

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 515.00: MANAGED CARE ORGANIZATION SERVICES PAYOR ASSESSMENT

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515.01: General Provisions

101 CMR 515.00 governs the collection of the managed care organization services payor assessment established under M.G.L. c. 118E, § 68.

515.02: Definitions

As used in 101 CMR 515.00, unless the context requires otherwise, terms have the meanings in 101 CMR 515.02.

Assessed Services. Services rendered by a managed care organization for which a premium or membership payment is made by or on behalf of the member; provided, however, that managed care organization services subject to assessment do not include services which are (i) rendered to members enrolled per month in Medicare managed care organizations; (ii) rendered to members dually enrolled per month in both Medicaid and Medicare; (iii) rendered to members in a Medicaid managed care organization who are 65 or older; (iv) rendered to members through a limited benefit plan; (v) rendered to members through an indemnity plan; or (vi) preempted from taxation by 5 U.S.C. section 8909(f); and provided further, that assessed services are identified and assessed through claims paid by managed care organizations for healthcare services rendered in Massachusetts.

Assessment. The total payment due by each managed care organization each month, as set forth in 101 CMR 515.00.

Assessment Year. The calendar year, from January 1 through December 31 of each year.

Center for Health Information and Analysis (CHIA). An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 12C.

Center for Health Information and Analysis Revenue Amount. An amount equal to the sum of the amount collected by CHIA from acute hospitals and ambulatory surgical centers under M.G.L. c. 12C, § 7.

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

Division of Insurance. An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 26.

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Entity. A natural person, corporation, partnership, trust, estate, or other legal entity operating as a managed care organization rendering managed care organization services in Massachusetts; and, in the case of an entity that is not a natural person, includes

- (1) any shareholder owning no less than 5%, any officer, and any director of any corporate entity;
- (2) any limited partner owning no less than 5% and any general partner of a partnership entity;
- (3) any trustee of any trust entity;
- (4) any sole proprietor of any entity that is a sole proprietorship; or
- (5) any mortgagee in possession and any executor or administrator of any entity that is an estate.

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

Health Policy Commission. An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 6D.

Health Policy Commission Revenue Amount. An amount equal to the sum of the amount collected by the health policy commission from hospitals and ambulatory surgical centers under M.G.L. c. 6D.

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

Health Safety Net Managed Care Organization Revenue Amount. An amount equal to \$160,000,000 plus 50% of the estimated cost, as determined by the secretary for administration and finance, of administering the Health Safety Net and related assessments in accordance with M.G.L. c. 118E, §§ 65 through 69.

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.

Immunization Revenue Amount. The estimated costs to purchase, store, and distribute vaccines for routine immunizations and to administer trust funds established for such purpose under M.G.L. c. 111, and to operate the computerized immunization registry, established in M.G.L. c. 111, § 24M, taking into consideration the limitations on expenditures described in M.G.L. c. 111, as well as any anticipated surplus or deficit in said trust funds, but excluding any costs anticipated to be covered by federal contribution.

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Indemnity Plan. A plan that does not offer benefits through a restricted or preferred network of healthcare providers, whether directly or through a third party.

Limited Benefit Plan. A plan for stand-alone coverage of dental, vision, or long-term-care services.

Managed Care Organization. An entity that is (i) accredited under M.G.L. c. 176O and that is (a) licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; (b) a nonprofit hospital service corporation organized under M.G.L. c. 176A; (c) a nonprofit medical service corporation organized under M.G.L. c. 176B; (d) a health maintenance organization organized under M.G.L. c. 176G; or (e) an organization entering into a preferred provider arrangement under M.G.L. c. 176I; (ii) a Medicaid managed care organization; (iii) a healthcare organization, as defined in M.G.L. c. 32A, § 2; (iv) a self-insured group for which a carrier provides administrative services under M.G.L. c. 176O, § 21; or (v) a health insurance plan that contracts with the commonwealth health insurance connector authority.

Managed Care Organization Reinvestment Revenue Amount. A fixed amount equal to \$246,000,000.

Massachusetts Child Psychiatry Access Project Revenue Amount. The amount equal to the amounts expended annually for the Massachusetts Child Psychiatry Access Project that are related to services provided on behalf of commercially insured clients.

MassHealth Program (MassHealth). The medical assistance benefits plans (Medicaid) operated and administered by EOHHS under M.G.L. c. 118E, § 1 and 42 U.S.C. § 1396, Title XXI of the Social Security Act (42 U.S.C. 1397), and other applicable laws and waivers to provide and pay for medical services to eligible members.

