101 CMR 614.00: HEALTH SAFETY NET PAYMENTS AND FUNDING

Section

614.01: General Provisions

Scope, Purpose, and Effective Date. 101 CMR 614.00 governs Health Safety Net payments and funding effective for dates of service beginning October 1, 2022, including payments to Acute Hospitals and Community Health Centers and payments from Acute Hospitals and Surcharge Payers. The criteria for determining services for which Acute Hospitals and Community Health Centers may be paid by the Health Safety Net are set forth in 101 CMR 613.00: *Health Safety Net Eligible Services*

614.02: Definitions

As used in 101 CMR 614.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 101 CMR 614.00 are capitalized.

340B Provider. An Acute Hospital or Community Health Center eligible to purchase discounted drugs through a program established by § 340B of United States Public Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their Patients, and registered and listed as a 340B Provider within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. Services of a 340B pharmacy may be provided at on-site or off-site locations.

Acute Hospital. A hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Administrative Day. A day of inpatient hospitalization on which a Patient's care needs can be provided in a setting other than an inpatient Acute Hospital in accordance with the standards in 130 CMR 415.000: *Acute Inpatient Hospital Services* and on which the Patient is clinically ready for discharge.

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to Patients not requiring hospitalization and meets the Centers for Medicare and Medicaid Services (CMS) requirements for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 U.S.C. § 1395k(a)(2)(F)(i). These services include only facility services and do not include physician fees.

Bad Debt. An account receivable based on services furnished to a Patient that is

(a) regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 101 CMR 613.06: *Allowable Bad Debt*;
(b) charged as a credit loss;
(c) not the obligation of a governmental unit or the federal government or any agency thereof; and
(d) not a Reimbursable Health Service.

614.02: continued

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

Centers for Medicare & Medicaid Services (CMS). The federal agency that administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Charge. The uniform price for a specific service charged by a Provider.

Community Health Center. A health center operating in conformance with the requirements of § 330 of the Public Health Service Act (42 U.S.C. § 254b), including all Community Health Centers that file cost reports with the Center. Such a health center must

(a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;

(b) meet the qualifications for certification (or provisional certification) by the MassHealth Agency and enter into a Provider agreement pursuant to 130 CMR 405.000: *Community Health Center Services*; and

(c) operate in conformance with the requirements of 42 U.S.C. § 254b.

Disproportionate Share Hospital (DSH). An Acute Hospital where a minimum of 63% of the Gross Patient Service Revenue is attributable to Title XVIII and Title XIX of the Social Security Act or other government payers, including the Premium Assistance Payment Program Operated by the Health Connector and the Health Safety Net.

Eligible Services. Services eligible for Health Safety Net payment pursuant to 101 CMR 613.03: *Eligible Services Requirements*. Eligible Services include

(a) Reimbursable Health Services to Low Income Patients;

(b) Medical Hardship; and

(c) Bad Debt as further specified in 101 CMR 613.00: *Health Safety Net Eligible Services* and 614.00.

Emergency Bad Debt. The amount of uncollectible debt for Emergency Services that meets the criteria set forth in 101 CMR 613.06: *Allowable Bad Debt*.

Emergency Services. Medically Necessary Services provided to an individual with an Emergency Medical Condition as defined in 101 CMR 613.02: *Definitions*.

Federal Poverty Level (FPL). The federal poverty income guidelines issued annually in the *Federal Register*.

Financial Requirements. An Acute Hospital's requirement for revenue that includes, but is not limited to, reasonable operating, capital, and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

Fiscal Year (FY). The time period of 12 months beginning on October 1st of any calendar year and ending on September 30th of the following calendar year.

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

Gross Patient Service Revenue. The total dollar amount of a hospital’s charges for services rendered in a Fiscal Year.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of an Acute Hospital's or Community Health Center's charge for services.

Health Connector. Commonwealth Health Insurance Connector Authority or Health Connector established pursuant to M.G.L. c. 176Q, § 2.

Health Safety Net. The payment program established and administered in accordance with M.G.L. c. 118E, §§ 8A, and 64 through 69 and regulations promulgated thereunder, and other applicable legislation.

614.02: continued

Health Safety Net Office. The office within the Office of Medicaid established under M.G.L. c. 118E, § 65.

Health Safety Net Trust Fund. The fund established under M.G.L. c. 118E, § 66.

Health Services. Medically necessary inpatient and outpatient services as authorized under Title XIX of the Social Security Act. Health services do not include

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures; and
(g) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives are payable.

Hospital Cost Report. The Massachusetts Hospital Statement of Costs, Revenues, and Statistics reported to the Center pursuant to 957 CMR 9.00: *Hospital Financial Data Reporting Requirements*.

Hospital Licensed Health Center. A Satellite Clinic that

(a) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center as provided at 130 CMR 410.413: *Medical Services Required on Site at a Hospital-licensed Health Center*; and
(b) is approved by and enrolled with MassHealth's Provider Enrollment Unit as a Hospital Licensed Health Center.

Hospital Services. Services listed on an Acute Hospital's license by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; and home health services, or separately licensed services, including residential treatment programs and ambulance services.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. chs. 175, 176A, 176B, 176G, or 176I to a group of Providers, including one or more Massachusetts Acute Hospitals or Ambulatory Surgical Centers, that then forward the payment to member Acute Hospitals or Ambulatory Surgical Centers; or a payment made to an individual to reimburse him or her for a payment made to an Acute Hospital or Ambulatory Surgical Center.

Individual Medical Visit. A face-to-face meeting at a Community Health Center between a Patient and a physician, physician assistant, nurse practitioner, nurse midwife, registered nurse, or paraprofessional for medical examination, diagnosis, or treatment.

Individual Payer. A Patient or Guarantor who pays his or her own Acute Hospital or Ambulatory Surgical Center bill and is not eligible for reimbursement from an insurer or any other source.

Institutional Payer. A Surcharge Payer that is an entity other than an Individual Payer.

Low Income Patient. A Patient who meets the criteria in 101 CMR 613.04(1): *General*.

Managed Care Organization. A managed care organization, as defined in 42 CFR 438.2, and any eligible health insurance plan, as defined in M.G.L. c. 118H, § 1, that contracts with MassHealth or the Commonwealth Health Insurance Connector Authority; provided, however, that a managed care organization does not include a senior care organization, as defined in M.G.L. c. 118E, § 9D, or an integrated care organization as defined in M.G.L. c. 118E, § 9F.

MassHealth. The medical assistance and benefit programs administered by the MassHealth Agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 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.

614.02: continued

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

Medically Necessary Service. A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity. Medically Necessary Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

Medicare Advantage. A type of Medicare health plan established by Title II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Medicare Program (Medicare). The medical insurance program established by Title XVIII of the Social Security Act.

Non-acute Hospital. A nonpublic hospital that is

(a) licensed by the Department of Public Health under M.G.L. c. 111, § 51 but not defined as an acute-care hospital under M.G.L. c. 111, § 25B; or

(b) licensed as an inpatient facility by the Department of Mental Health under M.G.L. c. 19, § 19 and regulations promulgated thereunder but not categorized as Class VII licensees under the regulations.

