Safety Net Care Pool Payment Methodologies

This Attachment describes methodologies for four distinct types of payments that will be made from the Safety Net Care Pool. Payment methodologies pertaining to Commonwealth Care Health Insurance premium assistance payments are described on page 1; payment methodologies pertaining to acute hospital payments are described on page 1; payment methodologies pertaining to non-acute hospital payments are described on page 4; and payment methodologies pertaining to costs related to individuals residing in an Institution for Mental Disease are described on page 8.

Premium Assistance Payment Methodologies

Income-based sliding scale premium contribution payment for individuals with household income that does not exceed 300% FPL according to a schedule to be developed by the Commonwealth Care Health Insurance Connector Authority. Further detail on the exact payment methodology will be submitted not later than December 31, 2006.

Acute Hospital Payment Methodologies

MassHealth will assist Hospitals that carry a financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with the terms and conditions of the Commonwealth's 1115 waiver governing Safety Net Care, and subject to compliance with all applicable federal requirements, MassHealth will make an additional payment above the state plan rate to Hospitals which qualify for such payment under any one or more of the classifications listed below. Only Hospitals that have an executed Contract with the Executive Office of Health and Human Services (EOHHS), pursuant to the Acute Hospital Request for Applications (RFA), are eligible for the following safety net care payments. If a Hospital's RFA Contract is terminated, its payment shall be prorated for the portion of the year during which it had a Contract with EOHHS. The remaining funds it would have received shall be apportioned to remaining eligible Hospitals. The following describes how Hospitals will qualify for each type of safety net care payment and the methodology for calculating those payments.

When a Hospital applies to participate in MassHealth, its eligibility and the amount of the following safety net care payments shall be determined. As new Hospitals apply to become MassHealth providers, they may qualify for such payments if they meet the criteria under one or more of the following classifications. Therefore, some safety net care payments may require recalculation. Hospitals will be informed if the payment amount will change due to reapportionment among the qualified group and will be told how overpayments or underpayments by EOHHS will be handled at that time.

All Safety Net Care payments are subject to the availability of federal financial participation.

1. Section 122 of Chapter 58 Safety Net Health System Payments

The Executive Office of Health and Human Services will make supplemental payments to the two publicly operated or public-service disproportionate share hospitals with the highest relative volume of uncompensated care costs in hospital fiscal year 2007. The payment amount will be determined according to Section 122 of Chapter 58 of the Acts of 2006, and will not exceed $200 million for total unreimbursed free care and Medicaid services, including Medicaid managed care services, and the operation of the respective safety net health care systems.

2. High Public Payer Hospitals: Sixty-Three Percent Hospitals (Total Annual Funding: $11,700,000)

The eligibility criteria and payment formula for this classification are specified by regulations of the Division of Health Care Finance and Policy (DHCFP). High Public Payer Hospital payments shall be made in accordance with such regulations, as they may be amended, or in accordance with successor regulations. (See current regulations at 114.1 CMR 36.07(2) attached as **Exhibit 1**). For purposes of this classification only, the term "disproportionate share Hospital" refers to any Acute Hospital that exhibits a payer mix where a minimum of sixty-three percent of the Acute Hospital's Gross Patient Service Revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payers and free care.

3. Public Service Hospital Safety Net Payment

a. Determination of Eligibility

The Public Service Hospital Safety Net Care payment is an additional payment for the following eligible hospitals:

(1) is a public hospital or a public service hospital;

(2) has a volume of free care charges in FY93 that is at least 15% of total charges; and

(3) is an essential safety net provider in its service area, as demonstrated by delivery of services to populations with special needs, including persons with AIDS, trauma victims, high-risk neonates, and indigent patients without access to other providers.

b. Payment Methodology

An additional adjustment shall be calculated for Hospitals that are eligible for the Public Service Hospital Safety Net Care payment.

(1) This payment amount shall be reasonably related to the services provided to patients eligible for medical assistance under Title XIX, or to low-income patients.

(2) EOHHS shall make a Public Service Hospital Safety Net Care payment; provided that such payment shall be adjusted if necessary, to ensure that such payment does not exceed 100% of such hospital’s total unreimbursed free care and Medicaid charges for the fiscal year. Such unreimbursed charges shall be calculated by EOHHS using the best data available, as determined by EOHHS for the fiscal year.

(3) The payment of the Public Service Hospital Safety Net Care payment to a qualifying hospital in any rate year shall be contingent upon the continued availability of federal financial participation for such payments.

4. Uncompensated Care Safety Net Care Payment

Hospitals eligible for this payment are those acute facilities that incur costs for services to low-income patients as defined in DHCFP regulations at 114.6 CMR 11.00 (see **Exhibit 2** for current

regulations). The payment amounts for eligible Hospitals are determined and paid by DHCFP in accordance with its regulations at 114.6 CMR 11.00, as they may be amended, or in accordance with successor regulations.

5. Safety Net Care Payments for Pediatric Specialty Hospitals and Hospitals with Pediatric Specialty Units

The eligibility criteria and payment formula for this classification are specified by regulations of DHCFP, as they may be amended, or in accordance with successor regulations (see current regulations at 114.1 CMR 36.07(8) attached as **Exhibit 1**). In order to be eligible for this adjustment, the Hospital must be a Pediatric Specialty Hospital or Hospital with a Pediatric Specialty Unit as defined Section II. In addition, the Hospital must have a signed Contract with EOHHS for the period that such adjustment is in effect.

Non-Acute Hospital Payment Methodologies

MassHealth will assist Hospitals that carry a financial burden of caring for uninsured and publicly insured persons of the Commonwealth. In accordance with the terms and conditions of the Commonwealth's 1115 waiver governing Safety Net Care, and subject to compliance with all applicable federal requirements, MassHealth will make an additional payment above the Title XIX state plan rate to Non-Acute Hospitals that qualify for such payment under any one or more of the classifications listed below. The following describes how Hospitals will qualify for each type of Safety Net Care payments and the methodology for calculating those payments.

All Safety Net Care payments are subject to the availability of federal financial participation.

1. Safety Net Care Payment for Special Population State-Owned Non-Acute Hospitals Operated by the Department of Public Health

The Commonwealth shall determine a Safety Net Care payment for all eligible Special Population State-Owned Non-Acute Hospitals, using the data and methodology described below.

A. Data Sources

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the Safety Net Care payment to determine the cost, free care, Charge, patient day, and net revenue amounts. If the DHCFP-403 report is not available, the Commonwealth shall use the most recent available pervious DHCFP-403 report to estimate these variables.