Medicare. The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant) established by Title XVIII of the Social Security Act.

Total Assessment Amount. An amount to be determined annually by MassHealth, and noticed to managed care organizations annually via administrative bulletin or other written issuance prior to the start of the assessment year, which equals the total of (i) the Managed Care Organization Reinvestment Revenue Amount; (ii) the Health Safety Net Managed Care Organization Revenue Amount; (iii) the Massachusetts Child Psychiatry Access Project Revenue Amount; (iv) the Immunization Revenue Amount; (v) the Health Policy Commission Revenue Amount; (vi) the Center for Health Information and Analysis Revenue Amount; (vii) the amount transferred, under M.G.L. c. 118E, § 66, to the Behavioral Health Access and Crisis Intervention Trust Fund established in M.G.L. c. 29, § 2WWWW; and (viii) the amounts necessary to prospectively incorporate all adjustments or reconciliations to account for under-assessments in the prior assessment year.

515.03: Managed Care Organization Services Groups

(1) Managed Care Organization Assessment Liability. Managed care organization assessment liability will vary by managed care organization services group, whether Medicaid or non-

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Medicaid services, and for Medicaid services, by the size of the Medicaid services as determined by Medicaid total revenues. The three groups of managed care organization services for purposes of 101 CMR 515.00 are defined as follows.

- (a) Group I. Non-Medicaid assessed services;
- (b) Group II. Medicaid assessed services provided by a managed care organization with annual total paid claims less than or equal to \$2,000,000,000; and
- (c) Group III. Medicaid assessed services provided by a managed care organization with annual total paid claims greater than \$2,000,000,000.

(2) Annual Application of Assessment. The assessment rate will be established annually and will apply to a managed care organization's assessed services, based on the managed care organization's assessed services in each assessment group described in 101 CMR 515.03(1), as such assessed services are reported each month by managed care organizations.

515.04: Calculation of Managed Care Organization Services Assessment

(1) Assessment Basis. To determine each managed care organization's assessment liability, the assessment rates established in accordance with 101 CMR 515.04 are applied to the managed care organization's monthly assessed services, calculated based on total claims paid by the managed care organization in the month assessed.

(2) Assessment Rate.

- (a) For the assessment year beginning January 1, 2025, the assessment will be applied as follows.

Assessment Group	Assessment Group Description	Assessment Rate
Group I	Commercial Services: Non-Medicaid assessed services	1.18%
Group II	Tier 1 Medicaid Services: Medicaid assessed services rendered by managed care organizations with annual revenues of less than or equal to \$2,000,000,000	8.00%
Group III	Tier 2 Medicaid Services: Medicaid assessed services rendered by managed care organizations with annual revenues of greater than \$2,000,000,000	0.50%

(b) For assessment years beginning on or after January 1, 2026, the assessment rates for each group will be issued via administrative bulletin and determined by the total assessment amount to be collected each assessment year, taking into account any reconciliation for over- or under-assessment amounts from the previous assessment year; provided that each assessment year, assessment rates are set in a manner to meet the requirements of 42 CFR 433.68(e)(2) and 42 CFR 433.68(f).

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(3) Assessment Rate Annual Determination and Reconciliation.

- (a) Prior to each assessment year, EOHHS will determine the assessment rate for the assessment year, incorporating any necessary adjustments to account for rates set in prior assessment years that were insufficient or in excess to assess the total assessment amount.
- (b) EOHHS may prospectively redetermine the assessment rate during an assessment year, if EOHHS projects that the initial assessment rate established for the assessment year will produce significantly less or more than the total assessment amount.
- (c) In each determination or redetermination of the assessment rate, EOHHS will use the best data available, as determined by EOHHS. EOHHS will incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

515.05: Payment of Managed Care Organization Services Assessment

(1) Managed Care Organization Services Monthly Assessment Payment. Beginning January 1, 2025, each managed care organization must pay a monthly assessment to EOHHS in a form and manner specified by EOHHS.

(2) Due Date.

- (a) Managed care organization services assessment payments are due the first business day after the month following the month assessed. For example, the January 1, 2025, monthly assessment is due on March 3, 2025.
- (c) If a managed care organization ceases to exist or ceases to render assessed services, it must pay any outstanding managed care organization services assessment obligations within 30 days of the date of such cessation. If a managed care organization is acquired by or merges with another managed care organization, any outstanding managed care organization services assessments owed by the managed care organization being acquired or merging must be paid within 30 days of the date of the acquisition or merger.