Office of Pharmacy Affairs (OPA). The Office of Pharmacy Affairs, and any successor agencies, is a division within the United States Department of Health and Human Services that monitors the registration of 340B pharmacies.

Patient. An individual who receives or has received Medically Necessary Services at an Acute Hospital or Community Health Center.

Pediatric Hospital. An Acute Hospital that limits services primarily to children and that qualifies as exempt from the Medicare Prospective Payment System (PPS).

Premium Assistance Payment Program Operated by the Health Connector. An insurance subsidy program that provides state subsidies for low-income individuals and families administered by the Health Connector.

Prospective Payment System (PPS) Rate. The Medicare Prospective Payment System rate for Community Health Centers set annually by CMS as described in 42 CFR 405.2467.

Provider. An Acute Hospital or Community Health Center that provides Eligible Services.

Publicly Aided Patient. A person who receives Acute Hospital or Community Health Center care and services for which a Governmental Unit is liable in whole or in part under a statutory obligation.

Registered Payer List. A list of Institutional Payers as defined in 101 CMR 614.05(3)(b).

Reimbursable Health Services. Eligible Services provided by Acute Hospitals or Community Health Centers to Uninsured and Underinsured Patients who are determined to be financially unable to pay for their care, in whole or in part and who meet the criteria for Low Income Patient; provided that such services are not eligible for reimbursement by any other public or third party payer.

Shortfall Amount. In a Fiscal Year, the positive difference between the sum of allowable Health Safety Net costs for all Acute Hospitals and the revenue available for distribution to Acute Hospitals.

Sole Community Hospital. Any Acute Hospital classified as a Sole Community Hospital by the U.S. Centers for Medicare & Medicaid Services', Medicare regulations, or any Acute Hospital that demonstrates to the Health Safety Net Office's satisfaction that it is located more than 25 miles from other Acute Hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

614.02: continued

Source Year. The Fiscal Year two Fiscal Years prior to the regulation effective date, from which data is collected to calculate current payment rates, unless otherwise specified by the Health Safety Net Office through administrative bulletin.

Surcharge Payer. An individual or entity that

(a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and

(b) meets the criteria set forth in 101 CMR 614.05(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to Acute Hospitals and Ambulatory Surgical Centers determined pursuant to 101 CMR 614.05(2).

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A Third Party Administrator may provide client services for a self-insured plan or an insurance carrier's plan. A Third Party Administrator is deemed to use a client plan's funds to pay for health care services whether the Third Party Administrator pays Providers with funds from a client plan, with funds advanced by the Third Party Administrator subject to reimbursement by the client plan, or with funds deposited with the Third Party Administrator by a client plan.

Total Surcharge Amount. An amount equal to $160,000,000 plus 50% of the estimated cost, as determined by the Secretary of Administration and Finance, of administering the Health Safety Net and related assessments in accordance with M.G.L. c. 118E, §§ 65 through 69.

Urgent Care Services. Medically Necessary Services provided in an Acute Hospital or Community Health Center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing a Patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent Care Services do not include Primary or Elective Care, as defined in 101 CMR 613.02: *Definitions*.

614.03: Sources and Uses of Funds

(2) Payments from the Health Safety Net Trust Fund.

(a) Payment Adjustments. Acute Hospital payments established under 101 CMR 614.06 may be adjusted to reflect additional funding made available during the Fiscal Year or to reflect the shortfall allocation in accordance with 101 CMR 614.03(2). The Health Safety Net may reserve up to 10% of available funding to ensure that funding is available for the entire Fiscal Year. The Health Safety Net may reserve an additional amount of available funding to ensure that funds are available to pay for claims that were denied or held during the Fiscal Year, but are later remediated in a subsequent Fiscal Year.

(b) Shortfall Allocation. The Health Safety Net Office, using the best data available, estimates the projected total Reimbursable Health Services provided by Acute Hospitals and Community Health Centers; total Medical Hardship services; total Bad Debt for Emergency and Urgent Care Services; and total Health Safety Net administrative expenses. If the Health Safety Net Office determines that, after adjusting for projected Community Health Center payments and administrative expenses, Health Safety Net payments to Acute Hospitals will exceed available funding, the Health Safety Net Office allocates the funding in a manner that reflects each Acute Hospital's proportional Financial Requirements for Health Safety Net payments through a graduated payment system. The Health Safety Net Office allocates the shortfall to Disproportionate Share Hospitals and other Acute Hospitals as follows.

1. Disproportionate Share Hospital. The Health Safety Net Office determines Disproportionate Share Hospital status using data reported on the Hospital Cost Report for the Source Year.

614.03: continued

2. Allocation Method. The Health Safety Net Office allocates the shortfall as follows.
   a. Determine the ratio of each Acute Hospital's total Patient care costs to the sum of all Acute Hospitals' total Patient care costs.
   b. Multiply this ratio by the total Shortfall Amount.
   c. If calculated amount is greater than an Acute Hospital's allowable Health Safety Net payments, then the shortfall allocation is limited to the Acute Hospital's allowable Health Safety Net payments. If an Acute Hospital's allowable Health Safety Net payment is a negative amount, then the shortfall allocation is limited to zero.
   d. The Health Safety Net's gross liability to each Acute Hospital is limited by the Acute Hospital's allowable Health Safety Net payments less the Shortfall Amount calculated in 101 CMR 614.03(2)(b)2.a. through c.
   e. Each Disproportionate Share Hospital is paid the greater of
      i. 85% of its allowable Health Safety Net payments; or
      ii. the revised payment calculated according to the shortfall methodology in 101 CMR 614.03(2)(b)2.a. through e.

(c) Final Settlement. The Health Safety Net Office may implement a final settlement between the Health Safety Net and an Acute Hospital for the Fiscal Year. The final settlement is calculated based on the Health Safety Net's gross liability to the Acute Hospital calculated pursuant to 101 CMR 614.06, and the payments made to the Acute Hospital during the Fiscal Year. The final settlement may occur when the Health Safety Net Office determines that it has sufficiently completed relevant claims adjudication and audit activity. For the purposes of the final settlement, the Health Safety Net Office may cease paying for claims that exceed the billing deadlines or other billing rules established at 101 CMR 613.00: *Health Safety Net Eligible Services*.

614.05: Surcharge on Acute Hospital Payments

(1) General. There is a surcharge on certain payments to Acute Hospitals and Ambulatory Surgical Centers. The surcharge amount equals the product of payments subject to surcharge as defined in 101 CMR 614.05(1)(b) and the Surcharge Percentage as defined in 101 CMR 614.05(2).

(a) Surcharge Payer.
   1. A Surcharge Payer is an individual or entity that makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services, including a Managed Care Organization; provided, however, that the term "surcharge payer" does not include Title XVIII and Title XIX of the Social Security Act programs and their beneficiaries or recipients, except Managed Care Organizations; other governmental programs of public assistance and their beneficiaries or recipients; and the workers' compensation program established pursuant to M.G.L. c. 152.
   2. The same entity that pays that Acute Hospital or Ambulatory Surgical Center for services must pay the surcharge. If an entity such as a Third Party Administrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, or advances funds to pay for the services for which it is reimbursed by the client plan, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge or advance funds to pay the surcharge for which it will be reimbursed by the client plan.

