowledgment of receipt of this information. Whenever any surgery that includes the possibility of a hysterectomy is scheduled, the member must be informed of the consequences of a hysterectomy, and must sign and date section (B) of the Hysterectomy Information (HI-1) form before surgery.

(2) Prior Sterility. If the member is sterile prior to the hysterectomy operation, the physician who performs the operation must so certify, describe the cause of sterility, and sign and date section (C)(1) of the Hysterectomy Information (HI-1) form.

(3) Emergency Surgery. If the hysterectomy is performed in an emergency, under circumstances that immediately threaten the member's life, and if the physician determines that obtaining the member's prior acknowledgment is not possible, the physician who performs the hysterectomy must so certify, describe the nature of the emergency, and sign and date section (C)(2) of the Hysterectomy Information (HI-1) form.

(4) Retroactive Eligibility. If the hysterectomy was performed during the period of a member's retroactive eligibility, the physician who performed the hysterectomy must certify that one of the following circumstances existed at the time of the operation:

(a) the woman was informed before the operation that the hysterectomy would make her sterile (the physician must sign and date section (D)(1) of the HI-1 form);

(b) the woman was sterile before the hysterectomy was performed (the physician must sign, date, and describe the cause of sterility in section (D)(2) of the HI-1 form); or

(c) the hysterectomy was performed in an emergency that immediately threatened the woman's life and the physician determined that it was not possible to obtain her prior acknowledgment (the physician must sign, date, and describe the nature of the emergency in section (D)(3) of the HI-1 form).

(C) Submission of the Hysterectomy Information Form. Each provider must attach a copy of the completed Hysterectomy Information (HI-1) form to each claim form submitted to the MassHealth agency for hysterectomy services. When more than one provider is billing the MassHealth agency for the same hysterectomy, each provider must submit a copy of the completed H1-1 form.

433.473: Clinical Nurse Specialist (CNS) Services

(A) General. 130 CMR 433.473 applies specifically to clinical nurse specialists. In general, however, subject to compliance with state and federal law, the requirements and limitations elsewhere in 130 CMR 433.000 that apply to a physician also apply to a clinical nurse specialist (CNS), such as service and payment limitations, recordkeeping and reporting requirements, and prior-authorization and other conditions of coverage.

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(B) Conditions of Payment. The MassHealth agency pays a CNS or group practice for CNS services when

(1) the services are limited to the scope of practice authorized by state law or regulation (including, but not limited to, 244 CMR: *Board of Registration in Nursing* or of the state licensing agency of another state in which the services are provided);

(2) the CNS or group practice is not an employee or contractor of the hospital or other facility in which the CNS services were performed, or is not otherwise paid by the hospital or facility for their services;

(3) the CNS participates in MassHealth pursuant to the requirements of 130 CMR 433.473(C); and

(4) for an out-of-state CNS the requirements of 130 CMR 433.403(C) are met.

(C) Clinical Nurse Specialist Provider Eligibility. A CNS may enroll as a MassHealth provider. Any CNS applying to participate as a provider in MassHealth must submit documentation, satisfactory to the MassHealth agency that he or she

(1) is licensed to practice as a CNS by the Massachusetts Board of Registration in Nursing or by the licensing agency of another state in which the CNS services are provided; and

(2) is a member of a group practice or is in a solo private practice.

(D) Consultation Between A Clinical Nurse Specialist and Physician. The MassHealth agency does not pay for a consultation between a CNS and a physician as a separate service.

433.485: CARES Program Services

(A) Introduction. The MassHealth Coordinating Aligned, Relationship-centered, Enhanced Support for Kids program (CARES program) is a Targeted Case Management (TCM) service rendered by CARES program providers certified in accordance with 130 CMR 433.485(D) to members younger than 21 years old who satisfy the eligibility criteria in 130 CMR 433.485(C). The MassHealth agency pays for CARES program services provided by CARES program providers subject to restrictions and limitations in 130 CMR 433.485(A) through 433.485(H) and Appendix M.

(B) Definitions. The following terms used in 130 CMR 433.485(A) through 433.485(H) have the meanings given in 130 CMR 433.485(B), unless the context clearly requires a different meaning.

Comprehensive Assessment. A systematic, timely, and clearly documented screening process that provides the foundation for care coordination and the individual care plan. The assessment includes information and data from multiple sources and reflects key information about the member and their parent/guardian's needs and priorities.

Individual Care Plan (ICP). A plan that specifies the goals and actions to address the medical, educational, social, behavioral, or other services needed by the member and their parent/guardian.

Local Education Agency. A public authority legally constituted by the state as an administrative agency to provide control of and direction for kindergarten through grade 12 public educational institutions.

Medical Complexity. A combination of multiorgan system involvement from chronic health condition(s) that often result in functional limitations, ongoing use of medical technology, and high resource need and use.

Natural Supports. Include family, friends, neighbors, and self-help groups intentionally identified to support the member. This support system is an active component of the ICP to support the member and their parent/guardian.

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Subspecialist. A provider who specializes in a narrow field of professional knowledge/skills within a medical specialty, such as pediatric congenital heart disease within the broad specialty of cardiology.

(C) Clinical Eligibility Criteria. To receive CARES program services, a member must:

(1) be younger than 21 years old;

(2) not reside in a nursing facility or other inpatient facility for longer than six consecutive months at the time of seeking CARES program services; and

(3) satisfy:

(a) all of the eligibility criteria in 130 CMR 433.485(C)(3)(b)(1); and

(b) all of the eligibility criteria in either 130 CMR 433.485(C)(3)(b)(2) or 130 CMR 433.485(C)(3)(b)(3), as follows:

1. The member is a child or youth with special health needs who requires ongoing medical management by at least two pediatric subspecialists. At least one of the specialists must treat a medical condition that results in all of the following:

a. functional impairment (*e.g.*, need for assistance with activities of daily living) that substantially interferes with or limits the member's role/functioning in family, school, and community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the member in achieving or maintaining developmentally appropriate, social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

b. at least one condition must be:

i. progressive, associated with persistent deteriorating health; or

ii. a chronic medical condition, expected to last at least a year and expected to be episodically or continuously debilitating and require ongoing treatment for control of the condition that will use health care resources above the level of a healthy child; or

iii. a progressive or metastatic malignancy.

2. At the time the member begins receiving CARES program services, the member is at high risk for adverse health outcomes due to both of the following:

a. Demonstrated inability to coordinate multiple medical, social, and other services impacting medical condition, as evidenced by:

i. two or more unplanned emergency department visits within the past 180 days; or

ii. a documented pattern of multiple missed primary care physician (PCP) or subspecialty appointments; or

iii. chronic school absenteeism directly related to the member's medical conditions.

b. Demonstrated health-related social needs impacting the management of the member's medical condition. Social complexity/health-related social needs are defined by at least one of the following:

i. experiencing homelessness or housing insecurity;

ii. experiencing food insecurity;

iii. parent/caregiver experiencing employment instability;

iv. lacking access to basic resources such as heat, electricity, internet, transportation, education, and social connections; or

v. living in unsafe or violent conditions.

3. The member requires more than two continuous hours of skilled nursing services to remain safely at home.

(D) Provider Requirements.

(1) Payment for services described in 130 CMR 433.485(A) through 433.485(H) will be made only to group practices participating in MassHealth on the date of service that are also certified by the MassHealth agency for the provision of CARES program services at that location on the date of service.

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433.485: continued

(2) A group practice seeking to provide CARES program services must meet the requirements listed in 130 CMR 433.485(A) through 433.485(H). A separate application for certification as a CARES program provider must be submitted for each group practice that seeks to render such services. The application must be made on the form provided by the MassHealth agency and must be submitted to the MassHealth agency's physician program. The MassHealth agency may request additional information from the applicant to evaluate the applicant's compliance with 130 CMR 433.485(A) through 433.485(H). Through this certification, the applicant must, among other things:

(a) agree to enter into a written agreement with the MassHealth agency in which the applicant agrees to satisfy all of the requirements in 130 CMR 433.485(A) through 433.485(H);

(b) agree to establish, maintain, and comply with written policies and procedures to satisfy all the requirements in 130 CMR 433.485(A) through 433.485(H);

(c) agree to assess and annually reassess each member in its care in accordance with 130 CMR 433.485(E)(3)(a) and 130 CMR 433.485(F)(1)(a) to ensure that each such member satisfies, and continues to satisfy, the clinical eligibility criteria for receipt of CARES program services;

(d) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 433.485(A) through 433.485(H);

(e) submit a written description of:

1. CARES program services offered by the applicant and its care objectives, and
2. how the applicant will fulfill the staffing requirements in 130 CMR 433.485(E);

(f) agree to participate in any CARES program provider orientation required by EOHHS;

(g) attest that it:

1. actively provides covered services to MassHealth members younger than 21 years old with medical complexities; and
2. has the capacity to provide on-call care coordination to members assigned to the applicant 24 hours per day, 365 days per year;

(h) agree to provide any documentation, data, and reports as required by EOHHS;

(i) agree to subscribe to and participate in the statewide ENS (Event Notification Service) Framework described in 101 CMR 20.11: *Statewide Event Notification Service Framework,* including having the capacity to receive and send admission, discharge, and transfer messages, as that term is defined in 101 CMR 20.04: *Admission, Discharge, and Transfer Messages (ADTs)*;

(j) agree to establish and implement policies and procedures to increase the technological capabilities to share information among providers involved in members' care, including increasing Health Information Exchange (HIE) connections and enhancing digital systems interoperability;

(k) agree to use CMS required CEHRT (Certified Electronic Health Record Technology) criteria (2015 edition or subsequent editions) and updates to said criteria, to document and communicate clinical care information;

(l) agree to comply with the Office of the National Coordinator for Health Information Technology (ONC) guidance on USCDI (United States Core Data for Interoperability) for standardized health data exchange, or such other guidance and standards for health data exchange as specified by EOHHS;

(m) agree to submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the CARES program provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 433.485(A) through 433.485(H); and

(n) agree to participate in any quality management and program integrity processes as required by the MassHealth agency.

(3) The MassHealth agency requires documentation from providers seeking to become CARES program providers. All required application documentation will be specified by the MassHealth agency and must be submitted and approved prior to participating as a CARES program provider in MassHealth.

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433.485: continued

(4) Based on the information provided in the certification application, the MassHealth agency will determine whether the applicant is certifiable as a CARES program provider. If the MassHealth agency determines that the applicant is not certifiable, the notice will contain a statement of the reasons for that determination and recommendations for corrective action so that the applicant may reapply for certification once corrective action has been taken.

(5) The certification is valid only for the group practice described in the application and is not transferable to any other provider. Any additional location established by the applicant at a satellite facility must obtain separate certification from the MassHealth agency in order to receive payment.

(E) CARES Team.

(1) The CARES program provider must establish a CARES team to meet the care coordination needs of members, including on call after-hours availability to assist as needed and to triage medical crises and emergencies. The CARES team must include a program director, senior care manager, care coordinator, and family support staff which may include a community health worker or peer, each of whom must satisfy the staff composition requirements specified in Appendix M. The CARES team must satisfy any other staff composition requirements specified in Appendix M. CARES team members may serve multiple roles for which they are qualified as long as the staffing responsibilities and programmatic requirements are met. In addition, care managers and supervisors serving on the CARES team must complete trainings as outlined in Appendix M. CARES program providers must establish policies and procedures relating to such trainings to ensure the completion of such trainings. CARES program providers must document compliance with training requirements for care managers and supervisors within three months of starting in that role.

(2) The CARES team is responsible for ensuring that needed medical, social, educational, and other CARES program services are accessed, coordinated, and delivered in a strength-based, individualized, member-driven, culturally informed, linguistically appropriate, and accessible manner. The CARES team must establish referral relationships with members' pediatric specialty providers, primary care providers, behavioral health providers, MassHealth managed care entities, and any other entity, agency, system, or provider as needed for the treatment of a member in the provider's care, as determined by the member's CARES team.

(3) The CARES team must:

(a) conduct a comprehensive assessment of each member seeking CARES program services from the provider in order to determine that the member is clinically eligible to receive such services. The CARES team will conduct this comprehensive assessment in accordance with 130 CMR 433.485(F) and Appendix M.

(b) make referrals for and coordinate services on- and off-site. These services include, but are not limited to, making referrals for and coordinating the following services:

1. medical and behavioral health care.
2. home and community long-term services and supports, such as Durable Medical Equipment (DME) and Continuous Skilled Nursing (CSN) services. For members enrolled in the Community Case Management (CCM) program, the CARES team will serve as the lead care coordination entity and will work directly with the CCM case manager to coordinate DME, CSN, and other home health services.
3. health-related social needs, goods, and services, including, but not limited to, housing stabilization and support services, utility assistance, and nutritional assistance.
4. educational services and entitlements.
5. any state agency services for which the member may be eligible.

(c) have standardized processes for referrals to ensure continuity of care, exchange of relevant health information, such as test results and records, and avoidance of service duplication. This process must also contain follow-up provisions to ensure that the referral is completed successfully.

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433.485: continued

(d) establish and maintain relationships with the member's health plan and any state or local agencies with which the member is involved, including, but not limited to, the Department of Children and Families (DCF), the Department of Developmental Services (DDS), the Department of Mental Health (DMH), the Department of Public Health (DPH), the Department of Transitional Assistance (DTA), the Department of Youth Services (DYS), and any Local Education Agency (LEA).

(e) support care coordination and facilitate collaboration through the establishment of regular case review meetings as specified in Appendix M.

(f) provide all CARES program services.

(F) Scope of Services. The CARES program provider must ensure that CARES program services are provided only by individuals serving on the CARES team who are qualified to render such services. Detailed service components are outlined in Appendix M.

(1) CARES program services must include at a minimum:

(a) a comprehensive assessment of the member at least once a year. These assessment activities include, but are not limited to:

1. taking the member's history, which must capture the full spectrum of medical, social, educational, and emotional needs;

2. identifying the member's needs and completing related documentation; and

3. gathering information from other sources such as the parent/guardian, medical providers, state agencies, social services providers, and educators, to complete the assessment or reassessment of the member.

(b) development of an ICP, which must be driven by the member and their parent/guardian, authorized health care decision maker, and other relevant providers, and it must be shared and included in transition of care communication with relevant providers, state agencies, and members of the care management team. The ICP must be in a form and format specified by the MassHealth agency and include:

1. goals and actions to address the medical, social, educational, and other services needed by the member;

2. a course of action to respond to the assessed needs of the member; and

3. an emergency plan;

(c) care coordination and family support activities such as, but not limited to:

1. having a designated CARES team member (either a care coordinator or a senior care manager) serve as the primary and "first line" contact for the member and their parent/guardian. The care manager must provide regular contact with the member and their parent/guardian (either face-to-face or by telehealth, in accordance with the preferences of the member and their parent/guardian);

2. providing a phone number and on-call capacity 24 hours per day, 365 days per year to respond to and triage any medical and care coordination related questions;

3. helping the parent/guardian/caregiver advocate for and access resources and services to meet the family's needs;

4. maintaining effective, coordinated, and communicative relationships with designees from the member's care team, such as primary care physicians, health systems, specialty providers, dental providers, behavioral health providers, CCM, and CSN supports, and other state agencies, in order to facilitate coordination;

5. coordinating with early intervention providers and school and early childhood education providers;

6. coordinating access to DME, home care needs, scheduling appointments, referrals to providers for needed medical services, and assistance with prior authorization;

7. coordinating goods and services related to health-related social needs;

8. providing ongoing support in maintaining MassHealth eligibility, accessing any eligible benefits through state agencies, and coordinating with primary insurance for members who have third-party coverage;

9. providing intensive support for transitions of care between different health and community settings and the member's home; and

10. performing any other activities as detailed in Appendix M.

(d) appropriate services to address identified needs and achieve goals specified in the ICP;

(e) intensive support for member transitions into adult care, beginning once the member reaches 16 years old; and

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(f) all monitoring and follow-up activities necessary to ensure that the ICP is implemented and adequately addresses the member's needs.

(2) A CARES program provider is responsible for providing any and all of the CARES program services described above to each member receiving CARES program services from that provider when medically necessary.

(G) Assignment and Removal of Assignment Procedures.

(1) To promote effective provision of targeted case management services and prevent duplication, a member seeking CARES program services may receive such services from only one CARES program provider at a time. To facilitate this requirement, a CARES program provider must, prior to rendering CARES program services to a member, check the Eligibility Verification System to determine whether the member has been assigned to another CARES program provider, in accordance with the process in Appendix M.

(a) If the member is assigned to another CARES program provider, the provider from whom the member seeks CARES program services must decline to provide such services to the member and refer the member to the CARES program to which they are assigned.

(b) If the member is not assigned to another CARES program provider, and if the member agrees to receive CARES program from the CARES program provider, the CARES program provider must assign the member to the CARES program provider in accordance with the process in Appendix M, including determining clinical eligibility and other education and information-sharing activities with the eligible member and parent/guardian.

(2) Removal of Assignment. If a member no longer needs or is no longer eligible for CARES program services provided by the CARES program provider, the CARES program must follow the removal of assignment procedures as specified in Appendix M, including convening a meeting with the member and their family to develop an aftercare/transition plan.

(H) Payment.

(1) The MassHealth agency pays a CARES program provider for CARES program services only if the member receiving CARES program services is eligible to receive such services under 130 CMR 433.485(C).

(2) The MassHealth agency pays a CARES program provider for services in accordance with the applicable payment methodology and rate schedule established by EOHHS. Rates of payment for CARES program services include only those services described in 130 CMR 433.485(F), and do not cover or include any direct medical care.

(3) The MassHealth agency makes a single monthly payment for all CARES program services rendered by a CARES program provider to a member during that calendar month. In order to qualify for payment of the monthly fee, the CARES program provider must provide at least two of the CARES program services described above to that member during that calendar month, with at least one of those services including live interaction between the provider and the member and their parent/guardian, whether in person or *via* telehealth. A CARES program provider may not bill MassHealth the monthly fee for any calendar month in which the provider renders only one of the services described above to the member.

(4) Payment for the CARES program is subject to the conditions, exclusions, and limitations in 130 CMR 433.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

(5) The MassHealth agency does not pay for CARES program services rendered to a member by a CARES program provider during any period of time in which the member is assigned to another CARES program provider.

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(6) If the member assigned to a CARES program provider is admitted to a nursing facility or other inpatient facility during the period of assignment, the MassHealth agency pays for CARES program services rendered by that CARES program provider to that member for up to six consecutive months from the date of admission, subject to compliance with all applicable requirements in 130 CMR 433.485(A) through 433.485(H) and Appendix M. MassHealth will not pay for CARES program services rendered to any member who has resided in a nursing facility or other inpatient facility for more than six consecutive months.

REGULATORY AUTHORITY

130 CMR 433.000: M.G.L. c. 118E, §§ 7 and 12.

(PAGES 479 AND 488 ARE RESERVED FOR FUTURE USE.)

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Docket # 461

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **205 CMR 229.00**

CHAPTER TITLE: **Review of a Proposed Transfer of Interests**

AGENCY: **Massachusetts Gaming Commission**

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

205 CMR 229.00 governs the process for review of transfers of interest in a sports wagering license. 205 CMR 229.03 is being amended to align its language regarding procedures for use of interim authorization in connection with a transfer of interest with the language set forth in 205 CMR 116.10 and to provide clarity, efficiency and administrative manageability in the interim authorization process.

REGULATORY AUTHORITY: **G.L. c. 23N, §§ 4 and 6(h)**

AGENCY CONTACT: **Autumn Birarelli** PHONE: **(617)533-9716**

ADDRESS: **101 Federal Street, 12th Floor, Boston MA 02110**

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

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

The Commission is promulgating this regulation on an emergency basis, in accordance with G.L. c. 23N, § 4(b), to protect the health, safety, and wellbeing of the public and participants in sports wagering and because delay would be contrary to the public interest. The regulation is necessary to facilitate the transfer of an interest in a sports wagering license.

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.*

N/A

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: **N/A**

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:

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*
Gaming Commission, Sports Wagering, Interim Authorization, Transfer of Interest, Notice and Approval

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 is amending the existing version of 205 CMR 229, specifically 205 CMR 229.03.

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: **Sep 24 2026**

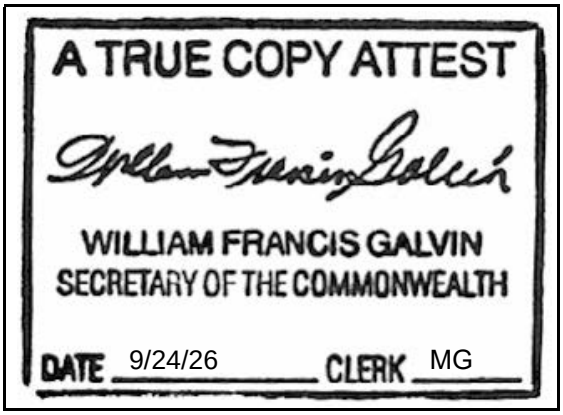
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/24/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
This is an Emergency Regulation.	**There are no Replacement Pages.**



205 CMR 229.00: REVIEW OF A PROPOSED TRANSFER OF INTERESTS

Section

229.01: Notice
229.02: Approval
229.03: Interim Authorization
229.04: Review of a Proposed Transfer of Interests
229.05: Fees for Review of Transfer

229.01: Notice

(1) Pursuant to M.G.L. c. 23N, § 6(h), no person shall transfer, or enter into an agreement to transfer, a Sports Wagering License, or a direct or indirect interest in such a license, or a personal or pecuniary interest in such a license, or enter into an option contract, management contract or other agreement or contract providing for such transfer in the present or future, or enter into an agreement granting the retention of a security interest in property delivered to the Sports Wagering Licensee without prior notification to the Bureau.

(2) Notwithstanding 205 CMR 229.01(1), the following transactions shall not be considered transfers subject to M.G.L. c. 23N, § 6(h), and do not require prior notification to the Bureau:

(a) The open market transfer of a publicly traded interest in a Sports Wagering Licensee, or holding, parent or intermediary company of a Sports Wagering Licensee where such transfer results in the transferee holding less than a 10% interest in the holding, parent or intermediary company.

(b) The granting of a security interest in return for financing to a bona fide banking institution, as defined in M.G.L. c. 167A, § 1, or a commercial financial institution as defined in M.G.L. c. 63, § 1, so long as the *bona fide* banking institution or the commercial financial institution does not, by virtue of its security interest, possess the intention to influence or affect the affairs or operations of a Sports Wagering Licensee or applicant or Qualifier for a Sports Wagering Licensee. The Sports Wagering Licensee, applicant, or Qualifier shall however, provide notice of the transaction promptly to the Bureau upon its consummation.

229.02: Approval

(1) Any transfer subject to M.G.L. c. 23N, § 6(h) that does not result in a new qualifier being designated in accordance with 205 CMR 215.02: *Persons Required to Be Qualified* may be approved by the Commission in a public meeting.

(2) Any transfer subject to M.G.L. c. 23N, § 6(h) that results in a new qualifier being designated in accordance with 205 CMR 215.02: *Persons Required to Be Qualified* must be approved by the Commission. Said approval shall be subject to the provisions of 205 CMR 229.04. Both the transferor and transferee shall be jointly and severally responsible for the payment of the investigatory and other fees provided for in 205 CMR 214.02(2).

(3) The Commission may reject any transfer requiring approval pursuant to 205 CMR 229.01(1) that it finds would be injurious to the interests of the Commonwealth of Massachusetts. Without implied limitation, a transfer may be considered injurious to the interests of the Commonwealth if the Commission determines that the proposed transferee does not satisfy the applicable considerations set forth in M.G.L. c. 23N, §§ 5, 6, or 9(a); 205 CMR 215.00: *Applicant and Qualifier Suitability Determination, Standards, and Procedures*; or any other applicable provisions of M.G.L. chs. 23K, 23N or 205 CMR, or if the transferee does not satisfy the provisions of 205 CMR 229.04.

(4) The Commission shall not approve the transfer of a Sports Wagering License for one year after the initial issuance of the license unless one of the following has occurred:

(a) the parent, holding company, or intermediary company of the Sports Wagering Licensee experiences a change in ownership resulting in a change of control;

(b) the Sports Wagering Licensee fails to maintain suitability; or

(c) the Commission determines that other circumstances exist which affect the Sports Wagering Licensee's ability to operate the Sports Wagering Platform successfully.

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229.02: continued

(5) Limitations on Certain Transfers.

(a) The Commission shall not approve of any transfer that would result in:

1. a Category 1 Operator holding more than one Category 1 License or more than two Tethered Category 3 Licenses; or

2. a Category 2 Operator holding a Category 1 License, more than one Category 2 License, or more than one Tethered Category 3 License.

(b) A Category 1 Sports Wagering License may only be transferred in connection with:

1. the transfer of the licensee's gaming license issued under M.G.L. c. 23K; and

2. the transfer of any Tethered Category 3 Licenses connected to the Category 1 Sports Wagering License to be transferred.

(c) A Category 2 Sports Wagering License may only be transferred in connection with:

1. the transfer of the licensee's license under Chapter 128A to conduct a live horse racing meeting, or rights as authorized by applicable law to conduct simulcast wagering; and

2. the transfer of any Tethered Category 3 License connected to the Category 2 Sports Wagering License to be transferred.

229.03: Interim Authorization

(1) Contractual Transfers. Whenever any person contracts to transfer a Sports Wagering License or an ownership interest in a Sports Wagering Licensee or its parent, holding or intermediary company, or any property relating to a sports wagering operation, under circumstances which require that the transferee obtain licensure or be found qualified pursuant to 205 CMR 215.00: *Applicant and Qualifier Suitability Determination, Standards, and Procedures* or M.G.L. c. 23N, the contract shall not specify a closing or settlement date which is earlier than 121 days after the submission of a completed transfer application. Said application shall consist of:

(a) For the transferee, the survey described at 205 CMR 211.01(1)(a);

(b) For the transferee and each new qualifier, the materials described at 205 CMR 211.01(1)(c) through(e), as appropriate;

(c) For the transferee and each new qualifier, any attestation forms required by the Bureau;

(d) A fully executed trust agreement in accordance with 205 CMR 229.03(6) which shall be subject to Commission approval. Any contract provision which specifies a closing or settlement date sooner than 121 days after submission of the transfer application shall be void for all purposes.

(2) Transfers of Publicly Traded Securities. Whenever any Person, as a result of a transfer of publicly traded securities of a Sports Wagering Licensee or its parent, holding or intermediary company, is required to be qualified under 205 CMR 215.02: *Persons Required to Be Qualified* or M.G.L. c. 23N, the Person including all related qualifiers shall, within 30 days after a Schedule 13D or 13G is filed with the U.S. Securities and Exchange Commission, or after the Bureau notifies the Person that qualification is required, or within such additional time as the Bureau may for good cause allow, file a completed transfer application as described in 205 CMR 229.03(1). No extension of the time for filing a completed transfer application shall be granted unless the Person submits a written acknowledgement recognizing the jurisdiction of the Commission and the obligations imposed by M.G.L c. 23N and 205 CMR. If a proposed transferee, including all related qualifiers, fails to timely file a complete transfer application, such failure shall constitute a negative finding of suitability to continue to act as a security holder, and the Commission shall take appropriate action including requiring divestiture by the transferee or redemption of the securities by the transferor.

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229.03: continued

(3) Request for Interim Authorization. If a prospective transferee files a transfer application in a timely manner the Commission may then request that the Bureau produce an interim authorization report under 205 CMR 229.03(5). Within 30 days after the Bureau's submission to the Commission of the interim authorization report, the Commission shall hold a hearing in accordance with 205 CMR 101.01(2)(d) and render a decision on the interim authorization of the proposed transferee. If interim authorization is approved for a transfer governed by 205 CMR 229.03(1) then the closing or settlement may occur, and the prospective transferee may hold the securities or interests subject to the provisions of 205 CMR 229.03(4) until a final determination of suitability is made by the Commission. If interim authorization is approved for a transfer governed by 205 CMR 229.03(2) then the prospective transferee may continue to hold the securities or interests subject to the provisions of 205 CMR 229.03(4) until a final determination of suitability is made by the Commission.

(4) Effect of Denial of Interim Authorization. If the Commission does not request that the Bureau produce an interim authorization report or if, after a hearing, the Commission denies interim authorization, there shall be no closing or settlement of a contract to transfer an interest governed by 205 CMR 229.03(1) until the Commission makes a final determination on the suitability of the transferee in accordance with 205 CMR 215.01(1). If the Commission denies interim authorization for a proposed transfer subject to 205 CMR 229.03(2), all securities and interests subject to the transfer shall be promptly transferred into the trust. If the commission grants interim authorization for any transfer, it may at any time thereafter order all securities and interests subject to the transfer transferred into the trust if it finds reasonable cause to believe that the proposed transferee may be found unsuitable. If a prospective transferee fails or refuses to timely transfer securities and interests into the trust upon direction from the Commission said transferee shall be issued a negative determination of suitability.

(5) Bureau Investigation. After determining that a person is required to be qualified in accordance with 205 CMR 215.02: *Persons Required to Be Qualified*, the Bureau shall commence an investigation into the suitability of the transferee, which may be limited to a review of the information required to be reviewed in an investigation undertaken in accordance with 205 CMR 215.01(2)(b). If the Commission so requests pursuant to 205 CMR 229.03(3), the Bureau shall produce and forward to the Commission an interim authorization report no later than 90 days after the date that a complete transfer application is submitted by the proposed transferee, or such later date as the Commission may allow. Following a hearing, the Commission may approve interim authorization if it finds that:

(a) The transferee has submitted a complete transfer application;

(b) The transferee has submitted a fully executed trust agreement in accordance with 205 CMR 229.03(6);

(c) The trustee or trustees required under 205 CMR 229.03(6) have satisfied the qualification criteria applicable to qualifiers;

(d) There is no preliminary evidence of anything that would serve to disqualify the transferee from licensure in accordance with M.G.L. c. 23N, §§ 5, 6, and/or 9(a) or 205 CMR 215.00: *Applicant and Qualifier Suitability Determination, Standards, and Procedures*, nor is there any other reason known at the time why a positive determination of suitability may not ultimately be achieved;

(e) The transfer would not violate 205 CMR 229.02(3) or (4);

(f) The transferee has certified that they are unaware of any reason why the transferee would not be found qualified pursuant to M.G.L. c. 23N, §§ 5, 6, and/or 9(a) or 205 CMR 215.00: *Applicant and Qualifier Suitability Determination, Standards, and Procedures*. (If the transferee is not an individual, the certification shall be made by the chief executive officer or like individual);

(g) It is in the best interests of the Commonwealth for the Sports Wagering Operation to continue to operate pursuant to interim authorization; and

(h) If the transfer will result in a change of control, the transferee has agreed in writing in accordance with 205 CMR 229.04 to comply with all of the transferor's existing license obligations or has otherwise petitioned the Commission for modification or elimination of one or more of those obligations.

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229.03: continued

If the Commission approves interim authorization, during the period of interim authorization, the Bureau shall continue its suitability investigation as may be necessary for a determination of the suitability of the person granted interim authorization. Within nine months after the interim authorization decision, which period may be extended by the Commission, the Commission shall hold a hearing and render a determination on the suitability of the applicant in accordance with 205 CMR 215.01(1). If the Commission denies interim authorization or interim authorization is not requested, the Commission and Bureau shall proceed with the qualification process pursuant to 205 CMR 215.00: *Applicant and Qualifier Suitability Determination, Standards, and Procedures* and shall complete that process within 13 months of the submittal of a completed transfer application, which 13-month period may be further extended by the Commission

(6) Trust Agreements. A trust agreement required to be submitted with a transfer application in accordance with 205 CMR 229.03(1) and (2) shall be fully executed upon submission and contain, at a minimum, the following:

(a) A provision for the transfer and conveyance to the trustee of all of the transferee's proposed present and future right, title and interest in the sports wagering licensee, or its parent, holding or intermediary company, including all voting rights in securities upon the occurrence of an event described in 205 CMR 229.03(4) or if otherwise directed to do so by the Bureau in its discretion, pending a final suitability determination by the Commission.

(b) A provision consistent with the provisions of 205 CMR 229.03 for the distribution of any trust res upon a positive determination of suitability, negative determination of suitability, or at the direction of the Commission in accordance with 205 CMR 229.03(8).

(c) A provision identifying the trustee(s) and requiring the trustee to timely submit the materials described in 205 CMR 211.01(1)(c) through(f), as applicable, in order to be found qualified by the Commission in accordance with 205 CMR 215.01(1).