B. Determination of Eligibility

1. In order to qualify for the extraordinary Safety Net Care payment, a State-Owned Non-Acute Hospital must:

   a. be owned or operated by the Massachusetts Department of Public Health;

   b. provide treatment to people with AIDS, tuberculosis patients, the medically needy homeless, multiply handicapped pediatric patients and patients with combined medical and psychiatric needs; and

   c. participate as a Non-Acute Hospital provider in the MassHealth program.

C. Determination of Payment

For each state-owned special population Non-Acute Hospital that qualifies for the Safety Net Care payment this Section, the payment amount shall be calculated as follows:

1. first, determine the annual cost and revenue of providing hospital services to Medicaid-eligible and uninsured individuals using the data sources describe in this Section;

2. second, subtract the annual revenue from the annual costs to determine the uncompensated costs of providing services to Medicaid-eligible and uninsured individuals;

3. calculate adjustments to account for any significant changes in utilization, cost trends, or payment methods. Inflation will be considered by applying a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals;

4. the Safety Net Care payment amount shall be computed up to 100% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

2. <u>Safety Net Care payment for State-Owned Non-Acute Hospitals Operated by the Department of Mental Health</u>

The Commonwealth shall determine a Safety Net Care payment for all eligible State-Owned Non-Acute Hospitals operated by the Department of Mental Health, using the data and methodology described below.

A. Data Sources

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the Safety Net Care payment to determine the cost, free care, Charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Commonwealth shall use the most recent available previous DHCFP-403 report to estimate these variables.

B. Determination of Eligibility

1. In order to be eligible for the Safety Net Care payment, a State-Owned Non-Acute Hospital operated by the Department of Mental Health must:

   a. be owned or operated by the Massachusetts Department of Mental Health;

   b. specialize in providing psychiatric/psychological care and treatment; and,

   c. participate as a Non-Acute Hospital provider in the MassHealth program.

C. Determination of Payment

For each State-Owned special population Non-Acute Hospital determined eligible for the Safety Net Care payment under this section, the payment amount shall be

calculated as follows:

1. first, determine the annual cost and revenue of providing hospital services to Medicaid-eligible and uninsured individuals using the data sources set forth in this Section;

2. second, subtract the annual revenue from the annual costs to determine the uncompensated costs of providing services to Medicaid-eligible and uninsured individuals;

3. calculate adjustments to account for any significant changes in utilization, cost trends, or payment methods. Inflation will be considered by applying a composite index comprised of two cost categories: labor and non-labor. The categories are weighted according to the weights used by CMS for PPS-excluded hospitals. The inflation proxy for the labor cost category is the Massachusetts Consumer Price Index (optimistic forecast). The inflation proxy for the non-labor cost category is the non-labor portion of the CMS market basket for hospitals;

4. the Safety Net Care payment amount shall be computed up to 100% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

3 <u>Safety Net Care payment for Pediatric Non-Acute Hospitals</u>

A. Data Sources

The Commonwealth shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the Safety Net Care payment to determine the cost, free care, Charge, patient day, and net revenue amounts. If said DHCFP-403 report is not available, the Commonwealth shall use the most recent available previous DHCFP-403 report to estimate these variables.

B. Determination of Eligibility

1. In order to be eligible for the Safety Net Care payment, a Non-Acute Hospital must:

   a. limit admissions primarily to children; and

   b. participate as a Non-Acute Hospital provider in the MassHealth program.

C. Determination of Payment

For each special population Non-Acute Hospital determined eligible for the Safety Net Care payment under this section, the payment amount shall be calculated as follows:

1. first, calculate the ratio of MassHealth pediatric days to the total MassHealth pediatric days for all hospitals that limit admissions primarily to children;

2. second, multiply the above ratio by the total allocation cited in regulations of the Division of Health Care Finance and Policy at 114.3 CMR 36.07(7)(c) to determine the individual payment amount for each eligible hospital; and,

3. the Safety Net Care payment amount shall be computed up to 100% of the uncompensated costs of providing hospital services to Medicaid-eligible and uninsured individuals.

Institution for Mental Disease Payment Methodologies

The following sections describe the methods and standards utilized by the Commonwealth of Massachusetts to establish Safety Net Care rates of payment for services rendered by Institutions for Mental Diseases to inpatients who are otherwise eligible for MassHealth benefits but who are age 21 or over, under age 65 and not enrolled in a MassHealth managed care organization. Safety Net Care rates of payment to Institutions for Mental Diseases will be described in a written contract with each Institution for Mental Disease. Safety Net Care payments are limited to inpatient care in Institutions for Mental Diseases of persons who are otherwise eligible for MassHealth benefits but who are age 21 or over and under age 65. Safety Net Care payment for inpatient services in an Institution for Mental Diseases shall be paid up to a maximum of 30 consecutive days per admission and up to a maximum of 60 inpatient days per calendar year per inpatient. There are no Safety Net Care payments for outpatient services. In Massachusetts, most Institutions for Mental Diseases are privately owned and operated.

Safety Net Care Payment for Inpatient Services

The Commonwealth proposes the establishment of a Safety Net Care Inpatient Per Diem Rate for Institutions for Mental Diseases, covering services provided to inpatients who would otherwise be eligible for MassHealth benefits (but for the IMD exclusion) and who are not enrolled in a MassHealth managed care organization. The Safety Net Care Inpatient Per Diem Rate will consist of two components: (i) a Statewide Standard Per Diem Component; and (ii) a Transitional Add-on Component. The Statewide Standard Per Diem Component is derived from cost report information submitted by Institutions for Mental Diseases. The Commonwealth will calculate base period standards using the HCFP-403 cost reports. Standards will be computed in four categories, the sum of which will be the Statewide Standard Per Diem Component: (a) Standard for Inpatient Direct Routine Costs; (b) Standard for Inpatient Direct Ancillary Costs; (c) Standard for Inpatient Overhead Costs; and (d) Standard for Inpatient Capital. The base period cost information will be updated using the appropriate MassHealth acute inpatient hospital update factors (SPAD inflation factors) to generate the Statewide Standard Per Diem Component. In addition to this component, the Commonwealth will include a transitional add-on component, which shall mitigate any significant differences between the Statewide Standard Per Diem Component and the rates that were payable in prior years to Institutions for Mental Diseases years under the Commonwealth's then-existing 1115 Demonstration.