(b) Payments Subject to Surcharge. Payments subject to surcharge include
   1. direct and indirect payments made by Surcharge Payers to Massachusetts Acute Hospitals for the purchase of Acute Hospital Services and to Massachusetts Ambulatory Surgical Centers for the purchase of Ambulatory Surgical Center Services, with the following exceptions:
      a. except for Managed Care Organization payments for MassHealth members and Commonwealth Care enrollees, the surcharge applies to all payments made on or after January 1, 1998, regardless of the date services were provided; and
      b. for Managed Care Organization payments for MassHealth members younger than 65 years old and for Commonwealth Care enrollees, the surcharge applies to all payments made on or after December 1, 2010, regardless of the date services were provided;

614.05: continued

2. payments made by national health insurance plans operated by foreign governments and payments made by an embassy on behalf of a foreign national not employed by the embassy;

3. direct payments made under an employer health plan by a health care reimbursement arrangement funded by the employer; and

4. payments made by Medicare supplemental plans and other health insurance plans secondary to Medicare.

(c) Payments Not Subject to Surcharge. Payments not subject to surcharge include

1. payments, settlements, and judgments arising out of third party liability claims for bodily injury that are paid under the terms of property or casualty insurance policies;

2. payments made on behalf of MassHealth members by MassHealth, Medicare beneficiaries by Medicare (including Medicare Advantage plans) except as provided in 101 CMR 614.05(1)(b), persons enrolled in the Premium Assistance Payment Program Operated by the Health Connector, or persons enrolled in policies issued pursuant to M.G.L. c. 176K or similar policies issued on a group basis, except that payments made by Managed Care Organizations on behalf of MassHealth members younger than 65 years old who are not enrolled in an integrated care organization and Commonwealth Care enrollees are subject to surcharge;

3. payments made by an Acute Hospital to a second Acute Hospital for services that the first Acute Hospital billed to a Surcharge Payer;

4. payments made by a group of Providers, including one or more Massachusetts Acute Hospitals or Ambulatory Surgical Centers, to member Acute Hospitals or Ambulatory Surgical Centers for services that the group billed to an entity licensed or approved under M.G.L. chs. 175, 176A, 176B, 176G, or 176I;

5. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act at 5 U.S.C. 8901 *et seq*.;

6. payments made on behalf of an individual covered under the workers' compensation program under M.G.L. c. 152; and

7. payments made on behalf of foreign embassy personnel who hold a Tax Exemption Card issued by the United States Department of State.

(d) The surcharge is distinct from any other amount paid by a Surcharge Payer for the services provided by an Acute Hospital or Ambulatory Surgical Center. Surcharge amounts paid are deposited in the Health Safety Net Trust Fund.

(e) The Health Safety Net Office may issue additional guidance to clarify policies and understanding of substantive provisions of 101 CMR 614.05(1).

(2) Calculation of the Surcharge Percentage. The Health Safety Net Office uses the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to Acute Hospitals and Ambulatory Surgical Centers, established in M.G.L. c. 118E, § 68. The Health Safety Net Office establishes the Surcharge Percentage before September 1st of each year, as follows.

(a) The Health Safety Net Office determines the total amount to be collected by adjusting the Total Surcharge Amount for any over or under collections from Institutional Payers and individuals in previous years, including audit adjustments, as well as any over or under collections projected for October or November of the coming year.

(b) The Health Safety Net Office projects annual aggregate payments subject to the surcharge based on historical data, excluding projected annual aggregate payments made by Managed Care Organizations on behalf of MassHealth members and Commonwealth Care enrollees, with any adjustments the Health Safety Net Office deems necessary.

(c) The Health Safety Net Office divides the amount determined in 101 CMR 614.05(2)(a) by the amount determined in 101 CMR 614.05(2)(b).

(3) Payer Registration.

(a) Except for non-United States national insurers that have made fewer than ten payments per year in the prior three years to Massachusetts Acute Hospitals and/or Ambulatory Surgical Centers, all Institutional Payers must register with the Health Safety Net Office by completing and submitting the Surcharge Payer Registration form. These payers must submit the registration form to the Health Safety Net Office within 30 days after making a payment to any Massachusetts Acute Hospital or Ambulatory Surgical Center.

614.05: continued

(b) The Health Safety Net Office compiles lists of registered Institutional Payers, and updates the lists quarterly. The Health Safety Net Office distributes these lists to Acute Hospitals and Ambulatory Surgical Centers upon request.

(c) Institutional Payers must register only once, except that an Institutional Payer that is also a Managed Care Organization must register separately as a Managed Care Organization. A registered payer is automatically registered for the next Fiscal Year.

(4) Billing Process for Institutional Payers.

(a) Each Acute Hospital and Ambulatory Surgical Center must send a bill for the Health Safety Net surcharge to Surcharge Payers, as required by M.G.L. c. 118E, § 68. Acute Hospitals and Ambulatory Surgical Centers must send this bill to Surcharge Payers from whom they have received payment for services in the most recent four quarters for which data is available. The bill must state the Surcharge Percentage. Acute Hospitals and Ambulatory Surgical Centers must send this bill to payers before September 1st of each Fiscal Year and before the effective date of any Surcharge Percentage.

(b) Each Acute Hospital and Ambulatory Surgical Center must also send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers who have not registered with the Health Safety Net Office pursuant to 101 CMR 614.05(3)(a) and from whom they have received payment. The bill must be sent within 30 days of receiving the payment from the unregistered payer. The bill must state the Surcharge Percentage, but not the dollar amount owed, and must include notification of the surcharge payment process set forth below, as well as a registration form specified by the Health Safety Net Office. Until the Acute Hospital or Ambulatory Surgical Center receives the Registered Payer List, it must send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers that it did not already bill pursuant to 101 CMR 614.05(4)(a).

(5) Payment Process for Institutional Payers.

(a) Monthly Surcharge Liability. After the end of each calendar month, each Institutional Payer must determine the surcharge amount it owes to the Health Safety Net Trust Fund for that month. The amount owed is the product of the amount of payments subject to surcharge, as defined in 101 CMR 614.05(1)(b), by the Surcharge Percentage in effect during that month. The Institutional Payer may adjust the surcharge amount owed for any surcharge over- or under-payments in a previous period.

1. Institutional Payers that pay a global fee or capitation for services that include Acute Hospital or Ambulatory Surgical Center Services, as well as other services not subject to the surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by Acute Hospitals or Ambulatory Surgical Centers. Such Institutional Payers must file this allocation method by October 1st of each Fiscal Year. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the Institutional Payer must file the new method with the Health Safety Net Office before the new payment arrangement takes effect. Institutional Payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

a. The Health Safety Net Office will review allocation plans within 90 days of receipt. During this review period the Health Safety Net Office may require an Institutional Payer to submit supporting documentation or to make changes in this allocation method if it finds that the method does not reasonably allocate the portion of the global payment or capitation intended to be used for services provided by Acute Hospitals or Ambulatory Surgical Centers.

b. An Institutional Payer must include the portion of the global payment or capitation intended to be used for services provided by Acute Hospitals or Ambulatory Surgical Centers, as determined by this allocation method, in its determination of payments subject to surcharge.