(d) A provision identifying the compensation for the service, costs and expenses of the trustee(s), which shall be made subject to the approval of the Commission.

(e) A mechanism by which the trustee may effectuate divestiture or redemption of securities, or a like process, in the event of a negative determination of suitability being issued to the transferee.

(f) Any additional provisions the Commission deems necessary and desirable.

(7) Power of Trustee. The trustee of the trust shall exercise all rights incident to the ownership of the property subject to the trust, and shall be vested with all powers, authority and duties necessary to the unencumbered exercise of such right, and the transferee shall have no right to participate in the earnings of the Sports Wagering Licensee or receive any return on its investment or debt security holdings during the time the securities or interest are in the trust. Earnings may, however, accrue to or into the trust.

(8) Termination of Trust Agreement. The trust agreement shall remain operative until the Commission issues the transferee a positive determination of suitability in accordance with 205 CMR 215.01(1)(e) (and in the event the interest has been placed into the trust, the trustee distributes the trust res) or the Commission issues the transferee a negative finding of suitability and the trust res is disposed of in accordance with 205 CMR 229.03(9). The trust shall otherwise only be revocable prior to a determination of suitability being issued upon Commission approval at the request of the settlor. In the event of such a request the Commission may direct the trustee to dispose of the trust res in accordance with 205 CMR 229.03(9).

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229.03: continued

(9) Effect of Negative Determination of Suitability. If the Commission issues a negative determination of suitability in accordance with 205 CMR 215.01(1)(e)1., a contract for the transfer of interests shall thereby be terminated for all purposes without liability on the part of the transferor. In the event of such negative determination, where the subject interests have been transferred into a trust in accordance with 205 CMR 229.03(4), the trustee shall endeavor and be authorized to attempt to sell, assign, convey or otherwise dispose of all trust res in accordance with the means established in accordance with 205 CMR 229.03(6)(e) or as otherwise directed by the Commission. Any subsequent transferee must be appropriately licensed or qualified in accordance with 205 CMR 229.00. The disposition of trust res by the trustee shall be completed within 120 days of the denial of qualification, or within such additional time as the Commission may for good cause allow. The proceeds of such disposition shall be distributed to the unsuitable transferee only in an amount not to exceed the lower of the actual cost of the assets to such unsuitable transferee, or the value of such assets calculated as if the investment had been made on the date the assets were transferred into the trust, and any excess remaining proceeds shall be paid to the Massachusetts Sports Wagering Control Fund in accordance with M.G.L. c. 23N, § 15.

229.04: Review of a Proposed Transfer of Interests

(1) If a proposed transfer of interests subject to 205 CMR 229.00 will result in a change of control as defined in 205 CMR 102.02: *Definitions*, the proposed transferee shall, as a condition of the transfer, unless otherwise allowed by the Commission in accordance with 205 CMR 229.01(2), provide the Commission with a written agreement to assume all obligations of the Sports Wagering Licensee including, but not limited to, commitments made in the Sports Wagering License Application, all terms and conditions contained in the Sports Wagering License, Operation Certificate, and all permits, licenses, and other approvals issued by any federal, state, and local governmental agencies. Additionally, the written agreement shall include an attestation from the transferor and transferee, accompanied by relevant supporting documentation, that said transfer comports with all applicable terms and conditions of the aforementioned instruments.

(2) Prior to submitting the written agreement referenced in 205 CMR 229.04(1), a proposed transferee may petition the Commission to allow for the modification of any terms, conditions, or agreements applicable to the Sports Wagering License or Operation Certificate held by the transferor, provided that the modifications are not inconsistent with any applicable provisions of M.G.L. c. 23N and 205 CMR.

(3) Notwithstanding 205 CMR 229.04(1):

(a) The Commission may in its discretion require submission of any additional application material as described in 205 CMR 211.00: *Category 1, Category 2, and Category 3 Sports Wagering License Applications*, 205 CMR 215.00: *Applicant and Qualifier Suitability Determination, Standards, and Procedures*, or 205 CMR 218.00: *General Sports Wagering Application Requirements, Standards, and Procedures* to assist in its determination as to whether to allow a modification in accordance with 205 CMR 229.04(2) and/or approve a transfer of interests in accordance with 205 CMR 229.02.

(b) A proposed transferee shall have the same duty to cooperate with such requests for information as does an Applicant under 205 CMR 212.01: *Additional Information and Cooperation*.

229.05: Fees for Review of Transfer

(1) Pursuant to M.G.L. c. 23N, § 6(h), the transferor shall be responsible for paying to the Commission all costs incurred by the Commission, directly or indirectly, for reviewing any transfer that requires prior notification to the Bureau.

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229.05: continued

(2) For purposes of 205 CMR 229.05, the costs associated with reviewing the transfer shall include, without limitation:

(a) All costs for conducting an investigation into any new qualifiers, the transferee, the trustee, and any other person subject to the jurisdiction of the Commission under M.G.L. c. 23N relating to the transfer in question; and

(b) All fees for services, disbursements, out of pocket costs, allocated overhead, processing charges, administrative expenses, professional fees, and other costs directly or indirectly incurred by the Commission, including without limitation all such amounts incurred by the Commission to and through the Bureau, the Division, the Gaming Enforcement Unit, the Gaming Liquor Enforcement Unit, and any contract investigator.

(3) If, pursuant to 205 CMR 214.02(3), the Commission establishes a schedule of fees, wages, and other charges for the cost of investigating applicants, said schedule shall also govern the assessment of costs under this 205 CMR 229.05.

(4) The Commission shall assess to the transferor all other costs paid by or for the Commission, directly or indirectly, to any other Person for conducting an investigation into a transferor plus an appropriate percent for overhead, processing and administrative expenses.

(5) Other Requirements for Review Fees.

(a) All required review fees pursuant to 205 CMR 229.05 shall be non-refundable, due and payable notwithstanding the withdrawal, abandonment, or denial of any transfer application.

(b) The transferor and the transferee shall be jointly and severally liable for any amounts chargeable to the transferor pursuant to 205 CMR 229.05.

(c) All fees in 205 CMR 229.05 shall be deposited into the Sports Wagering Control Fund established in M.G.L. c. 23N, § 15.

REGULATORY AUTHORITY

205 CMR 229.00: M.G.L. c. 23N, § 4.

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Docket # 635

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 361.00**

CHAPTER TITLE: **Rates for Continuous Skilled Nursing Agency and Independent Nursing Services**

AGENCY: **Executive Office of Health and Human Services**

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

Establishes the payment rates for MassHealth covered continuous skilled nursing (CSN) agency and independent nursing services.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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: Mar 13, 2026
Regulatory Review approval: Sep 1, 2026

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: **Apr 28, 2026**

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

For the first and second year: **The estimated aggregate annual fiscal impact associated with the proposed amendments is a savings of $15,000.**

For the first five years:

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:

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 101 CMR 361.00

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: **Sep 25 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/9/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
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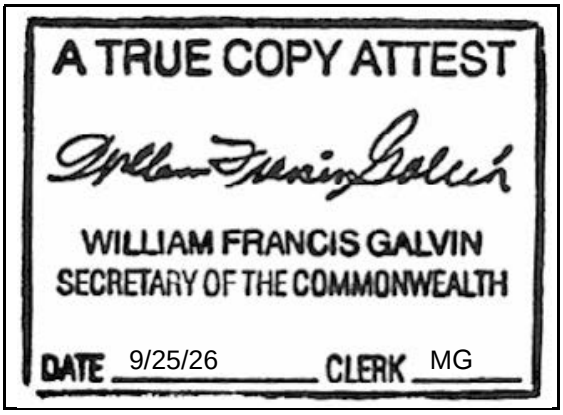


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101 CMR 361.00: RATES FOR CONTINUOUS SKILLED NURSING AGENCY AND INDEPENDENT NURSING SERVICES

Section

361.01: General Provisions
361.02: General Definitions
361.03: General Rate Provisions
361.04: Rates of Payment
361.05: Administrative Adjustment
361.06: Filing and Reporting Requirements
361.07: Severability

361.01: General Provisions

(1) Scope. 101 CMR 361.00 establishes rates of payment for continuous skilled nursing agency services and independent nursing services rendered by eligible providers to publicly aided individuals. The rates set forth in 101 CMR 361.00 also apply to individuals covered by M.G.L. c. 152 (the Workers' Compensation Act).

(2) Applicable Dates of Service. Rates contained in 101 CMR 361.00 apply for dates of service on or after October 9, 2026, unless otherwise specifically noted.

(3) Coverage.

(a) Separate rates are specified for the following situations.

1. The eligible provider bills as an individual practitioner for professional services rendered, and the services are not covered by a facility rate.

2. The eligible provider bills as a provider agency and employs, either through contractual agreement or salary, qualified professionals who do not bill independently for professional services rendered and whose services are not covered by a facility rate.

(b) The allowable fees established pursuant to 101 CMR 361.00 for services provided to publicly aided individuals apply to all continuous skilled nursing services, registered nurse (RN) supervisory visits, and complex care assistant services, as defined in 101 CMR 361.02, regardless of the type of program under which MassHealth is purchasing the services. The allowable fees are full compensation for the continuous skilled nursing services, RN supervisory visits, and complex care assistant services rendered including, but not limited to, administrative or supervisory duties and costs in connection with service provision.

(4) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify its policy on substantive provisions of 101 CMR 361.00 and to specify the information and documentation necessary to implement 101 CMR 361.00.

(5) Coding Updates and Corrections. EOHHS may publish procedure code updates and corrections in the form of an administrative bulletin. Updates may reference coding systems including, but not limited to, the American Medical Association's Current Procedural Terminology (CPT) and/or the Healthcare Common Procedure Coding System (HCPCS). The publication of such updates and corrections will list:

(a) codes for which the code numbers change, with the corresponding cross-references between new codes and the codes being replaced. Rates for such new codes are set at the rate of the code that is being replaced;

(b) codes for which the code number remains the same, but the description has changed; and

(c) deleted codes for which there are no corresponding new codes.

(6) Disclaimer of Authorization of Services. 101 CMR 361.00 is not authorization for or approval of the substantive services, or lengths of time, for which rates are paid pursuant to 101 CMR 361.00. Governmental units or workers' compensation insurers that purchase services from eligible providers are responsible to define, authorize, and approve the services extended to covered individuals and the length of time for which the approval is applicable.

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361.02: General Definitions

As used in 101 CMR 361.00, terms have the meanings set forth in 101 CMR 361.02, unless the context requires otherwise.

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

Complex Care Assistant. A person who is employed or contracted by a CSN agency and meets the qualifications of a complex care assistant to perform certain health-related services as described in 130 CMR 438.415(C): *Recordkeeping*.

Complex Care Assistant Intake Visit. The initial assessment visit performed by a registered nurse or licensed practical nurse employed by the CSN agency before a MassHealth member begins receiving complex care assistant services from the agency.

Continuous Skilled Nursing (CSN) Agency. A public or private organization that meets the requirements of 130 CMR 438.000: *Continuous Skilled Nursing Agency* and provides CSN agency services to complex care members within the member's home.

Continuous Skilled Nursing (CSN) Agency Services. CSN services and complex care assistant services as described in 130 CMR 438.402: *Definitions* and delivered to MassHealth-eligible members. For details on requirements, *see* 130 CMR 438.000: *Continuous Skilled Nursing Agency*.

Continuous Skilled Nursing (CSN) Services. Skilled nursing care provided by a licensed nurse to complex care members who require more than two continuous hours of nursing services per day and as defined in 130 CMR 438.000: *Continuous Skilled Nursing Agency*.

Continuous Skilled Nursing (CSN) Training Time. In-home, member specific training for nurses who are new to a MassHealth member's care and who will be providing CSN services to the member.

Eligible Provider. An individual practitioner or an organization that meets such conditions of participation as have been or may be adopted by a governmental unit purchasing CSN or CSN agency services.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, division, or political subdivision of the Commonwealth.

Home Health Agency. An organization that meets the requirements of 130 CMR 403.000: *Home Health Agency* to provide home health services, including continuous skilled nursing.

Individual Practitioner. An RN or licensed practical nurse (LPN), who directly provides authorized continuous skilled nursing services and who bills independently for professional services rendered as defined in 130 CMR 414.402: *Independent Nurse*.

Provider Agency. A partnership, corporation, or other entity, other than an individual, that provides authorized CSN agency services, as defined in 101 CMR 361.02: *Continuous Skilled Nursing (CSN) Agency Services*, by an RN, LPN, or complex care assistant (as applicable) who is its employee.

Publicly Aided Individual. A person who receives health care and services for which a governmental unit is in whole or part liable under a statutory program.

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361.02: continued

Reasonable Costs. Those reasonable and necessary costs incurred by an eligible provider of CSN, subject to the requirements and limitations of 101 CMR 361.00. In determining the reasonableness of costs, EOHHS may consider the particular services offered, the introduction of efficiency measures, the requirements for staffing, and the costs of providing comparable service.

Security/Escorts. The provision of security services to direct care personnel in the performance of a reimbursable home health visit.

Sixty-day Supervisory Visit (60-day Supervisory Visit). The 60-day supervisory visit conducted and described in 130 CMR 438.415(C)(5)(c), made to the member's home in order to observe and assess the complex care assistant while they are performing care. A reassessment of the member's needs may be done at this time.

Weekday. The hours from 7:00 A.M. to 3:00 P.M., Monday through Friday.

Weekend and Nights.

(a) Weekend. The hours from 12:00 A.M. Saturday to 11:59 P.M. Sunday.

(b) Nights. The hours from 3:00 P.M. to 7:00 A.M., Monday through Friday.

(c) Holidays. All official Commonwealth of Massachusetts holidays. For purposes of 101 CMR 361.00, holidays that occur on a weekend are observed on that day and not the preceding Friday or following Monday.

New Year's Day
Martin Luther King Jr. Day
Presidents' Day
Patriots' Day
Memorial Day
Juneteenth Independence Day
Independence Day
Labor Day
Indigenous Peoples' Day
Veterans Day
Thanksgiving Day
Christmas Day

361.03: General Rate Provisions

Rates of payment for authorized continuous skilled nursing services to which 101 CMR 361.00 applies will be the lower of

(a) the eligible provider's usual fee to patients other than publicly aided patients; or

(b) the schedule of rates set forth in 101 CMR 361.04.

361.04: Rates of Payment

(1) Continuous Skilled Nursing Services.

(a) Single Patient, per Straight-time Hour. Weekend rates are the same as night rates.

Rates per 15 Minutes: Single Patient, per Straight-time Hour				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002		$23.61	$19.46	RN Services, Weekday
T1002	UJ	$25.14	$20.88	RN Services, Nights
T1002		$33.12	$28.22	RN Services, Holidays
T1003		$16.35	$13.47	LPN Services, Weekday
T1003	UJ	$17.41	$14.46	LPN Services, Nights
T1003		$23.01	$19.60	LPN Services, Holidays

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361.04: continued

(b) Multiple-patient Nursing.

1. Two Individuals, per Straight-time Hour. When only one of the individuals is publicly aided, the fee for services to the publicly aided individual will be ½ of the appropriate rate listed in the table "Two Individuals, per Straight-time Hour." Weekend rates are the same as night rates.

Rates per 15 Minutes: Two Individuals, per Straight-time Hour				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002	TT	$33.21	$28.13	RN Services, Weekday
T1002	U1	$35.36	$30.18	RN Services, Nights
T1002	TT	$46.59	$40.80	RN Services, Holidays
T1003	TT	$23.10	$19.56	LPN Services, Weekday
T1003	U1	$24.61	$20.99	LPN Services, Nights
T1003	TT	$32.52	$28.46	LPN Services, Holidays

2. Three Individuals, per Straight-time Hour. When only one of the individuals is publicly aided, the fee for services to the publicly aided individual will be ⅓ of the appropriate rate listed. When two of the individuals are publicly aided, the fee for services to the publicly aided individuals will be ⅔ of the appropriate rate listed. Weekend rates are the same as night rates.

Rates per 15 Minutes: Three Individuals, per Straight-time Hour				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002	U2	$39.68	$32.62	RN Services, Weekday
T1002	U3	$42.24	$35.00	RN Services, Nights
T1002	U2	$55.66	$47.31	RN Services, Holidays
T1003	U2	$28.04	$22.68	LPN Services, Weekday
T1003	U3	$29.87	$24.34	LPN Services, Nights
T1003	U2	$39.47	$33.00	LPN Services, Holidays

(c) Overtime. Weekend rates are the same as night rates.

Rates per 15 Minutes: Overtime				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002	TU	$32.66	$27.88	RN Services, Weekday
T1002	U4	$34.77	$29.91	RN Services, Nights
T1002	TU	$48.77	$40.43	RN Services, Holidays
T1003	TU	$22.74	$19.41	LPN Services, Weekday
T1003	U4	$24.22	$20.83	LPN Services, Nights
T1003	TU	$32.01	$28.25	LPN Services, Holidays

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361.04: continued

(d) Complex Care Assistant and RN Supervisory Visits. Claims for complex care assistant intake visits will pay at the 60-day Supervisory Visit rate.

Rate per 15 Minutes: Complex Care Assistant and Supervisory Visits			
Code	**Modifier**	**Agency**	**Description**
T1002	U5	$23.61	60-day Supervisory Visit (RN)
T1003	U5	$16.35	60-day Supervisory Visit (LPN)
T1004		$11.25	Complex Care Assistant Visit

(e) CSN Training Time. There is no separate training time rate for nighttime shifts. Shifts that take place between 3:00 P.M and 7:00 A.M. Monday through Friday will pay at the weekday rate.

Rates per 15 Minutes: Single Patient, per Straight-time Hour				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002	U6	$23.61	$19.46	RN Services, Weekday
T1002	U6	$25.14	$20.88	RN Services, Weekend
T1002	U6	$33.12	$28.22	RN Services, Holidays
T1003	U6	$16.35	$13.47	LPN Services, Weekday
T1003	U6	$17.41	$14.46	LPN Services, Weekend
T1003	U6	$23.01	$19.60	LPN Services, Holidays

Rates per 15 Minutes: Two Individuals, per Straight-time Hour				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002	TT U6	$33.21	$28.13	RN Services, Weekday
T1002	TT U6	$35.36	$30.18	RN Services, Weekend
T1002	TT U6	$46.59	$40.80	RN Services, Holidays
T1003	TT U6	$23.10	$19.56	LPN Services, Weekday
T1003	TT U6	$24.61	$20.99	LPN Services, Weekend
T1003	TT U6	$32.52	$28.46	LPN Services, Holidays

Rates per 15 Minutes: Three Individuals, per Straight-time Hour				
Code	**Modifier**	**Agency**	**Individual Practitioner**	**Description**
T1002	U2 U6	$39.68	$32.62	RN Services, Weekday
T1002	U2 U6	$42.24	$35.00	RN Services, Weekend
T1002	U2 U6	$55.66	$47.31	RN Services, Holidays
T1003	U2 U6	$28.04	$22.68	LPN Services, Weekday
T1003	U2 U6	$29.87	$24.34	LPN Services, Weekend
T1003	U2 U6	$39.47	$33.00	LPN Services, Holidays

361.05: Administrative Adjustment

(1) A certified home health agency or CSN agency may apply for a change in rate(s) of payment due to costs associated with providing interpreter and security/escort services as defined in 101 CMR 361.02.

(2) Administrative adjustment may be provided on a prospective basis only.

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361.05: continued

(3) Administrative relief will consist of an adjustment to the rate calculated by dividing the costs from the most recently filed and reviewed Cost Report filed pursuant to 101 CMR 361.06, by the number of service units reported for that corresponding period. The costs allowed will be limited to reasonable costs as defined in 101 CMR 361.02.

(4) An administrative adjustment that an agency was awarded in a prior period may be updated by EOHHS using data from the most recent Cost Report.

361.06: Filing and Reporting Requirements

(1) Required Cost Reports. Cost reporting requirements are governed by 957 CMR 6.00: *Cost Reporting Requirements*.

(2) Penalty for Noncompliance. The purchasing governmental unit may impose a penalty in the amount of up to 15% of its payments to any provider that fails to submit required information. The purchasing governmental unit will notify the provider in advance of its intention to impose a penalty under 101 CMR 361.06(2).

361.07: Severability

The provisions of 101 CMR 361.00 are severable. If any provision of 101 CMR 361.00 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 361.00 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

101 CMR 361.00: M.G.L. c. 118E.

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Docket # 636

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 411.00**

CHAPTER TITLE: **Rates for Certain Placement, Support, and Shared Living Services**

AGENCY: **Executive Office of Health and Human Services**

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

Governs the rates paid by governmental units for certain placement, support, and shared living services provided to publicly aided individuals. Services with rates established by this regulation are purchased by the Department of Children and Families, the Department of Youth Services, the Department of Developmental Services, MassAbility, and the Massachusetts Commission for the Blind.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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: 5/22/26
Regulatory Review approval: 9/14/26

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: **6/26/26**

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

For the first and second year: **total estimated annualized increase of $19.92 million**

For the first five years:

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: **N/A**

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 101 CMR 411.00.

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: **Sep 25 2026**

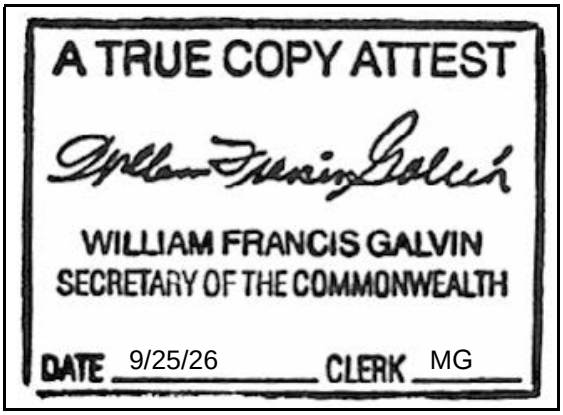
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/9/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
931 & 932 **935 - 938**	**931 & 932** **935 - 938**



101 CMR 411.00: RATES FOR CERTAIN PLACEMENT, SUPPORT, AND SHARED LIVING SERVICES

Section

411.01: General Provisions
411.02: Definitions
411.03: Rate Provisions
411.04: Filing and Reporting Requirements
411.05: Severability

411.01: General Provisions

(1) Scope. 101 CMR 411.00 governs the payment rates for certain placement, support, and shared living services purchased by a governmental unit including, but not limited to, the Department of Developmental Services (DDS), the Massachusetts Commission for the Blind (MCB), MassAbility (formerly MRC), the Department of Children and Families (DCF), and the Department of Youth Services (DYS).

(2) Applicable Dates of Service. Rates contained in 101 CMR 411.00 apply for dates of service provided on or after July 1, 2026.

(3) Disclaimer of Authorization of Services. 101 CMR 411.00 is neither authorization for nor approval of the services for which rates are determined pursuant to 101 CMR 411.00. Governmental units that purchase such services are responsible for the definition, authorization, and approval of services extended to clients.

(4) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify its policy on substantive provisions of 101 CMR 411.00.

411.02: Definitions

As used in 101 CMR 411.00, unless the context requires otherwise, terms have the meanings in 101 CMR 411.02.

Add-on Rate. A rate that is intended to provide an additional, necessary service not included in the current programmatic model, which will be instituted at the discretion of the purchasing governmental unit.

Adoption Management Support Services (AMSS). Services that address specific client needs and provide specific services or full case management. Examples of AMSS include a provider's recruitment of an adoptive family for a specific child, the assessment of a child for adoption, the training and home study of prospective adoptive families, and the management of pre-adoptive homes. Purchasing governmental unit requests for responses contain specific definitions of AMSS. There are specific rates that are determined by the child's needs (mild, moderate, severe), or the placement of a specific number of siblings with the child in an adoptive family.

Child Home-based Rehabilitation. An IFC Other Model that provides IFC Placement and specialized, intensive foster care services for children with problem sexualized behavior and sexually abusive youth. In addition to placement in specially trained, intensive foster care homes, youth receive intensive case management, clinical, psychiatric, psychopharmacological, health care, educational, and recreational services supported by 24-hour per day, seven days per week emergency coverage.

Client. An individual who receives placement, support, and shared living services purchased by a governmental unit.

Community-based Alternative to Detention. Services that are an alternative to the juvenile locked secure detention component of the juvenile justice system.

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411.02: continued

Community-based Alternative to Detention Bed Hold. Services to retain Community-based Alternative to Detention caregivers while a Community-based Alternative to Detention bed is unoccupied.

Complex Medical Foster Care. A foster care program that is designed to provide care and treatment supports to children and youth who have medically complex or unstable conditions and require intensive medical care management and coordination. Care often involves multiple medical specialists.

Cost Report. The document used to report costs and other financial and statistical data. The Uniform Financial Statements and Independent Auditor's Report (UFR) is used when required.

Emergency Shelter Homes. An IFC Other Model that provides IFC placement for children from birth through 22 years old for a duration not to exceed 45 days. IFC emergency foster care providers are responsible for facilitating emergency health care, emergency school placement, intensive family work to support reunification, and collaboration with community providers that have preexisting relationships with youth placed.

Enhanced Intensive Foster Care (EIFC). Services provided to a client at a higher level of intensity in accordance with specifications determined by the purchasing governmental unit.

EOHHS. The Executive Office of Health and Human Services, established under M.G.L. c. 6A.

Family Residential Homes. Licensed foster homes with expertise sufficiently compatible with IFC Level One clients, where the caregiver is considered an employee of the agency and up to six IFC clients can reside within the same home.

Governmental Unit. The Commonwealth, any board, commission, department, division, or agency of the Commonwealth, and any political subdivision of the Commonwealth.

IFC Level One Homes. Licensed foster homes with expertise sufficient to meet the needs of children and youth referred for nonspecialized Intensive Foster Care.

IFC Level Two Homes. Licensed foster homes with expertise compatible with IFC Level One where caregivers have additional applicable training and extensive previous foster home experience.

Individual Consideration (IC). Payment rates for certain services are designated as individual consideration (IC). Where IC rates are designated, the purchasing governmental unit will determine the appropriate payment as the actual cost of the item or service as evidenced by invoice, published tuition amount, or other price reasonably obtained by a competitive market for the product or service.

Intensive Foster Care (IFC). Programs that provide therapeutic services and supports in a family-based placement setting to children and youth, from birth through 22 years old, for whom a traditional foster care environment is not sufficiently supportive; who are transitioning from a residential/group home level of care and require the intensity of services available through this program; or who are discharging from a hospital setting. Referred children and youth come from diverse cultural, linguistic, religious, ethnic, or racial backgrounds and have varying sexual or gender orientations. They may have a range of behavioral, cognitive, and mental health strengths and needs. With the appropriate program strengths, safety planning, and supports, this range for IFC could include children with fire-setting, sexual offending and sexual reactive behaviors, or various medical needs. Ideally, and when appropriate, children remain in their communities, attend their school of origin, maintain their social network, and continue contact with their families. Some are teenage mothers who need support and guidance with their parenting skills.

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411.02: continued

Youth Permanency Connections. A service that addresses the core need of helping youth who are transitioning from structured settings (residential, group home, foster care) toward independent living, by identifying committed responsible adults to help ensure the transitioning youth's success. The model focuses on identifying positive adults, connecting them with youth, and providing the youth with training and support, including youth support groups. Promoting permanency through task and goal-setting is a core principal, and regular team meetings (youth, adults, collateral individuals) are an integral component of the program. This service is established on a *per diem* rate basis.

411.03: Rate Provisions

(1) Services Included in the Rate. The approved rate includes payment for all care and services that are part of the program of services of an eligible provider, as explicitly set forth in the terms of the purchase agreement between the eligible provider and the purchasing governmental unit or units.

(2) Reimbursement as Full Payment. Each eligible provider must, as a condition of acceptance of payment made by any purchasing governmental units for services rendered, accept the approved program rate as full payment and discharge of all obligations for the services rendered. Payment from any other source is used to offset the amount of the purchasing governmental unit's obligation for services rendered to the publicly assisted client.

(3) Payment Limitations. No purchasing governmental unit may pay less than or more than the approved program rate, except as cited in 101 CMR 411.03.

(4) Blended Contract Rate Calculation. Purchasing governmental units may pay a Blended Contract Rate for the purchase of programs serving two or more clients. The blended rate will be calculated according to the following formula: {Sum of [(Operational Rate 1 * Units purchased of Operational Rate 1) plus (Stipend Rate 1 * Units Purchased of Stipend Rate 1)], plus [(Operational Rate 2 * Units purchased of Operational Rate 2) plus (Stipend Rate 2 * Units Purchased of Stipend Rate 2)], plus [(Operational Rate 3 * Units purchased of Operational Rate 3) plus (Stipend Rate 3) * (Units Purchased of Stipend Rate 3)],..., plus [Total funding for Add-ons] minus [Total Offsetting Revenue]} Divided by the sum of the Operational Rate Units purchased for all clients in the contract.

(5) Approved Program Rates. For all purchases, the approved rate is the lower of the provider's charge or amount accepted as payment from another payer or the rate listed in 101 CMR 411.03(5).

(a) Intensive Foster Care.

Service	Operational	Stipend	Total Rate	Unit
Community-based Alternative to Detention Bed Hold	N/A	$37.74	$37.74	Per Day
Sibling	$11.51	$37.74	$49.25	Per Placement Per Day
Intensive Foster Care One	$88.64	$75.40	$164.03	Per Placement Per Day
Intensive Foster Care Two	$88.64	$87.12	$175.76	Per Placement Per Day
Community-based Alternative to Detention	$91.49	$103.08	$194.57	Per Placement Per Day
Teen Parent	$100.56	$113.14	$213.70	Per Placement Per Day
Enhanced Intensive Foster Care	$157.83	$110.56	$268.38	Per Placement Per Day

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411.03: continued

(b) Intensive Foster Care Specialty.

Service	Operational	Stipend	Total Rate	Unit
Transitions to Adulthood	$120.92	$84.77	$205.69	Per Placement Per Day
Emergency Shelter Homes	$108.24	$96.50	$204.74	Per Placement Per Day
Child Home-based Rehabilitation	$106.57	$99.00	$205.57	Per Placement Per Day
Transitions to Adult Services	$221.08	$76.89	$297.97	Per Placement Per Day
Multiple Acute Level A	$183.41	$129.42	$312.83	Per Placement Per Day
Multiple Acute Level B	$309.76	$129.42	$439.19	Per Placement Per Day
Sexually Exploited Youth	$178.89	$134.00	$312.89	Per Placement Per Day
Family Residential	$275.70	N/A	$275.70	Per Placement Per Day

(c) AMSS. All rates are paid upon completion of the particular product-based service.

AMSS Product-based Services	Rate
1. Adoption Consultation Services:	
Adoption Assessment of a Child	$2,380.85
Adoption Assessment/Home Study of a Foster/relative family (with whom the child is placed)	$2,380.85
Adoption Assessment/Home Study of a relative (child is not in the home)	$2,994.56
MAPP training/Home Study of a referred person or couple	$2,994.56
Appearance fee	$359.82
MAPP Training only	$620.96
2. Adoption Placement Case Management Services:	
Case acceptance/assignment	$620.96
Adoption Assessment of a child	$2,380.85
Adoption Assessment/Home Study of a family with whom the child is placed	$2,380.85
Placement	
Mild	$4,941.60
Moderate	$7,950.67
Severe	$12,015.96
Family Development	
Mild	$3,968.08
Moderate	$6,363.44
Severe	$9,545.16
Reevaluations	
Mild	$973.52
Moderate	$1,587.23
Severe	$2,380.85
Child(ren)/Legalization	
Mild	$4,941.60
Moderate	$7,950.67
Severe	$12,015.96
Adjustment for a case held at least three years, but less than five.	$748.64

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411.03: continued

Sibling Bonus in Same Home/Legalization	
Two siblings	$1,407.33
Three siblings	$2,994.56
Four siblings	$5,539.35
Five or more siblings	$1,767.14
Family Bonus for Provider's Home at Legalization per child, minimum of two children	$620.96
Closure	$1,587.23
Case Maintenance	$435.23
Delayed Adoption-legal Delay/Appeal	$539.72
Conflict of Interest Family Resource	$298.86
Transfer of case	$1,407.33
3. Adoption Family Development Services:	
Purchase of Home	$5,989.11
Reuse of a Closed Home	$2,118.25
4. Recruitment:	
Child-specific recruitment	$2,118.25
Child-specific recruitment renewal	$2,118.25
5. Intervention Services (per hour)	$59.24
6. Interstate Cases:	
Home Study	$2,811.26
Assignment	$620.96
Case Supervision	$4,941.60
7. Puerto Rico Cases:	
Family Evaluation Home Study in Puerto Rico	$2,029.73
Family Evaluation Home Study in Puerto Rico (Daily Rate)	$34.24
8. International Cases:	
International Family Evaluation Home Study	IC

(d) Additional Support Services.