Safety Care Payment for Administrative Days

The Commonwealth proposes paying for Administrative Days of inpatients who would otherwise be eligible for MassHealth benefits (but for the IMD exclusion) and who are not enrolled in a MassHealth managed care organization by using a Safety Net Care Administrative Day Per Diem Rate (AD Rate). The Safety Net Care AD Rate will be an all-inclusive daily rate paid for each Administrative Day. The AD Rate will be based on the MassHealth acute hospital inpatient administrative day rate.

Safety Care Payment for Inpatient Services at Community-Based Detoxification Centers

Safety Net Care payments to community-based detoxification centers shall be made based upon a fixed fee schedule established by the Division of Health Care Finance and Policy in accordance with its duly promulgated regulation.

Outpatient Services Governed by Title XIX State Plan

There are no Safety Net Care payments for outpatient services. Payment for outpatient services are not affected by the federal IMD exclusion; therefore, outpatient service payments for persons eligible for Title XIX coverage will continue to be governed by the Commonwealth's Title XIX state plan. The Commonwealth will continue to pay Institutions for Mental Diseases for Outpatient Services to persons who are eligible for MassHealth benefits. The Commonwealth will utilize its existing payment methodology for hospital outpatient services, which is derived from historical cost and charge information filed with the Division of Health Care Finance and Policy.

Exhibit 1

Excerpts from 114.1 CMR 36.07
Division of Health Care Finance and Policy Regulations

36.07: Safety Net Care Acute Hospital Payments Under the MassHealth 1115 Demonstration

…

(2) High Public-Payer Hospitals

(a) Eligibility. Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.04 are eligible for the adjustment in 114.1 CMR 36.07(2)(b).

(b) Calculation of Adjustment.

1. EOHHS allocates $11.7 million for this payment adjustment.
2. The Division then calculates for each eligible hospital the ratio of its allowable free care charges, as defined in M.G.L. c. 118G, to total charges. The Division will obtain free care charge data from the hospitals UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).
3. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.07(2)(b)2.
4. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.07(2)(b)2.
5. Hospitals that meet or exceed the 75th percentile qualify for a High Public-Payer Hospital payment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.6 CMR 11.04 to determine allowable free care costs.
6. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(2)(b)5 for all hospitals that qualify for a High Public-Payer payment.
7. Each eligible hospital's High Public-Payer Hospital payment is equal the amount allocated in 114.1 CMR 36.07(2)(b)1 multiplied by the amount determined in 114.1 CMR 36.07(2)(b)5 and divided by the amount determined in 114.1 CMR 36.07(2)(b)6.

(3) Basic Safety Net Care Payment

(a). The Division determines a Basic Safety Net Care Payment for all eligible hospitals, using the data and methodology described below. The Division uses the following data sources in its determination of the Basic Safety Net Payment, unless the specified data source is unavailable. If the specified data source is unavailable, then the Division determines and uses the best alternative data source.

1. The Division uses free care charge data from the prior year filing of the Division's uncompensated care reporting form.
2. The prior year RSC-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient charges, and the state and/or local cash subsidy.

(b). The Division calculates a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of acute care hospitals for the Basic Safety Net Care Payment. The Division determines such threshold as follows:

1. First, the statewide weighted average Medicaid inpatient utilization rate is calculated. This is determined by dividing the sum of Medicaid inpatient days for all acute care hospitals in the state by the sum of total inpatient days for all acute care hospitals in the state.
2. Second, the statewide weighted standard deviation for Medicaid inpatient utilization statistics is calculated.
3. Third, the statewide weighted standard deviation for Medicaid inpatient utilization is added to the statewide average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.
4. Lastly, each hospital's Medicaid inpatient utilization rate is calculated by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3, then the hospital is eligible for the Basic Safety Net Care Payment under the Medicaid utilization method.

(c). The Division then calculates each hospital's low-income utilization rate as follows:

1. First, the Medicaid and subsidy share of gross revenues is calculated as follows:

$$\frac{\text{Medicaid gross revenues + state and local government cash subsidies}}{\text{Total revenues + state and local government cash subsidies}}$$

2. Second, the free care percentage of total inpatient charges is calculated by dividing the inpatient share of free care charges less the portion of state and local government cash subsidies for inpatient services by total inpatient charges.
3. Third, the low-income utilization rate is calculated by adding the Medicaid and subsidy share of total revenues calculated pursuant to 114.1 CMR 36.07(3)(c)1 to the free care percentage of total inpatient charges calculated pursuant to 114.1 CMR 36.07(3)(c)2. If the low-income utilization rate exceeds 25%, the hospital is eligible for the Basic Safety Net Care Payment under the low-income utilization rate method.

(d). Payment Methodology. The payment under the Basic Safety Net Care Payment is calculated as follows:

1. For each hospital determined eligible for the Basic Safety Net Care Payment under the Medicaid utilization method established in 114.1 CMR 36.07(3), the Division divides the hospital's Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)4 by the threshold Medicaid inpatient utilization rate calculated pursuant to 114.1 CMR 36.07(3)(b)3. The resulting ratio is the Basic Medicaid ratio.
2. For each hospital determined eligible for the Basic Safety Net Care Payment under the low-income utilization rate method, but not found to be eligible for the Basic Safety Net Care Payment under the Medicaid utilization method, the Division divides the hospital's low-income utilization rate by 25%. The resulting ratio is the Basic Medicaid ratio.

3. The Division then determines, for the group of all eligible hospitals, the sum of Basic Medicaid ratios calculated pursuant to 114.1 CMR 36.07(3)(d)1. and 114.1 CMR 36.07(3)(d)2.

4. The Division then calculates a minimum payment by dividing the amount of funds allocated pursuant to 114.1 CMR 36.07(3)(e) by the sum of the Basic Medicaid ratios calculated pursuant to 114.1 CMR 36.07(3)(d)3.

5. The Division then multiplies the minimum payment by the Basic Medicaid ratio established for each hospital pursuant to 114.1 CMR 36.07(3)(d)1 and 2. The product is the payment under the Basic Safety Net Care Payment method. This payment ensures that each hospital's utilization rate exceeds one standard deviation above the mean.

(e). The total amount of funds allocated for payment to acute care hospitals under the Basic Safety Net Care method is $200,000 per year. These amounts are paid by EOHHS, and distributed among the eligible hospitals as determined pursuant to 114.1 CMR 36.07(3)(d)5.

...

(7) Safety Net Care Payments for Pediatric Specialty Hospitals and Units**.**

(a) Eligibility. In order to be eligible for this adjustment, the hospital must meet the definition of a Pediatric Specialty Hospital or Unit as defined in 114.1 CMR 36.02. In addition, the hospital must have a signed contract with EOHHS for the period that such adjustment is in effect.