(4) Administration. EOHHS may provide updates and further details for implementation of the managed care organization services assessment, by administrative bulletin or other written issuance. Such written issuances may provide additional requirements for matters including, but not limited to, procedures for the payment and collection of the managed care organization services assessment, reporting requirements, annual assessment rate setting, mid-assessment year rate adjustments, enforcement processes and procedures, etc.

(5) Interest and Late Fees.

- (a) EOHHS may assess interest and late fees on unpaid liabilities. If a managed care organization fails to remit an assessment by the due date, EOHHS may assess interest at up to 3% per month on the outstanding balance and calculate the interest from the due date. EOHHS will calculate the interest on the outstanding balance as of the due date.
- (b) EOHHS may assess up to an additional 3% penalty against the outstanding balance and prior penalties for each month that a managed care organization remains delinquent. EOHHS will credit partial payments from delinquent managed care organizations to the current outstanding liability. If any amount remains from the partial payment, EOHHS will then credit such amount to the penalty amount.

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- (c) In determining the penalty amount, EOHHS may consider factors including, but not limited to, the managed care organization's payment history, financial situation, and relative share of the payments.
- (6) Assessment Revenue. An amount equal to the total amount of assessments collected, plus any penalties and interest, will be credited to the Health Safety Net Trust Fund.

515.06: Reporting Requirements

- (1) General. Each managed care organization must file or make available information that EOHHS deems reasonably necessary for calculating and collecting the assessment.
- (2) Required Reporting for Managed Care Organizations with Change of Status. Any new managed care organization, merging managed care organization, acquiring or acquired managed care organization, or managed care organization ceasing to operate or provide managed care organization services, must inform EOHHS of its change in status at least 14 days prior to such change in status. Any such managed care organization entities must provide projected annual revenue information and any additional supporting documentation, as requested by EOHHS, in the form and format requested by EOHHS within 30 days of beginning operations.
- (3) Additional Documentation. Each managed care organization must submit any additional documentation requested by EOHHS or its designee to verify the accuracy of the data submitted.
- (4) Audit. EOHHS or its designee may inspect and copy the records of a managed care organization for purposes of auditing its calculation of the assessment. If EOHHS or its designee determines that a managed care organization has either overpaid or underpaid the assessment, it will notify the managed care organization of the amount due or refund the overpayment.
- (5) Penalties. EOHHS may impose a *per diem* penalty of \$100 per day if a managed care organization fails to furnish documentation required or requested under 101 CMR 515.06 within the timeframes specified in 101 CMR 515.06(2) or as specified by EOHHS upon request, or in administrative bulletins or other written issuances.
- (6) Enforcement Provisions. In addition to interest and late fees imposed under 101 CMR 515.06(5), EOHHS may take enforcement actions including, but not limited to, the following:
- (a) for managed care organizations licensed by the department of insurance, notifying the department of the unpaid assessments and such information may be considered by the department when reviewing managed care organizations' financial reports or conducting other regulatory oversight;
 - (b) creating, after demand for payment, a lien in favor of the commonwealth in an amount not to exceed the delinquent fees owed, including any interest, penalties, and reasonable attorneys' fees; encumbering the building in which the delinquent managed care organization is located; encumbering the real property upon which the delinquent managed care organization is located, including fixtures, equipment, or goods used in the operation of the delinquent managed care organization; or encumbering any real property in which the delinquent managed care organization holds an interest; or
 - (c) take any other action, through EOHHS or in partnership with other state agencies, to collect on the delinquent debt permissible under law.

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515.07: Other Provisions

(1) Severability. The provisions of 101 CMR 515.00 are severable. If any provision or the application of any provision to an applicable individual, entity, or circumstance is held invalid or unconstitutional, that holding will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 515.00 or application of those provisions to applicable individuals, entities, or circumstances.

(2) Application of this Regulation. The provisions of 101 CMR 515.00 implement statutory requirements enacted through St. 2024, c. 140, which repealed, as of January 1, 2025, payor surcharges on payments for services rendered by acute hospitals and ambulatory surgical centers. Therefore, the statutory requirement is applicable for assessment years beginning on or after January 1, 2025, and supersedes the collection of such payor surcharges provided, however, that such payor surcharges shall continue to be applicable for all surcharge amounts due for months prior to January 1, 2025.

REGULATORY AUTHORITY

101 CMR 515.00: M.G.L. c. 118E, § 68; Stat. 2024, c. 140.