Support Contracts	Rate	Unit
Youth Permanency Connections	$64.88	Per Client Per Day Rate
Multiple Pre-adoption Services	$87,814	Accommodation Rate Per Month
Complex Foster Care Medical	$400.59	Per Client Per Day Rate
Multiple Post-adoption Services	$182,494	Accommodation Rate Per Month
Multiple Foster Parent Support Services	$191,890	Accommodation Rate Per Month

(e) Shared Living.

1. Operational Rates.

Service	Operational	Units
A	$71.36	Per Placement Per Day
B	$109.16	Per Placement Per Day
C	$186.81	Per Placement Per Day
Direct Care Add-on Rate	$31.01	Per Hour
Clinician (LICSW) Add-on Rate	$61.84	Per Hour
Registered Nurse (RN)	$77.66	Per Hour
Licensed Practical Nurse (LPN)	$56.64	Per Hour

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411.03: continued

2. Stipend Rates.
a. Stipend amounts for caregivers are established at a rate within the applicable rate limit for a given Operational Rate tier, as noted in the chart in 101 CMR 411.403(5)(e)2.a.

Operational Rate Level	Maximum Stipend Level
A	9
B	13
C	17
Specialty Exception	18-21

b. Purchasing governmental units may approve exceptions to the maximum stipend level in 101 CMR 411.03(5)(e)2.a. for caregivers providing services as of September 30, 2016. In these cases, the stipend rate is no higher than the amount paid as of September 30, 2016, as may be adjusted to reflect applicable stipend inclusions and exclusions, in keeping with provisions contained in the procurement for these services. This payment level continues at the current level until there are sufficient material changes in client circumstances to warrant a reassessment of the stipend level or a change in caregiver takes place, at which point revised stipend levels may not exceed applicable maximum amounts. Stipend levels 18 through 21 are available only by special application to the purchasing governmental unit.

Shared Living Stipend Levels		
Level	**Daily Stipend Rate**	**Stipend Level**
1	$81.97	$28,444
2	$92.23	$32,004
3	$102.47	$35,557
4	$112.71	$39,110
5	$122.97	$42,671
6	$133.23	$46,231
7	$143.45	$49,777
8	$153.70	$53,334
9	$163.96	$56,894
10	$174.19	$60,444
11	$184.45	$64,004
12	$194.69	$67,557
13	$204.95	$71,118
14	$215.18	$74,667
15	$225.44	$78,228
16	$235.69	$81,784
17	$245.93	$85,338
18	$255.15	$88,537
19	$266.43	$92,451
20	$277.69	$96,358
21	$286.93	$99,565

Remote Direct Supports	Per Hour
Remote Direct Supports	$21.47

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Docket # 637

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **101 CMR 412.00**

CHAPTER TITLE: **Rates for Family Transitional Support Services**

AGENCY: **Executive Office of Health and Human Services**

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

Governs the payment rates for family transitional support services provided to publicly aided individuals by governmental units. These services are purchased by the Department of Public Health.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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: 6/2/26
Regulatory Review approval: 9/21/26

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: **7/10/26**

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

For the first and second year: **total estimated annualized increase of $2.2 million**

For the first five years:

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: **N/A**

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 101 CMR 412.00.

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: **Sep 25 2026**

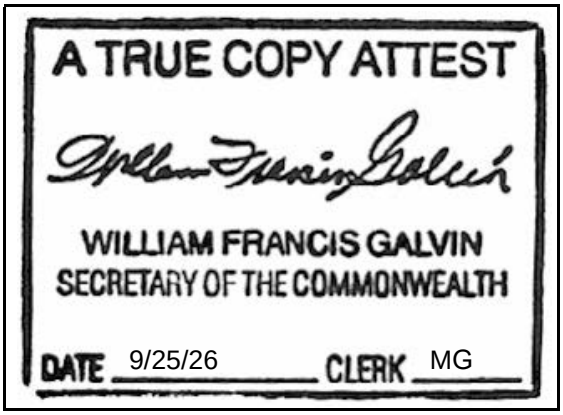
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/9/26**

CODE OF MASSACHUSETTS REGULATIONS

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943 - 946	**943 - 946**



101 CMR 412.00: RATES FOR FAMILY TRANSITIONAL SUPPORT SERVICES

Section

412.01: General Provisions
412.02: Definitions
412.03: Rate Provisions
412.04: Filing and Reporting Requirements
412.05: Severability

412.01: General Provisions

(1) Scope. 101 CMR 412.00 governs the payment rates for family transitional support (FTS) services purchased by a governmental unit.

(2) Applicable Dates of Service. Rates contained in 101 CMR 412.00 apply for dates of service provided on or after July 1, 2026.

(3) Disclaimer of Authorization of Services. 101 CMR 412.00 is neither authorization for nor approval of the services for which rates are determined pursuant to 101 CMR 412.00. Governmental units that purchase the services described in 101 CMR 412.00 are responsible for the definition, authorization, and approval of services extended to clients.

(4) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify its policy on substantive provisions of 101 CMR 412.00.

(5) Services and Rates Covered by Other Regulations. Payment rates for the services listed in 101 CMR 412.01(5) are not included within the scope of 101 CMR 412.00 and are governed by other regulations promulgated by EOHHS as follows.

Service	Regulation
Client Financial Assistance/Flex Funding Administration	101 CMR 414.00: *Rates for Family Stabilization Services*

412.02: Definitions

As used in 101 CMR 412.00, unless the context requires otherwise, terms have the meanings in 101 CMR 412.02.

Client. A family that receives family transitional support services purchased by a governmental unit.

Client Financial Assistance/Flexible Funding. A method whereby, subject to availability, a purchasing governmental unit may provide individual resource allocations to both families of children and adults across the state. Flexible funding may be provided through a number of means, including: a stipend issued directly to the family; reimbursement to the family for specific expenses and support services; or funds directed by the family to a qualified provider for specific services.

Client Financial Assistance/Flexible Funding Administration. A service in which the provider performs the function necessary to successfully administer flexible funding expenditures to families for permissible support services, services, or goods.

Cost Report. The document used to report costs and other financial and statistical data. The Uniform Financial Statements and Independent Auditor's Report (UFR) is used when required.

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412.02: continued

Domestic Violence, Substance Misuse, and Trauma (DVSMT) Services. Residential programs that help individuals who need to leave an unsafe situation due to domestic and/or sexual violence, and who need longer-term recovery support to address substance misuse and/or trauma. In addition to housing, DVSMT programs provide a range of activities and services designed to support the individual, familial, and social needs of survivors of domestic violence and their children and/or dependents. Service locations must be designed and furnished to offer families a welcoming and child-friendly environment, in addition to being physically accessible, safe, and secure. Providers who can shelter individuals and families in their own community are preferred.

Emergency Shelter. A program that provides individuals and families who need to leave an unsafe situation with timely and easy access to shelter within their own communities to help them achieve immediate safety while retaining access to school, work, and other supportive connections. The program must

(a) allow adults and children to remain connected to informal support from family, friends, counselors, pastors, and others they depend upon in the community; and

(b) demonstrate the capacity to shelter and serve children as well as adults, and be able to accommodate families requiring assistance with visitation and/or reunification.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Family Transitional Support (FTS) Services. A service class of programs that provide families with temporary housing in a specialized congregate or individual setting, to enable stabilization and transition to a safe, permanent, and self-sufficient home environment.

Governmental Unit. The Commonwealth, any board, commission, department, division, or agency of the Commonwealth and any political subdivision of the Commonwealth.

Housing Stabilization Advocacy and Supportive Services. A type of residential housing stabilization program that is either located in donated space or receives additional funding to cover facility costs from another funding source. This program provides supportive services to help survivors of domestic violence locate and maintain employment and/or complete their education, parent their children and establish routines with them, make it possible to be involved in a faith community of their choosing, provide opportunities for children and youth to be involved in after-school activities, prepare survivors for economic independence, and ultimately secure more permanent housing.

Individual Consideration (IC). Payment rates for certain services are designated as individual consideration (IC). If IC rates are designated, the purchasing governmental unit determines the appropriate payment as the actual cost of the item or service as evidenced by invoice, published tuition amount, or other price reasonably obtained by a competitive market for the product or service.

Lower Facility Cost Program. A program identified by the purchasing governmental unit as having nominal facility related costs due to either donated space or additional funding that covers the cost of the residence.

Provider. Any individual, group, partnership, trust, corporation, or other legal entity that offers services for purchase by a governmental unit and that meets the conditions of purchase or licensure that have been adopted by a purchasing governmental unit.

Reporting Year. The provider's fiscal year for which costs incurred are reported to the Operational Services Division on the Uniform Financial Statements and Independent Auditor's Report (UFR).

Residential Housing Stabilization. A program that helps victims and their families find stability within their communities, expand their networks of support, and build their capacity to live independently and securely. Support services help program participants access and maintain permanent housing, access employment and/or attend school, parent their children, and generally prepare for economic independence. Housing may be

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412.02: continued

(a) scattered site rental apartments in which families assume the lease once the program has provided the unit;
(b) condominiums or single family homes purchased by families through home buying assistance provided by the program; or
(c) apartments in multiple dwelling buildings.

412.03: Rate Provisions

(1) Services Included in the Rate. The approved rate includes payment for all care and services that are part of the program of services of an eligible provider, as explicitly set forth by the purchasing governmental unit(s).

(2) Reimbursement as Full Payment. Each eligible provider must, as a condition of payment by any purchasing governmental unit, accept the approved rate as full payment and discharge of all obligations for the services rendered. Payment by the purchasing governmental unit for services rendered to the client are reduced by the amount of any payment by any other source.

(3) Payment Limitations. No purchasing governmental unit may pay less than or more than the approved rate.

(4) Approved Rates. The approved rate is the lower of the provider's charge or amount accepted as payment from another payer or the rate listed in 101 CMR 412.03(4).

Program/Service Type	Rate	Unit
Emergency Shelter: Full program rate	$287.67	Per room per day
Emergency Shelter: Lower facility cost program	$264.17	Per room per day
Residential Housing Stabilization: Full program rate	$136.15	Per room per day
Residential Housing Stabilization: Lower facility cost program	$114.92	Per room per day
Housing Stabilization Advocacy and Supportive Services	$76.97	Per room per day
Domestic Violence, Substance Misuse, and Trauma: Full program rate	$319.84	Per room per day
Client Financial Assistance/Flex Funding	IC	N/A

Add-on Staff		
Title	**Unit of Service**	**.25 FTE**
Direct Care Staff	Monthly	$1,402.45

412.04: Filing and Reporting Requirements

(1) General Provisions.
(a) Accurate Data. All reports, schedules, additional information, books, and records that are filed or made available to EOHHS must be certified under pains and penalties of perjury as true, correct, and accurate by the executive director or chief financial officer of the provider.
(b) Examination of Records. Each provider must make available to EOHHS or purchasing governmental unit upon request all records relating to its reported costs, including costs of any entity related by common ownership or control.

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412.04: continued

(2) Required Reports. Each provider must file
(a) an annual Uniform Financial Statements and Independent Auditor's Report completed in accordance with the filing requirements of 808 CMR 1.00: *Compliance, Reporting and Auditing for Human and Social Services*;
(b) any cost report supplemental schedule as issued by EOHHS; and
(c) any additional information requested by EOHHS within 21 days of a written request.

(3) Penalty for Noncompliance. The purchasing governmental unit may impose a penalty in the amount of up to 15% of its payments to any provider that fails to submit required information. The purchasing governmental unit will notify the provider in advance of its intention to impose a penalty under 101 CMR 412.04(3).

412.05: Severability

The provisions of 101 CMR 412.00 are severable. If any provision of 101 CMR 412.00 or application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 412.00 or application of those provisions to applicable individuals, entities, or circumstances.

REGULATORY AUTHORITY

101 CMR 412.00: M.G.L. c. 118E.

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Docket # 1191

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 401.000**

CHAPTER TITLE: **Independent Clinical Laboratory Services**

AGENCY: **Division of Medical Assistance**

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

130 CMR 401.000 contains regulations governing independent clinical laboratory services under MassHealth. All independent clinical laboratories participating in MassHealth must comply with regulations governing MassHealth.

REGULATORY AUTHORITY: **M.G.L. c. 118E**

AGENCY CONTACT: **Deborah M. Briggs** PHONE: **617-921-1744**

ADDRESS: **MassHealth Publications, 1 Enterprise Drive, 5th 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.*

145 Letters: June 11, 2026
A&F Approval: June 11, 2026

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: **July 24, 2026**

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: **none**

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: **September 18, 2026**

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:*

130 CMR 401.000 is being amended.

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: **Sep 25 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/9/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
1 & 2	**1 & 2**
7 & 8	**7 & 8**
16.1 & 16.2	**16.1 & 16.2**
101-104.2	**101-104.2**

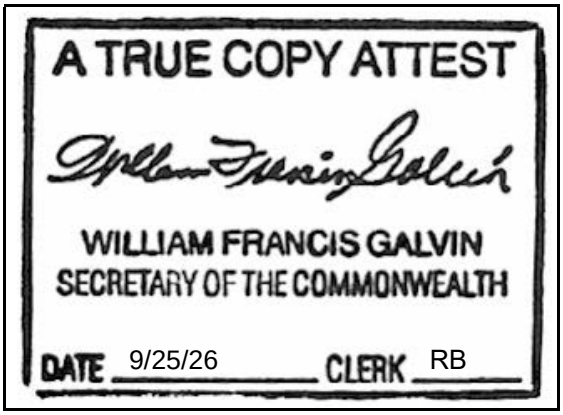


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130 CMR 401.000: INDEPENDENT CLINICAL LABORATORY SERVICES

Section

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401.401: Introduction

130 CMR 401.000 contains regulations governing independent clinical laboratory services under MassHealth. All independent clinical laboratories participating in MassHealth must comply with the regulations governing MassHealth, including, but not limited to, 130 CMR 401.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

401.402: Definitions

The following terms used in 130 CMR 401.000 have the meanings given in 130 CMR 401.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 401.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 401.000 and 450.000: *Administrative and Billing Regulations*

Authorized Prescriber. Any individual who is authorized under state law to prescribe drugs pursuant to M.G.L. c. 94C and also authorized to order the test under M.G.L. c. 111D and for the sole purpose of ordering medically necessary drug screen services, Massachusetts Department of Public Health licensed substance abuse treatment programs only when such requests are initiated in writing by a physician who is employed or contracted by the substance abuse treatment program to make such requests and whose written request fully complies with all requirements set forth in 130 CMR 401.416(A) through (C).

Bulk Purchase. A single purchase of the same laboratory services (one or more tests) to be uniformly and concurrently performed on a minimum of 40 specimens.

Clinical Laboratory. A laboratory that conducts microbiological, serological, chemical, hematological, biophysical, radiobioassay, cytological, immunohematological, immunological, pathological, or other examinations of materials derived from the human body, to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

Hospital Laboratory. A clinical laboratory that is owned and operated by a hospital, licensed by the Massachusetts Department of Public Health, and an approved Medicare provider.

Independent Clinical Laboratory. A freestanding clinical laboratory that is not affiliated with a hospital.

Panel Test. Any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified member on a specified day and has at least one of the following characteristics:

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401.402: continued

(1) the group of tests is designated as a panel by the clinical laboratory performing the tests; or

(2) the group of tests is performed by the clinical laboratory at a usual and customary fee that is lower than the sum of that laboratory's usual and customary fees for the individual tests in that group.

Referring Laboratory. A clinical laboratory that forwards specimens to another clinical laboratory for specific tests that cannot be performed by the referring laboratory.

Standing Order. A request by an authorized prescriber for an independent clinical laboratory to repeat one or more tests over a specified period of time.

Subsidiary-related Entity. A wholly owned subsidiary of a testing or referring laboratory, or both.

Testing Laboratory. A clinical laboratory that performs one or more tests on a specimen forwarded by a referring laboratory.

Usual and Customary Fee. The lowest fee in effect at the time of service, other than a fee offered for a bulk purchase, that is charged by an independent clinical laboratory for any laboratory service, including profile tests, specified in the fee schedule or by the laboratory.

401.403: Eligible Members

(A)(1) MassHealth Members. The MassHealth agency covers independent clinical laboratory services only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations. MassHealth regulations at 130 CMR 450.105: *Coverage Types* specifically state, 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: *Reserved*.

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107.

401.404: Provider Eligibility

An independent clinical laboratory must be enrolled in MassHealth on the date of service in order to be eligible for payment.

(A) In-state Providers. To be eligible to enroll as a MassHealth provider, an independent clinical laboratory must be

(1) located and doing business in the Commonwealth of Massachusetts;

(2) certified as an independent clinical laboratory by the Centers for Medicare & Medicaid (CMS), based on the criteria set forth in the Clinical Laboratory Improvement Amendments (CLIA) of 1988; and

(3) licensed as a clinical laboratory by the Massachusetts Department of Public Health.

(B) Out-of-state Providers. A clinical laboratory that does not meet the requirements of 130 CMR 401.404(A)(1) and (3) may enroll in MassHealth only if the clinical laboratory is licensed as a clinical laboratory in its own state and meets the requirements of 130 CMR 401.404(A)(2), 401.405, and 130 CMR 450.109: *Out-of-state Services*.

(C) Multiple Facilities. When two or more independent clinical laboratories have the same director or owner, whether or not the laboratories have different names, each laboratory must enroll separately with the MassHealth agency and have its own MassHealth provider number.

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401.405: Laboratory Services Provided Outside of Massachusetts

When provided out of state, independent clinical laboratory services are reimbursable only if

(A) the member is temporarily out of state and requires clinical laboratory services under the circumstances described in 130 CMR 450.109: *Out-of-state Services*;

(B) the MassHealth agency determines that the independent clinical laboratory services required by the member are not available from any laboratory in Massachusetts; or

(C) the out-of-state independent clinical laboratory is a subsidiary-related entity of an in-state independent clinical laboratory that meets the requirements of 130 CMR 401.404(A) and is enrolled in MassHealth.

401.410: Covered Services

MassHealth covers independent clinical laboratory services that are medically necessary for the diagnosis, treatment, and prevention of disease, and for the maintenance of the health of MassHealth members, subject to all restrictions and limitations described in 130 CMR 401.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

401.411: Noncovered Services and Payment Limitations

(A) The MassHealth agency does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). The cost for such services is included in the payment for conducting the test and analysis.

(B) The MassHealth agency does not pay for the following services:

(1) laboratory tests associated with male or female infertility, unless those tests are for diagnostic purposes;

(2) calculations (for example, red cell indices, A/G ratio, creatinine clearance), and ratios calculated as part of a profile;

(3) tests performed for experimental or clinical investigational purposes (*e.g.*, to establish safety and effectiveness), or that are themselves experimental or clinically investigational;

(4) tests performed only for purposes of civil, criminal, administrative, or social service agency investigations, proceedings, or monitoring activities;

(5) tests performed for residential monitoring purposes;

(6) tests performed to establish paternity;

(7) post-mortem examinations;

(8) tests where the request is not in accordance with 130 CMR 401.416;

(9) tests that are not medically necessary as defined in 130 CMR 450.204: *Medical Necessity*; and

(10) any other tests or activities performed for any purpose other than those described in 130 CMR 401.410.

(C) The MassHealth agency does not pay independent clinical laboratories for services that the laboratory is not certified by the Centers for Medicare & Medicaid Services (CMS) to perform.

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

The MassHealth agency pays for all medically necessary laboratory services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction*, without regard to service limitations described in 130 CMR 401.000, and with prior authorization.

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401.415: Specimen Referral

(A) If an independent clinical laboratory cannot perform a requested test, it may refer the specimen to another laboratory that can perform the test. The testing laboratory must be an independent clinical laboratory or a hospital laboratory participating in MassHealth.

(B) When providing the test results, the referring laboratory must inform the authorized prescriber of the name and address of the testing laboratory.

(C) The testing laboratory must inform the referring laboratory of each test result within one business day of completing each test.

(D) The referring laboratory may not bill the MassHealth agency for tests performed by the testing laboratory.

(E) Under no circumstances may both the referring and testing laboratories bill for the same procedure performed on the same specimen.

401.416: Request for Laboratory Services

(A) Request Requirements. The independent clinical laboratory may not bill for a service unless it has received a written request to perform that specific service from an authorized prescriber who is treating the member and will use the test for the purpose of diagnosis, treatment, or an otherwise medically necessary reason as defined in 130 CMR 450.204: *Medical Necessity*. Any independent clinical laboratory billing for a service must maintain such request in its records, and make such records available to the MassHealth agency and the Attorney General's Medicaid Fraud Division upon request. If the laboratory that billed for the service cannot produce the original request, the MassHealth agency may deny or recover payment for all services the laboratory provided based on that request.

(B) Standing Orders. An authorized prescriber may request an independent clinical laboratory to perform one or more tests on a single date, or issue a standing order for such tests. Standing order requests may not exceed 180 days in length with the exceptions of

(1) standing order requests for clinical laboratory services for substance use disorder, which may not exceed 30 days in length, and

(2) standing order requests for clinical laboratory services related to End Stage Renal Dialysis (ESRD) treatment, which may not exceed 365 days in length.

Standing order requests are not permissible unless such repeated tests are medically necessary and required as part of the member's medical or drug treatment plan.

(C) Required Information. Requests for laboratory services must be written and include the following information:

(1) the date of the request;

(2) the name or any other means of identifying the member to be tested;

(3) the name and address of the authorized prescriber (if the authorized prescriber is a Massachusetts Department of Public Health licensed substance abuse treatment program for the sole purpose allowed pursuant to 130 CMR 401.402, the request must include the names and addresses of both the substance abuse treatment program and the physician initiating the request);

(4) the name of the specific laboratory tests to be performed;

(5) the frequency for performing each laboratory test (applicable to standing orders only);

(6) the duration and maximum number of times each laboratory test or tests are to be performed (applicable to standing orders only); and

(7) a statement by the authorized prescriber that such testing is required as part of the member's medical or drug treatment plan (applicable to standing orders only).

(D) Recordkeeping. If a laboratory refers a specimen to a testing laboratory, the referring laboratory must forward the original request to perform the service to the testing laboratory. The testing laboratory must maintain such request in its records in accordance with 130 CMR 401.416(A).

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401.417: Recordkeeping Requirements

Both referring and testing laboratories must keep a record of each written request for laboratory services, each specimen, and each test result for at least six years from the date on which the results were reported to the authorized prescriber. If the testing laboratory is a subsidiary-related entity of the referring laboratory, such records may be maintained at one location, but must be made available to the MassHealth agency and the Attorney General's Medicaid Fraud Division upon request, in accordance with 130 CMR 450.205: *Recordkeeping and Disclosure*. If an independent clinical laboratory cannot produce the record to substantiate a MassHealth claim, the MassHealth agency may deny or recover payment for that claim. The laboratory record must contain the following information:

(A) The written request for laboratory services with all information required by 130 CMR 401.416;

(B) the identification number of the specimen;

(C) the name or any other means of identifying the person from whom the specimen was taken;

(D) the name of the authorized prescriber and, if applicable, the referring laboratory that submitted the specimen;

(E) the date on which the specimen was collected by the authorized prescriber or laboratory, the location of the collection, and the name of the collector;

(F) the date on which the specimen was received in the laboratory;

(G) the condition of unsatisfactory specimens when received (for example, broken, leaked, hemolyzed, or turbid);

(H) the specific tests performed;

(I) the date or dates on which each test was performed;

(J) the results of each test, the name and address of all persons to whom each test result is reported, and the date of reporting; and

(K) the name and address of the laboratory to which the specimen was referred, if applicable.

401.418: Maximum Allowable Fees

The MassHealth Agency pays for independent clinical laboratory services with rates set by the Executive Office of Health and Human Services (EOHHS) at 101 CMR 320.00: *Rates for Clinical Laboratory Services*, subject to the conditions, exclusions, and limitations set forth in 130 CMR 401.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

401.419: Individual Consideration

(A) Some tests listed in Subchapter 6 of the *Independent Clinical Laboratory Manual* are designated "IC," an abbreviation for individual consideration. A fee has not been established for these services. Payment for an individual-consideration service is determined by the MassHealth agency's professional advisers, based on the laboratory's description of the test, which must be included with the claim.

(B) If a test is not listed in Subchapter 6 of the *Independent Clinical Laboratory Manual*, an independent clinical laboratory may submit a claim by using the appropriate "unlisted test" service code. Payment for an unlisted test is determined by individual consideration, based on the laboratory's description of the test, which must be included with the claim.

(C) The MassHealth agency considers the following factors when determining the appropriate payment for an individual-consideration service:

(1) the amount of time required to perform the service;

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401.419: continued

(2) the degree of skill required to perform the service;
(3) policies, procedures, and practices of other third-party payers;
(4) prevailing medical-laboratory ethics and accepted custom of the medical-laboratory community; and
(5) other standards and criteria as may be adopted by the MassHealth agency.

401.420: Panel Tests

The MassHealth agency does not pay an independent clinical laboratory separately for a test included in a panel test when a panel test has been performed by that laboratory or requested by an authorized prescriber.

401.421: Quality Assurance and Provider Review

The MassHealth agency conducts reviews of providers and administers quality-control programs to ensure that MassHealth members are receiving high-quality medical services. An independent clinical laboratory must maintain its own quality-control program and successfully participate in one or more proficiency testing programs that cover all Medicare-certified specialties and subspecialties of the laboratory. The laboratory must make the results of the proficiency testing programs available to the MassHealth agency and the Attorney General's Medical Fraud Division upon request or during an on-site visit.

REGULATORY AUTHORITY

130 CMR 401.000: M.G.L. c. 118E, §§ 7 and 12.

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Docket # 1193

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 414.000**

CHAPTER TITLE: **Independent Nursing Services**

AGENCY: **Division of Medical Assistance**

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

Governs MassHealth independent nurses who provide continuous skilled nursing (CSN) services and provides program requirements and conditions of payment for the provision of CSN services by independent nurses to MassHealth members.

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

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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: Mar 13, 2026
Regulatory Review approval: Sep 1, 2026

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: **Apr 28, 2026**

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

For the first and second year: **No fiscal impact.**

For the first five years:

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: **9/23/26**

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 414.000.

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: **Sep 25 2026**

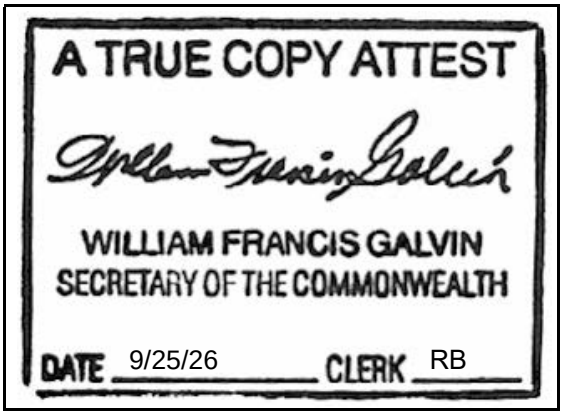
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/9/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
255-262.6	**255-262.8**



130 CMR 414.000: INDEPENDENT NURSING SERVICES

Section

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414.402: Definitions
414.403: Eligible Members
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414.408: Continuous Skilled Nursing Services
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414.421: Prohibited Marketing Activities
414.422: Providing Continuous Skilled Nursing Services out of State

414.401: Introduction

130 CMR 414.000 states the requirements for the payment of nursing services provided by an independent nurse participating in MassHealth and applies to nurses who contract independently with MassHealth. All independent nurses participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 414.000 and 450.000: *Administrative and Billing Regulations*.

414.402: Definitions

The following terms used in 130 CMR 414.000 have the meanings given in 130 CMR 414.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 414.402 is not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 414.000 and 450.000: *Administrative and Billing Regulations*.

Accountable Care Organization (ACO). An entity that enters into a population-based payment model contract with the Executive Office of Health and Human Services (EOHHS) as an ACO, 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 managed care organization administered ACOs.

Calendar Week. Seven consecutive days beginning Sunday at 12:00 A.M. and ending Saturday at 11:59 P.M.

Capitated Program. An integrated care organization, senior care organization, ACO, or Program of All-inclusive Care for the Elderly 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.

Care Management. A function performed by the MassHealth agency or its designee that assesses and reassesses the medical needs of complex care members and authorizes or coordinates long-term services and supports (LTSS) that are medically necessary for such members to remain safely in the community.

Certification Period. A period of no more than 60 days for which the member's physician has certified that the plan of care is medically appropriate and necessary.

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414.402: continued

Clinical Manager. A registered nurse (RN) employed by the MassHealth agency or its designee, who performs the in-person assessment of a member for MassHealth coverage of continuous skilled nursing (CSN) services and, if it is determined that CSN services are medically necessary, coordinates authorization of medically necessary LTSS for the member.

Complex Care Assistant Services. Medically necessary services as described in 130 CMR 438.000: *Continuous Skilled Nursing Agency Services* and identified in the CSN provider's plan of care that is delivered to complex care members.

Continuous Skilled Nursing (CSN) Agency. A public or private organization that provides CSN services to complex care members within their homes. CSN agency providers are governed by MassHealth regulations at 130 CMR 438.000: *Continuous Skilled Nursing Agency Services*.

Continuous Skilled Nursing (CSN) Services. A nurse visit of more than two continuous hours of nursing services.

Co-vending. An arrangement through which a member's CSN services are provided by one or more CSN agencies or independent nurses, with each provider possessing its own MassHealth prior authorization to provide nursing services to the member.

Home Health Agency. A public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c). Home health agency providers are governed by MassHealth regulations at 130 CMR 403.000: *Home Health Agency*.

Household. A place of residence where two or more people are living that is

(1) a group home, a residential care home, or another group living situation;

(2) at the same street address if it is a single-family house that is not divided into apartments or units; or

(3) at the same apartment number or unit number if members live in a building that is divided into apartments or units.

Independent Nurse. A licensed nurse who independently enrolls as a provider with MassHealth to provide CSN services. Independent nurse providers are governed by 130 CMR 414.000.

Long-term Services and Supports (LTSS). Certain MassHealth-covered services intended to enable a member to remain in the community. Such services include, but are not limited to, home health, durable medical equipment (DME), oxygen and respiratory equipment, personal care attendant (PCA) services, and other health-related services as determined by the MassHealth agency or its designee.

Medical History. A component of the member’s medical record that provides a summary of all health-related information about the member. A history includes, but is not limited to, medical and nursing-care histories as well as summaries of physician physical examination and nursing-assessment results.

Medical Record. Documentation, maintained by the independent nurse, that includes medical history, nursing progress notes, the member’s plan of care, and other information related to the member.

Medical Records Release Form. A signed authorization from the member or the member’s parent or legal guardian, if the member is a minor, that allows the designated releasee to access the member’s confidential health information from other health care providers.

Member with Medical Complexity. An individual who is a MassHealth member and whose medical needs, as determined by the MassHealth agency or its designee, are such that they require a nurse visit of more than two continuous hours of nursing services to remain in the community.

Nurse. A person licensed as an RN or a licensed practical nurse (LPN) by a state's board of registration in nursing.

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414.402: continued

Nursing Progress Notes. A component of the medical record that indicates the outcome of nursing interventions.

Nursing Services. The assessment, planning, intervention, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Ordering Non-physician Practitioner. A nurse practitioner, physician's assistant, or clinical nurse specialist who is licensed in Massachusetts to perform medical services according to their scope of practice. Ordering non-physician practitioners are also allowed to conduct face-to-face encounters. In the case of nurse practitioners and clinical nurse specialists, ordering is permitted only when the nurse is under the supervision of a physician or has a collaborative practice agreement with a physician.

Primary Natural Caregiver. The individual, other than the nurse, who is primarily responsible for providing ongoing care to the member and is also connected to the member in some other way, such as a parent, spouse, other family member, or close friend.

414.403: Eligible Members

(A) (1) MassHealth Members. The MassHealth agency covers nursing services provided by independent nurses only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations at 130 CMR 414.000 and 450.000: *Administrative and Billing 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*.