(b) Methodology. The Division will calculate an adjustment as follows:

1. For each eligible hospital, the Division will calculate the ratio of MassHealth pediatric days to the total MassHealth pediatric days for all eligible hospitals.

2. The Division will multiply the ratio calculated in 114.3 CMR 36.07(7)(b)(1) by the total allocation cited in 114.3 CMR 36.07(7)(c) to determine the payment amount for each hospital.

3. This payment will reimburse only those costs that have not otherwise been paid and will be paid subject to the availability of federal financial participation.

(c) Payment Amount. The total amount of funds allocated for payment to hospitals will be the amount appropriated for such. These amounts are determined pursuant to 114.1 CMR 36.07(7)(b). Payments are made by EOHHS and distributed among eligible hospitals determined pursuant to 114.1 CMR 36.07(7)(a).

Exhibit 2

Excerpts from 114.6 CMR 11:00
Division of Health Care Finance and Policy Regulations

114.6 CMR 11.00: ADMINISTRATION OF THE UNCOMPENSATED CARE POOL

11.01 General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 11.00 governs the procedures effective October 1, 2005 for administering the Uncompensated Care Pool, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers.

(2) Authority: 114.6 CMR 11.00 is adopted pursuant to M.G.L. c. 118G and Chapter 240 of the Acts of 2004.

11.02 Definitions

Meaning of Terms: As used in 114.6 CMR 11.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 11.00 are capitalized.

Actual Acquisition Cost (AAC). The amount a pharmacy pays for a drug, net of discounts, rebates, charge backs, and other adjustments to the price of the drug.
Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring Hospitalization and meets the Health Care Financing Administration requirements for participation in the Medicare program.

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

Charge. The uniform price for a specific service charged by a Hospital or Community Health Center.

Community Health Center. A clinic that provides comprehensive ambulatory services and that (a) is licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s.51; (b) meets the qualifications for certification (or provisional certification) by the Division of Medical Assistance and enters into a provider agreement pursuant to 130 CMR 405.000; (c) operates in conformance with the requirements of 42 U.S.C. s254(c); and (d) files cost reports as requested by the Division.

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

Compliance Liability Revenues. Amounts paid by Hospitals into the Uncompensated Care Trust Fund pursuant to St. 1991, c 495, s. 56.

Cost to Charge Ratio. A percentage used to reduce Uncompensated Care Charges to costs, calculated pursuant to 114.6 CMR 11.04(3).

Disproportionate Share Hospital. A Hospital that serves a disproportionate share of low income patients and that meets the criteria set forth in 114.1 CMR 36.04.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Eligible Services. Services eligible for payment from the Uncompensated Care Trust Fund pursuant to 114.6 CMR 12.00, including Services to Low Income Patients under 114.6 CMR 12.03, Medical Hardship Services under 114.6 CMR 12.05, and Emergency Bad Debt under 114.6 CMR 12.04.

Emergency Bad Debt. The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR 12.04.

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

Free Care. Unpaid Hospital or Community Health Center Charges for services that meet the criteria set forth in 114.6 CMR 12.00 and M.G.L. c. 118G.

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 patient care services rendered in a Fiscal Year.

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

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

Hospital Licensed Health Center. A facility that is not physically attached to the hospital, or located on or proximate to the Hospital campus, that: (a) operates under the hospital's license; (2) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center under 130 CMR 410.413; (3) is approved by and enrolled with the MassHealth Enrollment Unit as a

Hospital Licensed Health Center; (4) possesses a distinct Hospital Licensed Health Center MassHealth provider number; (5) is subject to the fiscal, administrative and clinical management of the hospital; and (6) provides services solely on an outpatient basis.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I 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.

Individual Dental Visit. A face-to-face meeting between a patient and a dentist within the Community Health Center setting, for purposes of examination, diagnosis, or treatment.

Individual Medical Visit. A face-to-face meeting between a patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, or licensed social worker within the Community Health Center setting, for purposes of examination, diagnosis, or treatment.

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

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

Low Income Patient. A patient that meets the criteria in 114.6 CMR 12.03(3).

Medical Hardship. Services provided to patients that meet the criteria in 114.6 CMR 12.05.

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

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 a Hospital or Community Health Center.

Payment. 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.

Pharmacy and Therapeutics (P&T) Committee. An advisory group to the medical staff and serves as the organizational line of communication between the medical staff and the pharmacy department. The group is composed of physicians, pharmacists, and other health professionals selected with the guidance of the medical staff to recommend policy to the medical staff and administration on matters related to the therapeutic use of drugs.

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c.118G, s.18.

Private Sector Charges. GPSR attributable to all patients less GPSR attributable to Titles XVIII, XIX, and XXI, other publicly aided patients, free care and bad debt. For each Pool Fiscal Year, a Hospital's Private Sector Charges are determined using data reported in the RSC-403 for that Pool Fiscal Year.

Provider. A Hospital, including hospital-licensed off-campus entities, or Community Health Center that provides and submits claims for Eligible Services.

Public Service Hospital. A public Hospital or an acute Hospital operating pursuant to St. 1995, c. 147, with a private sector payer mix of less than 35% of its GPSR and with Uncompensated Care charges of more than 20% of its GPSR.

Publicly Aided Patient. A person who receives 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 114.6 CMR 11.06(3)(b).

Shortfall Amount. In a fiscal year, the positive difference between the sum of Allowable Uncompensated Care Costs for all Hospitals and the revenue available for distribution to Hospitals.

Sole Community Hospital. Any acute Hospital classified as a Sole Community Hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any Hospital that demonstrates to the Division'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.

Specialty Hospital. An acute Hospital qualifying as exempt from the Medicare prospective payment system regulations or any acute Hospital that limits its admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to children or patients under obstetrical care.

…

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. Third Party Administrators 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.

Uncompensated Care. The sum of reported net Free Care and Emergency Bad Debt.

11.03 Reporting Requirements

(1) General. Each Provider … shall file or make available information that is required or that the Division deems reasonably necessary for implementation of 114.6 CMR 11.00.

(a) Due Date. For any filing requirement without a specified time for filing, the submission is due 15 days from the date of the request of the Division. The Division may, for cause, extend the filing date. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(b) Patient Level Data. Providers must make patient level data available to the Division, upon request, for patients for whom they have submitted a claim for Eligible Services. These patient level data include but are not limited to cost data, patient diagnoses and types of Eligible Services provided, patient demographics, write-off amounts, unique patient identifiers, and other such data that enable the Division to conduct analyses, verify eligibility, and calculate settlements on a case-by-case basis.