2. An Institutional Payer must include all payments made as a result of settlements, judgments, or audits in its determination of payments subject to surcharge. An Institutional Payer may include payments made by Massachusetts Acute Hospitals or Ambulatory Surgical Centers to the Institutional Payer as a result of settlements, judgments, or audits as a credit in its determination of payments subject to surcharge.

614.05: continued

(b) Monthly Payments. Institutional Payers must make payments to the Health Safety Net Trust Fund monthly. Each Institutional Payer must remit the surcharge amount it owes to the Health Safety Net Trust Fund, determined pursuant to 101 CMR 614.05(5)(a), to the Health Safety Net Office for deposit in the Health Safety Net Trust Fund. Institutional Payers must remit the surcharge payment by the first business day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to Acute Hospitals and Ambulatory Surgical Centers in January are due by March 1st.

(c) Biannual Surcharge Payment Option.

1. An Ambulatory Surgical Center may request a biannual surcharge payment option if

a. it has remitted four or fewer payments during the previous Fiscal Year;

b. it has remitted all required surcharge payments and submitted all monthly coupons;

c. it submitted a Surcharge Verification Form for the previous Fiscal Year; and

d. it has reported less than $10,000 in surcharge payments in the Surcharge Verification Form.

2. The Health Safety Net Office notifies payers eligible for the biannual option. The Payer may elect to receive biannual surcharge notices or to continue to receive monthly notices. Each biannual surcharge payment equals the product of the appropriate surcharge percentage and all payments made by the payer to Massachusetts Acute Hospitals and Ambulatory Surgical Centers for the prior six months.

(d) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office assesses a $30.00 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) Any Institutional Payer, except Third Party Administrators, that has a surcharge liability of less than $5.00 in any month or biannual payment period may delay payment until its surcharge liability is at least $5.00. For example, XYZ Company's surcharge liability for July is $3.50 and its liability for August is $2.00. XYZ Company may delay payment in July but must remit a check for $5.50 in August.

(6) Payment Process for Individual Payers (Self-pay). There is a surcharge on certain payments made by Individual Payers to Acute Hospitals and Ambulatory Surgical Centers.

(a) Billing.

1. Acute Hospitals and Ambulatory Surgical Centers must include the surcharge amount on all bills to Individual Payers unless

a. the Patient's liability is less than the individual payment threshold of $10,000;

b. the Patient is a non-Massachusetts resident for whom the Acute Hospital or Ambulatory Surgical Center can verify that the Patient's income would otherwise qualify the Patient as a Low Income Patient under 101 CMR 613.04: *Eligible Services to Low Income Patients*; or

c. the Patient is approved for Medical Hardship in accordance with the requirements of 101 CMR 613.05: *Medical Hardship*. The bill must direct Individual Payers to pay the surcharge to the Acute Hospital or Ambulatory Surgical Center when making payment for services.

2. The amount of the surcharge billed is the product of the Patient's liability to the Acute Hospital or Ambulatory Surgical Center, and the Surcharge Percentage in effect on the billing date.

3. The amount of the surcharge owed by an Individual Payer is the product of the total amount paid by the individual to an Acute Hospital or Ambulatory Surgical Center and the Surcharge Percentage in effect on the payment date. Payments greater than or equal to the threshold received by Acute Hospitals and Ambulatory Surgical Centers from Individual Surcharge Payers are subject to the surcharge.

(b) Acute Hospitals and Ambulatory Surgical Centers must remit to the Health Safety Net Office the surcharge amount owed by Individual Payers for every payment greater than or equal to the threshold made by Individual Payers. If an Individual Payer makes separate payments over a 12-month period that are equal to or greater than the threshold and relate to an outpatient visit or inpatient stay, the surcharge amount due applies to the aggregate amount paid for the outpatient visit or inpatient stay. The first surcharge payment is due to the Health Safety Net Office when the total Individual Payer payment amount reaches the threshold.

614.05: continued

(c) Acute Hospitals and Ambulatory Surgical Centers must remit such surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by Acute Hospitals and Ambulatory Surgical Centers in January are due to the Health Safety Net Office on March 1st. Acute Hospitals and Ambulatory Surgical Centers may deduct collection agency fees for the collection of surcharge payments from Individual Payers from the total amount of surcharge payments forwarded to the Health Safety Net Office.

(d) All payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office assesses a $30.00 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) If an embassy of a foreign government pays an Acute Hospital or Ambulatory Surgical Center bill on behalf of an individual, the Provider may either bill the embassy for the individual's surcharge according to the billing and payment process for Individual Payers set forth in 101 CMR 614.05(6) or bill the embassy according to the billing process for Institutional Payers as set forth in 101 CMR 614.05(4). If the Provider chooses to bill the embassy as an Institutional Payer and the embassy is not listed on the Registered Payer List, the Provider must include the embassy on the Unmatched Payer Report and send surcharge payer registration information to the embassy.

(7) Penalties. If an Acute Hospital, Ambulatory Surgical Center, or Surcharge Payer fails to forward surcharge payments pursuant to 101 CMR 614.05, the Health Safety Net Office imposes an additional 1.5% interest penalty on the outstanding balance. The interest is calculated from the due date. For each month a payment remains delinquent, an additional 1.5% penalty accrues against the outstanding balance, including prior penalties.

(a) The Health Safety Net Office credits partial payments first to the current outstanding liability, and second to the amount of the penalties.

(b) The Health Safety Net Office may reduce the penalty at the Health Safety Net Office's discretion. In determining a waiver or reduction, the Health Safety Net Office's consideration includes, but is not limited to, the entity's payment history, financial situation, and relative share of the payments to the Health Safety Net Trust Fund.

(8) Administrative Review. The Health Safety Net Office may conduct an administrative review of surcharge payments at any time.

(a) The Health Safety Net Office reviews data submitted by Acute Hospitals, Ambulatory Surgical Centers, and Institutional Payers pursuant to 101 CMR 614.08, the Surcharge Payer Registration forms submitted by Institutional Payers pursuant to 101 CMR 614.05(3)(a), and any other pertinent data. All information provided by, or required from, any Surcharge Payer, pursuant to 101 CMR 614.00 is subject to audit by the Health Safety Net Office. For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Health Safety Net Office pursuant to 101 CMR 614.05(5)(a)1., the Health Safety Net Office's review is limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(b) The Health Safety Net Office may require the Surcharge Payer to submit additional documentation reconciling the data it submitted with data received from Acute Hospitals.

(c) If the Health Safety Net Office determines through its review that a Surcharge Payer's payment to the Health Safety Net Trust Fund was materially incorrect, the Health Safety Net Office may require a payment adjustment. Payment adjustments are subject to interest penalties and late fees, pursuant to 101 CMR 614.05(7), from the date the original payment was owed to the Health Safety Net Trust Fund.

(d) Processing of Payment Adjustments.

1. Notification. The Health Safety Net Office notifies a Surcharge Payer of its proposed adjustments. The notification is in writing and contains a complete listing of all proposed adjustments, as well as the Health Safety Net Office's explanation for each adjustment.