414.404: Provider Eligibility

To participate in MassHealth as a MassHealth independent nurse provider, a nurse must

(A) be licensed and in good standing as a nurse by the board of registration in nursing, or equivalent agency, for the state(s) in which the nursing services are provided;

(B) meet all provider eligibility requirements in 130 CMR 450.212: *Provider Eligibility: Eligibility Criteria*, including 130 CMR 450.212(A)(6);

(C) at the time of enrollment, satisfy at least one of the following experience qualifications:
(1) Demonstrated work experience:
(a) Have at least three years' experience providing direct patient care as a licensed nurse;
(b) Have at least two years' work experience providing CSN services through a qualified agency provider; or
(c) Have worked as a licensed nurse for at least one year in an intensive care unit or acute care unit; or
(2) Submit to the MassHealth agency or its designee documentation that demonstrates that services provided by the nurse will meet the following criteria.
(a) The nurse will provide CSN services to an identified MassHealth member or members in the same household.
(b) The MassHealth member and/or their representative has provided written consent to work with this provider as an independent nurse, without having met the experience requirements described under 414.404(C)(1).

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414.404: continued

(c) If the independent nurse would like to work with another MassHealth member before they have met the experience requirements described under 414.404(C)(1), they must obtain written consent from that MassHealth member and/or their representative and must submit documentation to the MassHealth agency or its designee.

(D) sign a MassHealth provider contract and receive a MassHealth provider number. The MassHealth agency does not pay an independent nurse for nursing services provided before the date on which the nurse is approved by the MassHealth agency to participate in MassHealth;

(E) agree to comply with all the provisions of 130 CMR 414.000, 130 CMR 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations, including but not limited to administrative tasks such as maintenance of the member's record;

(F) participate in any independent nurse provider orientation and training required by EOHHS;

(G) maintain their own general and professional liability insurance to protect against claims of negligence, damage, or injury to a member or their property;

(H) have an active certification, valid course completion card, or equivalent documentation reflecting completion of a basic life support (BLS) course with an in-person component from a reputable organization, including but not limited to, the American Red Cross or American Heart Association;

(I) agree, and respond in a timely manner, to periodic audits by the MassHealth agency or its designee that assess the quality of member care and ensure compliance with 130 CMR 414.000; and

(J) 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*.

414.405: Provider Responsibilities

The independent nurse must do the following.

(A) Maintain current physician or non-physician practitioner orders as described in 130 CMR 414.412 for all CSN services provided to members.

(B) Document all care provided to the member as described in 130 CMR 414.417.

(C) Maintain a copy of the member's record in the member's home and retain a copy of the member's record in a secure location that meets federal and state requirements for confidential patient information and protected health information. This could include a password-protected, electronic record that is only accessible by the independent nurse.

(D) Comply with requests from the MassHealth agency or its designee for annual Criminal Offender Record Information and Sexual Offender Record Information requirements and other provider requirements.

(E) Comply with all federal and state requirements for nurses and health care workers, including but not limited to, M.G.L. c. 112, §§ 74 through 81T and 244 CMR 9.00: *Standards of Conduct for Nurses*;

(F) Comply with the reporting, surveillance, isolation, and quarantine requirements as established under 105 CMR 300.000. If an independent nurse is directed by their local board of health and/or the Department of Public Health to stop providing direct care, the independent nurse must contact the MassHealth agency or its designee to end any prior authorizations they have in place for CSN services.

(G) Provide all skilled care as prescribed and include teaching during a CSN visit. During a CSN visit, the independent nurse may teach the member, family members, or primary natural caregivers how to manage the member's treatment regimen as applicable. Ongoing teaching must occur when there is a change in the procedure or the member's condition. All teaching activities must be documented in the member's record.

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(H) Make every attempt to coordinate care and/or changes in shifts with other CSN providers.

(I) Adhere to the applicable scope of nursing licensure as established at 244 CMR 3.00: *Registered Nurse and Licensed Practical Nurse*.

(J) Follow any guidance established by EOHHS regarding discharge and transfer policies for MassHealth members.

(K) Adhere to all regulations set forth in 130 CMR 414.000.

414.408: Continuous Skilled Nursing Services

(A) Clinical Eligibility for Continuous Skilled Nursing Services. A member is clinically eligible for MassHealth coverage of CSN services when all of the following criteria are met:

(1) there is a clearly identifiable, specific medical need for a nursing visit to provide nursing services, as described in 130 CMR 414.408(B), of more than two continuous hours;

(2) the CSN services are medically necessary to treat an illness or injury in accordance with 130 CMR 414.409(C); and

(3) the nurse has obtained prior authorization in accordance with 130 CMR 414.413.

(B) Clinical Criteria for Nursing Services.

(1) A nursing service is a service that must be provided by an RN or LPN to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only an RN or LPN can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct intervention of an RN or LPN, the service is not considered a nursing service, unless there is no one trained and able to provide it.

(4) The independent nurse must assess the member to ensure that continued nursing services are necessary. Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

(5) A member's need for nursing care is based solely on their unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(C) Member Must Be under the Care of a Physician or Ordering Non-physician Practitioner. The MassHealth agency pays for CSN services only if the member's physician or ordering non-physician practitioner certifies the medical necessity for such services on an established individual plan of care in accordance with 130 CMR 414.412. A member may receive CSN services only if the member is under the care of a physician or ordering non-physician practitioner. Independent nurses who are also qualified as ordering non-physician practitioners may neither certify the medical necessity nor establish the plan of care for members whom they are providing CSN services.

(D) Safe Maintenance in the Community. The member's physician or ordering non-physician practitioner and the independent nurse must determine that the member can be maintained safely in the community with medically appropriate CSN services.

(E) Clinical Eligibilty for CSN Training Time. A MassHealth member is eligible for CSN training time when an independent nurse begins working with a MassHealth member for the first time and requires training for the member’s specific care needs.

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414.409: Conditions of Payment

(A) Place of Service. The MassHealth agency pays for nursing services provided by an independent nurse to a member who meets the clinical criteria in 130 CMR 414.408 and resides in a noninstitutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. The MassHealth agency pays for nursing services provided by an independent nurse when the independent nurse must accompany the member in transport to or from an institutional setting to ensure medical stability during transitions in or out of the institutional setting. The MassHealth agency does not pay for nursing services provided by an independent nurse when the member is under the direct care of a hospital or emergency room, nursing facility, intermediate care facility, or any other institutional setting providing medical, nursing, rehabilitative, or related care.

(B) Limit of Hours. The MassHealth agency does not pay an independent nurse for more than 60 hours of nursing care provided during any consecutive seven-day period or for more than 12 hours within a 24-hour period, regardless of the number of MassHealth members receiving care from the independent nurse. An independent nurse may work up to 16 hours within a 24-hour period under the following circumstances:

(1) An emergency, where no other paid or unpaid trained caregiver is available to care for the member. In this case,

(a) An independent nurse may work up to 16 hours within a 24-hour period provided that the member has CSN hours authorized and available for use.

(b) The independent nurse must notify the MassHealth agency or its designee by the next business day and provide the reason for working more than 12 hours within a 24-hour period.

(2) The MassHealth or their representative has provided written or verbal confirmation to the MassHealth agency or its designee that they approve the independent nurse to work up to 16 hours within a 24-hour period, including the length of time they are requesting that the independent nurse work up to 16 hours in a 24-hour period; so long as

(a) the independent nurse does not work for another member or employer during the remaining eight hours of the same 24-hour period in which they work up to 16 hours; and

(b) the independent nurse submits a signed attestation to the MassHealth agency or its designee affirming that they will not work or seek alternative employment for the remaining eight hours of the same 24-hour period.

(C) Medical Necessity Requirement. In accordance with 130 CMR 450.204: *Medical Necessity*, the MassHealth agency pays for only those nursing services that are medically necessary.

(D) Plan of Care. The MassHealth agency pays only for nursing services that are provided pursuant to a plan of care authorized by a physician or non-physician practitioner and meet the plan of care requirements in 130 CMR 414.412(B).

(E) Continuous Skilled Nursing. The MassHealth agency pays for CSN services when

(1) the member meets the clinical eligibility criteria for CSN services as stated in 130 CMR 414.408;

(2) the CSN services are provided under an individualized plan of care developed for the member in accordance with 130 CMR 414.412; and

(3) prior authorization for CSN services has been obtained from the MassHealth agency or its designee, in accordance with 130 CMR 414.413.

(F) Members for Whom Services Are Approved. The MassHealth agency does not pay for nursing services provided to any individual other than the member who is eligible to receive such services and for whom such services have been authorized by the MassHealth agency or its designee.

(G) Teaching Activities. As part of a regular nursing treatment service, the independent nurse must teach a member, family member, or caregivers how to manage the member's treatment regimen. Ongoing teaching is required, as necessary, where there is a change in the procedure or the member's condition.

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(H) Continuous Skilled Nursing Service Documentation in the Member's Home. The independent nurse and any other nursing providers must maintain a copy of the member's medical record in the member's home. The record must include the total number of approved nursing hours for the member, the names and telephone numbers of all the providers involved in co-vending care, the number of nursing hours approved for each provider by the MassHealth agency or its designee, and all other recordkeeping requirements as described in 130 CMR 414.417(E).

(I) CSN Training Time.

(1) The MassHealth agency will reimburse for CSN training time when the following conditions have been met:

(a) The independent nurse is newly working with the member and requires training for the MassHealth member's specific care needs;

(b) The independent nurse receives in-home, member-specific training from

1. another CSN provider who is familiar with the member's care; or
2. the member's natural caregiver or other family member who is familiar with the member's care; and

(c) The independent nurse uses the CSN training time units within the first six weeks of the prior authorization period.

(2) Independent nurses providing training to other CSN providers may not use CSN training time units. CSN training time units may only be used by the independent nurse when the independent nurse is receiving in-home, member-specific training.

414.410: Multiple-patient Care

(A) The MassHealth agency pays for one nurse to provide CSN services simultaneously to more than one member, but not more than three members, if

(1) the members have been determined by the MassHealth agency or its designee to meet the criteria listed at 130 CMR 414.408;

(2) the members receive services in the same household and during the same time period;

(3) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the independent nurse has received a separate prior authorization from the MassHealth agency or its designee for each member as described in 130 CMR 414.413.

(B) Services provided pursuant to 130 CMR 414.410(A) must be billed by using the multiple-patient service code and modifier that reflects the number of members receiving the services.

414.411: Administrative Care Management

For complex care members, as defined in 130 CMR 414.402, the MassHealth agency or its designee provides care management that includes service coordination with independent nurses as appropriate. The purpose of care management is to ensure that a complex care member is provided with a coordinated LTSS service package that meets the member's individual needs and to ensure that the MassHealth agency pays for nursing and other LTSS only if they are medically necessary in accordance with 130 CMR 450.204: *Medical Necessity*. The MassHealth member eligibility verification system identifies complex care members.

(A) Care Management Activities.

(1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members who it has determined require a nurse visit of more than two continuous hours of nursing and informs such members of the name, telephone number, and role of the assigned clinical manager.

(2) LTSS Needs Assessment. The clinical manager performs an in-person visit with the member to evaluate whether they meet the criteria to be a complex care member as described in 130 CMR 414.402. If the member is determined to meet the criteria for a complex care member, the clinical manager will complete an LTSS needs assessment. The LTSS needs assessment will identify

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(a) skilled and unskilled care needs within a 24-hour period;
(b) current medications the member is receiving;
(c) DME currently available to the member;
(d) services the member is currently receiving in the home and in the community; and
(e) any case management activities in which the member participates.

(3) Service Record. The clinical manager

(a) develops a service record, in consultation with the member, the member's primary natural caregiver, and where appropriate, the independent nurse and the member's physician or ordering non-physician practitioner, that

1. lists those LTSS services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community and to be authorized by the clinical manager;
2. describes the scope and duration of each service;
3. lists other sources of payment (*e.g.*, third-party liability, Medicare, Department of Developmental Services, adult foster care); and
4. informs the member of their right to a hearing, as described in 130 CMR 414.414;

(b) provides the member with copies of the service record, one copy of which the member or the member's primary natural caregiver is asked to sign and return to the clinical manager. On the copy being returned, the member or the member's primary natural caregiver must indicate whether they accept or reject each service as offered and that they have been notified of the right to appeal and provided an appeal form; and

(c) provides information to the independent nurse about services authorized in the service record that are applicable to the independent nurse.

(4) Service Authorizations. The MassHealth agency or its designee will authorize the LTSS services in the service record, including nursing, that require prior authorization and that are medically necessary, as provided in 130 CMR 414.413, and coordinate all nursing services and any subsequent changes with the CSN agency, home health agency, or independent nurse prior authorization, as applicable. The MassHealth agency or its designee may also authorize other medically necessary LTSS including, but not limited to, PCA services, complex care assistant services, therapy services, DME, oxygen and respiratory therapy equipment, and prosthetics and orthotics.

(5) Discharge Planning. The clinical manager may participate in member hospital discharge-planning meetings as necessary to ensure that LTSS that are medically necessary to discharge the member from the hospital to the community are authorized and to identify third-party payers.

(6) Service Coordination. The clinical manager will work collaboratively with any other identified case managers assigned to the member.

(7) Clinical Manager Follow-up and Reassessment. The clinical manager will provide ongoing care management for members to

(a) determine whether the member continues to meet the definition of a complex care member; and

(b) reassess whether services in the service plan are appropriate to meet the member's needs.

(B) Independent Nurse — Coordination with the Clinical Manager. The independent nurse must closely communicate and coordinate with the MassHealth agency's or its designee's clinical manager about the status of the member's nursing needs, including, but not limited to, the following:

(1) the number of authorized CSN hours the independent nurse is able and unable to fill upon accepting the member's case, and periodically any significant changes in availability;
(2) any recent or current hospitalizations or emergency department visits, including providing copies of discharge documents, when known;
(3) any known changes to the member's nursing needs that may affect their CSN needs;
(4) needed changes in the independent nurse's CSN prior authorization; and
(5) any incidents or accidents warranting an independent nurse submitting to the MassHealth agency or its designee an incident or accident report (*see* 130 CMR 414.417(H)).

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414.412: Plan of Care

All CSN services must be provided under an individualized plan of care developed for the member. The physician or ordering non-physician practitioner must sign the plan of care before services are provided to the member. On request, the independent nurse must make the plan of care available to the member and/or the member's representative.

(A) Providers Qualified to Establish a Plan of Care.

(1) The member's physician or the ordering non-physician practitioner in consultation with the independent nurse must establish a written plan of care, and the physician or ordering non-physician practitioner must recertify, sign, and date the plan of care every 60 calendar days.

(2) The independent nurse may establish an additional plan of care, when appropriate, that may be incorporated into the physician's or ordering non-physician practitioner's plan of care or be prepared separately. The additional plan of care does not substitute for the physician's or ordering non-physician practitioner's plan of care.

(3) If an independent nurse is co-vending a case with other providers, each provider is responsible for establishing a separate plan of care signed by the member's physician or ordering non-physician practitioner.

(4) Independent nurses who are qualified ordering non-physician practitioners may neither certify the medical necessity nor establish the plan of care for members for whom they are providing CSN services.

(B) Content of the Plan of Care. The orders on the plan of care must specify the total number of CSN hours that MassHealth agency or its designee has authorized to be provided to the member. The physician or ordering non-physician practitioner must sign and date the plan of care before the independent nurse submits the claim for the services to the MassHealth agency for payment. Alternatively, the physician or ordering non-physician practitioner must comply with the verbal order provisions in 130 CMR 414.412(D). Any increase in the total number of CSN hours must be requested in advance by the physician or ordering non-physician practitioner with verbal or written orders and authorized by the MassHealth agency or its designee. If the member is enrolled in the Primary Care Clinician (PCC) Plan, the independent nurse must communicate with the member's PCC both when the goals of the care plan are achieved and when there is a significant change in a member's health status. The plan of care must also include

(1) the member's name and date of birth;

(2) all pertinent diagnoses, including the member's mental, psychosocial, and cognitive status;

(3) types of medical supplies and DME required;

(4) the member's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments;

(5) the total number of nursing hours requested by the independent nurse, if different from the total number of CSN hours authorized by the MassHealth agency or its designee;

(6) any teaching activities to be conducted by the nurse to teach the member, family member, or caregiver how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in member's condition or treatment);

(7) all skilled nursing interventions to be provided, including the frequency, clinical assessment(s), and clinical parameters triggering escalation to the treating provider;

(8) a description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors;

(9) a plan for medical emergencies;

(10) goals toward discharge planning from CSN services when appropriate; and

(11) any additional items the independent nurse or physician or non-physician practitioner chooses to include.

(C) Certification Period. The plan of care required under 130 CMR 414.412(A)(1) must be reviewed, signed, and dated by a physician or ordering non-physician practitioner at least every 60 days, unless the provider follows the verbal order provisions in 130 CMR 414.412(D).

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(D) Physician Verbal Orders.

(1) Notwithstanding the requirements of 130 CMR 414.412(A), services that are provided from the beginning of the certification period (*see* 130 CMR 414.412(C)) and before the ordering physician or ordering non-physician practitioner signs the plan of care are considered to be provided under a plan of care established and approved by the physician or ordering non-physician practitioner if

(a) the clinical record contains a documented verbal order from the ordering physician or ordering non-physician practitioner for the care before the services are provided; or

(b) the physician or ordering non-physician practitioner signature is on the 60-day plan of care either before the claim is submitted or within 60 days after a claim is submitted for that period.

(2) If the member has other health insurance (whether commercial or Medicare), the provider must comply with the other insurer's regulations for physician or ordering non-physician practitioner signature before billing the MassHealth agency.

(E) Corrections to the Plan of Care. When correcting errors on a paper copy of the plan of care before it is signed by the physician, the independent nurse must cross out the error with a single line and place their initials and the date next to the correction. The use of correction fluid or correction tape on a plan of care is not permitted.

(F) MassHealth Members Enrolled in the Primary Care Clinician Plan. If a member is enrolled in the PCC Plan, the independent nurse must provide the PCC with a copy of the member's plan of care for each certification period.

414.413: Prior Authorization Requirements

(A) Prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite for payment for CSN services and before services are provided to the member. Without such prior authorization, CSN services will not be paid by the MassHealth agency.

(B) 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.

(C) The MassHealth agency or its designee will conduct the assessment of need for CSN services and coordinate other MassHealth LTSS for the member, as appropriate. When the MassHealth agency or its designee conducts an assessment of need for CSN services and authorizes CSN services for the member, the member will select the independent nurse who will be responsible for providing CSN services. The MassHealth agency or its designee will provide written notification of its assessment to the member, and if applicable, the independent nurse selected by the member.

(D) The MassHealth agency or its designee will specify on the prior authorization for CSN services the number of CSN hours that have been determined to be medically necessary and that are authorized for the member per calendar week and the duration of the prior authorization. Any CSN hours provided to the member by the independent nurse that exceed what the MassHealth agency or its designee has authorized in a calendar week are not payable by MassHealth except as described in 130 CMR 414.413(H).

(E) If the frequency of the nursing services needs to be adjusted because

(1) the member's medical needs have changed from current authorization, the independent nurse must contact the MassHealth agency or its designee to request an adjustment to the prior authorization; or

(2) there is a change in other nursing services or care from current authorization (*e.g.*, PCA services, changes in adult day health or day habilitation schedules, adult foster care services), the independent nurse or the member must contact the MassHealth agency or its designee to request a review of the prior authorization.

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(F) Prior authorization for CSN services may be approved for more than one independent nurse or CSN agency, or both, provided that

(1) each provider is authorized only for a specified portion of the member's total hours; and

(2) the sum total of the combined hours approved for co-vending providers does not exceed what the MassHealth agency or its designee has determined to be medically necessary and authorized for the member per calendar week, except as described in 130 CMR 414.413(H).

(G) The independent nurse must contact the MassHealth agency or its designee for all prior authorization requests in accordance with the MassHealth agency's administrative and billing regulations and instructions and must submit such requests to the appropriate addresses listed in Appendix A of the *Independent Nurse Manual*.

(H) If there are unused hours of nursing services in a calendar week, they may be used at any time during the current authorized period.

(I) In connection with a prior authorization, at the request of the MassHealth agency or its designee, the independent nurse is required to provide to the MassHealth agency or its designee a signed plan of care under 130 CMR 414.412 and supporting clinical documentation including, but not limited to, nursing progress notes, medication records, and clinical logs for all members authorized for CSN services.

(J) The MassHealth agency or its designee may authorize additional medically necessary CSN services on a temporary, three-month basis if the member meets the clinical criteria for CSN services and the primary natural caregiver is unavailable because they

(1) have an acute illness, have been hospitalized, or have a suspected illness;

(2) have abandoned the member or have died in the past 30 days;

(3) have a high-risk pregnancy that requires significant restrictions;

(4) have given birth within the four weeks before a request for additional services;

(5) require surgery and/or are recovering from surgery in the hospital, in a rehabilitation facility, or at home; or

(6) are required to be away from the MassHealth member for an extended period of time.

This temporary increase in authorized units will be evaluated at the end of the three-month period to determine whether additional authorization is needed.

(K) MassHealth members and/or primary natural caregivers will determine when authorized independent nurses will be used in order to best support the member's needs. This can include scheduling authorized nursing hours in increments of less than two hours in order to meet the member's needs and best utilize authorized hours.

414.414: Notice of Approval or Denial of Prior Authorization

(A) Notice of Approval. For all approved prior authorization requests for nursing services, the MassHealth agency or its designee will send written notice to the member and the independent nurse specifying the frequency and duration of care authorized and the effective date of the authorization.

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

(1) For all denied or modified prior authorization requests, the MassHealth agency or its designee will notify both the member and the independent nurse of the denial or modification, reason, right to appeal, and appeal procedure. The independent nurse will receive the information about the modification and the reason from the MassHealth agency or its designee.

(2) A member may request a fair hearing from the MassHealth agency if the MassHealth agency or its designee denies or modifies a prior authorization request. The member must request a fair hearing in writing within 60 days after the date of the denial or modification unless otherwise decided by EOHHS. The Office of Medicaid Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

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(C) Notice of Discontinuation and Right of Appeal.

(1) For members who no longer meet clinical criteria for CSN services, the MassHealth agency or its designee will notify the member and the independent nurse of the discontinuation and the reason for it. The member will also receive notification of their right to appeal and the appeal procedure.

(2) A member may request a fair hearing from the MassHealth agency if the MassHealth agency or its designee discontinues authorization of CSN services. Any fair hearing request must be made in writing within 30 days after the date of the discontinuation. The Office of Medicaid Board of Hearings will conduct the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

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

The MassHealth agency pays for all medically necessary CSN agency services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction,* with prior authorization.

414.416: Overtime

(A) The MassHealth agency will pay an overtime rate for nursing services provided by an independent nurse when the following conditions are met:

(1) prior authorization for overtime has been obtained from the MassHealth agency or its designee; and

(2) nursing services are provided by the same independent nurse and exceed 40 hours in a given calendar week for one MassHealth member.

(B) The MassHealth agency or its designee will only evaluate and authorize overtime on request by the independent nurse.

(C) In no event will any independent nurse be authorized for a total of more than 60 hours of nursing care provided during any seven-day calendar week, regardless of the number of MassHealth members receiving care from the independent nurse.

414.417: Recordkeeping Requirement and Utilization Review

(A) The record maintained by an independent nurse for each member must conform to 130 CMR 450.000: *Administrative and Billing Regulations*. Payment for any service listed in 130 CMR 414.000 requires full and complete documentation in the member's medical record. The independent nurse must maintain records for each member to whom nursing services are provided.

(B) In order for a medical record to completely document a service to a member, the record must disclose fully the nature, extent, quality, and necessity of the nursing services furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the MassHealth agency may disallow payment (*see* 130 CMR 450.000: *Administrative and Billing Regulations*).

(C) The independent nurse 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 414.409(C). The independent nurse 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*.

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(D) The independent nurse must maintain an up-to-date medical record of nursing services provided to each member that must be reviewed by the independent nurse at least monthly. The medical record must contain at least the following:

(1) the member's name, address, phone number, date of birth, and MassHealth ID number;
(2) the name and phone number of the member's primary care physician;
(3) the primary natural caregiver's name, address, phone number, and relationship to member;
(4) the name and phone number of the member's emergency contact person;
(5) a copy of the approved prior authorization decision;
(6) a copy of the plan of care signed by the member's physician and, if appropriate, verbal orders signed by the physician;
(7) a medical history as defined in 130 CMR 414.402;
(8) accessible and legible nursing progress notes for each visit, signed by the independent nurse, that include the following information:
  (a) the full date of service and time that each visit began and ended;
  (b) all treatments and services ordered by the physician or ordering non-physician practitioner that are included in the member's plan of care, as well as documentation of the treatments and services that were provided during the visit and the member's response;
  (c) any additional treatment or service that is not included in the member's plan of care provided, as well as the member's response, including documentation of medication administration as described in 130 CMR 414.417(D)(9);
  (d) any service or treatment the member may have declined during the visit and an explanation of the denial;
  (e) the member's vital signs and any other required measurements;
  (f) progress toward achievement of long- and short-term goals as specified in the plan of care, including, when applicable, an explanation of why goals are not achieved as expected;
  (g) a pain assessment, as appropriate;
  (h) the status of any equipment maintenance and management, as appropriate; and
  (i) any contacts with physicians or other health-care providers about the member's needs or change in plan of care, as applicable;
(9) a current medication-administration list or other documentation, such as nursing notes, that includes the time of administration as ordered, drug identification and dose, the route of administration, the member's response to the medication being administered, and the signature of the person administering the medication;

(10) documentation about teaching provided to the member, member's family, or primary natural caregiver by the independent nurse on how to manage the member's treatment regimen, any ongoing teaching required by a change in the procedure or the member's condition, and the response to the teaching, if applicable;
(11) any clinical tests and their results;
(12) the names and telephone numbers of all the providers involved in co-vending care and the number of nursing hours approved for each provider by the MassHealth agency or its designee, to the best of the independent nurse's ability;
(13) a signed medical records release form; and
(14) a discharge summary, if applicable, including the reason for discharge and any activities completed by the independent nurse related to the discharge.

(E) The independent nurse must maintain a copy of the member's medical record in the member's home as described in 130 CMR 414.417(D). The copy must be made available to the member and/or their representative on request. The independent nurse must make every attempt to coordinate care and/or changes in shifts with other CSN providers.

(F) The independent nurse is responsible for maintaining the member's medical record. The independent nurse must maintain the member's original medical record along with current and previous certification period documentation in accordance with 130 CMR 414.417(A) and (B).

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414.417: continued

(G) On the request of the member or their representative, the independent nurse must provide a copy of the medical record free of charge to a person or entity that the member or their representative designates. Additionally, on request of the MassHealth agency or its designee, the independent nurse must provide a copy of the member's complete medical record to the agency or designee.

(H) Incident and Accident Records. The independent nurse must maintain an easily accessible record of the members' incidents and accidents. The record may be kept in the individual member medical record.

(1) The independent nurse must submit to the MassHealth agency or its designee an incident or accident report within five days under the following circumstances:

(a) an incident or accident that occurred during a CSN service visit that results in serious injury to the member;

(b) an incident or accident resulting in the member's unexpected death even if the independent nurse was not involved in the incident or accident;

(c) an incident of abuse or neglect involving the independent nurse and the member; or

(d) an incident of abuse or neglect committed by another provider who was supporting the member (if known).

(2) The incident or accident report must include at least the following:

(a) general information including but not limited to the member's name and MassHealth ID number;

(b) the general nature of the incident or accident; and

(c) any action that was taken as a result of the incident or accident, including all outcomes.

414.418: Maximum Allowable Fees

(A) Independent nurse providers must accept MassHealth payment in full for nursing services according to the rates and regulations established by EOHHS as set forth in 101 CMR 361.00: *Rates for Continuous Skilled Nursing Agency and Independent Nursing Services*. Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 414.000 and 450.000: *Administrative and Billing Regulations*.

(B) The payments made by the MassHealth agency to the independent nurse constitute payment in full for nursing services as well as for all administrative duties relating to such services.

414.419: Transfers and Discharge Planning

(A) Discharge Procedures.

(1) An independent nurse may discharge a MassHealth member upon the member's request or when the independent nurse may no longer serve the member, such as under the following conditions:

(a) if the member no longer meets the clinical eligibility for CSN services;

(b) if the member selects another service that is duplicative of CSN services;

(c) if the member transitions to another CSN provider; or

(d) if the independent nurse ceases enrollment with the MassHealth agency.

(2) A member may be discharged by the independent nurse provider if the independent nurse cannot safely serve the member in the home due to the member or other persons in the member's home being disruptive, abusive, or uncooperative to the extent that delivery of care is seriously impaired. Prior to discharge, the independent nurse must

(a) notify the member, representative, ordering physician, and the MassHealth agency or its designee that a discharge for cause is being considered;

(b) notify the member, representative, ordering physician, and the MassHealth agency or its designee at least 14 days in advance that a discharge is planned to ensure member or provider safety. If the independent nurse has documented that continued provision of CSN services poses significant risks to provider safety, an independent nurse may discontinue services and discharge the member immediately;

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414.419: continued

(c) make diligent efforts to solve the problem(s) present and document these efforts in the member's clinical records;

(d) provide the member and/or caregiver contact information for alternative CSN providers; and

(e) document the discharge and independent nurse activity related to the discharge in the member's clinical record.

(3) An independent nurse may not discharge a MassHealth member in violation of any discrimination provisions established in state or federal law;

(4) When an independent nurse makes the determination that a member no longer meets the clinical eligibility for CSN services and would like to proceed with discharge as described at 130 CMR 414.419(A)(1)(a), the independent nurse must consult with the MassHealth agency or its designee at minimum 14 days before the planned discharge to allow the MassHealth agency or its designee to perform a reassessment of the member's medical necessity for CSN services as described at 130 CMR 414.411(A)(7).

(5) When an independent nurse ceases to provide continuous skilled nursing services and does not plan to provide continuous skilled nursing services in the future, they must notify the MassHealth agency, its designee, and any MassHealth members it serves. In addition, the independent nurse must

(a) provide the member and/or caregiver the number of non-billed units remaining on the prior authorization;

(b) provide the member and/or caregiver contact information for alternative CSN providers;

(c) work with the MassHealth agency or its designee to assist in the transfer of members' care to another CSN provider; and

(d) end their enrollment as a MassHealth independent nurse provider.

414.420: Denial of Services and Administrative Review

(A) A failure or refusal by an independent nurse to furnish services that have been ordered by the member's attending physician and that are within the range of payable services is not an action by the MassHealth agency or its designee that a member may appeal, but such failure or refusal constitutes a violation of 130 CMR 414.000 for which administrative sanctions may be imposed.

(B) When an independent nurse believes that services ordered by the attending physician are not payable under 130 CMR 414.000, the independent nurse must refer the matter to the MassHealth agency for a payment decision. If and to the extent the MassHealth agency determines that the ordered services are payable, the independent nurse must provide those services.

414.421: Prohibited Marketing Activities

An independent nurse must not

(A) with the knowledge that a member is enrolled in a 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 capitated program in order to obtain 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 independent nurse to provide CSN 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 independent nurse; or

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

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414.422: Providing Continuous Skilled Nursing Services Out-of-State

The MassHealth agency does not pay an independent nurse to provide CSN services outside Massachusetts unless all of the following conditions are met:

(A) The independent nurse has a current prior authorization to provide CSN services as described in 130 CMR 414.413; and

(B) The independent nurse has an active nursing license in the state where the member is present or that the member plans to travel to.

REGULATORY AUTHORITY

130 CMR 414.000: M.G.L. c. 118E, §§ 7 and 12.

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Docket # 1195

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Regulation Filing

To be completed by filing agency

CHAPTER NUMBER: **130 CMR 438.000**

CHAPTER TITLE: **Continuous Skilled Nursing Agency Services**

AGENCY: **Division of Medical Assistance**

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

Governs MassHealth agency providers of continuous skilled nursing (CSN) agency services and provides program requirements and conditions of payment for the provision of CSN agency services to MassHealth members.

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

AGENCY CONTACT: **Deborah M. Briggs, MassHealth Publications** PHONE: **617-921-1744**

ADDRESS: **1 Enterprise Drive, 4th 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: Mar 13, 2026
Regulatory Review approval: Sep 1, 2026

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: **Apr 28, 2026**

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

For the first and second year: **No fiscal impact.**

For the first five years:

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: **9/23/26**

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 438.000.