(c) Audit. The Division may audit data submitted under 114.6 CMR 11.03 to ensure accuracy. The Division may adjust reported Uncompensated Care to reflect audit findings.

(2) Hospitals.

(a) Low Income Patient Data.

1. UC Form. Each Hospital must submit a DHCFP UC-Form within 45 days after the end of the each month. The Form must include the total charges for Eligible Services to Low Income Patients, Medical Hardship, and Emergency Bad Debt written off during the month in accordance with the provisions of 114.6 CMR 12.00.

2. Electronic Data Submissions. Each Hospital must submit application and claims data to the Division in accordance with the requirements of 114.6 CMR 11.03(6).

3. The Division may require Hospitals to submit interim data on revenues and costs to monitor compliance with federal Upper 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, and all payers combined; and total patient service expenses for all payers combined.

…

(c) Penalties. The Division may deny payment for Eligible Services to any Hospital that fails to comply with the reporting requirements of 114.6 CMR 11.00 until such Hospital complies with the requirements. The Division will notify such Hospital of its intention to withhold reimbursement.

(3) Community Health Centers

(a) Low Income Patient Payment Voucher. Each Community Health Center must submit a monthly payment voucher detailing the center's Individual Medical Visits provided to Low Income or Medical Hardship Patients within 45 days after the last day of the designated reporting period.

(b) Each Community Health Center must, upon request, provide the Division with patient account records and related reports as set forth in 114.6 CMR 11.03(1)(b).

(c) Electronic Data Submission. Each Community Health Center must submit application and claims data to the Division in accordance with the requirements of 114.6 CMR 11.03(6).

(d) Penalties. The Division may deny payments for Eligible Services to any Community Health Center that fails to comply with the reporting requirements of 114.6 CMR 11.00 until such Community Health Center complies with the requirements. The Division will notify Community Health Centers of its intention to withhold reimbursement.

…

(6) Electronic Data Submission Requirements

(a) Low Income Patient Application Data

1. Providers must meet the requirements of 114.6 CMR 12.00 concerning Low Income Patient Determination.

2. If the provisions of 114.6 CMR 12.03(4)(b) apply, Providers must use electronic free care application software provided by the Division to collect free care application data and must maintain such data in a database as specified by the Division. A Provider may continue to use paper applications but must insure that all applications, whether approved or denied, are submitted electronically and maintained in its database. Each Provider must submit application data at least monthly, in accordance with a schedule to be determined by the Division.

3. Each Provider must ensure that its hardware and technical infrastructure supports the Division's electronic data collection process.

(b) Eligible Services Claims Data

1. Hospitals and Community Health Centers must submit medical claims information for all Eligible Services. Providers must complete and submit claims, and resubmit failed claims, in accordance with Division specifications.

2. Hospitals will continue to submit UC Forms to document monthly charges for Eligible Services. Community Health Centers will continue to submit PV Forms to claim payment for Eligible Services.

3. Each Hospital claim for Eligible Services must contain a site-specific Identification Number as assigned by the Division. The Division will assign individual an Identification Numbers to each Hospital, Hospital Licensed Health Centers, satellite clinics, and other off-campus locations that provide Eligible Services.

(c) Other

1. The Division may revise the data specifications, the data collection scheduled, or other administrative requirements from time to time by administrative bulletin.

2. Providers must maintain records sufficient to document compliance with all screening and documentation requirements of 114.6 CMR 12.00.

11.04 Sources and Uses of Funds

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(2) Payments from the Uncompensated Care Trust Fund. In FY 2006, payments from the Uncompensated Care Trust Fund will be made as follows:

(a) $445,200,000 for payments to Hospitals;

(b) $53,500,000 for payments to Community Health Centers;

(c) $3,200,000 for Demonstration Projects pursuant to §§ 156 to 158 of Chapter 184 of the Acts of 2002.

(3) FY 2006 Payments may be increased if additional funding becomes available.

...

11.07 Payments to Hospitals.

(1) Gross Liability to Hospitals. The Division will determine each Hospital's FY 2006 Total Payment for Low Income Patients pursuant to the provisions of Chapter 45 of the Acts of 2005. Each Hospital's FY 2006 Total Payment for Low Income Patients is a fixed percentage of its FY 2006 Low Income Patient Care Costs.

(a) FY 2006 Low Income Patient Care Costs. For each Hospital, the Division will determine FY 2006 Low Income Patient Care costs as follows:

1. calculate each hospital's actual free care cost for the 12-month period from October 1, 2003, to September 30, 2004, inclusive, by using each hospital's actual submitted free care charges to the division on the UC-04 times its ratio of costs to charges for pool fiscal year 2004;
2. project each hospital's free care costs above for pool fiscal year 2006 by using a cost growth factor of 7.6 per cent;
3. project each hospital's total free care costs for pool fiscal year 2006 by multiplying each hospital's pool fiscal year 2006 projected free care costs from subclause (2) by a cost growth factor of 7.6 per cent

(b) Total Payment for Low Income Patients. The Division will multiply each Hospital's Total Payment for Low Income Patients by a fixed percentage Payment Ratio determined in accordance with Chapter 45 of the Acts of 2005.

1. Disproportionate Share Hospitals.
   a. The Division will determine the Disproportionate Share Hospitals with the highest relative volume of low income patient care costs by (1) calculating each hospital's FY 2003 uncompensated care costs by multiplying its reported FY 2003 uncompensated care charges by its Cost to Charge Ratio and (2) ranking each hospital by its ratio of uncompensated care costs to total statewide uncompensated care costs.
   b. For the two Disproportionate Share Hospitals with the highest relative volume of Allowable Patient Care Costs in FY 2003, the FY 2006 Payment Ratio shall be at least 85%.
   c. For the fourteen Disproportionate Share Hospitals with the next highest relative volume of Allowable Patient Care Costs in FY 2003, the FY 2006 Payment Ratio shall be at least 88%.
2. Other Hospitals.
   a. For all other hospitals, the Division will calculate the Total Payment for Low Income Patients as follows:
      1. There shall be a payment adjustment of $5.79 million for freestanding pediatric hospitals, and,
      2. Determine available revenue by deducting the payment adjustment to freestanding pediatric hospitals from total available revenue of $445,200,000;

3. Add Total Allowable Low Income Patient Care Costs for all other hospitals;
4. Determine the ratio of (1) revenue available for payments to all other hospitals to (2) Total Allowable Low Income Patient Care Costs for all other hospitals;
5. Apply ratio to each other hospital's Total Allowable Patient Care Costs to determine the hospital's FY Total Payment for Low Income Patients.

