105 CMR 223.000: PEDIATRIC IMMUNIZATION PROGRAM ASSESSMENT

Section

223.001: Scope and Purpose

105 CMR 223.000 governs the procedures for collecting an assessment to fund the Pediatric Immunization Program. The assessment is a surcharge on certain payments made to Massachusetts acute hospitals and ambulatory surgical centers.

223.002: Authority

105 CMR 223.000 is adopted pursuant to St. 2013, c. 38, Line Item 4580-1000 and M.G.L. c. 111, § 3.

223.003: Definitions

Ambulatory Surgical Center means any distinct entity located in Massachusetts that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the U.S. Centers for Medicare and Medicaid (CMS) requirements for participation in the Medicare program.

Ambulatory Surgical Center Services means 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.

Department means the Massachusetts Department of Public Health.

Hospital means an acute 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.

Hospital Services means services listed on an acute hospital's license issued by the Department.

Indirect Payment means a payment made by a payer to a group of providers, including one or more Massachusetts acute care hospitals or ambulatory surgical centers, that then forward the payment to member hospitals or ambulatory surgical centers; or a payment made to an individual to reimburse him or her for a payment made to a hospital or ambulatory surgical center.

Managed Care Organization means a managed care organization as defined in M.G.L. c. 118E, § 64.

Medicaid means the medical assistance program administered by the Executive Office of Health and Human Services Office of Medicaid pursuant to M.G.L. c. 118E and in accordance with Titles XIX and XXI of the Federal Social Security Act, and a Section 1115 Demonstration Waiver.

Medicare Program means the medical insurance program established by Title XVIII of the Social Security Act.

Payer means a surcharge payer that meets the criteria set forth in 105 CMR 223.100(B).

Payment means a check, draft, or other paper instrument, an electronic fund transfer, or any order, instruction, or authorization to a financial institution to debit one account and credit another.

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Payments Subject to Surcharge means all amounts paid, directly or indirectly, by surcharge payers to acute hospitals for health services and ambulatory surgical centers for ambulatory surgical center services; provided, however, that it shall not include:

(a) payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies; and

(b) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under M.G.L. c. 176K or similar policies issued on a group basis; provided further, that it shall include payments made by a managed care organization on behalf of:

1. Medicaid recipients under age 65; and

2. enrollees in the commonwealth care health insurance program; and provided further, that it may exclude amounts established under regulations promulgated by the department for which the costs and efficiency of billing a surcharge payer or enforcing collection of the surcharge from a surcharge payer would not be cost effective.

Surcharge means the surcharge on payments made to hospitals and ambulatory surgical centers established by M.G.L. c. 118E, § 68.

Surcharge Payer means an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers; provided, however, that it shall include a managed care organization; and provided further, that it shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients and the workers' compensation program established under M.G.L. c. 152.

Third Party Administrator means 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 will be 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.

223.100: Determination of Assessment Liability and Payment

(A) The Department shall collect an assessment on certain payments to hospitals and ambulatory surgical centers. The assessment amount equals the product of

(1) payments subject to the assessment as defined in 105 CMR 223.100(C); and

(2) the assessment percentage as defined in 105 CMR 223.100(D).

(B) (1) Payers are subject to the assessment if:

(a) the payer is a surcharge payer; and

(b) the payer's payments subject to surcharge were $1,000,000 or more during the previous state fiscal year or the most recent state fiscal year for which data is available.

(2) The same entity that pays the hospital or ambulatory surgical center for services must pay the assessment.

(3) A payer that pays for hospital or ambulatory surgical center services on behalf of a client plan must pay the assessment on those services. A payer that administers payments for health care services on behalf of a client plan in exchange for an administrative fee will be deemed to use the client plan's funds to pay for health care services whether the payer pays providers with funds from the client plan, with funds advanced by the payer subject to reimbursement by the client plan, or with funds deposited with the payer by the client plan.

(C) Payments subject to the assessment include direct and indirect payments made by payers in a time period as determined by the Department and released annually, to hospitals for the purchase of hospital services; and to ambulatory surgical centers for the purchase of ambulatory surgical center services.