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: **Sep 25 2026**

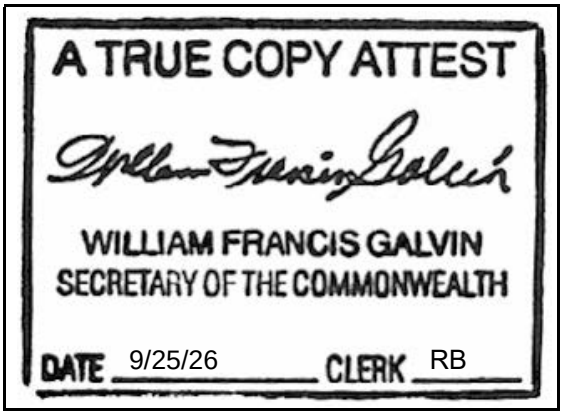
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **10/9/26**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
513 - 516.14.2	**513 - 516.14.4**



130 CMR 438.000: CONTINUOUS SKILLED NURSING AGENCY SERVICES

Section

438.401: Introduction
438.402: Definitions
438.403: Eligible Members
438.404: Provider Eligibility
438.408: Services Provided under Contract
438.409: Administrative Requirements
438.410: Clinical Eligibility Criteria for CSN Agency Services
438.411: Prior Authorization Requirements
438.412: Notice of Prior Authorization and Clinical Eligibility Determination
438.413: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
438.414: Administrative Care Management
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438.416: Plan of Care Requirements
438.417: Quality Management, Utilization Review, and Reporting Requirements
438.418: Transfers and Discharge Planning
438.419: Conditions of Payment
438.420: Maximum Allowable Fees
438.421: Denial of Services and Administrative Review
438.422: Prohibited Marketing Activities
438.423: Providing Continuous Skilled Nursing Agency Services out of State

438.401: Introduction

130 CMR 438.000 states the requirements for the payment of continuous skilled nursing (CSN) services and complex care assistant (CCA) services provided by a CSN agency. All CSN agencies participating in MassHealth must comply with MassHealth regulations including, but not limited to, 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

438.402: Definitions

The following terms used in 130 CMR 438.000 have the meanings given in 130 CMR 438.402, unless the context clearly requires a different meaning. The reimbursed services defined in 130 CMR 438.402 are not determined by these definitions, but by the application of regulations elsewhere in 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

Accountable Care Organization (ACO). An entity that enters into a population-based payment model contract with the Executive Office of Health and Human Services (EOHHS) as an ACO, 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 managed care organization (MCO)-administered ACOs.

Branch Office. A location or site from which a CSN agency provides services within a portion of the total geographic area served by the parent CSN agency. The parent CSN agency must provide supervision and administrative control of any branch office on a daily basis.

Calendar Week. Seven consecutive days beginning Sunday at 12:00 A.M. and ending Saturday at 11:59 P.M.

Capitated Program. An integrated care organization (ICO), senior care organization, ACO, or Program of All-inclusive Care for the Elderly (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.

Care Management. A function performed by the MassHealth agency or its designee that assesses and reassesses the medical needs of complex care members and authorizes or coordinates long-term services and supports (LTSS) that are medically necessary for such members to remain safely in the community.

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Certification Period. A period of no more than 60 days for which the member's physician has certified that the plan of care is medically appropriate and necessary.

Clinical Manager. A registered nurse (RN) employed by the MassHealth agency or its designee, who performs the in-person assessment of a member for MassHealth coverage of CSN services and, if it is determined that CSN services are medically necessary, coordinates authorization of medically necessary LTSS for the member.

Complex Care Assistant. A person who is employed or contracted by a CSN agency and meets the qualifications of a complex care assistant to perform certain health-related services as described at 130 CMR 438.415(C).

Complex Care Assistant Services. Medically necessary services as described at 130 CMR 438.000 and identified in the plan of care delivered to complex care members.

Complex Care Assistant Supervisor (CCA Supervisor). A registered nurse or licensed practical nurse who is familiar with the member and the member's plan of care as described at 130 CMR 438.416 and is deignated by the CSN agency as a supervisor of CCA service delivery.

Continuous Skilled Nursing (CSN) Agency. A public or private organization that provides CSN services, or CSN agency services to complex care members within the members' homes.

Continuous Skilled Nursing (CSN) Agency Services. CSN services and CCA services as described at 130 CMR 438.402 and delivered to MassHealth-eligible members.

Continuous Skilled Nursing (CSN) Services. Skilled nursing care provided by a licensed nurse to complex care members who require more than two continuous hours of nursing services per day, including any CSN training time as described at 130 CMR 438.410(H).

Co-vending. An arrangement through which a member's CSN services are provided by more than one CSN agency or independent nurse, with each provider obtaining its own MassHealth prior authorization to provide CSN services to the member.

Home Health Agency. A public or private organization that provides nursing and other therapeutic services to individuals whose place of residence conforms to the requirements of 42 CFR 440.70(c). Home health agency providers are governed by MassHealth regulations at 130 CMR 403.000: *Home Health Agency*. Home health agencies providing CSN services must also comply with 130 CMR 438.000 for the provision of those services.

Household. A place of residence where two or more people are living that is:

(1) a group home, a residential care home, or another group living situation;

(2) at the same street address if it is a single-family house that is not divided into apartments or units; or

(3) at the same apartment number or unit number if members live in a building that is divided into apartments or units.

Independent Nurse. A licensed nurse who independently enrolls as a provider with MassHealth to provide CSN services. Independent nurse providers are governed by 130 CMR 414.000: *Independent Nurse Services*.

Integrated Care Organization (ICO). An organization with a comprehensive network of medical care, behavioral health care, and 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.

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438.402: continued

Long-term Services and Supports (LTSS). Certain MassHealth-covered services intended to enable a member to remain in the community. Such services include, but are not limited to, home health, durable medical equipment (DME), oxygen and respiratory equipment, personal care attendant (PCA), and other health-related services as determined by the MassHealth agency or its designee.

LTSS Needs Assessment. The standardized assessment the MassHealth agency or its designee uses to determine a member's eligibility for CSN services and if found eligible, quantifies the medically necessary CSN, CCA services, and other LTSS services.

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 CSN agency 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 CSN agency provider, whether by inducing that member

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

Medical History. A component of the member's medical record that provides a summary of all health-related information about the member. A history includes, but is not limited to, medical and nursing-care histories as well as summaries of physician physical examination and nursing-assessment results.

Medical Record. Documentation, maintained by the CSN agency, that includes medical history, nursing progress notes, the member's plan of care, and other information related to the member.

Medical Records Release Form. A signed authorization from the member or the member's parent or legal guardian, if the member is a minor, that allows the designated release to access the member's confidential health information from other health care providers.

Member with Medical Complexity. An individual who is a MassHealth member and whose medical needs, as determined by the MassHealth agency or its designee, are such that they require a nurse visit of more than two continuous hours of nursing services to remain in the community.

Nurse. A person licensed as an RN or licensed practical nurse (LPN) by a state’s board of registration in nursing.

Nursing Services. The assessment, planning, intervention, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that require the skills of a nurse.

Ordering Non-physician Practitioner. A nurse practitioner, physician's assistant, or clinical nurse specialist who is licensed in the state of Massachusetts to perform and order medical services according to their scope of practice and who has a collaborative practice agreement with a physician. Ordering non-physician practitioners are also allowed to conduct face-to-face encounters.

Primary Natural Caregiver. The individual, other than the nurse, who is primarily responsible for providing ongoing care to the member and is also connected to the member in some other way, such as a parent, spouse, other family member, or close friend.

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438.402: continued

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

Senior Care Organization (SCO). An MCO 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.

Unfair or Deceptive Acts or Practices. Any unfair or deceptive acts or practices, as that term is defined in M.G.L. c. 93A, § 2, and the regulations promulgated thereunder by the Massachusetts Attorney General.

438.403: Eligible Members

(A)(1) MassHealth Members. The MassHealth agency covers CSN agency services provided by CSN agencies only when provided to eligible MassHealth members, subject to the restrictions and limitations described in MassHealth regulations at 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing 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*.

438.404: Provider Eligibility

To participate in MassHealth as a MassHealth CSN agency provider, an agency must

(A) be accredited or certified as

(1) a provider of home health services by a CMS-approved accrediting organization including one of the following: Accreditation Association for Ambulatory Health Care, Accreditation Commission for Health Care, Community Health Accreditation Partner, the Joint Commission on Accreditation of Healthcare Organizations, and meet all requirements of the CMS-approved accrediting organization; or

(2) a provider of home care services by the Accreditation Commission for Health Care or the Community Health Accreditation Partner and meet all requirements of this accrediting organization; or

(3) a provider of home health services under the Medicare program by the Massachusetts Department of Public Health and meet all requirements within the Medicare Conditions of Participation for home health agency services;

(B) obtain a MassHealth provider number before providing CSN agency services;

(C) participate in, and be in compliance with, other MassHealth enrollment requirements that may include, but are not limited to, provider site visit requirements;

(D) accept MassHealth payments as payment in full for all CSN agency services;

(E) agree to comply with all the provisions of 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, and all other applicable MassHealth rules and regulations;

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438.404: continued

(F) meet all provider participation requirements described at 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*;

(G) agree to periodic inspections, by the MassHealth agency or its designee, that assess the quality of member care and ensure compliance with 130 CMR 438.000;

(H) participate in any CSN agency provider orientation required by the EOHHS;

(I) submit to the MassHealth agency or its designee a statement of fiscal soundness attesting to the financial viability of the CSN agency provider supported by documentation to demonstrate that the provider has adequate resources to finance the provision of services in accordance with 130 CMR 438.000 and as specified in 130 CMR 438.415(E);

(J) except as provided in 130 CMR 438.404(K) regarding change in scope of service or business, 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, change in status of accreditation and/or reaccreditation or Medicare certification, and additional CSN agency branch office;

(K) notify the MassHealth agency, its designee, and MassHealth members in writing at least 60 days in advance of any change in the CSN agency's scope of business or services (for example, if a provider decides to no longer provide certain services or if a CSN agency will be disenrolling as a MassHealth provider); and

(L) An out-of-state provider must also
(1) provide services to a member in accordance with 130 CMR 450.109: *Out-of-state Services*; and
(2) participate in the Medicaid program in its state.

438.408: Services Provided under Contract

(A) Introduction. A CSN agency may provide CSN agency services directly or through contractual arrangements made by the CSN agency. Whether the services are provided directly or through contracts, the CSN agency is responsible for submitting claims for services and for meeting the requirements in 130 CMR 438.000 and all other applicable state and federal requirements.

(B) Contract Requirements.
(1) If the CSN agency contracts with another provider participating in MassHealth (*e.g.*, hospital, nursing facility, a home health agency, another CSN agency, or hospice), a written contract must document the services to be provided and the corresponding financial arrangements.
(2) If the CSN agency contracts with a provider that does not participate in MassHealth, the written contract must include
(a) a description of the services to be provided;
(b) the duration of the agreement and how frequently it is to be reviewed;
(c) a description of how personnel are supervised;
(d) a statement that the contracting organization will provide its services in accordance with the plan of care established by the member's physician in conjunction with the CSN agency's staff;
(e) a description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and in-service training;
(f) a description of the method of determining reasonable costs and payments by the home health agency for the specific services to be provided by the contracting organization; and
(g) an assurance that the contracting organization will comply with Title VI of the Civil Rights Act and all relevant MassHealth provider requirements.

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438.409: Administrative Requirements

Whether services are provided by the CSN agency directly or through contractual arrangements made by the agency, the agency must

(A) accept the member for treatment in accordance with its admission policies;

(B) maintain a complete medical record as defined at 130 CMR 438.402 relating to all services provided in accordance with 130 CMR 438.415(D)(3);

(C) obtain from the physician or ordering non-physician practitioner the required certifications and recertifications of the plan of care in accordance with 130 CMR 438.416(C); and

(D) ensure that the CSN agency's staff review the medical necessity of services and the physician or ordering non-physician practitioner certification on a regular basis.

438.410: Clinical Eligibility Criteria for CSN Agency Services

(A) Clinical Criteria for Nursing Services.

(1) A nursing service is a service that must be provided by an RN or LPN to be safe and effective, considering the inherent complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice.

(2) Some services are nursing services on the basis of complexity alone (for example, intravenous and intramuscular injections). However, in some cases, a service that is ordinarily considered unskilled may be considered a nursing service because of the patient's condition. This situation occurs when only an RN or LPN can safely and effectively provide the service.

(3) When a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct intervention of an RN or LPN, the service is not considered a nursing service, unless there is no one trained and able to provide it.

(4) The CSN agency must assess the member to ensure that continued nursing services are necessary.

(5) Medical necessity of services is based on the condition of the patient at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period.

(6) A member's need for nursing care is based solely on their unique condition and individual needs, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

(B) Clinical Eligibility for CSN Services. A member is clinically eligible for MassHealth coverage of CSN services when all of the following criteria are met.

(1) There is a clearly identifiable, specific medical need for a nursing visit to provide nursing services, as described at 130 CMR 438.410(A), of more than two continuous hours;

(2) The CSN services are medically necessary to treat an illness or injury in accordance with 130 CMR 438.410; and

(3) Prior authorization is obtained by the CSN agency in accordance with 130 CMR 438.411.

(C) Clinical Eligibility for Complex Care Assistant (CCA) Services. A member is clinically eligible for MassHealth coverage of CCA services when

(1) they are found eligible for CSN services as described at 130 CMR 438.410(B);

(2) services described at 130 CMR 438.415(C)(3)(a)2. may be safely performed by a CCA; and

(3) services are not duplicative of other services the member is receiving.

(D) Member Must Be under the Care of a Physician or Ordering Non-physician Practitioner. The MassHealth agency pays for CSN agency services only if the member's physician or ordering non-physician practitioner certifies the medical necessity for such services on an established individual plan of care in accordance with 130 CMR 438.419(C). A member may receive CSN agency services only if the member is under the care of a physician or ordering non-physician practitioner. The physician or ordering non-physician practitioner providing the certification of medical necessity must not be a physician or ordering non-physician practitioner on the staff of, or under contract with, the CSN agency or related home health agency.

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438.410: continued

(E) Safe Maintenance in the Community. The member's physician, ordering non-physician, and CSN agency must determine that the member can be maintained safely in the community with medically appropriate CSN agency services.

(F) Multiple-patient Care for CSN Services. The MassHealth agency pays for one nurse to provide CSN services simultaneously to more than one member, but not more than three members, if

(1) the members have been determined by the MassHealth agency or its designee to meet the criteria listed at 130 CMR 438.410(A);

(2) the members receive services in their place of residence and during the same time period;

(3) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the CSN agency has received a separate prior authorization for each member as described at 130 CMR 438.411.

(G) Limitations on Covered Services. The MassHealth agency pays for CSN agency services to a member who resides in a non-institutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. The MassHealth agency does not pay for CSN agency services when a member is under the direct care of a hospital or emergency room, nursing facility, intermediate care facility, or any other institutional facility providing medical, nursing, rehabilitative, or related care. The MassHealth agency pays for CSN agency services when the CSN agency must accompany the member in transport to and from an institutional setting to ensure medical stability.

(H) Clinical Eligibility for Continuous Skilled Nursing (CSN) Training Time. A MassHealth member is eligible for CSN Training time when a nurse employed by the CSN agency is newly assigned to the member to provide CSN services and requires training for the member's specific care needs.

438.411: Prior Authorization Requirements

(A) Prior authorization must be obtained from the MassHealth agency or its designee as a prerequisite for payment for CSN agency services and before services are provided to the member. Without such prior authorization, CSN agency services will not be paid by the MassHealth agency.

(B) 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.

(C) The MassHealth agency or its designee will conduct the assessment of need for CSN agency services, including CSN services and CCA services, and coordinate other MassHealth LTSS for the member, as appropriate. When the MassHealth agency or its designee conducts an assessment of need for CSN agency services and authorizes CSN agency services for the member, the member will select the CSN agency or agencies that will be responsible for providing CSN agency services. The MassHealth agency or its designee will provide written notification of its assessment to the member and, if applicable, the CSN agency or agencies selected by the member.

(D) At the request of the MassHealth agency or its designee, CSN agencies are required to provide a signed plan of care under 130 CMR 438.416 and supporting clinical documentation including, but not limited to, nursing progress notes, CCA progress notes, medication records, and clinical logs to the MassHealth agency or its designee for all members authorized for CSN agency services.

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(E) The MassHealth agency or its designee will specify on the prior authorization for CSN agency services the number of CSN hours, including CSN training hours, and CCA hours, including CCA supervision and intake visits, as applicable, that have been determined to be medically necessary and that are authorized for the provider to provide to the member per calendar week and the duration of the prior authorization. MassHealth will authorize up to two hours (eight units) for CCA intake visits at the beginning of a new prior authorization period. CSN agencies may not request more units for CCA intake visits. Any CSN hours or CCA hours provided to the member by the CSN agency that exceed what the MassHealth agency or its designee has authorized in a calendar week are not payable by MassHealth, except as described at 130 CMR 438.411(F).

(F) If there are unused hours of CSN and/or CCA services in a calendar week, they may be used at any time during the remainder of the current authorized period.

(G) MassHealth members and/or primary natural caregivers will determine when authorized CSN hours and CCA hours will be used in order to best support the member's needs. This can include scheduling authorized service hours in increments of less than two hours in order to meet the member's needs and best utilize authorized hours.

(H) If the frequency of the member's CSN agency services needs to be adjusted because

(1) the member's medical needs have changed from current authorization, the CSN agency must contact the MassHealth agency or its designee to request an adjustment to the prior authorization;

(2) there is a change in other nursing and health care services or care from current authorization (for example, PCA services, changes in adult day health or day habilitation schedules, adult foster care services), the CSN agency or the member may contact the MassHealth agency or its designee to request a review of the prior authorization.

(I) The MassHealth agency or its designee may authorize additional medically necessary CSN agency services on a temporary three-month basis if the member meets the clinical criteria for nursing services and the primary natural caregiver is unavailable because they

(1) have an acute illness, have been hospitalized, or have a suspected illness;
(2) have abandoned the member or have died within the past 30 days;
(3) have a high-risk pregnancy that requires significant restrictions;
(4) have given birth within the four weeks prior to a request for additional services;
(5) require surgery and/or are recovering from surgery in the hospital, in a rehabilitation facility, or at home; or
(6) are required to be away from the MassHealth member for an extended period.

This temporary increase in authorized units will be evaluated at the end of the three-month period in order to determine whether additional authorization is needed.

(J) Prior authorization for CSN services may be approved for more than one CSN agency or independent nurse, or both, provided that

(1) each provider is authorized only for a specified portion of the member's total hours; and
(2) the sum total of the combined hours approved for co-vending providers does not exceed what the MassHealth agency or its designee has determined to be medically necessary and authorized for the member per calendar week.

438.412: Notice of Prior Authorization and Clinical Eligibility Determination

(A) Notice of Approval. For all approved prior authorization requests for CSN agency services, the MassHealth agency or its designee sends written notice to the member and the CSN agency, if applicable, specifying the frequency and duration of care authorized, and the effective date of the authorization.

(B) Notice of Modification and Right of Appeal.

(1) For all modified prior authorization requests, the MassHealth agency or its designee notifies the member of the modification, reason, member's right to appeal, and appeal procedure. The CSN agency receives the information about the modification and the reason from the MassHealth agency or its designee.

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

(C) Notice of Discontinuation and Right of Appeal.

(1) For members who no longer meet clinical criteria for CSN agency services, the MassHealth agency or its designee notifies the member and the CSN agency provider of the discontinuation and the reason for discontinuation. The member also receives notification of the member's right to appeal, and the appeal procedure.

(2) A member may request a fair hearing from the MassHealth agency if the MassHealth agency or its designee discontinues authorization of CSN agency services. The member must request a fair hearing in writing within 30 days after the date of the discontinuation. The Office of Medicaid Board of Hearings conducts the hearing in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules.*

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

The MassHealth agency pays for all medically necessary CSN agency services for EPSDT-eligible members in accordance with 130 CMR 450.140: *Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services: Introduction*, with prior authorization.

438.414: Administrative Care Management

For complex care members, as defined in 130 CMR 438.402, the MassHealth agency or its designee provides administrative care management that includes service coordination with CSN agencies as appropriate. The purpose of administrative care management is to ensure that a complex care member is provided with a coordinated LTSS package that meets the member's individual needs and to ensure that the MassHealth agency pays for nursing, CCA services, and other community LTSS only if medically necessary in accordance with 130 CMR 450.204: *Medical Necessity*. The MassHealth member eligibility verification system identifies complex care members.

(A) Care Management Activities.

(1) Enrollment. The MassHealth agency or its designee automatically assigns a clinical manager to members who may require a nurse visit of more than two continuous hours of nursing and informs such members of the name, telephone number, and role of the assigned clinical manager.

(2) LTSS Needs Assessment. The clinical manager performs an in-person visit with the member to evaluate whether the member meets the criteria to be a complex care member as described at 130 CMR 438.402 and 438.410(B). If the member is determined to meet the criteria as a complex care member, the clinical manager will complete an LTSS needs assessment. The LTSS needs assessment will include input from the member; the member's caregiver, if applicable; LTSS providers; and other treating clinicians. The LTSS needs assessment will identify

(a) skilled and unskilled care needs within a 24-hour period;
(b) current medications the member is receiving;
(c) DME currently available to the member;
(d) services the member is currently receiving in the home and in the community; and
(e) any other case management activities in which the member participates.

(3) Service Record. The clinical manager

(a) develops a service record, in consultation with the member, the member's primary natural caregiver, and where appropriate, the CSN agency and the member's physician or ordering non-physician practitioner, that

1. lists those LTSS services that are medically necessary, covered by MassHealth, and required by the member to remain safely in the community, and to be authorized by the clinical manager;

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2. describes the scope and duration of each service;
3. lists other sources of payment (*e.g.*, third-party liability, Medicare, Department of Developmental Services, adult foster care); and
4. informs the member of their right to a hearing, as described at 130 CMR 438.414.

(b) provides the member with copies of
1. the service record, one copy of which the member or the member's primary natural caregiver is requested to sign and return to the clinical manager. On the copy being returned, the member or the member's primary natural caregiver should indicate whether they accept or reject each service as offered and that they have been notified of the right to appeal and provided an appeal form; and
2. the LTSS needs assessment.

(c) provides information to the CSN agency about services authorized in the service record that are applicable to the CSN agency.

(4) Service Authorizations. The MassHealth agency or its designee will authorize those LTSS in the service record, including nursing and CCA services, that require prior authorization and that are medically necessary, as provided in 130 CMR 438.412, and coordinate all nursing services and CCA services; any applicable home health agency services; and any subsequent changes with the CSN agency, home health agency, or independent nurse prior authorization, as applicable. The MassHealth agency or its designee may also authorize other medically necessary LTSS including, but not limited to, PCA services, therapy services, DME, oxygen and respiratory therapy equipment, and prosthetics and orthotics.

(5) Discharge Planning. The clinical manager may participate in member hospital discharge-planning meetings as necessary to ensure that medically necessary LTSS necessary to discharge the member from the hospital to the community are authorized and to identify third-party payers.

(6) Service Coordination. The clinical manager will work collaboratively with any other identified case managers assigned to the member.

(7) Clinical Manager Follow-up and Reassessment. The clinical manager will provide ongoing care management for members to

(a) determine whether the member continues to meet the definition of a complex care member; and

(b) reassess whether services in the service record are appropriate to meet the member's needs.

(B) CSN Agency Care Management Activities. The CSN agency must closely communicate and coordinate with the MassHealth agency's or its designee's clinical manager about the status of the member's nursing and CCA needs, in addition, but not limited to

(1) The amount of authorized CSN and CCA hours the agency is able and unable to fill upon agency admission, and periodically with any significant changes in availability;

(2) Any recent or current hospitalizations or emergency department visits, including providing copies of discharge documents, when known;

(3) Any known changes to the member's nursing needs and services that may affect the member's CSN agency service needs;

(4) Needed changes in the agency's CSN agency PA; and

(5) Any incidents warranting an agency submitting to the MassHealth agency or its designee an incident or accident report. *See* 130 CMR 438.415(D)(2).

438.415: Provider Responsibilities

In addition to meeting all of the qualifications set forth in 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*, CSN agencies must meet all of the following requirements.

(A) Policies and Procedures. Each CSN agency must develop comprehensive policies and procedures governing the delivery of CSN agency services. The agency must maintain the policies and procedures, review/update them, comply with them, and make them available to members, in part or in their entirety, on request. At a minimum, the policies and procedures must contain the following:

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(1) administrative policies and procedures including, but not limited to,
(a) human resource and personnel;
(b) staff and staffing requirements;
(c) backup staff in the event coverage is required due to illness, vacation, or other reasons;
(d) staff education and training;
(e) CSN agency staff evaluation and supervision;
(f) emergencies including fire, safety and disasters, including notifying the fire department and police in emergencies;
(g) MassHealth member rights;
(h) human rights and nondiscrimination;
(i) incident and accident reporting;
(j) staff and member grievances;
(k) staff cultural competency;
(l) quality assurance and improvement;
(m) emergency services and plans for members;
(n) recognizing and reporting abuse (physical, sexual, emotional, psychological), neglect, self-neglect, and financial exploitation;
(o) Health Insurance Portability and Accountability Act (HIPAA);
(p) procedures to be followed if a member is missing or lost; and
(q) member complaint resolution protocol.

(2) clinical policies and procedures including, but not limited to,
(a) clinical evaluations;
(b) privacy and confidentiality;
(c) documentation of visits and progress notes;
(d) medication management;
(e) infection control and communicable disease;
(f) discharge criteria;
(g) coordination of CSN agency services with other services the member is receiving, including co-vending;
(h) coordination of CSN agency services with other CSN providers. CSN providers must include how the provider ensures documentation is accessible to family and other providers;
(i) medical record management in the member's home;
(j) first aid and cardiopulmonary resuscitation requirements;
(k) prevention of workplace fatigue for direct-care nursing staff; and

(3) any additional administrative or clinical policies the agency chooses to implement.

(B) Nurse Teaching Activities. During a CSN services visit and established in the plan of care, the nurse may teach the member, family member, or unpaid caregivers how to manage the member's treatment regimen as applicable. Ongoing teaching should occur when there is a change in the procedure or the member's condition. All teaching activities must be documented in the member's record.

(C) Complex Care Assistant (CCA) Service Delivery.

(1) Complex Care Assistant Qualifications. CSN agencies providing CCAs and submitting reimbursement to the MassHealth agency for CCA services must ensure CCAs meet the following qualifications:
(a) be legally authorized to work in the United States;
(b) be at least 18 years old;
(c) not be on the List of Excluded Individuals and Entities as provided by the Office of Inspector General of the U.S. Department of Health and Human Services, or other applicable lists excluding individuals or entities from participating in MassHealth under state or federal law;
(d) meet reading and writing comprehension standards sufficient to effectively communicate and report on the member's CCA services; and
(e) complete training requirements for CCA services as described at 130 CMR 438.415(C)(3).

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(2) CCA Payment and Assignment.

(a) Payment. The CSN agency is required to directly pay CCAs at least 65% of the reimbursement rate established for CCA services under 101 CMR 361.00: *Rates for Continuous Skilled Nursing Agency and Independent Nursing Services*.

(b) Member Assignment. CCAs are assigned to serve a specific member by the CSN agency. CCAs may only serve members they have been specifically trained to care for.

(3) CCA Training Requirements.

(a) CSN agencies providing CCA services and submitting reimbursement to the MassHealth agency for these services must ensure all CCAs complete a competency training and comprehension program that:

1. meets the home health aide qualification standards set forth in 42 CFR 484.80(a); and

2. provides, through hands-on practical training, education on how to perform the following activities that do not require the skills of a nurse, as ordered for a specific complex care member the assistant is being trained to serve:

a. enteral G-tube/J-tube feedings

b. skin care including application of OTC products or routine G-tube/J-tube care

c. oxygen therapy

d. oral (dental) suction to remove superficial oral secretions

e. ostomy and catheter care

f. modified meal preparation

g. equipment management and maintenance (wheelchair, CPAP/BiPAP, oxygen and respiratory) and paperwork

h. braces, splints, and/or pressure stockings

i. transportation to medical providers / pharmacy (by driving the member or going alone)

j. incidental services

(b) The training and comprehension program must document the training provided and evaluate the CCA's proficiency in safely performing the activities listed in 130 CMR 438.415(C)(3)(a)2.

(c) CCAs who are evaluated and have documented competency and proficiency in safely performing the activities listed in 438.415(C)(3)(a) are exempt from completing the full training program. They are, however, required to complete any elements for which they are evaluated and not determined to be competent and proficient.

(4) Member Care Instructions. The CCA supervisor must prepare written member care instructions that are specific to the complex care member's needs and follow the member's plan of care as ordered by their physician or non-physician ordering practitioner.

(5) CCA Service Supervision. CCA services must be assessed regularly by the CCA supervisor described at 130 CMR 438.415(C)(4) to ensure quality and safe care delivery.

(a) 60-day Supervisory Visits. The CCA supervisor must make an on-site visit to the member's home no less frequently than every 60 days to assess the quality and safety of the CCA services provided. The CCA does not need to be present during these supervisory visits. The supervisory visit must be documented and maintained in the member's medical record and be clearly identified as a CCA supervisory visit note. The visit may be concurrent with the CSN agency's recertification of the plan of care.

(b) Identifying Deficiencies. If the CCA supervisor notes an area of concern in CCA services during a supervisory visit, then the CCA supervisor must make another on-site visit to observe and assess the CCA while they are providing CCA services to the member.

(c) Addressing Deficiencies. If the CCA supervisor verifies a deficiency in CCA services during an on-site visit, then the CSN agency must conduct, and the CCA must complete, reeducation and training to address the specific deficiency. Documentation of satisfactory completion of reeducation and training must be maintained in the CCA's employment file and in accordance with 130 CMR 438.415(D).

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(6) CCA 12-month Evaluation. A 12-month enhanced care evaluation must be conducted by an RN or LPN employed by the CSN agency. The evaluation must review the member-specific enhanced care tasks the CCA performs according to the applicable member's care instructions. The CCA's proficiency must be evaluated and new training provided as necessary. The CSN agency must document the 12-month evaluation and any additional training that demonstrates the CCA's continued proficiency in performing the enhanced care tasks.

(D) Recordkeeping.

(1) Administrative Records. CSN agencies must maintain administrative records in compliance with the record retention requirements set forth in 130 CMR 450.205: *Recordkeeping and Disclosure*. All records including, but not limited to the following, must be accessible and made available on site for inspection by the MassHealth agency:

(a) payroll and staff records, including any CCA's satisfactory completion of the competency training and comprehension program in the CCA's employment file, as well as any other evidence of completed staff orientation and training;

(b) financial records;

(c) staffing levels;

(d) complaints and grievances;

(e) contracts for subcontracted services, including a description of how the CSN agency will supervise the subcontracted services;

(f) contracts for independent contractor services; and

(g) job descriptions that include titles, reporting authority, qualifications, and responsibilities.

(2) Incident and Accident Records. CSN agencies must maintain an easily accessible record of member and staff incidents and accidents. The record may be kept within the individual member medical record or employee record or within a separate, accessible file.

(a) The CSN agency must submit to the MassHealth agency or its designee an incident or accident report within five days under the following circumstances:

1. an incident or accident that occurred during a CSN agency service visit that results in serious injury to the member;

2. an incident or accident resulting in the member's unexpected death even if the CSN agency was not involved in the incident or accident;

3. an incident of abuse or neglect involving a staff member of the CSN agency and the member; or

4. an incident of abuse or neglect committed by another provider supporting the member (if known).

(b) The incident or accident report must include at least the following information:

1. general information including, but not limited to, member's name and members MassHealth ID number;

2. general nature of incident or accident; and

3. any action that was taken as a result of the incident or accident including all outcomes.

(3) Member Records. In order for a medical record to completely document a service to a member, the record must describe fully the nature, extent, quality, and necessity of the care furnished to the member. When the information contained in a member's record does not provide sufficient documentation for the service, the MassHealth agency may disallow payment (*see* 130 CMR 450.205: *Recordkeeping and Disclosure*).

(a) The record maintained by a CSN agency for each member must conform to 130 CMR 450.000: *Administrative and Billing Regulations*. Payment for CSN agency services described at 130 CMR 438.000 requires complete documentation in the member's medical record. The CSN agency must maintain records for each member to whom services are provided and a copy of the member's complete medical record must be maintained in the member's home.