2. Objection Process. If a Surcharge Payer wishes to object to a Health Safety Net Office proposed adjustment contained in the notification letter, it must do so in writing, within 15 business days of the mailing of the notification letter. The Surcharge Payer may request an extension of this period for cause. The written objection must, at a minimum, contain

a. each adjustment to which the Surcharge Payer is objecting;

614.05: continued

b. the Fiscal Year for each disputed adjustment;
c. the specific reason for each objection; and
d. all documentation that supports the Surcharge Payer's position.

3. Upon review of the Surcharge Payer's objections, the Health Safety Net Office notifies the Surcharge Payer of its determination in writing. If the Health Safety Net Office disagrees with the Surcharge Payer's objections, in whole or in part, the Health Safety Net Office provides the Surcharge Payer with an explanation of its reasoning.

4. The Surcharge Payer may request a conference on objections after receiving the Health Safety Net Office's explanation of reasons. The Health Safety Net Office schedules such conference on objections only when it believes that further articulation of the Surcharge Payer's position is beneficial to the resolution of the disputed adjustments.

(e) Payment of Adjustment Amounts. Adjustment amounts and any interest penalty and late fee amounts are due to the Health Safety Net Trust Fund 30 calendar days following the mailing of the notification letter. If the Surcharge Payer submitted a written objection, then adjustment amounts and any interest penalty and late fee amounts are due to the Health Safety Net Trust Fund 30 calendar days following the mailing of the Health Safety Net Office's determination. The Health Safety Net Office may establish a payment schedule for adjustment amounts.

614.06: Payments to Acute Hospitals

(1) General Provisions.

(a) The Health Safety Net pays Acute Hospitals based on claims in accordance with the requirements of 101 CMR 613.00: *Health Safety Net Eligible Services*. The Health Safety Net Office monitors the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the Provider's service delivery patterns and/or billing activity including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

(b) Payment Types.

1. The Health Safety Net Office calculates Health Safety Net payments for each Acute Hospital for the following categories of claims for which the Health Safety Net is the primary payer:

a. Inpatient - Medical (under 101 CMR 614.06(2)(a) and (b));
b. Inpatient - Psychiatric (under 101 CMR 614.06(2)(c));
c. Inpatient - Rehabilitation (under 101 CMR 614.06(2)(d));
d. Outpatient Services (under 101 CMR 614.06(3));
e. Physician Services (under 101 CMR 614.06(4));
f. Dental Services (under 101 CMR 614.06(5));
g. Acute Hospital Outpatient Pharmacies (under 101 CMR 614.06(6));
h. Vaccine Administration (under 101 CMR 614.06(7));
i. Emergency Bad Debt - Inpatient Medical (under 101 CMR 614.06(9));
j. Emergency Bad Debt - Inpatient Psychiatric (under 101 CMR 614.06(9));
k. Emergency Bad Debt - Outpatient (under 101 CMR 614.06(9)); and
l. Medical Hardship (under 101 CMR 614.06(10)).

2. Under 101 CMR 614.06(8), the Health Safety Net Office establishes payments for claims which the Health Safety Net is the secondary payer.

3. The Health Safety Net Office reduces payments by the amount of Emergency Bad Debt recoveries and investment income on free care endowment funds. The Health Safety Net Office determines the offset of free care endowment funds by allocating free care endowment income between Massachusetts residents and nonresidents using the best data available and offsetting the Massachusetts portion against Health Safety Net claims.

(c) Method of Payment. The Health Safety Net may make payments to Acute Hospitals for Eligible Services through a safety net care payment under the Massachusetts Section 1115 Demonstration Waiver, a MassHealth supplemental Acute Hospital rate payment, or a combination thereof. The Health Safety Net Office may limit an Acute Hospital's payment for Eligible Services to comply with requirements under the Massachusetts Section 1115 Demonstration Waiver governing safety net care, including cost limits or any other federally required limit on payments under 42 U.S.C. § 1396a(a)(13) or 42 CFR 447.

614.06: continued

(d) Provider Preventable Conditions. The Health Safety Net does not pay for services related to Provider Preventable Conditions defined in 42 CFR 447.26. The Health Safety Net Office may issue administrative bulletins clarifying billing requirements and payment specifications for Provider Preventable Conditions.

(2) Pricing for Inpatient Services. The Health Safety Net Office prices Acute Hospital claims in accordance with the Medicare Inpatient Prospective Payment System (IPPS) for non-psychiatric claims and the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for psychiatric claims for the current Fiscal Year. Medicare pricing data is published in the *Federal Register* and pricing methodologies are described in 42 CFR 412. Claims from Acute Hospitals classified by Medicare as Critical Access Hospitals (CAHs), PPS-exempt Hospitals, Medicare Dependent Rural Hospitals, and Sole Community Hospitals are priced in accordance with 101 CMR 614.06(2)(b).

(a) Inpatient Medical Pricing - Standard. The Health Safety Net Office uses Medicare pricing data and the most current version of the Medicare severity diagnostic related group (MS-DRG) weights to calculate the inpatient medical pricing according to the IPPS for all Acute Hospitals except other Acute Hospitals in accordance with 101 CMR 614.06(2)(b). The Health Safety Net Office may update values as needed to conform to changes implemented by the Medicare program during the Fiscal Year. The pricing calculation includes Medicare adjustments for items such as high-cost outliers, transfer cases, special pay post-acute DRGs, partially eligible stays, and participation in the Acute Hospital Inpatient Quality Reporting program.

(b) Inpatient Medical Pricing - Other Acute Hospitals.

1. Critical Access Hospitals and PPS-exempt Hospitals. The Health Safety Net Office calculates a per discharge payment for discharges occurring at Medicare Critical Access Hospitals and PPS-exempt cancer and Pediatric Hospitals as follows.

a. The Health Safety Net Office determines the average charge per discharge using adjudicated and eligible Health Safety Net claims data from the Source Year that is available at the time of rate calculation.

b. The Health Safety Net Office determines an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using data as reported on the Hospital Cost Report for the Source Year.

c. The average cost per discharge is increased by a cost adjustment factor determined by the percent change from the IPPS index level for the Source Year and the IPPS index level forecast for the Fiscal Year, as calculated by the Health Safety Net Office as of October 1st of the Fiscal Year, and an additional factor of 1%. The product of this calculation is the per discharge payment applicable to all discharges occurring during the current Fiscal Year, except that partially eligible stays are paid pursuant to 101 CMR 614.06(2)(b)3.

d. If the Acute Hospital has fewer than 20 discharges in the Source Year, the Health Safety Net Office sets a payment on account factor for the Acute Hospital.

e. If a case qualifies as a transfer case under Medicare rules, the Health Safety Net Office calculates a *per diem* rate, capped at the full discharge payment. The *per diem* rate is the hospital-specific payment calculated under 101 CMR 614.06(2)(b)1., divided by the Acute Hospital's average length of stay.

2. Sole Community Hospitals. The Health Safety Net Office calculates a hospital-specific per discharge amount for Acute Hospitals classified as Sole Community Hospitals, rather than the adjusted standardized amount. This amount is based on the hospital-specific rate provided by the Medicare fiscal intermediary, adjusted for inflation. The payments may include transfer, outlier, and special pay amounts, using the hospital-specific rate in these calculations, for qualifying cases. Partially eligible stays are paid pursuant to 101 CMR 614.06(2)(b)3.