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(D) The Department will determine the assessment percentage as follows:

(1) The Department will determine the total amount to be collected to cover the costs of purchasing and distributing childhood vaccines. The Department may adjust the amount to reflect over or under collections from the prior year's assessment.

(2) The Department will determine projected aggregate payments subject to the assessment based on payers' historical data related to the surcharge, adjusted as the Department deems necessary to create an accurate projection.

(3) The assessment percentage is determined by dividing the total amount to be collected determined under 105 CMR 223.100(D)(1) by total projected payments determined under 105 CMR 223.100(D)(2).

(4) The Department may establish the assessment percentage by Administrative Bulletin. The Department may adjust the assessment percentage by Administrative Bulletin if an adjustment is necessary to collect the revenue required to be collected.

(E) Each payer shall determine its assessment liability in accordance with guidance issued by the Department in administrative bulletins. The assessment liability is the product of the payer's payments subject to the assessment, as defined in 105 CMR 223.100(C) and the assessment percentage as defined in 105 CMR 223.100(D).

(F) Payers that pay a global fee or capitation for services that include hospital or ambulatory surgical center services, as well as other services not subject to the assessment, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by hospitals or ambulatory surgical centers. Such payers must file this allocation with the Department by February 1st of each year. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the payer must notify the Department and file a new allocation method at least 45 days before the new payment arrangement takes effect. Payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

(1) The Department will review allocation plans within 90 days of receipt. During this review period, the Department may require a 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 hospitals or ambulatory surgical centers.

(2) A payer must include the portion of the global payment or capitation intended to be used for services provided by hospitals or ambulatory surgical centers, as determined by this allocation method, in its determination of payments subject to the assessment.

(G) A payer must include all payments made as a result of settlements, judgments or audits in its determination of payments subject to the assessment. A payer may include payments made by Massachusetts hospitals or ambulatory surgical centers to the payer as a result of settlements, judgments or audits as a credit in its determination of payments subject to the assessment.

(H) Each payer shall pay its assessment liability in accordance with a schedule developed and released by the Department through administrative bulletin.

223.200: Administrative Review

(A) The Department may conduct an administrative review of assessment liability payments at any time.

(B) The Department will review data submitted by hospitals, ambulatory surgical centers, and any other relevant data, including surcharge data. All information provided by, or required from, any payer, pursuant to 105 CMR 223.000 shall be subject to audit by the Department. For assessment liability payments based upon a global fee or capitation payment allocated according to an allocation method accepted by the Department pursuant to 105 CMR 223.100(F), the Department's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(C) The Department may require the payer to submit additional documentation reconciling the data it submitted with data received from hospitals and ambulatory surgical centers.

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(D) If the Department determines through its review that a payer's assessment liability payment was materially incorrect, the Department will require a payment adjustment.

(1) Notification. The Department shall notify the payer in writing if it determines there should be a payment adjustment. The notification will include a detailed explanation of the proposed adjustment.

(2) Objection Process. A payer may object to proposed adjustment in writing, within 15 business days of the mailing of the notification letter. The payer may request an extension of this period for cause. The written objection must, at a minimum, contain:

(a) the specific reason(s) for each of the payer's objections; and

(b) all documentation that supports the payer's position.

(3) Written Determination. Following review of the payer's objection, the Department will notify the payer of its determination in writing, with an explanation of its reasoning.

(4) Payment of Adjustment Amounts. Payment of adjustment amounts are due within 30 days following the mailing of the determination letter.

223.300: Other Provisions

(1) Reporting Requirements. Each payer shall file or make available information that is required or that the Department deems reasonably necessary for calculating and collecting the assessment.

(2) Administrative Bulletins. The Department may issue administrative bulletins to clarify policies, update administrative requirements, and specify information and documentation necessary to implement 105 CMR 223.000.

223.400: Severability

The provisions of 105 CMR 223.000 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 105 CMR 223.000 or the application of such provisions.

REGULATORY AUTHORITY

105 CMR 223.000: M.G.L. c. 111, § 3 and St. 2013, c. 38.