(b) The CSN agency must maintain an up-to-date medical record of services provided to each member. The medical record must contain at least the following in addition to the information defined at 130 CMR 438.415(D):

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1. the member's name, address, phone number, date of birth, and MassHealth ID number;
2. the name and phone number of the member's primary care physician or ordering non-physician practitioner;
3. the primary natural caregiver's name, phone number, and relationship to the member;
4. the name and phone number of the member's emergency contact person;
5. a copy of all verbal orders, properly authenticated;
6. accessible and legible progress notes for each visit, signed by the person providing the service, that include the following information:
   a. the full date of service and time that each visit began and ended;
   b. for CSN services, all treatments and services ordered by the physician or ordering non-physician practitioner included in the member's plan of care and documentation of which treatments and services were provided during the visit and the member's response;
   c. for CCA services, documentation of the treatments and services in the plan of care, and written in the member care instructions described at 130 CMR 438.415(C)(4), that were provided during the visit, as well as the member's response;
   d. any additional treatment or service not included in the member's plan of care provided, as well as the member's response, including, for CSN services, documentation of medication administration as described at 130 CMR 438.415(D)(3)(b)7;
   e. any service or treatment the member may have declined during visit and explanation of denial;
   f. the member's vital signs and any other required measurements, as appropriate;
   g. progress toward achievement of goals as specified in the plan of care including, when applicable, an explanation of why goals are not achieved as expected;
   h. a pain assessment, as appropriate;
   i. the status of any equipment maintenance and management, as appropriate; and
   j. any contacts with physicians or other health care providers about the member's needs or change in plan of care, as applicable.
7. a current medication administration list or other documentation, such as nursing notes, that includes the timing of administration as ordered, drug identification and dose, route of administration, the member's response to the medication being administered, and the signature of the person administering the medication;
8. any clinical tests and their results, as applicable;
9. a signed medical records release form, as applicable;
10. the number of authorized nursing hours for their agency per calendar week for the member;
11. the number of authorized CCA hours for the CSN agency per calendar week for the member, as applicable;
12. the names and telephone numbers of all the providers involved in co-vending care; the number of nursing hours; and, as applicable, the number of CCA hours approved for each provider by the MassHealth agency or its designee, to the best of the agency's ability;
13. a copy of the CSN agency's current prior authorization; and
14. a discharge summary, if applicable, including the reason for discharge and any activities by the CSN agency related to the discharge.

(4) Access to Records Maintained in Member's Home. The CSN agency must maintain a copy of the member's medical record in the member's home as described at 130 CMR 438.415(D)(3). The copy of the member's medical record maintained in the member's home must be provided to the member, and also the CSN agency must make every attempt to coordinate care and/or change in shifts with other CSN providers and, as applicable, CCAs.

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(5) Copies of Records. Upon the request of the member or the member's representative, the CSN agency must provide a copy of the medical record free of charge to the person or entity that the member or the member's representative designates. Additionally, upon request of the MassHealth agency or its designee, the CSN agency must provide a copy of the member's complete medical record.

(E) Statement of Fiscal Soundness.

(1) Submission Requirements. Under 130 CMR 438.404(I), CSN agencies must submit to the MassHealth agency or its designee annually and at enrollment a statement of fiscal soundness attesting to the financial viability of the CSN agency. To satisfy the fiscal soundness requirement, the CSN agency must demonstrate a cash reserve sufficient to meet one month of financial obligations in the operation of the provider's CSN agency program including, but not limited to, timely payment of staff wages and the agency's general and professional liability insurance coverage and workers' compensation insurance coverage. If using a line of credit to meet the cash reserve requirement, the agency must demonstrate the line of credit has been approved by a financial institution.

(2) Submission Due Date. The CSN agency must submit to the MassHealth agency or its designee a statement of fiscal soundness annually and by the end of May each year.

(3) Attestation. The CSN agency must attest that its available cash reserve will meet the average monthly cost at all times during the subsequent year.

(4) Noncompliance. For CSN agencies that fail to meet the fiscal soundness requirement pursuant to 130 CMR 438.404(I) and 438.415(E), the MassHealth agency may take further action, such as imposing sanctions in accordance with 130 CMR 450.238: *Sanctions*: *General* including, but not limited to, termination of the provider as a MassHealth CSN agency.

(F) Annual Staffing Report.

(1) Submission Requirements. CSN agencies must annually submit to the MassHealth agency or its designee a record of the gross hourly wage the CSN agency paid to all employee nurses the previous calendar year. The staffing report must include the median, average, and range of all direct-care nurse salaries and account for all wage differentials paid, licensure, other factors the CSN agency uses to determine nurse wages, and additional requirements issued by the EOHHS.

(2) Submission Due Date. The CSN agency must submit its staffing report to the MassHealth agency or its designee by the end of February each year.

(3) Attestation. The staffing report must include an attestation confirming, under the penalty of perjury, that the information provided in the report is accurate and complete for the previous calendar year. The attestation must be signed by the appropriate personal representative who is responsible for the CSN agency's operation in the state.

(4) Noncompliance. CSN agency providers that fail to submit the annual staffing report may be subject to sanctions in accordance with 130 CMR 450.238: *Sanctions: General*, including, but not limited to, termination as a MassHealth CSN agency.

(G) Member Complaint Resolution.

(1) Member Complaint Resolution Protocol. The CSN agency must have a member complaint resolution protocol that is maintained in its Policy and Procedure Manual described at 130 CMR 438.415(A). CSN agencies without an implemented member complaint resolution protocol may be subject to administrative sanction under 130 CMR 450.000: *Administrative and Billing Regulations.*

(a) The CSN agency must investigate complaints made by a member, the member's representative (if any), and the member's caregivers and family, including, but not limited to, complaints on the following topics:

1. treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and

2. mistreatment; neglect; verbal, mental, sexual, or physical abuse, including injuries of unknown source; and/or misappropriation of member property by anyone furnishing services on the CSN agency's behalf.

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(2) Content of Member Complaint Resolution Protocol. The member complaint resolution protocol must

(a) detail how the CSN agency will generally manage received member complaints;

(b) specify the agency employee(s) responsible for managing member complaint resolution; and

(c) indicate how the CSN agency will ensure a written response to all member complaints within two business days of the received complaint.

(3) Recordkeeping and Documentation. The CSN agency must document and maintain record of all received complaints (whether provided in person; by phone; or in writing in email, letter, or text), and the documentation must at least include

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

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

(c) a summary of the complaint;

(d) the date the provider received the complaint;

(e) the name of the person receiving the complaint;

(f) a summary of any investigation or actions taken by the CSN agency to resolve the complaint; and

(g) if the CSN agency determined that an investigation of the complaint or further action was not necessary, the name of the person making this decision and the reason for the decision.

438.416: Plan of Care Requirements

All CSN agency services must be provided under an individualized plan of care developed for the member. The physician or ordering non-physician practitioner must sign the plan of care before services are provided to the member.

(A) Providers Qualified to Establish a Plan of Care.

(1) The member's physician or ordering non-physician practitioner in consultation with the CSN agency must establish a written plan of care and the physician or ordering non-physician practitioner must recertify, sign, and date the plan of care every 60 calendar days.

(2) The CSN agency may establish an additional nursing plan of care, when appropriate, that may be incorporated into the physician or ordering non-physician practitioner's plan of care, or be prepared separately. The additional plan of care does not substitute for the physician or ordering non-physician practitioner's plan of care.

(3) If a CSN agency is co-vending a case with other CSN providers or home health agency providers, each provider is responsible for establishing a separate plan of care signed by the member's physician or ordering non-physician practitioner.

(B) Content of the Plan of Care. The orders on the plan of care must specify the total number of CSN hours and CCA hours, as applicable, that the MassHealth agency or its designee has authorized to be provided to the member. The physician or ordering non-physician practitioner must sign and date the plan of care before the CSN agency submits its claim for those services to the MassHealth agency for payment. Alternatively, the physician or ordering non-physician practitioner must comply with the verbal order provisions at 130 CMR 438.416(D). Any increase in the total number of CSN hours and CCA hours, as applicable, must be requested in advance by the physician or ordering non-physician practitioner with verbal or written orders and authorized by the MassHealth agency or its designee. If the member is enrolled in the Primary Care Clinician (PCC) Plan, the CSN agency must communicate with the member's PCC both when the goals of the care plan are achieved and when there is a significant change in a member's health status. The plan of care must also include

(1) the member's name and date of birth;

(2) all pertinent diagnoses, including the member's mental, psychosocial, and cognitive status;

(3) types of medical supplies and DME required;

(4) the member's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications, and treatments;

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438.416: continued

(5) the total number of nursing hours requested by the CSN agency, if different from the total number of CSN hours authorized by the MassHealth agency or its designee;
(6) the total number of CCA hours requested by the CSN agency, if different from the total number of CCA hours authorized by the MassHealth agency or its designee, as applicable;
(7) any teaching activities to be conducted by the nurse to teach the member, family member, or caregiver how to manage the member's treatment regimen (ongoing teaching may be necessary where there is a change in member's condition or treatment);
(8) a description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors;
(9) a plan for medical emergencies;
(10) goals toward discharge planning from CSN agency services when appropriate; and
(11) any additional items the CSN agency or physician or ordering non-physician practitioner chooses to include.

(C) Certification Period. The plan of care required under 130 CMR 438.416(A)(1) must be reviewed, signed, and dated by a physician or ordering non-physician practitioner at least every 60 days, unless the provider follows the verbal order provisions at 130 CMR 438.416(D).

(D) Verbal Orders.
(1) Notwithstanding the requirements of 130 CMR 438.416(A), services that are provided from the beginning of the certification period (*see* 130 CMR 438.416(C)) and before the ordering physician or ordering non-physician practitioner signs the plan of care are considered to be provided under a plan of care established and approved by the physician or ordering non-physician practitioner if
(a) the clinical record contains a documented verbal order from the ordering physician or ordering non-physician practitioner for the care before the services are provided; and
(b) the physician or ordering non-physician practitioner signature is on the 60-day plan of care either before the claim is submitted or within 90 days after submitting a claim for that period.
(2) If the member has other health insurance (whether commercial or Medicare), the provider must comply with the other insurer's regulations for physician or ordering non-physician practitioner signature before billing the MassHealth agency.

(E) Corrections to the Plan of Care. When correcting errors on a paper plan of care before it is signed by the physician or ordering non-physician practitioner, the CSN agency staff must cross out the error with a single line and place their initials and the date next to the correction. The use of correction fluid or correction tape on a plan of care is not permitted.

(F) Face-to-face Encounter Requirements.
(1) A face-to-face encounter between the member and an authorized practitioner is required for initial orders for CSN agency services. A face-to-face encounter is not required when the plan of care is reviewed and revised as required at 130 CMR 438.416(C) or at resumption of CSN agency services.
(2) CSN agencies must comply with the face-to-face patient encounter requirements established under 42 CFR 424.22(a)(1)(v).
(3) Documenting the Face-to-face Encounter in the Member's Record.
(a) The face-to-face encounter must be documented in the member's record either on the plan of care or in other medical notes sufficient to make the link between the individual's health conditions, the services ordered, an appropriate face-to-face encounter, and actual service provision.
(b) The ordering or acute/post-acute care attending physician or ordering non-physician practitioner may serve as the physician writing the plan of care. When the acute/post-acute care attending physician or ordering non-physician practitioner writes the plan of care, such attending practitioners must document that the face-to-face encounter is related to the primary reason the patient requires CSN agency services and that the encounter with an authorized practitioner occurred within the required timeframes. The plan of care or the medical notes must include which authorized practitioner conducted the encounter and the date of the encounter.

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438.416: continued

(c) If the face-to-face encounter was not provided by the ordering physician or ordering non-physician practitioner, the authorized practitioner who did conduct the face-to-face encounter is required to communicate the clinical findings of the face-to-face encounter to the ordering physician or ordering non-physician practitioner. This requirement is necessary to ensure that the ordering physician or ordering non-physician practitioner has sufficient information to determine the need for CSN agency services in the absence of conducting the face-to-face encounter himself or herself.

(d) The CSN agency must maintain a copy of the face-to-face documentation.

(G) MassHealth Members Enrolled in the Primary Care Clinician (PCC) Plan. If a member is enrolled in the PCC Plan, the CSN agency must provide the PCC with a copy of the member's plan of care for each certification period.

438.417: Quality Management, Utilization Review, and Reporting Requirements

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

(B) A CSN agency 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 CSN agency 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*.

(C) A CSN agency must provide the MassHealth agency or its designee any requested documentation for purposes of a member's medical necessity review for CSN agency services. The requested documentation must be submitted to the MassHealth agency or its designee within the MassHealth agency's or its designee's time specifications.

438.418: Transfers and Discharge Planning

(A) A CSN agency provider can discharge a MassHealth member upon the member's request or when the agency cannot reasonably continue to serve the member, such as under the following conditions:

(1) if the member no longer meets the clinical eligibility for CSN agency services;
(2) if the member selects another service that is duplicative of CSN agency services;
(3) if the member transitions all CSN agency services to another CSN provider; or
(4) if the CSN agency ceases operations.

(B) A member may be discharged by the CSN agency provider if the CSN agency cannot safely serve the member in the home due to the member or other persons in member's home being disruptive, abusive, or uncooperative to the extent that delivery of care is seriously impaired. Prior to discharge the CSN agency must

(1) notify the member, representative, ordering physician, and the MassHealth agency or its designee that a discharge for cause is being considered;

(2) notify the member, representative, ordering physician, and the MassHealth agency or its designee at least 14 days in advance that a discharge is planned to ensure member or provider safety. If a CSN agency has documented that the continued provision of CSN services poses significant risks to provider safety, a CSN agency may discontinue services and discharge the member immediately;

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438.418: continued

(3) make diligent efforts to solve the problem(s) present and document these efforts in the member's clinical records;
(4) provide the member and/or caregiver contact information for alternative CSN agency providers; and
(5) document the discharge and CSN agency activity related to the discharge in the member's clinical record.

(C) A CSN agency may not discharge a MassHealth member in violation of any discrimination provisions established in state or federal law.

(D) When a CSN agency makes the determination that a member no longer meets the clinical eligibility for CSN agency services and would like to proceed with discharge as described at 130 CMR 438.418(A)(1), the CSN agency must consult with the MassHealth agency or its designee at minimum 14 days prior to discharge planning to allow the MassHealth agency or its designee to perform a reassessment of the member's medical necessity for CSN services as described at 130 CMR 438.414(A)(7).

(E) When a CSN agency ceases operations, they must provide notification to the MassHealth agency, its designee, and any MassHealth members and/or caregivers it serves in accordance with 130 CMR 438.404(K). In addition, the CSN agency must
(1) provide the member and/or caregiver the number of non-billed units remaining on the prior authorization; and
(2) make diligent efforts to transfer the member's care to another CSN provider.

(F) If, upon discharging a member, the CSN agency is unable to transfer the member to another CSN provider, the CSN agency must
(1) provide the members and/or caregivers contact information for alternative CSN agency providers; and
(2) work with the MassHealth agency or its designee to assist in the transfer of members' care to another CSN provider.

438.419: Conditions of Payment

The following conditions for payment apply to all CSN agency services, in addition to conditions of payment described throughout 130 CMR 438.000.

(A) Place of Service. The MassHealth agency pays for CSN agency services provided to a member who meets the clinical criteria in 130 CMR 438.410 and resides in a noninstitutional setting, which may include, without limitation, a homeless shelter or other temporary residence or a community setting. The MassHealth agency does not pay for CSN agency services provided in a hospital, nursing facility, intermediate care facility, or any other institutional setting providing medical, nursing, rehabilitative, or related care. The MassHealth agency will pay for CSN agency services when the CSN agency must accompany the member in transport to and from an institutional setting to ensure medical stability during transitions in and out of the institutional setting. The MassHealth agency does not pay for CSN agency services provided to a member under the direct care of a hospital or emergency room, a nursing facility, an intermediate care facility, or any other institutional setting providing medical, nursing, rehabilitative, or related care.

(B) Medical Necessity Requirement. In accordance with 130 CMR 450.204: *Medical Necessity*, the MassHealth agency pays for only those CSN agency services that are medically necessary.

(C) Plan of Care. The MassHealth agency pays only for CSN agency services that are provided according to a plan of care authorized by a physician or a non-physician practitioner and meet the plan of care requirements at 130 CMR 438.416.

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438.419: continued

(D) Prior Authorization. The MassHealth agency pays for CSN agency services only when prior authorization has been obtained from the MassHealth agency or its designee, in accordance with 130 CMR 438.411.

(E) Members for Whom Services Are Approved. The MassHealth agency does not pay for CSN agency services provided to any individual other than the member who is eligible to receive such services and for whom such services have been authorized by the MassHealth agency or its designee.

(F) Multiple-patient Care and CSN Services. The MassHealth agency pays for one nurse to provide CSN services in the same household and during the same time period to more than one member, but not more than three members, if

(1) the members have been determined by the MassHealth agency or its designee to meet the criteria listed at 130 CMR 438.410(A) and (B);

(2) the members receive services in the same household and during the same time period;

(3) the MassHealth agency or its designee has determined that it is appropriate for one nurse to provide nursing services to the members simultaneously; and

(4) the CSN agency has received a separate prior authorization from the MassHealth agency or its designee for each member as described at 130 CMR 438.411.

(G) Complex Care Assistant 60-day Supervisory Visits. The MassHealth agency only pays for the 60-day CCA supervisory visit described at 130 CMR 438.415(C)(5)(a). The 60-day nurse reassessment visit may be made in conjunction with the supervisory visit.

(H) Complex Care Assistant (CCA) Intake Visits. The MassHealth agency will reimburse CSN agencies for CCA intake visits conducted by a registered nurse (RN) or licensed practical nurse (LPN) at the start of CCA services. CSN agencies may submit claims for CCA intake visits when a MassHealth member begins to receive CCA services from the agency. CSN agencies may not submit claims for CCA intake visits that take place after a member has already begun to receive CCA services.

(I) CSN Training Time. The MassHealth agency will reimburse for CSN training time when the following conditions are met:

(1) A nurse(s) employed by the CSN agency has been newly assigned to a MassHealth member and requires training to manage the member's treatment regimen;

(2) The agency nurse(s) receives in-home, member-specific training from

(a) another nurse employed by the same CSN agency who is familiar with the member's care;

(b) another CSN provider who is familiar with the member's care; or

(c) the member's natural caregiver or other family member who is familiar with the member's care.

(3) The CSN agency uses the CSN training time units during the first six weeks after the agency nurse's first shift working with the member; and

(4) The member and/or their natural caregiver or legal guardian have provided verbal consent for a new agency nurse to receive in-home, member-specific training.

CSN training time units must be used only for training a nurse to serve a specific member and may not be used for general training education or competency testing for agency nurses.

438.420: Maximum Allowable Fees

CSN agencies must accept MassHealth payment in full for CSN agency services in accordance with the rates and regulations established by EOHHS as set forth in 101 CMR 361.00: *Rates for Continuous Skilled Nursing Agency and Independent Nursing Services*. Payments are subject to the conditions, exclusions, and limitations set forth in 130 CMR 438.000 and 130 CMR 450.000: *Administrative and Billing Regulations*.

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438.421: Denial of Services and Administrative Review

(A) A failure or refusal by a CSN agency to furnish services that have been ordered by the member's attending physician or ordering non-physician practitioner and are within the range of payable services, constitutes a violation of 130 CMR 438.000 for which administrative sanctions may be imposed, with the exception of instances where the CSN agency does not have nursing availability to provide services.

(B) When a CSN agency believes that services ordered by the attending physician or ordering non-physician practitioner are not payable under 130 CMR 438.000, the CSN agency must refer the matter to the MassHealth agency for a payment decision. If and to the extent the MassHealth agency determines that the ordered services are payable, the CSN agency must provide those services.

438.422: Prohibited Marketing Activities

A CSN agency provider must not

(A) with the knowledge that a member is enrolled in a 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 capitated program in order to obtain 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 CSN agency provider to provide CSN agency 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 CSN agency provider; or

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

438.423: Providing Continuous Skilled Nursing Agency Services out of State

The MassHealth agency does not reimburse CSN agencies to provide CSN agency services outside Massachusetts unless all of the following conditions are met:

(A) The CSN agency has a current prior authorization to provide CSN agency services as described in 130 CMR 438.411; and

(B) For CSN services, the CSN agency nurse who will be providing the services has an active nursing license in the state where the member is present or that the member plans to travel to.

REGULATORY AUTHORITY

130 CMR 438.000: M.G.L. c. 118E, §§ 7 and 12.

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Docket # 309

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Notice of Correction

Regulation Filing *To be completed by filing agency*

CHAPTER NUMBER: **205 CMR 143.00**

CHAPTER TITLE: **Gaming Devices and Electronic Gaming Equipment**

AGENCY: **Massachusetts Gaming Commission**

ORIGINAL PUBLICATION REFERENCE: **1399** *Date:* **9/6/19**

SUMMARY OF CORRECTION:

When 205 CMR 143 was initially promulgated in 2014, 205 CMR 143.12 referenced internal control submissions in accordance with 205 CMR 138.01. That is an incorrect citation as 205 CMR 138.01 is the definitions section. The correction would change the reference to 205 CMR 138.02(1).

AGENCY CONTACT: **Autumn Birarelli** PHONE: **(617)533-9716**

ADDRESS: **101 Federal Street, 12th Floor, Boston MA 02110**

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: **Sep 24 2026**

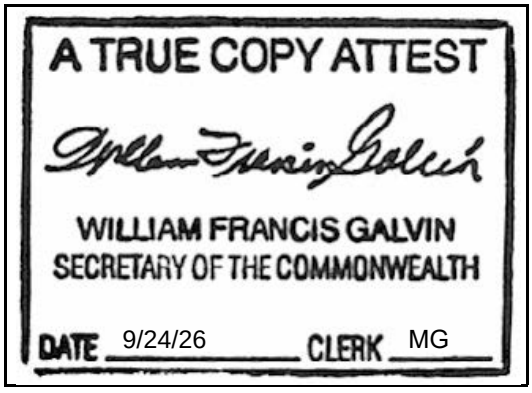
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/6/19**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
504.3 & 504.4	**504.3 & 504.4**



143.09: Electronic Table Game Systems

(1) A gaming licensee and gaming device vendor shall comply with and the Commission adopts and incorporates by reference *Gaming Laboratories International, LLC Standard GLI-24: Electronic Table Game Systems*, version 1.3, released September 6, 2011, subject to the following amendments:

(a) Delete section 1.1.

(b) Delete section 1.3.

(2) An electronic table game shall be considered a slot machine in accordance with M.G.L. c. 23K, § 2, unless the simulation requires the intervention of a gaming employee prior to the final determination of winnings.

(143.10: Dealer Controlled Electronic Table Games: Reserved)

(143.11: Wireless Gaming Systems: Reserved)

143.12: Network Security

As part of its internal controls submission in accordance with 205 CMR 138.02(1), a gaming licensee shall annually submit an infrastructure and data security plan to the Commission for review and approval. The plan should employ best practices (*i.e.*, NIST SP 800-53 or ISO/IEC 27001) for protecting infrastructure and data.

143.13: Player User Interface Systems

A gaming licensee and gaming device vendor shall comply with and the Commission adopts and incorporates by reference *Gaming Laboratories International, LLC Standard GLI-28: Player User Interface Systems*, version 1.0, released February 14, 2011, subject to the following amendments:

Delete section 1.1.

(143.14: Card Shufflers and Dealer Shoes: Reserved)

(143.15: Electronic Raffle Systems: Reserved)

143.16: Communications Protocols

A slot machine or other electronic gaming device in operation in a gaming establishment may operate any industry standard open communication protocol approved by the Commission, provided that the system is fully compatible with the Commission's central monitoring system and all required gaming devices, and is capable of providing all data required by the Commission. A gaming licensee shall not operate any slot machine or other electronic gaming device in a gaming establishment, unless the slot machine:

(a) is able to bi-directionally communicate with the Commission's central monitoring system;

(b) transmits, on a per bet basis, data relative to amounts wagered, amounts won, cash in, cash out, and similar financial information necessary for tax collection and auditing;

(c) allows remote verification of gaming device software using a Commission approved verification tool;

(d) allows remotely activating and disabling slot machines; and

(e) transmits data relative to any restarts, shutdowns, resets, game changes, door open, and other maintenance events.

REGULATORY AUTHORITY

205 CMR 143.00: M.G.L. c. 23K, §§ 4(28) and 5.

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Docket # 120

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Notice of Correction

Regulation Filing *To be completed by filing agency*

CHAPTER NUMBER: **225 CMR 20.00**

CHAPTER TITLE: **SOLAR MASSACHUSETTS RENEWABLE TARGET (SMART) PROGRAM**

AGENCY: **Department of Energy Resources**

ORIGINAL PUBLICATION REFERENCE: **1556** *Date:* **9/12/25**

SUMMARY OF CORRECTION:

This correction deletes a duplicate instance of the definition for "Public Entity Solar Tariff Generation Unit" from 225 CMR 20.02.

AGENCY CONTACT: **Samantha Meserve** PHONE: **617-823-2214**

ADDRESS: **100 Cambridge St., 9th Floor, Boston, MA 02114**

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: **Sep 22 2026**

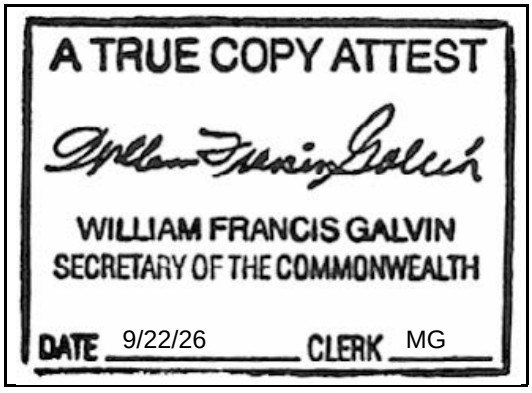
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **9/12/25**

CODE OF MASSACHUSETTS REGULATIONS

Remove these Pages:	*Insert these Pages:*
175 & 176	**175 & 176**



20.02: continued

MDAR. The Massachusetts Department of Agricultural Resources established by M.G.L. c. 20, § 1.

Megawatt (MW). A unit of power equal to one million watts, as measured in alternating current (AC).

Megawatt-hour (MWh). A unit of electrical energy or work equivalent to one million watts of power operating for one hour.

Municipality. A city or town in the Commonwealth of Massachusetts that has been issued a public identification number by the DPU pursuant to 220 CMR 18.00: *Net Metering*.

NEPOOL GIS. The New England Power Pool Generation Information System, which includes a generation information database and certificate system, operated by the New England Power Pool, its designee or successor entity, that accounts for Generation Attributes of electrical energy consumed and generated within, imported into, or exported from the ISO-NE Control Area.

Net Metered Generation Unit. A Solar Tariff Generation Unit that is also enrolled and compensated as Class I Net Metering Facility, Class II Net Metering Facility, or Class III Net Metering Facility, as defined under 220 CMR 18.02: *Definitions*.

Non-net Metered Generation Unit. A Solar Tariff Generation Unit that is also enrolled and compensated as a State Qualifying Facility under 220 CMR 8.00: *Sales of Electricity by Qualifying Facilities and On-site Generating Facilities to Distribution Companies, and Sales of Electricity by Distribution Companies to Qualifying Facilities and On-site Generating Facilities*.

On-site Load. Any new or existing electric load located at the site of a Solar Tariff Generation Unit, including any parasitic load that may result from the installation of the Solar Tariff Generation Unit, and that is wired to receive a portion of the electrical energy output from the Solar Tariff Generation Unit before the balance of such output passes through the Solar Tariff Generation Unit's metered interconnection onto the electric grid.

Other Governmental Entity. A Department or agency of the Commonwealth, and any other entity that has been issued a public identification number by the DPU pursuant to 220 CMR 18.00: *Net Metering*.

Owner. Any person or entity that, alone or in conjunction with others, has legal ownership of a Solar Tariff Generation Unit.

Preliminary Statement of Qualification. A document issued by the Department that qualifies a STGU under 225 CMR 20.00. Such qualification is contingent upon the STGU reaching mechanical completion within its Reservation Period and receiving a Final Statement of Qualification.

Primary Installer. The primary entity responsible for a Solar Tariff Generation Unit's installation. The Primary Installer must be a professional contractor licensed to conduct business in Massachusetts. Any electrical work performed on the installation must be conducted by an electrician holding a valid and current license in Massachusetts. The Primary Installer is directly responsible for turnkey project management and installation work, although the installation work may be sub-contracted. Homeowners or other individuals are not eligible to be a Primary Installer unless they are a Massachusetts licensed electrician completing an installation on their own property.

Priority Habitat. Means Priority Habitat as defined in 321 CMR 10.02: *Definitions*.

Public Entity Solar Tariff Generation Unit. A Solar Tariff Generation Unit that is:

(a) Sited on property owned by a Municipality or Other Governmental Entity and is either:
    1. owned or operated by a Municipality or Other Governmental Entity; or

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20.02: continued

2. the Owner has assigned 100% of its output to Municipalities or Other Governmental Entities; or

(b) Sited on privately owned property and is either:

1. Owned or operated by the Municipality in which the Solar Tariff Generation Unit is sited; or

2. the Owner has assigned 100% of its output to the Municipality or Other Governmental Entities in the Municipality in which the Solar Tariff Generation Unit is sited.

Publication Date. The date established by Department promulgation of revisions to the SMART Program pursuant to 225 CMR 20.07(5), specifically, April 15, 2020.

Renewable Generation. Means Renewable Generation, as defined in 225 CMR 14.02: *Definitions*.

Renewable Generation Attribute. Means a Renewable Generation Attribute, as defined in 225 CMR 14.02: *Definitions*.

Reservation Period. The period of time during which a Solar Tariff Generation Unit is entitled to a Statement of Qualification and Capacity Block reservation prior to the Solar Tariff Generation Unit's receipt of notice of authorization to interconnect from the Distribution Company.

RPS Class I Renewable Generation. Means RPS Class I Renewable Generation, as defined in 225 CMR 14.02: *Definitions*.

RPS Class I Renewable Generation Attribute. Means a RPS Class I Renewable Generation Attribute, as defined in 225 CMR 14.02: *Definitions*.

RPS Class I Renewable Generation Unit. Means a RPS Class I Renewable Generation Unit, as defined in 225 CMR 14.02: *Definitions*.

SMART Tariff. The SMART Provision tariff for each individual Distribution Company as reviewed and approved by the DPU, as may be amended from time to time.

Solar Massachusetts Renewable Target (SMART) Program. The solar incentive program established pursuant to 225 CMR 20.00.

Solar Program Administrator. The program administrator for 225 CMR 20.00 that is selected pursuant to the process set forth in 225 CMR 20.09.

Solar Tariff Generation Unit. A Generation Unit that generates electricity using solar photovoltaic technology and meets all of the eligibility criteria set forth in 225 CMR 20.05 and 20.06.

Standalone Solar Tariff Generation Unit (STGU). A Solar Tariff Generation Unit that serves no associated On-site Load other than parasitic or station load utilized to operate the Generation Unit or coupled Energy Storage System.

State Qualifying Facility. Means a Qualifying Facility, as defined by the DPU in 220 CMR 8.02: *Definitions*.

Statement of Qualification. A document issued by the Department that qualifies a Solar Tariff Generation Unit under 225 CMR 20.00.

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Docket # 31

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Notice of Correction

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**

ORIGINAL PUBLICATION REFERENCE: **1579** *Date:* **7/31/26**

SUMMARY OF CORRECTION:

Correction of five instances where the word "practicum" was mistakenly deleted from 262 CMR 2.00.

AGENCY CONTACT: **Sheila York** PHONE: **781-636-7138**

ADDRESS: **250 Washington St., 2nd Floor, Boston MA 02108**

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: **Sep 24 2026**

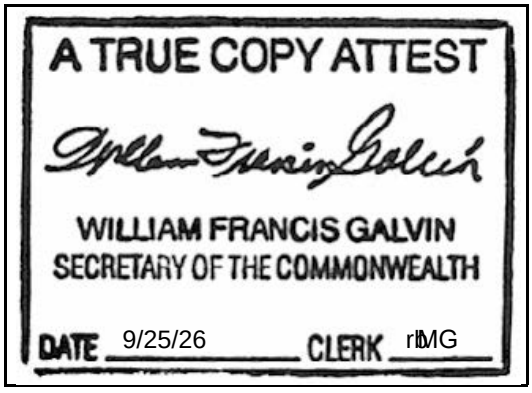
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

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

CODE OF MASSACHUSETTS REGULATIONS

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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 *practicum* provides for the development of clinical Mental Health Counseling and group work skills under supervision. A practicum 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

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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 *Practicum* 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.