3. Medicare Dependent Rural Hospitals. The Health Safety Net Office calculates a blended payment consisting of 75% of a hospital-specific payment and 25% of the Operating DRG Payment for Acute Hospitals classified by Medicare as Medicare Dependent Rural Hospitals. The payments may include transfer, outlier, and special pay amounts, using the hospital-specific blended rate in these calculations, for qualifying cases. Partially eligible stays are paid pursuant to 101 CMR 614.06(2)(b)3.

(c) Inpatient Psychiatric Pricing.

614.06: continued

1. Psychiatric Case. A case is classified as psychiatric if
   a. the Acute Hospital has a Medicare psychiatric unit;
   b. the primary diagnosis is related to a psychiatric disorder; and
   c. the claim includes psychiatric accommodation charges.

2. Psychiatric Pricing. The Health Safety Net Office uses Medicare pricing data to calculate a *per diem* price according to the IPF-PPS. The Health Safety Net Office may update values as needed to conform to changes implemented by the Medicare Program during the Fiscal Year. The pricing calculation includes Medicare adjustments such as a teaching hospital adjustment, electroconvulsive therapy (ECT) adjustment, high-cost outliers, adjustments for participation in the Inpatient Psychiatric Facilities Quality Reporting program, and any other adjustments in accordance with Medicare pricing provisions pursuant to 42 CFR 412.424, including adjustments for specific DRGs, the presence of comorbidities, Patient age, and length of stay.

(d) Inpatient Rehabilitation Pricing.

1. Rehabilitation Case. A case is classified as rehabilitation if
   a. the Acute Hospital has a Medicare rehabilitation unit; and
   b. the claim includes rehabilitation accommodation charges.

2. Payment. Rehabilitation cases are paid on a *per diem* basis. The payment is determined using the Acute Hospital's most recently filed CMS-2552 Cost Report. The rate is the sum of total rehabilitation PPS payments and reimbursable bad debts, divided by total rehabilitation days.

(e) Hospital-acquired Conditions.

1. All Acute Hospitals, including but not limited to PPS-exempt Acute Hospitals, are required to report the present on admission indicator for all diagnosis codes on inpatient claims.

2. The Health Safety Net Office does not assign an inpatient case to a higher paying MS-DRG if a hospital-acquired condition that was not present on admission occurs during the stay. For Hospital Services paid pursuant to 101 CMR 614.06(2)(a) and (b), the DRG payment is reduced in accordance with Medicare principles.

(f) Serious Reportable Events. The Health Safety Net does not pay for services related to Serious Reportable Events as defined in 105 CMR 130.332(A): *Definitions Applicable to 105 CMR 130.332* based on standards by the National Quality Forum. The Health Safety Net Office may issue administrative bulletins clarifying billing requirements and payment specifications for such services.

(g) Administrative Days. The Health Safety Net pays Administrative Days at the *per diem* rate established by MassHealth pursuant to the Acute Hospital Request for Applications for the current Fiscal Year when the Health Safety Net is the primary payer. When the Health Safety Net is not the primary payer, Administrative Days are paid per 101 CMR 614.06(8).

(3) Pricing for Outpatient Services. The Health Safety Net pays a per visit amount for each outpatient visit that exceeds $20.00. An outpatient visit includes all outpatient services, excluding hospital-based physician services provided in a single day, except for dental and pharmacy services, as described in 101 CMR 614.06(5) and (6). The outpatient per visit amount is determined as follows.

(a) For each Acute Hospital, the Health Safety Net Office calculates an average outpatient charge per visit, using such adjudicated and eligible Health Safety Net claims data from the Source Year as of June 15, 2016. Charges for dental claims, charges for claims that are $20.00 or below, and charges for outpatient claims within 72 hours of an inpatient admission are excluded. For Critical Access Hospitals and PPS-exempt Hospitals, only charges for claims within 24 hours of an inpatient admission are excluded.

(b) The Health Safety Net Office determines a hospital-specific Medicare payment on account factor (PAF), defined as the percent of Medicare outpatient charges that are paid on average. The PAF is calculated using the best available data and subject to review and adjustment by the Health Safety Net Office.

(c) The Health Safety Net Office determines an outpatient payment per visit by multiplying the average outpatient charge per visit by the Medicare PAF. This product is further increased by a cost adjustment factor as calculated in 101 CMR 614.06(2)(b)1.c.

(d) Disproportionate Share Hospitals and non-teaching Acute Hospitals receive a transitional add-on of 25% of the outpatient per visit payment rate.

614.06: continued

(e) The per visit payment for PPS-exempt cancer and Pediatric Hospitals and Medicare Critical Access Hospitals are determined using the ratio of costs to charges as reported on the Hospital Cost Report for the Source Year rather than the Medicare payment on account factor data.

(f) Claims for visits that are less than or equal to $20.00 are paid by multiplying the Medicare payment on account factor by the billed charges.

(4) Pricing for Physician Services. The Health Safety Net Office prices hospital-based physician service claims according to the Medicare Physician Fee Schedule.

(5) Dental Services. The Health Safety Net Office prices claims from Acute Hospitals for outpatient dental services provided at Acute Hospitals and Hospital Licensed Health Centers using the lesser of the allowable charges billed to the HSN, or the fees established in 101 CMR 314.00: *Dental Services*. No additional outpatient per visit payment is paid for dental services.

(6) Acute Hospital Outpatient Pharmacies.

(a) Prescribed Drugs. For Acute Hospitals with outpatient pharmacies, the Health Safety Net Office prices prescribed drugs using rates set forth in 101 CMR 331.00: *Prescribed Drugs*. The rate is reduced by the amount of Patient cost-sharing set forth in 101 CMR 613.00: *Health Safety Net Eligible Services*. Claims are adjudicated by the MassHealth Pharmacy Online Payment System.

(b) Part B Covered Services. Medical supplies normally covered by the Medicare Part B program that are dispensed by Acute Hospital outpatient pharmacies that are not Part B Providers are priced at 20% of the rates set forth in 101 CMR 322.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment* and 101 CMR 331.00: *Prescribed Drugs*.

(7) Vaccine Administration. The Health Safety Net Office allows for separate payment for a vaccine administration and an individual medical visit only if the vaccine administration is not occurring on the same day as the office visit. A separate fee for the administration of vaccines is payable only when the sole purpose for a visit is vaccine administration. The fee is priced in accordance with the provisions of 101 CMR 317.00: *Rates for Medicine Services*.

(8) Secondary Payer. The Health Safety Net pays claims for which it is not the primary payer as follows.

(a) 95% Rule. If a claim billed to the Health Safety Net has a ratio of total billed net charges to total claim charges that is greater than 95%, the Health Safety Net pays the claim in accordance with the applicable primary payment rules.

(b) Medicare as Primary Payer. For any allowable claim for which Medicare or a Medicare Advantage plan (as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) is the primary payer, the Health Safety Net pays in accordance with 101 CMR 613.03(1)(c)8. If Medicare or a Medicare Advantage plan denied services on a claim as non-covered services and those services are Eligible Services, the payment for the services is the product of the net billed charges and the Medicare payment on account factor as defined in 101 CMR 614.06(3)(b), except as provided at 101 CMR 614.06(8)(e).