(c) Data Sources. Each Hospital's FY 2006 Total Payment for Low Income Patients is based on uncompensated care charges reported on the UC Form and costs reported on the RSC-403 cost report as filed with the Division. There will be no further adjustments to the data sources used to calculate each Hospital's FY 2006 Allowable Patient Care Costs. If a Hospital did not file UC Forms for any of the months from October 2003 to September 2004, the Division will estimate uncompensated care charges using the best available data.

(2) FY 2006 Payment for Low Income Patients. The Division may make payment of each Hospital's Total Payment for Low Income Patients through a safety net care payment under the Massachusetts 1115 Demonstration waiver, a MassHealth supplemental hospital rate payment, or a combination thereof. The Division may limit a Hospital's Payment for Low Income Patients to comply with Federal Upper Payment Limits, limits and requirements under the Massachusetts Section 1115 Demonstration governing safety net care, or any other federally required limit on payments under 42 U.S.C. § 1396a(a)13 or 42 C.F.R. Part 447.

(3) Calculation of the Cost to Charge Ratio. The Division shall calculate a Cost to Charge Ratio for each Hospital. The Cost to Charge Ratio is the sum of each Hospital's inpatient reasonable costs and actual outpatient costs, divided by the Hospital's Gross Patient Service Revenues.

(a) Data Sources. The Division will obtain cost and charge information, including capital cost, malpractice data and organ acquisition costs, from the DHCFP-403 Report. The Division will review the DHCFP-403 Cost Report to ensure that the costs and Charges reported on the DHCFP-403 Report reconcile with those reported on audited financial statements, and are true, accurate, and complete.
For purposes of calculating case-mix indices, the Division will use the merged billing and case-mix information filed pursuant to 114.1 CMR 17.00.

(b) Fiscal Years through FY 2003.

1. The Division will calculate a preliminary Cost to Charge Ratio before the beginning of each Fiscal Year, utilizing data from two years prior to the rate year.
2. The Division will calculate an interim Cost to Charge Ratio midway through the Fiscal Year when year end financial data from the prior Fiscal Year becomes available.
3. The Division will calculate a final Cost to Charge Ratio after the end of the Fiscal Year when final audited financial data for the rate year becomes available.

(c) Reasonable Inpatient Costs. The Division will determine reasonable inpatient costs by summing the Hospital's reasonable comparable costs, reasonable capital cost, direct medical education cost, malpractice cost, organ acquisition cost, Hospital-based physician salaries, and adjustments for inpatient free care provided

by physicians and undocumentable free care, if applicable. The calculation is as follows:

Reasonable Inpatient Costs =

Reasonable comparable costs
+ Reasonable capital expense
+ Direct medical education expense
+ Malpractice expense
+ Organ acquisition expense
+ Hospital-based physician salaries
+ Adjustment for inpatient free care provided by physicians, if applicable
+ Adjustment for undocumentable free care, if applicable

The calculation of reasonable comparable costs is set forth in 114.6 CMR 11.07(3)(c)1.
The calculation of reasonable capital expense is set forth in 114.6 CMR 11.07(3)(c)2. The adjustment for inpatient free care provided by physicians is set forth in 114.6 CMR 11.07(3)(c)3. The adjustment for undocumentable free care is set forth in 114.6 CMR 11.07(3)(c)4.

1. Reasonable Comparable Costs. The Division will use an efficiency standard to determine reasonable comparable costs. Reasonable comparable costs equal the efficiency standard for Hospitals whose inpatient costs exceed the efficiency standard described below. Reasonable costs will equal actual costs for Hospitals whose costs do not exceed the efficiency standard. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will not be subject to the efficiency standard. The Division will calculate the efficiency standard as follows:

a. First, the Division will determine comparable costs by subtracting non-comparable costs from total inpatient costs. Non-comparable costs are: capital, direct medical education, malpractice, organ acquisition costs, and Hospital-based physician salaries. The methodology and specific data sources used to calculate these non-comparable costs will be distributed to Hospitals.

Comparable costs = Total inpatient costs
- Capital cost
- Direct Medical education cost
- Malpractice cost
- Organ acquisition cost
- Hospital-based physician salaries

b. Second, the Division will determine comparable costs per discharge by dividing the comparable costs by total discharges.

$$\text{Comparable cost per discharge} = \frac{\text{total comparable costs}}{\text{total discharges}}$$

c. Third, the Division will adjust the comparable cost per discharge for case mix and wage area. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will

be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken. The wage area indices will be those calculated by the Health Care Financing Administration (HCFA), and will be applied only to the labor portion of costs, also as determined by the Health Care Financing Administration. In Pool FY 1999 and forward, the wage area indices will be those calculated pursuant to 114.1 CMR 36.05(2)(c).

Standardized cost per discharge = Comparable cost per discharge
/ case mix index
/ wage area index

d. Fourth, the Division will calculate the mean standardized cost per discharge for all Hospitals weighted by the number of discharges in each Hospital. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will be excluded from this calculation. The statewide mean standardized cost per discharge is the efficiency standard.

e. Fifth, the Division will compare each Hospital's standardized cost per discharge to the efficiency standard.

i. For Hospitals whose own standardized cost per discharge is greater than the efficiency standard, the Division will calculate reasonable comparable costs as follows. First, the Division will adjust the efficiency standard for wage area and case-mix. The wage area index will be applied only to the labor portion of costs, as determined by the Health Care Financing Administration. Second, the Division will multiply these reasonable adjusted costs per discharge by total discharges to determine reasonable comparable costs.

Reasonable adjusted cost per discharge =
Efficiency standard
x wage area index
x case mix index

Reasonable comparable costs =
Reasonable adj. cost per discharge
x total discharges

(ii) For Hospitals whose standardized cost per discharge is less than the efficiency standard, and for Specialty Hospitals, Sole Community Hospitals and Public Service Hospitals, the Division will determine that reasonable comparable costs are equal to actual comparable costs as calculated in 114.6 CMR 11.07(3)(c)1a.