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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 *Practicum*; 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 *Practicum* 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;

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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;

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Docket # 32

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Notice of Correction

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**

ORIGINAL PUBLICATION REFERENCE: **1579** *Date:* **7/31/26**

SUMMARY OF CORRECTION:

In the Section list, the title of Section 3.05 is being corrected to read "Legally Protected Heath Care Activity."

AGENCY CONTACT: **Sheila York** PHONE: **781-636-7138**

ADDRESS: **250 Washington St., 2nd Floor, Boston MA 02108**

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: **Sep 24 2026**

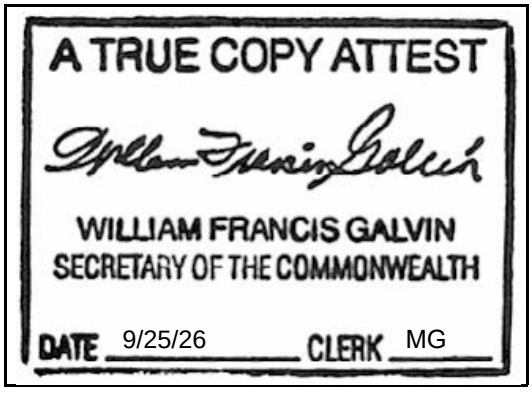
Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

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CODE OF MASSACHUSETTS REGULATIONS

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262 CMR 3.00: REQUIREMENTS FOR LICENSURE AS A MARRIAGE AND FAMILY THERAPIST

Section

3.01: Preface
3.02: Definitions
3.03: Licensure Eligibility Requirements
3.04: Reciprocity
3.05: Legally Protected Health Care Activity

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.

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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.

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Docket # 301

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Notice of Compliance

Regulation Filing *To be completed by filing agency*

CHAPTER NUMBER: **961 CMR 2.00**

CHAPTER TITLE: **RULES AND REGULATIONS**

AGENCY: **State Lottery Commission**

THIS REGULATION WAS ORIGINALLY FILED AS AN EMERGENCY:

Published in Massachusetts Register Number: **1580** Date: **8/14/26**

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.*

Notice to the Local Government Advisory Commission - 7/22/2026
Notice of Public Hearing published in the Boston Globe - 8/17/2026
Notice of Public Hearing published in the Boston Herald - 8/17/2026

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: **09/10/2026**

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: **September 14, 2026**

AGENCY CONTACT: **Gregory M. Polin, General Counsel** PHONE: **781-849-5515**

ADDRESS: **150 Mount Vernon Street, Suite 300, Dorchester, MA 02125**

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: **Sep 22 2026**

Publication - *To be completed by the regulations Division*

MASSACHUSETTS REGISTER NUMBER: **1584** DATE: **10/9/26**

EFFECTIVE DATE: **7/21/26**

CODE OF MASSACHUSETTS REGULATIONS

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A TRUE COPY ATTEST

WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

DATE 9/22/26 CLERK MG

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961 CMR 2.00: RULES AND REGULATIONS

Section

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2.01: Introduction

The Massachusetts State Lottery ("Lottery") was established by the enactment of St. 1971, c. 813. This law created a State Lottery Commission ("Commission") in the office of the State Treasurer who is Chairman of the Commission. Other members of the Commission are: the Secretary of Public Safety, the State Comptroller, and two persons appointed by the Governor for terms coterminous with that of the Governor. The Lottery directs the State Treasurer to appoint a Director of the Lottery, subject to the approval of the Governor.

Revenues derived from ticket sales from Sales Agents for the Lottery at the point of sale must be distributed as follows

(a) no less than 45% must be paid to holders of winning tickets;

(b) not more than 15% may be used for operating costs; and

(c) the balance must be distributed to the Local Aid Fund for the benefit of all the cities and towns in Massachusetts.

Revenues derived from the sale of lotteries conducted online, over the internet, through the use of a mobile application or through any other means as authorized by M.G.L. c. 10, § 24 except for those enumerated in M.G.L. c. 10, § 25(a) will be distributed as follows:

(a) payment of prizes to the holders of winning tickets or shares;

(b) not more than 5% of the total revenues accruing from the online sale of lottery tickets or shares may be used for operation and administration costs; and

(c) the balance must be distributed to the Early Education and Care Operational Grand Fund.

For prizes of games sold through both channels that are $601.00 or more, the prize payout for a winning ticket shall be distributed proportionately based on the percentage of sales from revenue collected at retail locations by sales agents, as set forth in M.G.L. c. 10, § 25(a), and from revenue collected online, as set forth in M.G.L. c. 10, § 25(b), for the applicable draw period. The balance to be distributed to aid cities and towns in Massachusetts and to the Early Education and Care Operation Grant Fund respectively under M.G.L. c. 10, §§ 25(a) and (b) shall be proportional to the revenues collected under each Section.

For prizes that are less than $601.00, 100% of the prize payout shall be distributed based upon whether the winning ticket was bought at a retail location or online. If the winning ticket is bought online, then 100% of the prize payout will come from revenues collected online, as set forth in M.G.L. c. 10, § 25(b). If the winning ticket is bought at a retail location, then 100% of the prize payout will come from revenues collected at retail locations, as set forth in M.G.L. c. 10, § 25(a).

Additional rules detailing the calculation of balances identified in M.G.L. c. 10, §§ 25(a) and (b) may be set by the Director in an Administrative Bulletin.

961 CMR 2.00 has been enacted pursuant to and under the authority of M.G.L. c. 30A and M.G.L. c. 10, § 24.

2.02: General Regulations

961 CMR 2.00 is established by the Massachusetts State Lottery Commission to define and regulate the operation and administration of the Massachusetts State Lottery. In addition to 961 CMR 2.00, rules for specific games, drawings or other matters may be found in Administrative Bulletins periodically issued by the Director.

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2.03: Definitions

Act or Law means M.G.L. c. 10, §§ 22 through 35 and § 36.

Administrative Bulletin means a set of rules or guidelines issued by the Director for the purpose of detailing the rules, procedures or specific details of games and/or drawings and other matters that may arise from time to time in the course of business.

Bank means and includes all banks, banking associations, cooperative banks, credit unions, trust companies and any other type or form of banking institution organized under the authority of the Commonwealth of Massachusetts or the United States of America whose principal place of business is within the Commonwealth of Massachusetts and is designated to perform such functions, activities, or service in connection with the operations of the Lottery for the deposit and handling of Lottery funds.

Claims Center, Claim Center or Office means any place designated by the Lottery where the holder or his or her representative may file a claim upon a paper form supplied by the Lottery for payment or acknowledgment of a Lottery prize and the submission of the winning ticket.

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Commission means a board of five members consisting of the State Treasurer, Secretary of Public Safety or his or her designee, the State Comptroller, or his or her designee, and two persons appointed by the Governor with the powers and authority to conduct a state Lottery as conferred by law.

Digitally Created Barcode means a machine-readable code which may include, but is not limited to, a quick response (QR) code, that is approved by the Lottery in its sole discretion and accepted by the On-line System.

Director means the Director of the Massachusetts State Lottery. Any reference to powers and duties of the Director also means the Director's authorized designee.

Gift Certificate means a document printed in fixed dollar amount redeemable for Lottery products.

High-frequency Prize Winner means a person, as defined in 961 CMR 2.03, who submits at least 20 claims for Lottery prizes, each with a value of at least $1,000.00, within any period of 365 days.

Instant/Pull Tab Ticket means a Lottery ticket issued by the State Lottery. Any reference herein to instant, instant ticket, or instant game shall have the same meaning as, and may be used interchangeably with, scratch, scratch ticket or scratch game respectively.

Lottery or State Lottery means the Lottery established and operated pursuant to M.G.L. c. 10, §§ 22 through 35 and § 36.

Lottery Online and/or Digital Property means one or more websites, mobile applications, or other on-line and/or digital services established by the Lottery.

Mobile Claim means a claim submitted through a Lottery Online and/or Digital Property in accordance with the Mobile Claim Process.

Mobile Claim Process means the terms, conditions, and requirements set, by the Director in his or her discretion for the submission and processing of Mobile Claims, which shall require, at a minimum, the claimant to submit sufficient claim and winning ticket information as determined by the Director, and which includes, but is not limited to, the claimant to have a registered player account for Mobile Claims, as defined by the Lottery to be valid, the claimant's digital signature, and the submission of barcode(s) for a valid ticket to be automatically verified against the Lottery's computer gaming system for eligibility.

On-line System means the Lottery's On-line Computer Wagering System consisting of ticket issuing terminals, central processing equipment and a communications network.

On-line Instant Ticket Cashing means a procedure by which Sales Agents are required, as a prerequisite to cashing, to validate instant tickets *via* an on-line bar code scanner.

On-line Ticket means a ticket produced on official paper stock in an authorized manner from the Lottery's on-line computer system.

Person means and includes any individual, association, corporation, club, trust, estate, society, company, joint stock company, receiver, trustee, designee, referee, executor, administrator, commissioner, charitable institution, fraternal organization, guardian, custodian, any legal entity created by law, all natural individuals in all capacities whether appointed by a court or otherwise and any other combination of individuals or legal entities. Person shall also be construed to mean and include all departments, commission, agencies, and instrumentalities of the Commonwealth of Massachusetts, including counties and municipalities, agencies, and instrumentalities thereof.

Prize means any award, financial or otherwise, awarded by the State Lottery.

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Prize Winner means the individual who represents him or herself to be the winner of a single prize or one or more individuals who represent themselves as winners of a portion of a single prize as identified on Internal Revenue Service Form 5754 at the time the claim is filed and reported as such to the Internal Revenue Service and the Department of Revenue.

Promotions means limited time marketing initiatives to promote the Lottery and its products, which may include special offers.

Remote Ticket Cashing Service means a function provided by the Lottery through the Lottery Online and/or Digital Properties which is designated to allow users to file Mobile Claims of eligible Lottery tickets, and transfer awarded prize winnings to a bank account pursuant to the Mobile Claims Process.

Sales Agent means a person who has been licensed to sell Lottery tickets or register bets on behalf of the player under M.G.L. c. 10, §§ 22 through 36.

Trust Account means a designated dedicated bank account for the receipt of Lottery proceeds.

Quic Pic or Quick Pick means a player option in which number selections are determined at random by computer software.

2.04: Lottery Director

The Director of the Massachusetts State Lottery shall supervise and administer the operation of the Lottery pursuant to M.G.L. c. 10, § 26.

2.05: Licensed Sales Agents

The Director shall license as Sales Agents such persons who, in his or her opinion, will best serve the public interest and convenience and promote the sale of tickets. Said Sales Agents must enter into a Lottery Sales Agent Agreement, on a form approved by the Director, permitting them to sell such tickets or shares as in the Director's opinion will promote the best interests of the Commission and produce maximum revenue, but a Sales Agent need not be permitted to sell all the Lottery games operated by the Commission. Each Licensed Sales Agent may be required to provide a list of guarantors who agree to be personally liable for any and all debts incurred by the Licensed Sales Agent.

2.06: Intervals and Ticket Amounts

Lottery tickets may be initiated in such amounts and at such intervals as may be determined in the discretion of the Commission or Director.

2.07: Erroneous or Mutilated Tickets

Lottery tickets erroneously printed, defective in any way, or mutilated when received by Sales Agent are to be returned by the Sales Agent immediately to the Lottery. Credit may be allowed for said tickets. Each ticket, to obtain credit or to claim a prize, must contain with legible certainty the Lottery number or winning symbols, serial number, and, if applicable, the drawing date. Unless the Director determines that a mutilated Lottery or otherwise defective or invalid ticket is genuine, no credit or prize will be issued to the holder of said ticket.

2.08: Lottery Sales Agents Application, Sales Agent Update and License

(1) Application.

(a) Any person may apply for a license to sell Lottery tickets as a Sales Agent by first filing with the Director an application on a form approved by the Director, said form to be signed under the pains and penalties of perjury, together with any supplements thereto.

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a. Use an implement acceptable to the Lottery to mark the slip

b. Place no more than one mark (—) in any column

c. Place a mark (—) in at least one column under each of the sections labeled PICK YOUR NUMBER, MARK YOUR BET(S), CHOOSE NUMBER OF DRAWS and SELECT TIME OF DRAW

d. Choose the number he or she wishes to play using the section of the slip labeled PICK YOUR NUMBER and mark an "—" in one or more of the columns to reflect his number choice.

e. Indicate the specific bets he or she wishes to make using the section labeled MARK YOUR BET(S); mark an "—" in the box corresponding to the money amount he wishes to wager for each specific bet type shown in the column he or she wishes to wager for each specific bet type shown in the column headings; mark as many Bet Selection columns as he or she desires to play. If a bettor wishes to bet amounts other than or in addition to those shown, he or she must use additional bet slips.

f. Choose the number of draw(s) he or she wishes his or her bet to be active by using the section column labeled "CHOOSE NUMBER OF DRAWS" and mark an "—" in the box corresponding to that number. Active days per week are Monday through Sunday (seven days). All bet selections made on the same slip will be active for the number of draw(s) specified. If a bettor desires to make multiple bet selections and have them active for a different number of draws, he or she must use separate slips. A bettor must make an entry in CHOOSE NUMBER OF DRAWS section even if his/her play is for one draw only.

g. Select the draw times he or she wishes his or her bet to be active by using the section labeled “SELECT TIME OF DRAW” and mark an “—“ in the box corresponding to the time of day desired. Drawing times are mid-day and evening seven days a week. If a bettor selects mid-day, the bet will be valid for mid-day drawings only for the number of draws selected. If a bettor selects evening, the bet will be valid for evening drawings only for the number of draws selected. If a bettor selects both, the bet will be valid for both mid-day and evening drawings for the number of draws selected, commencing with the draw after the bet is placed. If a bettor desires to make multiple bet selections and have them active for a different number of draws, he or she must use separate slips. A bettor must make an entry in SELECT TIME OF DRAW section even if his or her play is for one draw only.

2. Only official bet slips issued by the Lottery may be used to place bets.

3. Bet slips shall have no pecuniary or prize value, or constitute evidence of purchase or number selections.

(d) A bet may be canceled on the day it is placed prior to the close of betting for the selection of the winning number on the draw of the bet by using the cancellation procedure at the betting terminal. Bettors shall be entitled to a full refund of their bet upon cancellation and in no event shall a canceled ticket be entitled to a prize.

(e) Bets may be placed with any Lottery Numbers Game agent operating a terminal or at any Lottery operated facility accepting Numbers Game bets.

(f) Bets may be placed at any time during the day at such time or times as will be determined by the Director, but all bets must be placed and accepted by the Lottery computer prior to the close of betting for the selection of the winning number on the draw(s) for the bet or bets. In the event that a bet is placed subsequent to the drawing of the winning number, that bet shall be void and the Lottery's liability shall be limited to a refund of the amount of the bet.

(g) The bet as represented by the ticket produced by the computer terminal is the only bet on which a prize may be claimed. Bettors are cautioned to examine their bet ticket at the time it is issued prior to the appropriate number selection in order to ensure that the ticket accurately represents the correct number selection, bet selection, effective day or days, the correct drawing time(s) and purchase price.

(h) In the event that the Sales Agent or the computer terminal errs when the bet is placed, it shall be the responsibility of the bettor to determine that an error has been made and to request cancellation (provided betting for the draw has not closed) of the bet and the return of the purchase price. The Lottery shall not be liable for the payment of a prize because of Sales Agent or computer terminal error when the bet is placed.

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(i) The Lottery shall not be liable for the payment of a prize in the event that the bet is canceled intentionally or through inadvertence of the Sales Agent.

(j) It shall be the responsibility of the person who collects the prize to make certain that he or she is receiving the correct sum of prize money. The Lottery shall not be liable for any underpayment except that the Director in his or her discretion may direct that an additional prize payment be made in order to correct an obvious mistake.

(3) Betting Tickets.

(a) The betting ticket is a bearer instrument until a Mobile Claim is submitted, or if no valid Mobile Claim is submitted, then until signed by owner and prize may be claimed by anyone in possession of unsigned winning ticket if no valid Mobile Claim has been submitted.

(b) Sales Agents may pay claims up to and including the sum of $600.00. Any claim of more than $600.00 shall be made on a claim form supplied by the Lottery at all Sales Agent locations or pursuant to the Mobile Claim Process. The procedure to be followed for claims in excess of $600 and 961 CMR 2.00 governing each procedure shall be pursuant to 961 CMR 2.38.

(4) Lost, Mislaid or Stolen Numbers Game Tickets. The Lottery Commission may pay a prize to the holder of a Numbers Game ticket and the payment of such prize shall absolve the Commission of any further liability with respect to such ticket. In determining whether a prize has been paid on a Numbers Game Ticket, the Commission may rely solely upon its computer records in determining whether or not a particular prize has been paid and the status as determined by the Lottery's computer shall be binding on the holder. In the event of a lost, stolen or mislaid ticket, the Director may order an investigation, and if he or she is satisfied that the claimant in fact is the owner of the lost, stolen or mislaid ticket and it has not otherwise been paid, he or she may in his or her discretion pay the prize to the claimant thereof. All payments of prizes on lost, stolen or mislaid tickets shall not be made for a period of 90 days in the case of a prize of $200.00 or less and shall not be made for one year if the prize exceeds $200.00, unless the Director in his or her discretion shall decide otherwise.

(5) Sales Agents. Sales Agents are required to pay to the Lottery all sums due on the date established for payment. Failure to make payment when due or upon notice from the custodial bank that funds are not available will result in the immediate shut down of that Sales Agent's terminal and the Sales Agent's license to sell the Numbers Game and/or any other Lottery game shall be subject to revocation, suspension or nonrenewal pursuant to the provisions of 961 CMR 2.13.

(6) Payoffs. Prizes will be paid on a pari-mutuel basis in such amounts and in accordance with such formulae as may be established by the Director by Administrative Bulletin. The Director may by Administrative Bulletin establish minimum prizes, rules for rounding payments to the nearest dollar or otherwise, rules for subtracting overpayments from a pool from subsequent pools and adding underpayments from a pool to subsequent pools, and such other matters as may be necessary or desirable for the proper operation of the game.

(7) Multiplier Feature. The Massachusetts State Lottery Commission may offer a multiplier feature, which may be known by an associated trade name, for the Numbers Game. This is a feature by which a bettor, for an additional wager, may increase the pari-mutuel prize amount by a factor depending upon a multiplier number that is drawn prior to the Numbers drawing. Rules regarding the multiplier feature shall be set by the Director in an Administrative Bulletin governing the game.

(8) All other provisions of 961 CMR 2.00 shall, if applicable, apply to the On-line Numbers Game System.

2.53: On-line Number Selection Game – MEGABUCKS

As of November 12, 2023, MEGABUCKS DOUBLER shall be known as the trade name MEGABUCKS.

(1) Valid Bet. Except as otherwise provided in 961 CMR 2.53(1), a valid bet on MEGABUCKS using the On-line System shall be a bet which is:

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(9) Season Tickets.

(a) Season Tickets may be sold by the Massachusetts State Lottery Commission and by licensed Sales Agents operating on-line terminals and off-line by Season Ticket application.

(b) Season Tickets will be sold in the following manner:

1. Plan "A" - 52 consecutive drawings sold for the price of $50.00.
2. Plan "B" - 104 consecutive drawings sold for the price of $100.00.
3. Plan "C" - 26 consecutive drawings sold for the price of $25.00.

(c) The Director reserves the right to adjust both price and number of drawings as defined in 961 CMR 2.53(9)(b).

(d) Season Tickets become effective and eligible to win a prize starting with the effective date printed on the ticket. Season Tickets are not effective on the date of purchase.

(e) Based upon the Plan selected as defined in 961 CMR 2.53(9)(b), Season Tickets, unless renewed, automatically expire at the end of 52, 104 or 26 drawings. If, upon renewal, the customer requests a change in any or all of the six numbers to be played, his/her renewal application shall be treated as a new ticket rather than a renewal and the effective date of said new ticket will be the expiration date of the previous ticket. Renewal applications received after the time period specified upon the renewal form may be assigned a new effective date.

(f) Purchasers of Season Tickets shall select the six numbers he/she wishes to appear on the Season Ticket. Said purchasers are cautioned to examine his/her ticket upon purchase and prior to its effective date to assure the numbers printed represent the numbers desired. The Lottery will only be liable for the payment of a prize based upon the numbers as they appear on the Season Ticket and registered on the Lottery's Computer. In the event of a conflict, the numbers as registered on the Computer shall control.

(g) Purchasers of Season Tickets may elect to use the "quic pic" feature for the selection of his/her six numbers. The six numbers will be randomly selected by the Lottery Computer and printed on the Season Ticket. (The Lottery will only be liable for the payment of a prize based upon the numbers as they appear of the Season Ticket and registered on the Lottery's Computer. In the event of a conflict, the numbers as registered on the Computer shall control.)

(h) In the event the Lottery receives a Season Ticket application with less than six numbers selected by the applicant, the Lottery may randomly select all or any of those omitted numbers to assure each application contains six numbers.

(i) In the event the Lottery receives a Season Ticket application with seven or more numbers selected, the Lottery may randomly delete one or more of the numbers selected in order to obtain a valid six number ticket.

(j) The owner of a Season Ticket purchased through the On-line System must register his/her name with the Lottery on a form provided with the purchase of the ticket if prizes are to be paid automatically and renewal information to be sent.

(k) When more than one name appears on the application or registration form, the Lottery may select the first name listed and designate him/her as agent for collection. In the event the ticket wins a prize, it will be the responsibility of the recorded agent to make known to the Lottery, Internal Revenue Service, and the Department of Revenue, the name, social security number and proportionate share of each of the winners.

(l) A MEGABUCKS Season Ticket purchased through an off-line application is not effective until it is registered on the Lottery's computer and a Season Ticket issued to the applicant regardless of whether or not payment for such ticket has been accepted by the Commission prior to such registration or otherwise.

(m) The Director may change the field of numbers from which winning numbers will be selected to a number greater or less than the field available at the time the Season Ticket is purchased. In the event the field is enlarged, a Season Ticket holder may request in writing at least four weeks before the effective date of such change that his/her number selection be changed; provided, however, this option shall be limited to changing one or more numbers from the field of numbers in existence at the time the ticket was purchased to one or more of the numbers added to that field. In the event the field is decreased and one or more of the numbers selected at the time the tickets was purchased is eliminated from the field of available numbers, the holder may request, in writing, that the numbers so eliminated be replaced by one or more numbers from the field of numbers remaining after said decrease. In the event the holder fails to exercise this option at least four weeks prior to the effective date of such change, the Lottery may randomly select new numbers on the holders behalf in accordance with the limitations contained in 961 CMR 2.53(9)(m).

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(n) In the event the Commission cancels the operation of MEGABUCKS, the amount paid for drawings so canceled shall be refunded to the registered holder and said refund shall constitute the Commission's sole obligation to the holders of MEGABUCKS Season Tickets in the event of said cancellation.

(o) All other provisions of 961 CMR shall, if applicable, apply to the Season Ticket MEGABUCKS.

(10) Multiplier Feature. The Massachusetts State Lottery Commission may offer a multiplier feature, which may be known by an associated trade name, for the MEGABUCKS Game. This is a feature by which a bettor, for an additional wager, may increase the prize amount for non-jackpot prize levels by a factor depending upon a multiplier number that is drawn prior to the MEGABUCKS drawing. Rules regarding the multiplier feature shall be set by the Director in an Administrative Bulletin governing the game.

(11) Notwithstanding the foregoing, bets may be placed by the player via the iLottery Platform pursuant to the applicable provisions of 961 CMR 2.53 as determined by the Director and pursuant to the terms and conditions of the iLottery Platform, as set forth in 961 CMR 2.69.

(12) Miscellaneous. All other provisions of 961 CMR shall, if applicable, apply to the On-line Number Selection Game – MEGABUCKS.

2.54: On-line Semi-weekly Number Selection Game – MASS MILLIONS

(1) Valid Bet. Except as otherwise provided in 961 CMR 2.54(1), a valid bet on MASS MILLIONS using the On-line System shall be a bet which is:

(a) Placed with and accepted by a Sales Agent licensed to sell MASS MILLIONS or by a Lottery facility specifically designated for the purpose.

(b) Paid for in full at the time and place the bet is placed.

(c) Recorded correctly on a computer generated ticket in accordance with these rules.

(d) Represented by a ticket generated by a Lottery computer terminal. The ticket must contain the following information:

1. The numbers selected
2. The number of draws played
3. The date(s) of the drawing for which the bet is eligible
4. The amount wagered
5. A terminal identification number
6. An 18-digit ticket serial number
7. A machine readable (Bar Code) ticket serial number.
8. A verifiable numeric representation of the information contained on the ticket consistent with the information contained in the Lottery's computer records.

(e) Accepted by the Lottery Computer prior to the drawing of the winning numbers on the drawing date shown on the ticket.

(f) In the event of a contradiction between information as printed on the ticket and as accepted by the Lottery Computer, the bet accepted by the Lottery Computer shall be the valid bet.

(2) Placing Bets.

(a) Bets may be placed by the bettor orally instructing the Sales Agent of his/her number selections or requesting a "quic pic" and the Sales Agent then registering the bet via the terminal keyboard or by preparing a betting slip which is then entered into the terminal. Betting slips shall be prepared as follows:

1. Pick six numbers by marking a "|" in each of the six boxes containing the numbers selected by the bettor. "|" marks must remain inside each box. Bettor must use either pencil or blue ballpoint pen.
2. Only official bet slips issued by the Lottery and hand marked by the bettor(s) may be used to place bets. The use of mechanical, electronic, computer generated or any other method of marking betting slips is prohibited.
3. Bet slips shall have no pecuniary or prize value, or constitute evidence of purchase or number selections.

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(b) The terminal must generate a ticket as described in 961 CMR 2.54(1)(d) which is given to the bettor as his/her receipt.

(c) Bets cannot be canceled by the sales agent. Sales agents shall be liable for the price of all MASS MILLIONS tickets sold and accepted by the Lottery Computer as a valid bet. A bettor's refusal to pay for such a bet shall not relieve the sales agent from responsibility for payment of the price of that bet; except, at the sole discretion of the Director, sales agents may subsequently be given credit for bets so placed and not paid for by the bettor.

(d) Bets may be placed with any Sales Agent operating a terminal or at any Lottery operated facility accepting MASS MILLIONS bets.

(e) Bets may be placed at any time during the day at such time or times as determined by the Director, but all bets must be placed and accepted by the Lottery computer prior to the drawing of the winning numbers on the drawing date shown on the ticket.

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the claimant in fact is the owner of the lost, stolen, or mislaid ticket and it has not otherwise been paid, he or she may in his or her discretion pay the prize to the claimant thereof. All payments of prizes on lost, stolen, or mislaid tickets shall not be made for a period of 90 days in the case of a prize of $200.00 or less and shall not be made for one year if the prize exceeds $200.00, unless the Director in his or her discretion shall decide otherwise.

(5) Sales Agents. Sales Agents are required to pay to the Lottery all sums due on the date established for payment. Failure to make payment when due or upon notice from the custodial bank that funds are not available will result in the immediate shut down of the Sales Agent's terminal and the Sales Agent's license to sell the MASS CASH Game and/or any other Lottery game shall be subject to revocation, suspension or non-renewal pursuant to the provisions of 961 CMR 2.13.

(6) Prizes. All prize amounts shall be set by the Director by Administrative Bulletin. The Administrative Bulletin shall detail the total field of numbers to choose from, establish rules for rounding payments to the nearest dollar or otherwise, establish rules for subtracting overpayments from a pool from subsequent pools, and other such matters as may be necessary or desirable for the proper operation of the game.

All prizes will be paid in full (less required tax withholdings) at the time the claim is made and properly validated.

(8) Liability. The liability, whether by negligence or otherwise, of the Lottery and its licensed Sales Agents for invalid bets is limited to a refund of the amount wagered.

(9) Multiplier Feature. The Massachusetts State Lottery Commission may offer a multiplier feature, which may be known by an associated trade name, for the Mass Cash Game. This is a feature by which a bettor, for an additional wager, may increase the prize amount for all prize levels by a factor depending upon a multiplier number that is drawn prior to the Mass Cash drawing. Rules regarding the multiplier feature shall be set by the Director in an Administrative Bulletin governing the game.

(10) Notwithstanding the foregoing, bets may be placed by the player *via* the iLottery Platform pursuant to the applicable provisions of 961 CMR 2.55 as determined by the Director and pursuant to the terms and conditions of the iLottery Platform, as set forth in 961 CMR 2.69.

2.56: Pull Tab Tickets

(1) Definitions.

Deal. Each separate package, or series of packages, consisting of one game of pull tab tickets with the same serial number purchased from a distributor through the Lottery.

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Dispenser. A plastic cube or container from which pull tab tickets are sold.

Distributor. A person, company or organization authorized by the Lottery to sell pull tab tickets, containers, dispensers, or trinkets to licensed pull tab ticket sales agents.

Flare. A display card posted in the premises of a pull tab ticket sales agent that provides the prize structure of a particular game of pull tab tickets being sold at that time.

Lottery. Massachusetts State Lottery Commission.

Pull Tab Ticket means a single fold or banded ticket with a face covered to conceal one or more numbers or symbols.

Vending Machine. A coin or paper bill operated mechanism by which pull tab tickets may be sold.

(2) Game Rules.

(a) An organization desiring to obtain a license to sell Pull Tab tickets must make application to the Lottery on the form provided by Lottery, and be authorized by the Director to be licensed to sell Pull Tab tickets.

(b) Sales Agent must prominently display its license on the premises in a conspicuous location so that it can be observed by the players and/or patrons of the establishment.

(c) Flare cards listing all prize denominations of $25.00 or more for each deal or game being sold at that time, must be displayed in the immediate vicinity of the game tickets where it can be clearly observed by the players.

(d) Sales agents shall not pay a prize until the ticket has been verified as a winning ticket.

(e) Sales agents must mark the flare card after each prize listed on said flare card is claimed.

(f) The flare must be marked by crossing out the prize claimed so that the mark is clearly visible to the players.

(g) Validation of Pull Tab Tickets. A pull tab ticket is not valid if it fails to meet any of the following requirements:

1. The ticket must have been issued by the Lottery or its approved distributor(s) in an authorized manner.
2. The ticket must not be altered, unreadable, reconstructed or tampered with in any manner.
3. The ticket must be complete and not blank, or partially blank, miscut, misregistered, defective or printed in error.
4. The ticket must have exactly the play symbols and captions specified in the specific game rules.
5. The ticket must pass all validation tests.

Invalid tickets are void and not eligible to win any prize.

(h) Under no circumstances may a prize payout be made for a lost or unredeemed ticket.

(i) The sales agent shall be responsible for the proper conduct of the games.

(j) The sales agent must maintain, on the premises, a copy of the distributor's invoice for each pull tab deal on the premises.

(k) All winning tickets must be claimed immediately at the place of sale. Any ticket that leaves the premises where sold may be deemed an invalid ticket.

(l) Sales agents shall not have on the licensed premises any pull tab tickets that have not been issued by the Lottery or its approved distributor(s).

(m) Sales agents are not required to sell an entire deal. Sales agents may pull a game at any time he/she desires after giving his or her customers a reasonable time to claim winning tickets.

(n) Sales agents are prohibited from commingling games. Sales agents must sell out or discontinue a game by removing the unsold tickets from the dispenser or vending machine prior to the introduction of a subsequent game.

(o) Prior to the sale, of a portion of or the entire deal, the pull tab tickets in the deal must be placed in the container and stirred thoroughly.

(p) Pull tab tickets can only be sold on the licensed premises.

(q) Winning pull tab tickets must be prominently marked, defaced or punched to invalidate it in an area on the face of the ticket other than that which determines it is a winner.

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(r) Sales agents are responsible for the destruction and disposal of all unsold tickets that have been pulled from sale.
(s) Pull tab tickets must be sold for the price on the face of the ticket.
(t) The suspension or revocation of the sales agent's pouring or liquor license shall be grounds for the denial of a sales agent's pull tab license or suspension or revocation of a sales agent's pull tab license.
(u) Pull tab tickets may only be sold from dispensers or vending machines that have been approved by the Lottery.
(v) Promotional items, trinkets, displays, advertisements are subject to the approval of the Lottery.
(w) All other provisions of the 961 CMR, if applicable, apply to the Pull Tab Tickets Games.