(c) MassHealth as Primary Payer. Health Safety Net pays allowable claims with MassHealth as the primary payer in accordance with 101 CMR 613.03(1)(c).

(d) Premium Assistance Payment Program Operated by the Health Connector as the Primary Payer. Health Safety Net pays allowable claims with Premium Assistance Payment Program Operated by the Health Connector as the primary payer in accordance with 101 CMR 613.03(1)(c).

(e) Private Insurance and Other Primary Payers. For any allowable claim for which a payer other than the payers discussed in 101 CMR 614.06(8)(b) through (d) is the primary payer, the Health Safety Net pays claims in accordance to 101 CMR 613.03(1)(c)4. The payment is the product of the net billed charges and the Medicare payment on account factor as defined in 101 CMR 614.06(3)(b). For inpatient services, the payment will not exceed the amount the Health Safety Net Office would have paid if it were the primary payer.

614.06: continued

(9) Bad Debt Pricing. Except as provided at 101 CMR 614.06(9)(a), the Health Safety Net Office calculates Emergency Bad Debt payments for inpatient, psychiatric, and outpatient Eligible Services, using the methodology in 101 CMR 614.06(2) and (3), except that the Emergency Bad Debt outpatient rate does not include the transitional add-on cited in 101 CMR 614.06(3)(d).

(a) If an Acute Hospital has fewer than 20 Emergency Bad Debt claims during the Source Year, the Health Safety Net Office sets the Emergency Bad Debt rate as the outpatient primary per visit rate established in 101 CMR 614.06(3), excluding the transitional add-on under 101 CMR 614.06(3)(d).

(b) The Health Safety Net Office pays Hospital Licensed Health Centers 75% of the PPS Rate as published by Medicare for Bad Debt claims for Urgent Care Services that meet the requirements in 101 CMR 613.00: *Health Safety Net Eligible Services*.

(10) Medical Hardship. The Health Safety Net pays for claims for Patients deemed eligible for Medical Hardship pursuant to 101 CMR 613.00: *Health Safety Net Eligible Services*. The Health Safety Net Office reduces the amount of the billed charges by any third-party payments, third-party contractual discounts, Patient payments, and the amount of the Medical Hardship contribution. If the adjusted charges are less than the total claim charges, the claim is paid as a secondary claim in accordance with the provisions of 101 CMR 614.06(8). If the billed charges are not reduced, the Health Safety Net pays the claim as if it were a primary Health Safety Net claim.

(11) Other. The Health Safety Net makes an additional payment of $3.85 million to freestanding Pediatric Hospitals with more than 1,000 Medicaid discharges during the Source Year for which a standard payment amount per discharge was paid by MassHealth pursuant to the Acute Hospital Request for Applications, as determined by paid claims in the Medicaid Management Information System as of June 15, 2016, and for which MassHealth was the primary payer. The Health Safety Net may make an additional payment adjustment for the two Disproportionate Share Hospitals with the highest relative volume of free care costs in FY2006.

(12) Remediated Claims. Remediated claims include claims that were paid or voided during a prior Fiscal Year, but due to hospital resubmission or actions of the Health Safety Net Office were remediated by a payment or void during the current Fiscal Year. The Health Safety Net Office adjusts the payment or void amounts to reflect the applicable payment methods that would have been in use at the time of the original claim payment.

614.07: Payments to Community Health Centers

(1) General Provisions.

(a) The Health Safety Net pays Community Health Centers based on claims submitted to the Health Safety Net Office, less applicable cost sharing amount, in accordance with the requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* and claims specifications determined by the Health Safety Net Office. The Health Safety Net Office monitors the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the Provider's service delivery patterns including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

(b) The Health Safety Net will pay a Community Health Center for prescribed drugs only if the Community Health Center is providing prescribed drugs in accordance with 101 CMR 613.03(2).

(2) Payments for Services.

(a) The Health Safety Net will pay Community Health Centers a Medicare-based rate per Patient per day for Reimbursable Health Services unless otherwise specified by the table below. Payment will be either the PPS Rate, or the total charges applicable under the PPS Rate for services furnished, whichever is less. The PPS Rate will be adjusted for geographic differences in the cost of services based on the Medicare FQHC PPS Geographic Adjustment Factors. In addition, the PPS Rate will be increased according to 42 CFR 405.2467 when a Community Health Center furnishes care to a Patient that is new to the Community Health Center or to a Patient receiving a comprehensive initial visit or an annual wellness visit.

614.07: continued

(b) The PPS Rate applies to Individual Medical Visits, surgical procedures, behavioral health diagnostic and treatment services, diagnostic vision care, medical nutrition therapy, diabetes self-management treatment, and tobacco cessation services. Only one visit per Patient per day can be billed with the following exceptions:

1. when a mental health visit occurs on the same day as a medical visit; or
2. when an illness or injury necessitating a visit occurs on the same day as another visit.

(c) For Reimbursable Health Services not included in the PPS Rate, the Health Safety Net pays Community Health Centers according to the following table, except for claims for Bad Debt for Urgent Care Services. Payments are based on regulations named. Some Reimbursable Health Services under 101 CMR 614.07(2) may be listed as individual consideration in the regulations named. For individual consideration codes billable to the Health Safety Net, the payment rate is calculated as (total payments made to Community Health Centers by MassHealth for the code) / (total number of claims paid by MassHealth for the code) during the Source Year. If MassHealth payment and claims information for a code is not available for Source Year, the rate for the code will be based on Medicare fee schedules or other relevant sources. The Health Safety Net pays only for services listed in the HSN CHC Billable Procedure Codes list.

614.07: continued

Type of Service	Payment Rules	Payment Source
Medical Visit - Urgent Care (code 99051)	Payable separately from an Individual Medical Visit.	Rate for 99050 in 101 CMR 304.00: *Rates for Community Health Centers*
Pulmonary Diagnostic (technical component only)	Payable separately only if not occurring on the same day as an Individual Medical Visit.	101 CMR 317.00: *Rates for Medicine Services*.
Cardiology Diagnostic (technical component only)	Payable separately from an Individual Medical Visit.	101 CMR 317.00: *Rates for Medicine Services*.
Obstetrical Services	Payable separately from an Individual Medical Visit	101 CMR 316.00: *Rates for Surgery and Anesthesia Services*
Behavioral Health (group treatment, medication management, psychological testing, and methadone services)	Payable separately from an Individual Medical Visit.	For group treatment and medication visits, rates in 101 CMR 306.00: *Rates of Payment for Mental Health Services Provided in Community Health Centers and Mental Health Centers*; for psychological testing, rates in 101 CMR 329.00: *Psychological Testing, Treatment, and Related Services*; for methadone services, rates in 101 CMR 346.00: *Rates for Certain Substance-related and Addictive Disorders Programs*
Radiology	Payable separately from an Individual Medical Visit.	101 CMR 318.00: *Rates for Radiology Services*
Clinical Laboratory	Payable separately from an Individual Medical Visit.	101 CMR 320.00: *Rates for Clinical Laboratory Services*
Dental	Payable separately from an Individual Medical Visit.	Lesser of allowable charges billed to the HSN, or fees established in 101 CMR 314.00: *Rates for Dental Services*
340B Pharmacy Services	Payment will be reduced by the amount of Patient cost-sharing set forth in 101 CMR 613.00: *Health Safety Net Eligible Services*.	101 CMR 331.00: *Prescribed Drugs*
Vision Care (dispensing and repair)	Payable separately from an Individual Medical Visit.	101 CMR 315.00: *Vision Care Services and Ophthalmic Materials*
Family Planning Services	Family planning counseling, prescribed drugs, family planning supplies, and related laboratory tests can be billed in addition to an Individual Medical Visit. An Individual Medical Visit is not payable for the sole purpose of replenishing a Patient's supply of contraceptives.	101 CMR 312.00: *Rates for Family Planning Services*
Preventive Services/Risk Factor Reduction (code 99402)	Payable separately from an Individual Medical Visit.	101 CMR 312.00: *Rates for Family Planning Services*
Immunization Visits	Payable separately only if not occurring on the same day as an Individual Medical Visit.	101 CMR 317.00: *Rates for Medicine Services*
Vaccines Not Included in the Individual Medical Visit or Supplied by the Department of Public Health	Payable separately from an Individual Medical Visit.	101 CMR 317.00: *Rates for Medicine Services*