2. Reasonable inpatient capital costs. Inpatient capital costs will be held to reasonable limit. The Division will determine reasonable inpatient capital costs as follows:

a. The Division will calculate inpatient capital costs per discharge by dividing total capital costs allocated to inpatient by total discharges.

b. The Division will adjust inpatient capital costs per discharge for case mix. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken.

c. The Division will determine the case-mix adjusted capital costs limit (CMCCL) by first sorting acute care Hospital's adjusted costs in ascending order, and then producing a cumulative frequency of discharges. The CMCCL is established at the case-mix adjusted capital cost per discharge corresponding to the median discharge for the FY93 cost to charge calculation, and multiplied by an inflation factor. Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals will be excluded from this calculation.

d. Each Hospital's case-mix adjusted capital cost per discharge determined in 114.6 CMR 11.07(3)(c)2b is then compared to the case-mix adjusted capital costs limit (CMCCL) calculated in 114.6 CMR 11.07(3)(c)2c.

e. For Hospitals whose case-mix adjusted capital cost per discharge is less than or equal to the CMCCL, reasonable capital cost per discharge is equal to the Hospital's actual adjusted capital cost per discharge multiplied by the Hospital's case-mix index. For Hospitals whose case-mix adjusted capital cost per discharge is greater than the CMCCL, the reasonable capital cost per discharge is equal to the product of (a) the CMCCL, and (b) the Hospital's case-mix index.

f. The Division will determine reasonable inpatient capital costs by multiplying the reasonable capital cost per discharge calculated in 114.6 CMR 11.07(3)(c)2.e. by total discharges. For Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals, reasonable inpatient capital costs equal actual inpatient capital costs.

3. Allowance for free care Provided by Physicians. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for free care provided by physicians.

a. The Division will allocate $2,500,000 for this allowance.

b. Hospitals will qualify for the allowance for free care provided by physicians if they qualify for the High Public Payer Hospital Disproportionate Share Adjustment pursuant to 114.1 CMR 36.07(2).

c. The Division will determine Allowable Patient Care Costs pursuant to 114.1 CMR 36.07(2). For the final Cost to Charge Ratio Calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the rate year consistent with the Cost to Charge Ratio being processed. For preliminary and interim Cost to Charge Ratio calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital

Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the latest available year.

d. The Division will then determine the sum of the amounts determined pursuant to 114.6 CMR 11.07(3)(c)3e for all Hospitals that qualify for an allowance for free care provided by physicians.

e. Each Hospital's allowance for free care provided by physicians is equal to $2,500,000 times the ratio of the Hospital's Allowable Free Care Costs determined in 114.6 CMR 11.07(3)(c)3c to the total Allowable Free Care Costs of all qualifying Hospitals determined in 114.6 CMR 11.07(3)(c)3d.

f. The Division will increase the reasonable costs of eligible Hospitals by 'grossing up" the allowance to the level of total costs. The Division will divide the allowance for each Hospital pursuant to 114.6 CMR 11.04(3)(c)3e by the ratio of allowable Free Care Charges to total Charges pursuant to 114.6 CMR 11.04(3)(c)3c. The resulting amount will be added to total reasonable costs for the Hospital.

g. The Division will complete this calculation before the beginning of the Fiscal Year.

h. A Hospital that receives an allowance for the cost of free care provided by physicians must use the portion of Uncompensated Care Pool payments attributable to such allowance to reimburse such physicians for such Free Care .

4. Allowance for Undocumentable Free Care. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for undocumentable Free Care. This allowance is intended to contribute toward reimbursing Hospitals for Eligible Services provided to patients who are incapable of providing documentation of their status as Low Income Patients, but are patients who the Hospital has strong reason to believe would qualify as Low Income Patients under 114.6 CMR 12.00.

a. The Division will allocate $1,000,000 for this allowance.

b. Hospital will qualify for the allowance for Undocumentable free care if they qualify for the High Public Payer Hospital Disproportionate Share Adjustment pursuant to 114.1 CMR 36.07(2).

c. The Division will determine Allowable Free Care Costs pursuant to 114.1 CMR 36.07(2). For the final Cost to Charge Ratio Calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the rate year consistent with the Cost to Charge Ratio being processed. For preliminary and interim Cost to Charge Ratio calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the latest available year.. The Division will then determine the sum of the amounts determined pursuant to 114.6 CMR 11.04(3)(c)4c for all Hospitals that qualify for an allowance for undocumentable free care.

e. Each Hospital's allowance for undocumentable free care is equal to $1,000,000 times the ratio of the Hospital's Allowable Free Care Costs determined in 114.6 CMR 11.04(3)(c)4c to the total Allowable Free Care Costs of all qualifying Hospitals determined in 114.6 CMR 11.04(3)(c)4d.
f. The Division will increase the reasonable costs of eligible Hospitals by "grossing up" the allowance to the level of total costs. The Division will divide the allowance for each Hospital pursuant to 114.6 CMR 11.04(3)(c)4e by the ratio of allowable Free Care Charges to total Charges pursuant to 114.6 CMR 11.04(3)(c)4d. This amount will be added to total reasonable costs.
g. The Division will complete this calculation before the beginning of the Fiscal Year.

(4) Monthly Payments. The Division will calculate and process monthly Hospital payments. The Division will calculate each Hospital's gross assessment liability to the Pool and the Pool's liability to the Hospital and make payments to the Hospital on a net basis.

…

(b) The Division will make a monthly payment to each Hospital of one twelfth of its FY 2006 Total Payment for Low Income Patients. These are prospective payments and are not subject to final settlement.

(5) Final Settlements for Fiscal Years through FY 2003.

(a) General. There will be a final settlement between the Uncompensated Care Pool and a Hospital for each Fiscal Year through FY 2003. The Final Settlement will be calculated based upon the hospital's gross liability to the Pool as determined pursuant to 114.6 CMR 11.05, the Pool's gross liability to the Hospital as determined pursuant to 114.6 CMR 11.07(2), and the payments made to the Hospital during the Fiscal Year. If the difference is positive, the difference is the amount of the hospital's liability to the Pool. If the difference is negative, the difference is the amount of the Pool's liability to the Hospital.
(b) Calculation. The Final Settlement will occur upon completion of the relevant audit and calculations by the Division for that Fiscal Year. Final settlements for the years through FY 2003 will be determined using actual Private Sector Charges, final Cost to Charge Ratios and actual free care charges, adjusted for any audit findings; and will include interim payment reconciliations, special payments, and esti-mated payments to and from the Uncompensated Care Pool.
(c) The Division may use penalty and interest revenue collected pursuant to 114.6 CMR 11.07(6) to cover unpaid liabilities from the settlement year that the Division determines to be uncollectible, (2) payments to Community Health Centers, and (3) Shortfall Amounts for any fiscal year.
(d) The Division may adjust Pool calculations to reflect determinations made under eligibility and compliance audits pursuant to 114.6 CMR 12.00.