2.57: Gift Certificates

The Director is hereby authorized to issue Gift Certificates redeemable at all Lottery Offices and Licensed Sales Agents in accordance with 961 CMR 2.57(1) through (3).

(1) Gift Certificates will be printed in denominations to be determined by the Director.

(2) Gift Certificates shall have imprinted thereon a unique serial number and seal of the Commonwealth of Massachusetts.

(3) Redemption of Gift Certificates
(a) Gift Certificates are bearer instruments and may be redeemed by the holder of the certificate.
(b) Gift Certificates must be redeemed for the total dollar value when presented for redemption.
(c) Customers presenting Gift Certificates for redemption must be 18 years of age or older.
(d) Sales Agents are required to redeem Gift Certificates presented to them from a customer and account for them in accordance with the direction of the Director or his or her designee.
(e) Gift Certificates are void after the expiration date printed thereon.
(f) All other provisions of the 961 CMR, shall, if applicable, apply to the issuance and redemption of Gift Certificates.

2.58: On-line Number Selection Game – KENO

Definitions.

Consecutive Draws. The number of successive KENO draws (*i.e.* 2, 3, 4, 5, 10, 20) for which a player may make a selection on a single KENO ticket.

KENO or Keno. An on-line Lottery game in which a player selects from one to twelve numbers from a field of 80 numbers. The Lottery randomly selects 20 numbers from the same field of 80 numbers. Depending on the quantity of numbers matched and validation of the ticket, the player may win a prize.

Quic Pic. A function that allows an on-line terminal to automatically and randomly select KENO numbers for a player.

Replacement Ticket. The ticket issued to replace a consecutive draw ticket that is validated prior to the last game on the ticket.

Spots. The quantity of numbers (from one to 12) a player may play per game.

Winning Numbers. The 20 numbers between one and 80 randomly selected from each drawing.

(1) Valid Bet. Except as otherwise provided herein, a valid bet on KENO using the On-line System shall be a bet which is:

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(a) Placed with and accepted by a Sales Agent licensed to sell KENO or by a Lottery Facility specifically designated for the purpose.
(b) Paid for in full at the time the bet is placed.
(c) Recorded correctly on a computer generated ticket in accordance with 961 CMR 2.58.
(d) Represented by a ticket generated by a Lottery computer terminal. The ticket must contain the following information:

1. The number of spots;
2. The amount wagered per draw;
3. The numbers selected;
4. The date of sale;
5. The number of draws played;
6. The specific game number(s) for which the bet is eligible;
7. The price of the ticket;
8. A terminal identification number;
9. An 18-digit ticket serial number;
10. A machine readable (Bar Code) ticket serial number; and
11. A verifiable numeric representation of the information contained on the ticket consistent with the information contained in the Lottery's computer records.

(e) Accepted by the Lottery Computer prior to the drawing of the winning numbers for the drawing(s) shown on the ticket.
(f) In the event of a contradiction between information as printed on the ticket and as accepted by the Lottery Computer, the bet accepted by the Lottery Computer shall be the valid bet.

(2) Placing Bets.
(a) Bets may be placed by the bettor orally instructing the Lottery Sales Agent of his or her number selections and the Sales Agent then registering the bet *via* the terminal keyboard, or by orally instructing the Lottery Sales Agent to use the "quic pic" feature by which the on-line computer system randomly selects the numbers.
(b) Bets may be placed by preparing a Digitally Created Barcode which is scanned into the terminal in a manner approved by the Director. A Digitally Created Barcode shall have no pecuniary or prize value, or constitute evidence of purchase or number selections.
(c) Bets may be placed by preparing a bet slip which is then entered into the terminal in a manner approved by the Director. Bet slips shall be prepared as follows:

1. Select the desired quantity of numbers (spots) from one to 12.
2. Select the desired amount to be wagered for each game.
3. Select the number of games.
4. Select the specific number selection or mark the "quic pic" box and the Lottery will randomly select the numbers.
5. Only official bet slips issued by the Lottery may be used to place bets.
6. Bet slips shall have no pecuniary or prize value, or constitute evidence of purchase or number selections.

(d) The terminal must generate a ticket as described in 961 CMR 2.58(1)(d) which is given to the bettor as his or her receipt.
(e) A single drawing bet may be canceled on the day it is placed prior to the selection of the winning numbers for the game for which the bet is eligible. A consecutive drawing bet may be canceled on the day it is placed prior to the selection of the winning numbers for the first game for which the bet is eligible. Consecutive drawing bets cannot be canceled after the first game for which the bet is eligible takes place.
(f) A bet must be canceled at the on-line terminal in which the bet was placed. Bettors shall be entitled to a full refund of their bet upon cancellation and in no event shall a canceled ticket be entitled to a prize.
(g) Bets may be placed with any Sales Agent authorized to accept KENO bets or at any Lottery operated facility accepting Keno bets.
(h) Bets may be placed at any time during the day at such time or times as determined by the Director, but all bets must be placed and accepted by the Lottery computer prior to the drawing on the winning numbers for the specific drawings shown on the ticket.
(i) The bet as represented by the ticket produced by the computer terminal is the only bet on which a prize may be claimed. Bettors are cautioned to examine their bet ticket at the time it is issued and prior to the drawing of the winning numbers in order to ensure that the ticket accurately represents the correct number selections, date of bet, amount wagered, and the drawings for which it is eligible.

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(j) In the event that the Sales Agent or computer terminal errs when the bet is placed, it shall be the responsibility of the bettor to determine that an error has been made and to request a new ticket be issued by the Sales Agent (provided betting for that drawing has not closed) or return of the purchase prize.

(k) The Lottery shall not be liable for the payment of a prize in the event the bet is canceled intentionally or through inadvertence of the Sales Agent.

(l) It shall be the responsibility of the person who collects the prize to make certain that he or she is receiving the correct sum of prize money. The Lottery shall not be liable for any underpayment, except that the Director in his or her discretion may direct that an additional prize payment is made in order to correct an obvious mistake.

(3) Betting Tickets.

(a) The betting ticket is a bearer instrument until a Mobile Claim is submitted, and if no valid Mobile Claim is submitted, then until signed by the owner and a prize may be claimed by anyone in possession of an unsigned winning ticket if no valid Mobile Claim has been submitted.

(b) Keno Sales Agents may pay claims up to and including the sum of $600.00. Any claim of more than $600.00 shall be made on a claim form supplied by the Lottery at all Sales Agent locations or pursuant to the Mobile Claim Process. The procedure to be followed for claims of more than $600.00 and the rules and regulations governing each procedure shall be pursuant to 961 CMR 2.38.

(c) No more than one prize shall be paid on each bet placed.

(4) Lost, Mislaid or Stolen KENO Game Ticket. The Lottery Commission may pay a prize to the holder of a KENO game ticket and the payment of such prize shall absolve the Commission of any further liability with respect to such ticket. In determining whether a prize has been paid on a KENO game ticket, the Commission may rely solely upon its computer records in determining whether or not a particular prize has been paid and the status as determined by the Lottery's computer shall be binding on the holder. In the event of a lost, stolen, or mislaid ticket, the Director may order an investigation, and if he or she is satisfied that the claimant in fact is the owner of the lost, stolen, or mislaid ticket and it has not otherwise been paid, he or she may in his or her discretion pay the prize to the claimant thereof. All payments of prizes on lost, stolen or mislaid tickets shall not be made for a period of 90 days in the case of a prize of $200.00 or less and shall not be made for one year if the prize exceeds $200.00, unless the Director in his or her discretion shall decide otherwise.

(5) Sales Agents. Sales Agents are required to pay to the Lottery all sums due on the date established for payment. Failure to make payment when due or upon notice from the custodial bank that funds are not available will result in the immediate shut down of the Sales Agent's terminal and the Sales Agent's license to sell the KENO Game and/or any other Lottery game shall be subject to revocation, suspension or nonrenewal pursuant to the provisions of 961 CMR 2.13.

(6) Prizes.

(a) All prizes will be paid in full, (less required tax withholdings), at the time the claim is made and after the ticket is properly validated.

(b) All prizes will be a fixed amount (subject to restrictions) and set by the Director by Administrative Bulletin.

(7) Multiplier Feature. The Massachusetts State Lottery Commission may offer a multiplier feature, which may be known by an associated trade name, for the Keno Game. This is a feature by which a bettor, for an additional wager, may increase the prize amount for certain prize levels by a factor depending upon a multiplier number that is drawn prior to the Keno drawing. Rules regarding the multiplier feature shall be set by the Director in an Administrative Bulletin governing the game.

(8) Miscellaneous. All other provision of Lottery Rules and Regulations 961 CMR shall, if applicable, apply to the On-line Number Selection Game – KENO.

(9) In accordance with M.G.L. c. 10, § 27, the 961 CMR 2.58(9)(a) through (c) shall apply in determining whether a municipality should be exempt from the exclusion of Keno growth revenue as defined by M.G.L. c. 10, § 27A.

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(f) In no event shall installment payments be made in the Deferred Annuity Portion of the Annuity Option after the Annuitant's death.
(g) It shall be the Prizewinner's responsibility to provide the Lottery paying the Annuity any updated address information to which Prize installments will be mailed even if a full annual payment or multiple payments have been assigned to a third-party.
(h) Where a Claimant of a Grand Prize or Second Level Prize is a minor who has not yet attained a majority age in the applicable jurisdiction in which the lottery that sold the Play is located, such Prize will be subject to the laws and regulations governing the Selling Lottery.

2.69: Lotteries conducted online (iLottery)

(1) Definitions.

iLottery Platform shall mean a Lottery system that provides for the sale of lottery products and ancillary services *via* the internet through channels that may include, but are not limited to, online and mobile applications.

(2) Commencing on a date to be determined by the Director in their discretion, the Lottery shall offer for sale via its iLottery Platform lottery tickets, games, or shares as authorized by the Law and 961 CMR 2.00.

(3) All activity and use of the iLottery Platform, including the use of iLottery Player Accounts, are also subject to any terms, conditions, and requirements established by the Director in their discretion.

(4) iLottery Player Accounts. Players who wish to utilize the iLottery Platform to purchase lottery tickets, games, or shares, claim prizes, receive winnings, and engage/participate in such other activities as authorized by the Director, must duly register an account (referred to herein as "an iLottery Player Account") with the iLottery Platform.

(5) Age Verification. To purchase lottery tickets, games, or shares via the iLottery Platform, the player must be 21 years of age or older at the time of purchase. The Director shall use any reasonably designed identity and age verification measures, which may include but is not limited to, software, public databases, Lottery databases, financial information, or other Know Your Customer (KYC) functionality, to block access to and prevent sales of lottery tickets, games and shares via the iLottery Platform to persons younger than 21 years old.

(6) Location. To purchase lottery tickets, games, or shares *via* the iLottery Platform, the player must be physically present in the Commonwealth of Massachusetts at the time of purchase. The Director shall use measures such as geolocation software, geo-filtering software, geofencing software, or other software to limit the sale of lottery tickets, games, or shares *via* the iLottery Platform to transactions initiated and received, or otherwise made, within the Commonwealth at the time of purchase.

(7) Voluntary Self-exclusion. Any player may voluntarily prohibit or otherwise exclude themselves from purchasing via the iLottery Platform a lottery ticket, game, or share. The manner and process by which a player may voluntarily prohibit or otherwise exclude themselves is governed by the terms, conditions, and requirements set by the Director in their discretion. Any list or record that identifies a player as having voluntarily prohibited or otherwise excluded themselves from purchasing lottary tickets, games, or shares via the iLottery Platform is exempt from disclosure under M.G.L. c. 66, § 10 and M.G.L. c. 4, §7(26).

(8) Account Limits. Maximum limits for iLottery Player Account deposits and transactions of lottery tickets, games, or shares via the iLottery Platform shall be established by the Director by Administrative Bulletin; players may reduce their deposit or transaction limit to a lesser amount at any time subject to the terms, conditions, and requirements set by the Director in their discretion.

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(9) Account Withdrawal. Cash deposited and unspent in an iLottery Player Account belongs to the owner of the account. Said cash or any portion thereof may be withdrawn by the owner at any time subject to the terms, conditions, and requirements set by the Director in their discretion as authorized to maintain the security of customer funds and to prevent fraud and unauthorized or unlawful withdrawals. Such terms, conditions, and requirements may include, but not be limited to, restrictions on withdrawals of specified funds originating from a player's acceptance of a promotional offer.

(10) Promotional Activities. Pursuant to M.G.L. c. 10, § 24(b)(vi), as a cost incurred in the operation and administration of the sale of lottery tickets, games, and shares *via* the iLottery Platform, each fiscal year, an amount determined by the Director in their discretion shall be used in accordance with M.G.L. c. 10, § 25(b)(a)(ii) to fund promotional activities, which shall be determined by the Director in their discretion, to encourage the purchase of lottery tickets, games, or shares *via* licensed Sales Agents.

(11) Search Function. The user-facing website and mobile application of the iLottery Platform shall offer a search function enabling players to find nearby licensed Sales Agents offering lottery sales at brick-and-mortar retail stores located in the Commonwealth.

(12) As determined by the Director in their discretion but not less than annually, the Lottery shall supply the Department of Public Health with customer tracking data collected or generated by the sale of lottery tickets, games, or shares *via* the iLottery Platform ("Data"). The Data shall be anonymized to remove

(a) personally identifying information, including a player's name, street address, bank or credit information and the last four digits of a player's zip code, in compliance with M.G.L. c. 93H, § 2; and

(b) game identifying information, including game name and device manufacturing company, in protection of corporate intellectual property.

The Data shall include information on player characteristics including, but not limited to, gender, age and region of residence and player behavior including, but not limited to, frequency of play, length of play, speed of play, denomination of play, amounts wagered and, if applicable, characteristics of games.

(13) Procedure for Claiming Prizes for Tickets, Games or Shares Purchased through the iLottery Platform.

(a) Prizes up to $600.99 won as a result of a ticket, game or share purchased through the iLottery Platform will be posted to the player’s iLottery Account fund balance provided the claim has been validated by the applicable gaming system. At the discretion of the Director, it may be a requirement that the prize money be forwarded and/or provided to claimant in check form.

(b) Prizes of $601.00 to $49,999.99 won as a result of a ticket, game or share purchased through the iLottery Platform require the player to claim the prize and agree to applicable terms or agreements for iLottery claims *via* the iLottery Platform, the claim be validated by the applicable gaming system, and verified by applicable internal validation requirements. The prize money will be posted in the player’s iLottery Player Account fund balance. At the discretion of the Director, it may be a requirement that the prize money be forwarded and/or provided to claimant in check form.

(c) Prizes of $50,000.00 and greater, and annuity prizes, won as a result of a ticket, game or share purchased through the iLottery Platform require the player to initiate the claim and agree to applicable terms or agreements for iLottery claims *via* the iLottery Platform, the claim be validated by the applicable gaming system, the claim be verified by applicable internal validation requirements, and the player’s identity must be verified in person at the office of the Director. The prize money will be forwarded and/or provided to claimant in check form.

(d) Each claim for prizes of $601.00 or greater for tickets, games or shares purchased through the iLottery Platform incorporates by reference the following provisions:

1. Verification that the iLottery prize winner is not a person disqualified by law or by 961 CMR 2.00 to claim or otherwise accept a prize from the Lottery.

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2. The iLottery prize winner owner grants to the Commission the right to use his or her name, address, and photograph to publicize his or her winnings.

3. Indemnification of the Commission for any loss occasioned by an untruth or misrepresentation by the iLottery player claiming the prize in his or her behalf.

4. All information requested by the Commission which may include, but not be limited to, the iLottery prize winner's name, and social security number or taxpayer's identification number.

(e) The prize claim process for prizes won as a result of a ticket, game or share purchased through the iLottery Platform may incorporate any other term, condition or requirement as set by the Director in his or her discretion.

(f) For claims of tickets, games or shares purchased through the iLottery Platform, the ticket, game or share must be validated by the Lottery as a winner and the terms, conditions and requirements as determined by the Director must have been complied with and the claim must have been submitted prior to the expiration date of the ticket, game or share.

(f) 961 CMR 2.38(6), (7), (8), and 961 CMR 2.42, shall, as applicable, apply to the claiming of tickets, games and shares purchased through the iLottery Platform.

(g) If deemed applicable by the Director in their discretion, any other provision of 961 CMR 2.0 shall apply to the claiming of tickets, games or shares purchased through the iLottery Platform.

(14) Suspension or Termination of iLottery Account. If a player uses or attempts to use their iLottery Player Account or its functionality in a fraudulent or prohibited manner or in a manner other than for its intended purposes, the player's access to their iLottery Player Account may be suspended or terminated at the discretion of the Director. A prize in the possession of the player as a result of fraud, illegal activity, or prohibited behavior may be reclaimed or returned to the Lottery. A statute of limitations will not be applicable nor bar the Lottery from demanding that a prize be returned by such player due to fraud, illegal activity, or other prohibited behavior.

2.70: eInstant Game Rules

(1) Definitions.

eInstant Game means an electronic Lottery instant game, which is available to be played only through the Lottery's iLottery Platform.

(2) General Provisions.

(a) The terms of 961 CMR 2.71 apply to all eInstant Games. Specific game rules for each eInstant Game shall be detailed in an Administrative Bulletin issued by the Director. Each eInstant Game is governed by its Administrative Bulletin with respect to game play, odds, and available prizes.

(b) By purchasing any eInstant Game play, a player accepts and agrees to comply with all applicable Lottery rules and procedures. The Lottery reserves the right to make changes to any eInstant Game rules without any advance notice, and such changes will be effective immediately upon posting on the iLottery Platform.

(3) Purchasing eInstant Games.

(a) to purchase an eInstant Game play, the player must be at least 21 years old, be physically located in the Commonwealth of Massachusetts, and have a duly registered iLottery Account.

(b) All sales are final. Once the purchase of an eInstant Game play is completed, the player may not cancel the purchase. The player shall be solely responsible for ensuring that they have selected the correct eInstant Game and all applicable options, including but not limited to, purchase price, number of tickets, and price of tickets. Purchases made in error will not be refunded by the Lottery.

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(c) The player shall be solely responsible for obtaining and maintaining any equipment and connectivity necessary to access the iLottery Platform and purchase an eInstant Game play. eInstant Games may not be available on certain devices due to operating requirements associated with eInstant Games. The Lottery makes no representations or warranties, and does not accept any liability, as to a player's ability to access, purchase, and play any eInstant Game, or that the iLottery Platform or eInstant Games will display correctly on devices on which they can be viewed.

(4) Determination of Prize Winners.

(a) eInstant Games are games of chance, and the outcome of a play in the case of an eInstant Game is determined by the applicable gaming system at the point of purchase and is not affected by the skill, judgment, or action of the player. The applicable gaming system distributes outcomes based on the probabilities within the prize structure set forth in the eInstant Game's Administrative Bulletin. The overall chances of winning in an eInstant Game play at each prize level are determined by the prize structure as set forth in the Administrative Bulletin. Outcomes will not be affected by a disconnection from the iLottery Platform after point of purchase.

(b) The revealing of the play symbols is for entertainment purposes only. The revealing of the play symbols on the eInstant Game does not determine whether the eInstant Game play is a winner play.

(c) The applicable gaming system must indicate that an eInstant Game play is a winning play for it to be a valid winning play entitled to a prize. The eInstant Game play must pass all validation and security checks imposed by the Director for it to be a valid winning play entitled to a prize. In order to be a valid winning eInstant Game play, all transaction data must be recorded and verified as a winning eInstant Game play on the applicable gaming system, and the transaction data must satisfy all validation requirements in every respect.

(d) The eInstant Game play shall be void and the player shall not be entitled to a prize under any one or more of the following conditions:

1. The applicable gaming system indicates the eInstant Game play is not a winner;
2. The eInstant Game play was not validly purchased through the iLottery Platform and/or the iLottery Player Account;
3. The eInstant Game play is defective or tampered with in any manner;
4. The eInstant Game play does not pass all validation requirements; or
5. The eInstant Game play fails to meet any requirement contained in the Administrative Bulletin issued by the Director for any particular eInstant Game.

The Director shall make the final decision as to whether any eInstant Game play is valid or void and such decision shall be final.

(e) A player who validly purchases an eInstant Game play is the owner of the eInstant Game play, is entitled to any prize won on that play, subject to all requirements necessary to claim the prize. An eInstant Game play is not a bearer instrument. Neither the electronic record of purchase, nor any other confirmation of the purchase is a bearer instrument. An eInstant Game play may not be assigned except as permitted or required by law.

(f) If an eInstant Game play has been purchased by a player and the play is not played out to completion for any reason, including, but not limited to, the interruption of the player, loss of connectivity during the game play, or eInstant Game termination by the Lottery, the outcome of the play will be available in the player's iLottery Player Account.

(g) In the event of any direct conflict among the display of the eInstant Game play results, the applicable Administrative Bulletin, and any other information issued by the Lottery with respect to the eInstant Games, these regulations and the applicable eInstant Game Administrative Bulletin will prevail.

(5) Disputes. In the event a dispute between the Lottery and the eInstant Game player occurs as to whether the eInstant Game play is a winning play, and if the prize is not paid, the Director may, in their sole discretion, replace the disputed play with an unplayed eInstant Game play of equivalent sales price from a current Lottery iLottery eInstant Game or may refund the original purchase price of the eInstant Game play in dispute. This shall be the sole and exclusive remedy of the purchaser of the disputed play in the event of such disputes.

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2.70: continued

A claim shall not be premised on human or electronic error in the communication, display, or transmission of data regardless of how that data is recorded, displayed, or transmitted. A claim shall not be premised on any intentional human electronic or other form of communication not authorized by the Lottery.

(6) In the event an eInstant Game play is declared to be void, the Lottery may at its option replace the voided play with a play of equivalent sales price or refund the original purchase price thereof. This shall be the sole and exclusive remedy of the player.

(7) A player shall be eligible to win only one prize per each eInstant Game play, unless the eInstant Game Administrative Bulletin specifically states otherwise.

(8) Governing Law. In purchasing an eInstant Game play, the player agrees to comply with and abide by the laws of the Commonwealth of Massachusetts, all rules and regulations, directives, and final decisions of the Lottery, and all procedures established by the Director for the conduct of the eInstant Game.

(9) Claim Period. All prizes won on eInstant Game plays must be claimed no later than 366 days following the date on which the prize was won. The computation of time shall begin with the first day following the date the prize was won. If a valid claim is not made for a prize within the required time period, the prize shall be allocated in the same manner as iLottery revenues are allocated.

(10) Purchase, Sale, and Prize Restrictions.

(a) No eInstant Game play shall be sold to a person younger than 21 years old.

(b) No eInstant Game shall be purchased by, and no prize shall be paid to an officer or employee of any contractor or subcontractor who is involved in the production of eInstant Games, or to any spouse, child, brother, sister, or parent domiciled as a member of the same household of such officer or employee.

(c) No eInstant Game play shall be purchased by, and no prize shall be paid to any of the following persons: any member or employee of the Commission or to any spouse, child, brother, sister, or parent domiciled as a member of the same household of any member or employee of the Commission.

(11) Termination of eInstant Games. The Director at any time, with or without notice, may discontinue any eInstant Game in its entirety and the eInstant Game will no longer be offered for sale.

2.71: MASS 3

(1) Sales Start Date. Commencing on a date to be determined by the Director in their discretion, the Lottery shall offer MASS 3 for sale *via* its iLottery Platform.

(2) Drawings. MASS 3 drawings are conducted once a day, seven days a week. During each MASS 3 drawing, a set of three single-digit numbers between zero and nine will be selected.

(3) Purchasing MASS 3 Wagers.

(a) The sale and/or purchase of MASS 3 wagers is conducted exclusively on the iLottery Platform. To purchase a MASS 3 wager, the player must be at least 21 years old, be physically located in the Commonwealth of Massachusetts, and have a duly registered iLottery Account.

(b) By purchasing a MASS 3 wager, the player accepts and agrees to comply with all applicable Lottery rules and procedures.

(c) All sales are final. Once the purchase of a MASS 3 wager is completed, the player may not cancel the purchase. The player is solely responsible for their wager selections. Purchases made in error will not be refunded.

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2.71: continued

(d) The player is solely responsible for obtaining and maintaining any equipment and connectivity necessary to access the iLottery Platform and purchase a MASS 3 wager. MASS 3 may not be available on certain devices due to operating requirements associated with the MASS 3 game. The Lottery makes no representations or warranties, and does not accept any liability, as to a player's ability to access, and purchase a MASS 3 wager, or that the iLottery Platform will display correctly on all devices on which they can be viewed.

(4) Ticket Price.

(a) All ticket prices shall be set by the Director by the Administrative Bulletin governing the game.

(b) The Wicked Bonus Ball is an optional play type that can be added to each MASS 3 play and purchased for the amount equal to the price of the play, or multiples thereof in the case of a multi-draw wager, at the discretion of the player.

(c) The Lottery may offer wagers through promotions, including promotions that offer a discount.

(d) The Lottery may offer MASS 3 wagers as prizes in any other Lottery game offered *via* the iLottery Platform.

(5) Official MASS 3 Wager. A play/wager consisting of a set of three numbers, each from a field of zero to nine, that appears as a single board or panel that meets all requirements and is recorded on the applicable gaming system.

(6) Game Play.

(a) To play MASS 3, a player selects three numbers, each from a field of ten numbers (zero through nine), that will together form a three-digit number. Players must match the numbers selected in their play to those drawn by the Lottery on the designated drawing date and time to be eligible to win a prize.

(b) The winning MASS 3 numbers will be selected from a field of ten numbers (zero through nine), in the order drawn, according to certified random numbers generation.

(c) All play types shall be set by the Director by the Administrative Bulletin governing the game.

(d) Wicked Bonus. When purchasing a MASS 3 play/wager, the player can choose to participate in the Wicked Bonus add-on game.

1. Player can choose Yes/No for the Wicked Bonus add-on for each line or all lines.
2. Selecting Yes for the Wicked Bonus add-on doubles the cost of the line.
3. Wicked Bonus add-on does not change the liability of the line.

After the base winning numbers are drawn, the Wicked Bonus ball will be drawn from ten numbered balls (zero through nine) for each game. Wicked Bonus ball can replace any of the MASS 3 numbers drawn to create additional winning combinations (even if it is the same combination). The prize amounts are different for the Wicked Bonus winning combinations. The player numbers are compared to the additional winning combination and if there is a match, the player will win a Wicked Bonus prize, which is in addition to and separate from the main prizes. Player can win multiple Wicked Bonus wins on the same line.

(7) Multi-draw. Players may enter multiple drawings of MASS 3. Multi-draw will be subject to the policies, procedures and rules established by the Lottery.

(8) Prizes. All prize amounts shall be set by the Director by the Administrative Bulletin governing the game. The Administrative Bulletin shall detail limitations of prize liability and such other matters as may be necessary or desirable for the proper operation of the game.

(9) The procedure to be followed for claims shall be pursuant to 961 CMR 2.69(13).

(10) A player who validly purchases a MASS 3 play/wager is the owner of the play/wager, is entitled to any prize won on that play/wager, subject to all requirements necessary to claim the prize. A MASS 3 play/wager is not a bearer instrument. Neither the electronic record of the purchase, nor any other confirmation of the purchase is a bearer instrument. A MASS 3 play/wager may not be assigned except as permitted or required by law.

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2.71: continued

In determining whether or not a particular prize has been paid on a MASS 3 play/wager, the Commission may rely solely upon its applicable gaming system in determining whether or not a particular prize has been paid and the status as determined by the applicable gaming system shall be binding.

(11) The liability, whether by negligence or otherwise, of the Lottery for invalid bets is limited to a refund of the amount wagered.

2.72: MASS 4

(1) Sales Start Date. Commencing on a date to be determined by the Director in their discretion, the Lottery shall offer MASS 4 for sale *via* its iLottery Platform MASS 4. MASS 4 drawings are held once a day, seven days a week.

(2) Drawings. MASS 4 drawings are conducted once a day, seven days a week. During each MASS 4 drawing, a set of four single-digit numbers between zero and nine will be selected.

(3) Purchasing MASS 4 Wagers.

(a) The sale and/or purchase of MASS 4 wagers is conducted exclusively on the iLottery Platform. To purchase a MASS 4 wager, the player must be at least 21 years old, be physically located in the Commonwealth of Massachusetts, and have a duly registered iLottery Account.

(b) By purchasing a MASS 4 wager, the player accepts and agrees to comply with all applicable Lottery rules and procedures.

(c) All sales are final. Once the purchase of a MASS 4 wager is completed, the player may not cancel the purchase. The player is solely responsible for their wager selections. Purchases made in error will not be refunded.

(d) The player is solely responsible for obtaining and maintaining any equipment and connectivity necessary to access the iLottery Platform and purchase a MASS 4 wager. MASS 4 may not be available on certain devices due to operating requirements associated with the MASS 4 game. The Lottery makes no representations or warranties, and does not accept any liability, as to a player's ability to access, and purchase a MASS 4 wager, or that the iLottery Platform will display correctly on all devices on which they can be viewed.

(4) Ticket Price.

(a) All ticket prices shall be set by the Director by the Administrative Bulletin governing the game.

(b) The Wicked Bonus ball is an optional play type that can be added to each MASS 4 play and purchased for the amount equal to the price of the play, or multiples thereof in the case of a multi-draw wager, at the discretion of the player.

(c) The Lottery may offer wagers through promotions, including promotions that offer a discount.

(d) The Lottery may offer MASS 4 wagers as prizes in any other Lottery game offered *via* the iLottery Platform.

(5) Official MASS 4 Wager. A play/wager consisting of a set of four numbers, each from a field of zero to nine, that appear as a single board or panel that meets all requirements and is recorded on the applicable gaming system.

(6) Game Play.

(a) To play MASS 4, a player selects four numbers, each from a field of ten numbers (zero through nine), that will together form a four-digit number. Players must match the numbers selected in their play to those drawn by the Lottery on the designated drawing date and time to be eligible to win a prize.

(b) The winning MASS 4 numbers will be selected from a field of ten numbers (zero through nine), in the order drawn, according to certified random numbers generation.

(c) All play types shall be set by the Director by the Administrative Bulletin governing the game.

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2.72: continued

(d) Wicked Bonus. When purchasing a MASS 4 play/wager, the player can choose to participate in the Wicked Bonus add-on game.

1. Player can choose Yes/No for the Wicked Bonus add-on for each line or all lines.
2. Selecting Yes for the Wicked Bonus add-on doubles the cost of the line.
3. Wicked Bonus add-on does not change the liability of the line.

After the base winning numbers are drawn, the Wicked Bonus ball will be drawn from ten numbered balls (zero through nine) for each game. Wicked Bonus ball can replace any of the MASS 4 numbers drawn to create additional winning combinations (even if it is the same combination). The prize amounts are different for the Wicked Bonus winning combinations. The player numbers are compared to the additional winning combination and if there is a match, the player will win a Wicked Bonus prize, which is in addition to and separate from the main prizes. Player can win multiple Wicked Bonus wins on the same line.

(7) Multi-draw. Players may enter multiple drawings of MASS 4. Multi-draw will be subject to the policies, procedures and rules established by the Lottery.

(8) Prizes. All prize amounts shall be set by the Director by the Administrative Bulletin governing the game. The Administrative Bulletin shall detail limitations of prize liability and such other matters as may be necessary or desirable for the proper operation of the game.

(9) The procedure to be followed for claims shall be pursuant to 961 CMR 2.69(13).

(10) A player who validly purchases a MASS 4 play/wager is the owner of the play/wager, is entitled to any prize won on that play/wager, subject to all requirements necessary to claim the prize. A MASS 4 play/wager is not a bearer instrument. Neither the electronic record of the purchase, nor any other confirmation of the purchase is a bearer instrument. A MASS 4 play/wager may not be assigned except as permitted or required by law.

In determining whether or not a particular prize has been paid on a MASS 4 play/wager, the Commission may rely solely upon its applicable gaming system in determining whether or not a particular prize has been paid and the status as determined by the applicable gaming system shall be binding.

(11) The liability, whether by negligence or otherwise, of the Lottery for invalid bets is limited to a refund of the amount wagered.

REGULATORY AUTHORITY

961 CMR 2.00: M.G.L. c. 10, § 24 and c. 30A, § 3.

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