614.07: continued

(3) Bad Debt Payments for Urgent Care Services. The Health Safety Net pays Community Health Centers at 75% of the payment rates in 101 CMR 614.07(2) for Bad Debt claims for Urgent Care Services that meet the requirements in 101 CMR 613.00: *Health Safety Net Eligible Services*.

614.08: Reporting Requirements

(1) General. Each Provider, Surcharge Payer, and Ambulatory Surgical Center must file with or make available to the Health Safety Net Office or to an entity designated by the Health Safety Net Office to collect data, as applicable, information that is required or that the Health Safety Net Office deems reasonably necessary for implementation of 101 CMR 614.00.

(a) The Health Safety Net Office may revise the data specifications, the data collection scheduled, or other administrative requirements by administrative bulletin.

(b) The Health Safety Net Office or its designee may audit data submitted under 101 CMR 614.00 to ensure accuracy. The Health Safety Net Office may adjust payments to reflect audit findings. Providers must maintain records sufficient to document compliance with all documentation requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* and 614.00.

(2) Acute Hospitals.

(a) The Health Safety Net Office may require Acute Hospitals to submit interim data on revenues and costs to the Health Safety Net or to an entity designated by the Health Safety Net Office to collect data to monitor compliance with federal upper limit, cost limit, and disproportionate share payment limits. Such data may include, but not be limited to, gross and net patient service revenue for Medicaid non-managed care, Medicaid managed care, the Premium Assistance Payment Program Operated by the Health Connector, and all payers combined; and total patient service expenses for all payers combined.

(b) Surcharge Payment Data.

1. Unmatched Payer Report. Each Acute Hospital must submit to the Health Safety Net Office a quarterly Unmatched Payer Report. The Acute Hospital must report the total amount of payments for services received from each Institutional Payer that does not appear on the Registered Payer List. The Acute Hospital must report these data in an electronic format specified by the Health Safety Net Office.

2. Quarterly Report for Private Sector Payments. Each Acute Hospital must report to the Health Safety Net Office total payments made by the largest Institutional Surcharge Payers. The Health Safety Net Office specifies the Institutional payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements by administrative bulletin.

(c) Penalties. The Health Safety Net Office may deny payment for Eligible Services to any Acute Hospital that fails to comply with the reporting requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* or 614.00 until such Acute Hospital complies with the requirements. The Health Safety Net Office notifies such Acute Hospital in advance of its intention to withhold payment.

(3) Community Health Centers. The Health Safety Net Office may deny payment for Eligible Services to any Community Health Center that fails to comply with the reporting requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* or 614.00 until such Community Health Center complies with the requirements. The Health Safety Net Office notifies such Community Health Center in advance of its intention to withhold payment.

(4) Surcharge Payers.

(a) Monthly Surcharge Payment Report. The Health Safety Net Office may require that an Institutional Payer submit to the Health Safety Net Office monthly reports of payments to Acute Hospitals and Ambulatory Surgical Centers.

614.08: continued

(b) Third Party Administrators. A Third Party Administrator Surcharge Payer that makes payments to Acute Hospitals and Ambulatory Surgical Centers on behalf of one or more insurance carriers must file an annual report with the Health Safety Net Office. The report must include the name of each insurance carrier for which it makes surcharge payments. The Health Safety Net Office may also specify additional reporting requirements concerning payments made on behalf of self-insured plans. Reports must be in an electronic format specified by the Health Safety Net Office. Said reports must be filed by July 1st of each year for the time period requested by the Health Safety Net Office.

(c) Penalties. Any Surcharge Payer that fails to file data, statistics, schedules, or other information with the Health Safety Net Office pursuant to 101 CMR 614.08(4) or that falsifies same, is subject to a civil penalty of not more than $5,000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General brings any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 101 CMR 614.00.

(5) Ambulatory Surgical Centers.

(a) Unmatched Payer Report. Each Ambulatory Surgical Center must submit a quarterly Unmatched Payer Report to the Health Safety Net Office in accordance with a schedule specified by the Health Safety Net Office. The Ambulatory Surgical Center must report the total amount of payments for services received from each Institutional Surcharge Payer that does not appear on the Registered Payer List. The Ambulatory Surgical Center must report these data in an electronic format specified by the Health Safety Net Office.

(b) Quarterly Report for Private Sector Payments. Each Ambulatory Surgical Center must report to the Health Safety Net Office total payments made by the largest Institutional Surcharge Payers. The Health Safety Net Office specifies the Institutional Payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements by administrative bulletin.

614.09: Special Provisions

(1) Financial Hardship. An Acute Hospital or Surcharge Payer may request a deferment or partial payment schedule due to financial hardship.

(a) In order to qualify for such relief, the Acute Hospital or Surcharge Payer must demonstrate that its ability to continue as a financially viable going concern will be seriously impaired if payments pursuant to 101 CMR 614.05 were made.

(b) If the Health Safety Net Office finds that payments would be a financial hardship, the Health Safety Net Office may, at its discretion, establish the terms of any deferment or partial payment plan deferment. The deferment or payment schedule may include an interest charge.

1. The interest rate used for the payment schedule does not exceed the prime rate plus 2%. The prime rate used is the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.
2. A Surcharge Payer may make a full or partial payment of its outstanding liability at any time without penalty.
3. If a Surcharge Payer fails to meet the obligations of the payment schedule, the Health Safety Net Office may assess penalties pursuant to 101 CMR 614.05.

(2) Severability. The provisions of 101 CMR 614.00 are severable. If any provision or the application of any provision to any Acute Hospital, Community Health Center, surcharge payer, or Ambulatory Surgical Center or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 614.00 or the application of such provisions to Acute Hospitals, Community Health Centers, or circumstances other than those held invalid.

614.09: continued

(3) Administrative Bulletins. The Health Safety Net Office may issue administrative bulletins to clarify policies and understanding of substantive provisions of 101 CMR 614.00 and specify information and documentation necessary to implement 101 CMR 614.00.

REGULATORY AUTHORITY

101 CMR 614.00: M.G.L. c. 118E.