(6) Penalties

(a) If a Hospital does not pay its liability amount by the due date, the Division will assess a 1.5% penalty on the outstanding balance. The Division will

calculate the penalty from the due date. The Division will assess an additional 1.5% penalty against the outstanding balance and prior penalties for each month that a Hospital remains delinquent. The Division will credit partial payments from delinquent Hospitals to the current outstanding liability. If any amount remains, the Division will then credit it to the penalty amount.
(b) The Division may reduce a Hospital's penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the Hospital's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.
(c) The Division may adjust the monthly payment of any hospital that fails to submit required data, including but not limited to, DHCFP-403 or case mix data. The hospital's payment will be reduced by 5% for each month the hospital fails to file the required data. Failure to file the required data for more than two consecutive years may lead to denial of payment for low income patients.

11.08 Payments to Community Health Centers

(1) For FY 2006, total revenue available from the Uncompensated Care Trust Fund to pay freestanding community health centers for Eligible Services is $53,500.000.

(2) The Division may make payment for services by Community Health Centers through a MassHealth supplemental payment.

(3) Individual Medical Visits. The payment for an Individual Medical Visit is $94.20.

(a) Services to Low Income Patients.

1. The Division will pay for the following services provided to Low Income Patients determined pursuant to 114.6 CMR 12.03(a) at a percentage of the Individual Medical Visit rate as listed below:

Physician	100%
Nurse Practitioner, Nurse Midwife or Physician Assistant	100%
Dentist	75%
Clinical Psychologist	50%
Licensed Social Worker	50%

2. The Division will pay for the following services provided on-site at the Community Health Center as listed below:

Ancillary Laboratory	25% of Charges
Ancillary Radiology	25% of Charges
Ancillary - Miscellaneous	25% of Charges

3. Payment to an eligible Community Health Center for prescribed drugs shall be 100% of AAC + $7.50 dispensing fee for all generic drugs, and 90% of AAC + $7.50 dispensing fee for all brand drugs.

a. Conditions for Payment

i. The Community Health Center may bill only for prescribed drugs dispensed through its Community Health Center 340B Pharmacy; and

ii. The Community Health Center is only eligible for payment from the Uncompensated Care Pool for prescribed drugs if the Community Health Center is also providing

prescribed drugs to MassHealth members and receiving payment from MassHealth according to 114.3 CMR 31.07; and

iii. The Community Health Center must submit a copy of the OPA email or letter of notification to the Division stating that it has met the registration requirements in the OPA database, prior to billing the Uncompensated Care Pool; and

iv. The Community Health Center may not submit a claim to the Uncompensated Care Pool for MassHealth patients for a drug for which Prior Approval is required and (1) Prior Approval was not requested or (2) Prior Approval was denied; and

v. The Community Health Center may not submit a claim for the unpaid co-pays or deductibles of low income patients; and

vi. The Community Health Center may not submit a claim for a drug that is excluded by MassHealth under the provisions of 130 CMR 406.413(B); and

vii. The Community Health Center may not submit a claim for a prescribed drug that does not appear on the MassHealth Drug list as defined in 130 CMR 406 unless the prescription has been approved by the Community Health Center's Pharmacy and Therapeutics Committee.

b. The Community Health Center may establish a patient co-pay policy for patients eligible to receive Uncompensated Care Pool assistance. Revenue from this policy shall be limited to covering the aggregate remaining reasonable costs attributable to the unreimbursed portion of the AAC plus unreimbursed dispensing costs exceeding the $7.50 dispensing fee.

(b) Patient Contribution. The Division will pay for services, in excess of the patient contribution, provided to Low Income patients who meet the criteria set forth in 114.6 CMR 12.03(3)(b) or Medical Hardship set forth in 114.6 CMR 12.05.

(4) Individual Dental Visit An Individual Dental Visit shall consist of two or fewer procedures as defined by 114.3 CMR 14.00. A payment of $19.73 will be made for each additional procedure completed during a single Individual Dental Visit. The Division will pay for dental services, in excess of the patient contribution, provided to Low Income patients who meet the criteria set forth in 114.6 CMR 12.03(3)(b) or Medical Hardship set forth in 114.6 CMR 12.05.

11.09 Special Provisions

(1) MassHealth payment offset for Hospitals and Surcharge Payers. If a Hospital or Surcharge Payer fails to make scheduled payments and maintains an outstanding obligation to the Pool for more than 45 days, the Division may notify MassHealth to offset payments on the claims of the Hospital or Surcharge Payer, or any entity under common ownership, as defined in 130 CMR 450.101, or any successor in interest to the Hospital or Surcharge Payer, in the amount of payment owed to the Uncompensated Care Pool, including accrued interest, penalties and late fee. Payments offset in accordance

with this provision shall be credited to the Hospital's or Surcharge Payer's outstanding liability to the Pool.

(a) The Division shall notify the Hospital or Surcharge Payer in writing of the dollar amount to be offset from the Surcharge Payer's MassHealth claims. Such notification shall be sent to the Hospital or Surcharge Payer via certified mail at least ten days prior to notifying MassHealth.

(b) If a Hospital or Surcharge Payer believes the amount to be offset is incorrect because of an arithmetic, mechanical or clerical error, it may object in writing during this ten day period to the Division of Health Care Finance and Policy. The written objection must contain an explanation of the perceived error as well as documentation to support the Hospital's or Surcharge Payer's objection. Hospitals and Surcharge Payers may not appeal a payment offset to MassHealth.

(c) Upon review of the Hospital's or Surcharge Payer's objections, the Division shall notify the Hospital or Surcharge Payer of its determination in writing. If the Division disagrees with the Hospital's or Surcharge Payer's objections, in whole or in part, the Division shall provide the Surcharge Payer with an explanation of its reasoning.

(d) The Division shall notify MassHealth in writing of the dollar amount to be offset from the Hospital's or Surcharge Payer's MassHealth claims.

(e) Hospitals and Surcharge Payers to which payment is offset must serve all Title XIX recipients in accordance with the contract then in effect with MassHealth, or, in the case of a non-contracting Hospital or Disproportionate Share Hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to M.G.L. c. 118G.

…

(3) Severability. The provisions of 114.6 CMR 11.00 are severable. If any provision or the application of any provision to any 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 114.60 CMR 11.00 or the application of such provisions to Hospitals, Community Health Centers or circumstances other than those held invalid.

(4) Administrative Information Bulletins. The Division may issue administrative information bulletins to clarify policies and understanding of substantive provisions of 114.6 CMR 11.00 and specify information and documentation necessary to implement 114.6 CMR 11.00.